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Depression Treatment Among Rural Older Adults: Preferences and Factors Influencing Future Service Use

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Abstract

The purpose of this study was to investigate depression treatment preferences and anticipated service use in a sample of adults aged 55 years or older who reside in rural Wyoming. Sixteen participants (mean age = 59) completed 30- to 60-minute, semi-structured interviews. Qualitative methods were used to characterize common themes. Social/provider support and community gatekeepers were perceived by participants as important potential facilitators for seeking depression treatment. In contrast, perceived stigma and the value placed on self-sufficiency emerged as key barriers to seeking treatment for depression in this rural, young-old sample. Participants anticipated presenting for treatment in the primary care sector and preferred a combination of medication and psychotherapy for treatment. Participants were, however, more willing to see mental health professionals if they were first referred by a clergy member or primary care physician.

Keywords

aging; depression; therapies

We are entering a new and more hopeful era in the treatment of depression among older adults. There is a greater recognition of the prevalence of late-life depression, as well as an improved understanding of its impact on quality of life (Ellison, Kyomen, & Harper, 2012). Several efficacious pharmacological and psychological/psychosocial treatments (e.g., Areal et al., 2005; Schulberg, Katon, Simon, & Rush, 1998; Thompson, Coon, Gallagher-Thompson, Sommer, & Koin, 2001) and collaborative care approaches (e.g., Krahn et al., 2006; Unützer et al., 2002) are now available. Because of these advances, many treatment alternatives for patients are offered, which allow for the individualization of patient care (Ellison et al., 2012).

Despite the advancements in the treatment of late-life depression, it is well known that older adults underutilize mental health services despite the need for such services (Unützer, 2007). Both intrinsic and extrinsic barriers to accessing mental health services have been identified among older adults. Intrinsic barriers include internal barriers, such as the attitude among older adults that they are responsible for solving their own problems (Hadas & Midlarsky, 2000; Robb, Chen, & Haley, 2002) and a belief in the normality of late-life depression (Sarkisian, Lee-Henderson, & Mangione, 2003). Extrinsic barriers are those that are in the individual's environment, such as a lack of qualified mental health professionals (Jeste et al., 1999) and financial issues (Robb et al., 2002), which prevent individuals from accessing

services. Recent work by Pepin, Segal, and Coolidge (2009) compared barriers to mental health services among younger (i.e., aged 18–35 years) and older (i.e., aged 61–90 years) adults residing in an urban community. The authors found that younger adults reported experiencing more barriers on a checklist of barriers to mental health services than did older adults (e.g., knowledge and fear of psychotherapy, belief about the inability to find a therapist, insurance and payment concerns, and physician referral). Importantly, stigma was not a significant barrier among younger or older adults in this study. The authors also found that older adults varied, within their own group, in their perception of barriers to mental health services. Specifically, relative to young-old participants (i.e., 60–74 years old), old-old participants (i.e., 75–90 years old) had stronger beliefs that depressive symptoms were normal and had greater transportation concerns. Although these findings are vitally important to understanding barriers encountered by older adults in urban communities, the authors acknowledged that these results may not generalize to older adults residing in more rural areas, where residents may face additional barriers to using mental health services.

The presence of additional barriers has been well documented for individuals residing in rural areas. Residents in rural communities not only encounter shortages in the number of mental health providers (Merwin, Hinton, Dembling, & Stern, 2003) but also have fewer financial resources (McLaughlin & Jensen, 1993) and are less likely to be offered employer-based health insurance than their urban counterparts (Larson & Hill, 2005). Additionally, stigma associated with mental illness has been found to be greater in rural than in urban areas and has also been inversely related to population density, with levels of stigma being higher in smaller communities (Hoyt, Conger, Jill Gaffney, & Weihs, 1997). Because of the tight-knit nature of rural communities, many rural residents are particularly concerned about maintaining anonymity when seeking psychological services (Rost, Smith, & Taylor, 1993), which may reduce the likelihood that they will seek services when needed.

