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Shared Conceptualizations and Divergent Experiences of Counseling Among African American and White Older Adults

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Abstract

Research findings suggest that older adults prefer counseling for depression treatment; however, few older adults use counseling services. In this article we present the results of our analysis of semistructured interviews with 102 older adults to explore conceptualizations of counseling and impediments to use among African American and White older adults. We found that older adults believe counseling is beneficial; however, use was hindered in multiple ways. Older adults were skeptical about establishing a caring relationship with a professional. African American older adults did not mention social relationships to facilitate depression care, whereas White older adults described using personal relationships to navigate counseling services. African American older men were least familiar with counseling. Our findings suggest that African American and White older adults share a strong cultural model of counseling as beneficial; however, significant impediments exist and affect older adults differentially based on ethnicity.

Keywords

aging; depression; health care disparities; older people; research; qualitative

Depression is a common problem among older adults, limiting their function, decreasing their quality of life, and increasing their risk of mortality. It affects about 5% to 10% of older adults (Blazer, Landerman, Hays, Simonsick, & Saunders, 1998; Gallo & Lebowitz, 1999). Clinically significant depressive symptoms that do not meet the criteria for a major depressive disorder are equally important, and more prevalent among older adults, with rates of up to 15% to 20% (Beekman et al., 1995). Persons with depressive symptoms who do not meet the criteria for major depression are five times more likely to progress to meet criteria for major depression, and to have adverse functional, cognitive, and physical outcomes (Gallo, Rabins, Lyketsos, Tien, & Anthony, 1997; Lyness, 2008). Despite the burden of depression among older adults, the unmet need for mental health services in this group is great (Wang et al., 2005). Older adults commonly turn to their primary care physicians for

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depression care rather than mental health care specialists such as psychiatrists or psychologists (Bogner, de Vries, Maulik, & Unutzer, 2009); however, because of various factors they are often under-diagnosed and undertreated in this setting (U.S. Department of Health and Human Services, 1999). Despite comparable prevalence rates of major depression and depressive symptoms that can be effectively treated with medications and psychotherapies, minority older adults such as African Americans are less likely than White older adults to use mental health services and to be accurately diagnosed and adequately treated in primary care (Blazer et al.; Gallo, Cooper-Patrick, & Lesikar, 1998; Gonzalez et al., 2010).

Given a choice, older adults consistently state that they prefer psychological treatments compared to medications (Cooper-Patrick et al., 1997; Givens et al., 2006), but use of counseling remains low among depressed older adults despite its acknowledged efficacy. Even when offered in a setting where cost for service is low or eliminated and the location is convenient, only a small number of White older adults and an even smaller number of African American older adults take up counseling (Joo, Morales, de Vries, & Gallo, 2010; Unutzer et al., 2003; Wittink, Joo, Lewis, & Barg, 2009). Furthermore, African American patients attend fewer sessions and terminate treatment earlier than White patients (Richardson, Anderson, Flaherty, & Bell, 2003). When explaining rates of low use, access issues such as convenience and high cost are commonly cited for all older adults (Simon, Grothaus, Durham, VonKorff, & Pabiniak, 1996; Wei, Sambamoorthi, Olfson, Walkup, & Crystal, 2005). African Americans, as a minority group, face additional challenges related to stigma, differences in presentation of depression, perceptions of racism or discrimination, mistrust of medical providers and the mental health system, lack of knowledge of available mental health services, impersonal service, and lack of cultural sensitivity by counselors (Thompson, Bazile, & Akbar, 2004; Unutzer et al., 2001; U.S. Department of Health and Human Services, 2003; Ward, Clark, & Heidrich, 2009). Although researchers often focus on structural barriers of access to mental health services, attitudes and perceptions have been posited to be more influential in explaining low use of mental health treatments (Saunders, 1996; Weinberger, Mateo, & Sirey, 2009).

Provision of mental health services for older adults represents a conundrum: older adults often do not receive or accept the treatment they say they prefer. In this article, we examine the meanings behind “counseling” and “psychotherapy” to uncover the source of the paradox. What is it that older adults want when they express a preference for counseling, and what might lead to low use? We describe perceptions and experiences of counseling among White and African American older adults with the aim of exploring factors that might affect counseling use. We compare these two groups of older adults, reasoning that although the effects of ethnicity and socioeconomic class are difficult to disentangle, ethnicity has been shown to independently affect various health measures, including mental health service use (Farmer & Ferraro, 2005; Gornick et al., 1996). Furthermore, much of the literature on mental health service use focuses on summary measures of service access, but does not approach the topic from the perspective of the older adult, even though perceptions of older adults could be a stronger motivating force than external factors (Saunders, 1996). Our goal is to shed light on the reasons for the low use of psychological treatments so that effective and acceptable interventions can be developed for depressed older adults.