Little is known about the factors that influence mental health service utilization among older adults residing in rural communities. Investigating the barriers to obtaining mental health services for this population is vitally important, as the demographic characteristics of rural communities are shifting, with older adults being more likely to live in rural than metro areas (Ham, Goins, & Brown, 2003). Given the trend that younger individuals are relocating from rural to urban areas (Frey, 2011), it is reasonable to project that the concentration of older adults in rural areas will continue to grow (Dibartolo & McCrone, 2003). The growth in the rural older-adult population can naturally be expected to result in a concomitant increase in the number of rural older adults in need of mental health services.

The expected increase in the number of rural older adults in need of treatment, coupled with the limited health care resources in rural communities, creates a need to understand mental health service use in this rural group of older adults. It is important to examine which factors are likely to influence rural older adults' decisions to seek treatment for depression, as well as what types of treatment for depression and what treatment providers they prefer. Thus, the aim of this study was to qualitatively investigate these questions. Qualitative interviewing was chosen to address the present research question, because this new area of inquiry warrants a method that is designed to provide rich, detailed data about the participants' inner thoughts and beliefs about depression treatment. This approach serves as a starting point in the investigation of depression treatment preferences among those entering older adulthood, particularly those who reside in rural areas that are under served by mental health professionals.

Methods

This qualitative study was conducted through single-session, semi-structured, open-ended interviews. The interview protocol included the following six primary questions, which were derived from existing literature: (1) What do you know about depression?, (2) What do you think the chances are of becoming depressed for someone who is your age?, (3) What should someone do if he or she is depressed?, (4) What do you know about care, or treatment, for depression?, (5) What would influence someone your age to seek help or not to seek help for depression?, (6) What have been your personal experiences with depression? Although the interview protocol served as a guide, it did not dictate the specific course of the interview. Rather, the interviewer crafted questions based upon interviewees' responses (Seidman, 2006). Follow-up questions were asked to explore themes introduced by the interviewees.

A convenience sample of 16 adults from two rural communities was recruited for this study. The sample size, which was predetermined by the authors, was based on empirically derived evidence, suggesting that data saturation is regularly achieved within 6 to 12 individual interviews (Guest, Bruce, & Johnson, 2006). We chose to collect data above this estimate to ensure that all of the relevant thematic information was obtained. Participants were invited to enroll in the study if they were aged 50 or older, resided in a non-metro county (i.e., based on the 2003 Rural-Urban Continuum Codes) with a population of 2,500 to 19,999 and not adjacent to a metro area, and were able to provide informed consent. It has been well documented that the experiences, beliefs, and preferences of this young-old cohort are expected to be unique from previous groups of older adults (Whitbourne & Willis, 2006). Little is known about how the new generation of older adults will interact with the health and mental health care systems concerning the treatment of depression.

Procedure

The present study was approved by the Institutional Review Board at the University of Wyoming. Interviews were conducted in June of 2010 in two rural communities in northwest Wyoming (i.e., populations were approximately 9,000 and 6,000 residents, and both communities are approximately 2 hours from the closest urbanized area). We used chain sampling, a form of purposive sampling, which aims to identify cases of interest from enrolled participants (i.e., individuals who know other people who have the potential to be good interview participants; Patton, 1990). Initial recruitment strategies included advertisement by way of both flyers and media news releases (i.e., newspaper, radio). A toll-free number was provided for individuals to learn more about the study and to be screened for eligibility. If they qualified for the study, participants were scheduled for an interview with a researcher trained in qualitative interviewing. The same researcher (K.K.) conducted all of the interviews. All interviews were recorded using a digital recording device, with participant consent. Each participant was asked to complete a brief demographic questionnaire following the interview. Each interviewee received 20 dollars for his or her participation.

Data Analysis

Descriptive analyses of the sociodemographic data were first conducted. PASW version 18 (PASW, 2009) was used to calculate means, modes, ranges, standard deviations, and percentages of the study sample characteristics.

Given the breadth of data in the present study, we chose to focus on two of the six areas addressed in the semi-structured interviews. Only question number five, which addressed barriers and facilitators to seeking treatment, and question three, which assessed the participants' preferences for the treatment of depression, were analyzed. A grounded theory

approach, as defined by Corbin and Strauss (2008), formed the framework for qualitative analysis. Grounded theory methodology aims to systematically reduce data into codes, which are subsequently formulated into themes (Glaser & Strauss, 1967). The data-coding framework was developed using constant comparison analysis (Glaser, 1978; Glaser & Strauss, 1967). Prior to coding, each audio-recorded, semi-structured interview was transcribed verbatim. Two researchers (K.K., C.M.) were involved in data coding. Analysis began by reading the original data (224 text pages). Coding/analysis occurred over three stages (i.e., open coding, axial coding, selective coding). During the open-coding stage, the team leader (K.K.) developed an initial code list by repeatedly reviewing the data (Leech & Onwuegbuzie, 2007) and identifying all text associated with a particular discussion area (Guest & MacQueen, 2008). During the second stage, axial coding, large identified segments of text underwent in-depth analysis within or across topics. New codes were added, deleted, or refined as needed. A second team member (C.M.) subsequently reviewed the formulated code list and raw data. The team leader finalized the codebook once there was agreement regarding the scope and level of codes. As recommended by Guest and MacQueen (2008), the codebook contained a code name or mnemonic, a brief definition of the code, and a full definition of exclusion criteria to explain how each code differed from the others.

Inter-rater reliability was evaluated to establish rigor in the analysis. Specifically, the two coders independently coded the same selected segments of text (e.g., pages 5 and 10 of an interview transcript). These results were compared to determine how consistent the discovered themes were between coders. A percent-agreement, paper-and-pencil approach, described by Guest and McQueen (2008), was used to evaluate inter-rater reliability. An overall percent agreement of 85% was considered good agreement (Guest & MacQueen, 2008). Once an acceptable level of reliability was established (i.e., the overall percent agreement was 89%; the range of percent agreement for individual codes was 86–100%), inconsistencies were addressed by the team, and revisions were made to the codebook. During the final stage of analysis (i.e., selective coding), coders integrated and refined the emerging themes (Corbin & Strauss, 2008).

As suggested by Kerr, Nixon, and Wild (2010), a combination of documenting the codebook development and creating saturation tables was used to ensure that data saturation was reached. Data saturation, as defined by Bowen (2008), is when new participants are continually brought into the study “...until the data set is complete, as indicated by data replication or redundancy” (p. 140). The development of a codebook allowed for the data to be quantitatively summarized and enabled team-based coding with well-defined rules for the use of each code. Throughout the coding process, each change made to the codebook was documented, which provided evidence of how and when saturation was achieved (Guest, Bruce, & Johnson, 2006). Next, saturation tables were created to further document data saturation (e.g., Brod, Tesler, & Christensen, 2009). Within the table, rows were labeled by code, columns indicated the names of the coders, and each cell contained a marker to indicate the presence or absence of a code. Systematic recording of codes in each successive interview provided documentary evidence that saturation was achieved. Given the homogenous nature of the sample, and the evidence that data saturation is frequently achieved within 6 to 12 individual interviews (Guest, Bruce, & Johnson, 2006), it was anticipated that data saturation would be reached early in the data collection process. The coders found that 100% of the codes were present and that saturation was reached after the fifth interview. Additional interviews were analyzed to confirm that all relevant thematic information was obtained.

Results

Participants

Sixteen participants (i.e., eight men, eight women) aged 56 to 63 years completed interviews lasting between 30 and 60 minutes. A majority of the interviewees were Caucasian, married, and lived in a house with a significant other. One half of the participants reported having lived in their current geographic area for at least 30 years. The education level and employment status of the participants varied, yet most had at least some college education and were employed either full-time or part-time (Table 1).

Factors Influencing the Likelihood of Seeking Depression Treatment

Respondents identified several salient factors that may influence depression treatment-seeking patterns among rural adults in their age group. The three main themes that emerged in the data were community support systems, perceived stigma, and self-sufficiency.

Community support—Participants identified individuals in the community who may be instrumental in helping to recognize depression and encouraging individuals with depression to seek services. Clergy members, in particular, were described as being knowledgeable about local residents and were considered likely to notice when individuals within the community struggle with various issues. Because of the strong connections between clergy and many community members, participants believed that awareness among the clergy of mental health service availability is important.

“Whether we’re agnostics, or atheists, or committed churchgoers...my impression is that most of us probably know a clergyman or talk to somebody who knows a clergyman who can talk with you.” (Interview 14)

“...I know that uh a lot of times people in churches take time to find out what’s going on so that they can be a better help in advising people what to do or to go somewhere...” (Interview 5)

“Some people, if they have a faith, I think that can help you with it considerably. And if you have trust in a pastor you can go to him...her.” (Interview 11)

Stigma—Individuals in this sample indicated that they experience both internal self-stigma and external social stigma about mental health issues. Participants frequently noted that many people within their cohort associate mental health care with a “*sense of failure*” or having a personal “*weakness*.” (Interview 1) One individual, who denied ever being depressed herself, described worrying about an employer’s perception of a depressed employee: “*Are they capable of doing the job? Are they going to have a meltdown? Are they going to not show up because they’re not feeling good? Are they giving 100%, because it’s such an effort to even get to work, let alone do a good job?*” (Interview 9)

A majority of participants indicated that mental health stigma was associated with traditions learned during childhood. Although participants agreed that stigma had decreased from their parents’ generation, they reported that stigma was still incorporated into their views of mental health treatment. One participant, who reported that he currently takes antidepressant medication and believes that medication is a more “*secretive*” means of treating depression than therapy, discussed his thoughts about stigma: “*I think it’s improving, but I think there’s still this little thing that was ingrained way back when. Those things die hard.*” (Interview 12) Similarly, another participant, who experienced symptoms of depression after facing serious health problems and the loss of his career, stated, “*We’re associated enough with the previous generation and their thoughts on it [depression] that we are the in-between generation that realizes that there shouldn’t be the stigma there is, but it’s still lingering in*

the background...My wife grew up with the idea that there's no reason for people to be depressed." (Interview 2)

The relative lack of anonymity in small towns was reported to be a substantial barrier to treatment-seeking behavior among individuals in this sample. One participant described moving back to Wyoming after many years and realizing that "...there are no secrets. It is small. People are...everywhere, and they're paying attention." (Interview 10) Another individual described personally experiencing an inability to anonymously utilize mental health services in a small community when he sought mental health counseling, "It's more difficult in a small town to be private. If your car is parked in front of the doctor's office, they know you went to the doctor...that plays on your mind about who you go see about what." (Interview 13)

Self-sufficiency—Participants reported that the value of independence among rural members of their cohort would likely prevent many from seeking needed help. "People in my age group...the people I interact with are really just pretty self-reliant," stated one participant. (Interview 15) Other participants referred to a sense of self-sufficiency among rural adults. Many witnessed the self-reliance of their parents as they recovered financially from the Great Depression. Others referred to characteristics of rural communities and the value that those who live in rural environments place on independence. This valuing of independence was acknowledged by these participants and endorsed as a factor that affects treatment-seeking beliefs:

"I think there is a sense of self-sufficiency among the Baby Boomers...we saw our parents pull themselves up from the bootstraps coming out of the Depression [Great Depression]...I see a lot of fierce independence in my age group." (Interview 3) *"I think you always see people in smaller towns of Wyoming—they're so independent."* (Interview 16)

"A lot of Wyoming folk are very stoic" and have a "...go-it-alone, survivor kind of attitude that is perhaps more alive here than in other venues." (Interview 10)

"We're kind of Wyoming tough out here...I've seen people that have had cuts practically to the bone, and they wrap it up in a Band-Aid and keep on a going..." (Interview 3)

"I have a tendency to buck up and do it—whatever the heck needs doing! And so if my hand hurts, I quit using my hand that much, but I keep going. And it would be the same way if I felt I was depressed. I still got to go to work every day, still got to get up and meet everybody, got to do the thing." (Interview 13)

Depression Treatment Preferences

Initial course of action—Whereas the majority of participants reported that they thought people should seek professional help at the first sign of clinical depression, others recommended first talking with a family member/close friend or engaging in some other action (e.g., changing one's lifestyle, reading self-help material, praying). Most felt that it would be useful to discuss problems with others who are emotionally close before seeking professional services because these individuals are highly accessible, know them best, and are trustworthy. For instance, one participant spoke very highly of relying on friends for advice and information about available resources in the community for help with depression. This participant, who sought depression treatment herself after a friend informed her about a good local therapist, stated, "...if you have friends that you trust and they can refer you to someone, that's a place to start." (Interview 3) Other participants spoke of different benefits of consulting with friends, family, or other trusted individuals about depression.

“First line should be their family. If they have a good family, the family knows them better than anybody...I actually got friends that grew up here that probably know me better than my family now. So, if you’re getting depressed later on in life, you know, go talk to a friend. As you get into your 50s your families get scattered, but the guy you go down and play golf with or whatever you do, he knows you as good as anyone.” (Interview 4)

“...dialogue with a trusted friend or several trusted friends, pastor, doctor, spouse, or friends outside the family or, you know, anybody that you would trust to give some kind of good advice is a way to go about that...” (Interview 8)

“So, if you’ve got a support network, trusted friend, clergymen, somebody, like I said earlier, you’ve got to have somebody in your corner. It’s hard to fly solo. It really is...I think for people, they have to have a safe place. Because some people you talk to about depression, they don’t get it. They don’t get it, they don’t want to hear about it, and so you’ve got to be with people...you’ve got to have a support group that’s healthy. And by that I mean not people who will pull you down and add to it, but can encourage and support you.” (Interview 3)

Preferred provider—Every participant agreed that professional services may be helpful for some individuals. A family physician or general practitioner was the provider of choice for depression treatment among members of this sample. Interviewees reported feeling trust and comfort with, as well as respect for, their family physician. Although only a few interviewees stated that they would first seek help from a mental health professional, most indicated that they would visit a mental health professional if first referred by their family doctor. One participant, who described depression in his father, but not himself, explained this process by stating, *“You’ve been my family doctor my whole life, or most of my adult life, or all of my kid’s life. That’s the kind of authority I expect to be able to shunt me in the right direction. Now, once they have [referred to a mental health professional] would I go to a community [mental health] center? Sure. I’d go wherever they sent me.” (Interview 13)* Other participants described similar views of their family doctor.

“I think personally I would probably go first to the doctor to see if it was anything that had to do with like a chemical balance, because I am amazed at what they can find out now from just what your body is physically telling you.” (Interview 9)

“I think that most people would rather talk to a doctor [as opposed to a mental health provider]...Most people have confidence in their doctor and listen to what doctors pretty much say.” (Interview 4)

Preferred treatment—Despite the type of clinician sought for depression treatment, most participants preferred to visit a general medical setting. Integrated care, or seeing a mental health professional in a clinic where multiple services are offered, was favorably endorsed by all participants. A combination of medication and psychotherapy was the most preferred treatment. Participants viewed combination treatment as being a more effective option than either medication or therapy alone. They also believed that it was a safer treatment option, as they believed that medication should be closely monitored by a health or mental health care provider. Importantly, participants’ preferences for psychotherapy, medication, or a combination treatment did not affect their preferred treatment setting. A general medical setting was preferred by the majority of participants regardless of treatment preference. One participant, who noted that his wife once sought mental health treatment following a difficult family situation, described a preference for receiving mental health care in a general medical or primary care setting if he were to seek treatment: *“I would trust my doctor to*

pick the right person [mental health professional], and if that's the right person and they're right there [in a medical office], that would be great." (Interview 1)

Discussion

The rural young-old adults in the present study were generally accepting of mental health treatment for depression and stated that they would rely first on trusted community and provider support (e.g., family, friends, clergy, primary care providers) to help them facilitate treatment access if needed. The barriers of stigma and self-reliance, however, appeared to reduce the likelihood that participants would seek mental health services. Themes that emerged in the present study are consistent with literature documenting the barriers and facilitators to seeking mental health treatment among rural individuals (Hoyt et al., 1997; Rost et al., 1993). Likewise, our findings parallel Rural Nursing Theory (Long & Weinert, 1989), a theory developed to address the special health care perceptions and needs of rural populations. Specifically, results of the present study correspond with the theory's assertion that mental health treatment-seeking behavior among rural residents is hindered by concern about the lack of anonymity in rural areas, stigma related to mental health treatment, reluctance to interact with unfamiliar health professionals, and the value placed on self-sufficiency.

Consistent with Rural Nursing Theory and with the literature on mental health service use among older adults, individuals in our study reported greater comfort addressing mental health concerns with familiar and trusted professionals, such as primary care physicians (e.g., Arian, Alvidrez, Barrera, Robinson, & Hicks, 2002; Long & Weinert, 1989). There are problems, however, associated with mental health treatment for older adult populations that are delivered solely by primary care physicians, including a lack of time for treating depression (Koenig, 2007) and the need for a greater emphasis on depression during training (Glasser & Gravdal, 1997).

In addition to being consistent with literature about rural residents and mental health treatment-seeking behavior, treatment preferences for rural, young-old adults, identified in this study, are consistent with existing research on the treatment preferences for depression among older adults in general. Studies that have been conducted to examine what types of depression treatment are most preferable to older adults have shown that psychosocial treatments are more acceptable than pharmacological treatments (Gum et al., 2006; Landreville, Landry, Baillargeon, Guerette, & Matteau, 2001). Work by Hanson and Scogin (2008) revealed that older adults preferred a combination of cognitive therapy and antidepressant medication over either treatment by itself, which parallels the most preferred form of mental health treatment reported by participants in this study.

Although there are similarities to previous older adult cohorts identified in this study, there are also some differences. For example, unlike previous cohorts of older adults, these participants appeared to be more open to mental health services under some conditions, such as being referred by a clergy member or primary care physician. In addition, perceived stigma has not been identified as a barrier to treatment for some populations of older adults (Pepin et al., 2009). However, similar to rural samples, our rural, young-old participants did identify stigma as a barrier to treatment.

Given these findings, several strategies have the potential to address the enduring barriers to mental health care access for older adults in rural communities. These approaches include integrated and collaborative care models, community gatekeeper models, promotion of physical activity, and technology-based mental health outreach efforts.

Collaborative care models (Thielke, Vannoy, & Unützer, 2007), such as the Improving Mood, Promoting Access to Collaborative Treatment (IMPACT) model (Unützer et al., 2002), directly integrate mental health professionals into a primary care practice and may enhance access to mental health treatment in a way that is palatable for rural adults by improving privacy and reducing the perception of stigma. In addition to reducing stigma, collaborative care significantly improves patient satisfaction (Deen, Fortney, & Pyne, 2011). Additional research is, however, needed to determine what factors are associated with the successful implementation of evidence-based collaborative-care models like IMPACT in rural communities or what features require adaptation to effectively serve rural young-old adults.

Although participants in the present study preferred to seek mental health treatment in the primary care sector, each participant described a local clergy member as an individual who could offer support or make a referral to a health care professional. Thus, gatekeeper models that incorporate clergy members may be an effective way to enhance the identification and referral of young-old adults who are struggling with depression and are in need of mental health treatment. With more than 600,000 clergy members in the United States, 365,000 of whom lead congregations (Carroll, 2006; Wind, 2006), clergy members are professionals who are represented over a wide geographic region, including rural areas. Clergy members also have the unique opportunity to notice behavioral changes among community members, especially among older adults (Pickard & Guo, 2008; Weaver, 1995). The importance of clergy members in assisting rural individuals, which was highlighted in every interview in the present study, parallels previous work showing that older adults, in particular, seek help for mental health issues from clergy members more frequently than from formal mental health/health care professionals (Hohmann & Larson, 1993; Pickard & Tang, 2009). Given this finding, it is important to note that the clergy may be inadequately trained to recognize and respond to mental illness, including depression (Kramer et al., 2007; Moran et al., 2005; Weaver, 1995). Clergy members' referral practices, knowledge, and attitudes about depression may also differ across religious affiliations (Spangler, 2001) and levels of education (Langston, Privette, & Vodanovich, 1994). Little is known, however, about depression knowledge among clergy members, the referral practices of this group, or the extent to which training programs designed for clergy improve their knowledge, alter their attitudes, or enhance their referral practices.

Because of values of self-sufficiency reported by the rural young-old participants in this study, evidence-based treatment approaches and novel referral strategies may not result in increased service use when it is needed. Other strategies, such as promoting physical activity and exercise programs is a potential avenue by which to address depressive symptoms while still honoring the need for self-sufficiency. Exercise has the potential to be an effective treatment or treatment adjunct for late-life depression (e.g., Blake, Mo, Malik, & Thomas, 2009; Sjosten & Kivela, 2006). Even for older adults with fragility or health issues, low-intensity exercises can be pursued and may help build strength and improve self-efficacy (Unützer & Park, 2012). Other specific forms of exercise, such as yoga, may also improve depressive symptomology for young-old adults (Patel, Newstead, & Ferrer, 2012).

Although participants in our study were not questioned about their perceptions of telemental health, technology-based mental health outreach efforts (e.g., telepsychology/psychiatry, telemental health) may be a way to reduce the mental health provider burden, supplement existing services, and circumvent stigma associated with seeking face-to-face help in rural communities. There is support for the efficacy of telemental health in producing reliable clinical assessment results (Cullum, Weiner, Gehrman, & Hynan, 2006; Elford et al., 2000; Hyler, Gangure, & Batchelder, 2005), reducing depressive symptoms (Clarke et al., 2002; Emmelkamp, 2005), and retaining benefits beyond treatment closure (Mackinnon, Griffiths,

& Christensen, 2008). There is insufficient evidence, however, as to whether telemental health services are acceptable and effective for rural older adults (Egede et al., 2009). Future studies should investigate acceptability and palatability of telemental health among the rapidly increasing population of rural young-old adults, in particular.

Regardless of strategies adopted to enhance the use of services, a new approach to marketing psychotherapy may be needed to reach and appeal to the rural population of young-old adults. According to the Healthy People 2010, the promotion of mental health in rural areas is a high priority of rural health leaders (Gamm, Hutchison, Bellamy, & Dabney, 2002). Some work suggests that health promotion efforts directed at middle-aged and older adults should emphasize prevention (Pettigrew & Donovan, 2010), civic engagement (Tan et al., 2010), and peer support programs (Chapin et al., 2012). Relabeling psychotherapy and mental health treatment as wellness “groups” or “classes” may also be more appealing to older members of rural communities.

Limitations

The present findings should be considered within the context of the study’s limitations. Although the participants in this study were racially representative of Wyoming rural communities, rates of college education were higher than is typical of rural adults within this age group (U.S. Census Bureau, 2012). A higher percentage of our participants were also married, as compared with adults aged 60 years and older in the general Wyoming population (State of Wyoming Department of Health, 2008). The method of sampling used by the authors in this study (i.e., purposive chain sampling) also may have resulted in a group of participants who were more open to discussing depression than are members of the general population. Despite these limitations, this is one of the first studies, to our knowledge, that was designed to qualitatively explore depression treatment preferences and factors influencing anticipated mental health service use among a sample of young-old adults residing in a rural setting. Future work may examine similarities and differences in treatment barriers and preferences among young-old and old-old adults who reside in both rural and urban settings to tease apart factors associated with age and those associated with rural living.

The results of the present study suggest that there are aspects of current mental health treatment delivery strategies that may warrant additional research and current delivery strategies may require some changes to better serve the needs of this rural, aging population. Findings also support the need to address both intrinsic and extrinsic barriers that prevent rural young-old adults from seeking treatment for depression. Preferences for depression treatments and service settings should be integrated into future health care initiatives and interventions for this cohort of rural young-old adults.

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Table 1Characteristics of the Study Sample ($n = 16$)

Characteristic	<i>n</i> (%)
Age (mean, 59.19 ± 2.59 ; range, 56–63)	
60 years old	7 (44)
Sex (male)	8 (50)
Ethnicity	
White	15 (94)
Hispanic	1 (6)
Marital status	
Married	14 (88)
Divorced	1 (6)
Widowed	1 (6)
Living arrangement	
In a house with significant other	14 (88)
Alone in house	1 (6)
Alone in apartment	1 (6)
Children	15 (94)
Highest education level	
High school	2 (13)
Some college	3 (19)
Associate degree	1 (6)
Bachelor's degree	5 (31)
Graduate degree	5 (31)
Employment status	
Unemployed or disabled	2 (13)
Retired	2 (13)
Employed part-time	5 (31)
Employed full-time	7 (44)
Household income	
\$10,000–\$24,999	2 (13)
\$25,000–\$49,999	3 (19)
\$50,000–\$99,999	9 (56)
\$100,000–\$249,999	1 (6)
\$250,000	1 (6)
Duration living in current geographic location	
>50 years	4 (25)
30–50 years	4 (25)
10–29 years	6 (38)
1–9 years;	1 (6)
<1 year	1 (6)