Theoretical Framework

We draw on the cultural models theory to inform our analysis and interpretation. The cultural models theory explains how people know what they know. Specifically, a cultural model is cognitive in nature and is constituted of schemas which are learned, internalized patterns of thought–feeling that mediate the interpretation of ongoing experience, past memories, and expectations about the future (D’Andrade & Strauss, 1992). The schemas are derived from concrete associations that individuals experience in life that are both personal and extrapersonal, or social; for instance, messages from the media, implicit and explicit social messages, as well as discrete personal experiences (D’Andrade & Strauss). Cultural models are influenced by personal relationships, which can affect what information is exchanged, between whom, and to what extent, and can also affect how something is interpreted. For instance, the perception of whether a psychological treatment is more or less effective is based to a degree on the individual’s interpersonal milieu (Blake et al., 2002).

Cultural models about illness often are a subset of more general cultural models about ways to function as a bona fide member of a group (D’Andrade & Strauss, 1992). For instance, subgroups based on gender, region, ethnicity, or historical experience might have the same or similar cultural model based on shared experience. At the same time that cultural models are shared, centripetal forces, such as class, ethnic identity, and noninteraction across group settings exist that cause cultural models to diverge (Strauss & Quinn, 1997). Finally, cultural models can have motivational force, because they label and describe the world and also set forth goals and include desires; however, cultural knowledge does not serve as a fixed script that dictates behavior, but rather guides behavior, which responds to context and practical exigencies (D’Andrade & Strauss). Cultural models have been used to understand help-seeking behavior for health conditions such as diabetes (Chowdhury, Helman, & Greenhal, 2000), AIDS (Baer et al., 1999), and breast cancer (Coreil, Wilke, & Pintado, 2004).

Methods

Data for this article come from the Spectrum study, in which our goal was to characterize the range of depression in older primary care patients. The study included two phases. The quantitative phase, Spectrum I, was designed to describe depression in late life that might not meet standard criteria for major depression by using standard survey measures (Barg et al., 2006; Gallo et al., 2005). In Spectrum I, we recruited patients aged 65 and older from primary care practices in Baltimore, Maryland. The sample is described in detail in Bogner et al. (2005). Participants were screened for depression in their primary care doctors’ offices (2,560 older adults were screened; 773 were asked to participate; 355 agreed to participate and completed a baseline in-home assessment). Standard scripted interviews were used to assess depression, anxiety, hopelessness, daily functioning, cognition, medical conditions, religiosity, and personality.

The qualitative phase, Spectrum II, was designed to give participants an opportunity to express their views about depression and to integrate participants’ views within the structured responses given in Spectrum I. Participants for Spectrum II were identified from the pool of older adults who participated in Spectrum I and who agreed to be contacted and

interviewed again. The purposive sampling strategy is described in detail in Barg et al. (2006). In brief, we selected at random an initial subsample of participants and formed ideas for selection criteria for the subsequent subsamples. Subsequent subsamples included persons with a family history of depression, persons for whom there was discordance between the level of depressive symptoms and the doctor's opinion about whether the person was depressed, men with relatively good physical functioning, and the oldest participants in Spectrum I. We also sampled to achieve an equal number of African American and White participants. Permission to recontact and reinterview Spectrum I participants was granted, and the study was approved by the University of Pennsylvania Institutional Review Board. A Certificate of Confidentiality was obtained from the Department of Health and Human Services as an additional confidentiality safeguard. In all, 102 persons from the Spectrum I study participated in individual, semistructured interviews in Spectrum II.

Interview Procedures

Spectrum II consisted of semistructured interviews.¹ The older adults ($N = 102$) were interviewed by professional interviewers who were trained and supervised by two of the project coinvestigators (Wittink and Barg). Interviews began with vignettes designed to elicit older adults' views on depression without using the word *depression* (for example, in one vignette, *depression* is expressed in other words, such as "the blues" or "being down"). Then respondents were asked a series of open-ended questions, including questions about what causes depression, what depression is like, and what to do about depression. Respondents were also asked a series of open-ended questions about counseling, including: Some people find that talking things over helps when they are depressed. Is this something you would consider? What do you think about getting counseling or therapy? What kind of person would make a good counselor? Is it hard to get counseling? Interviewers were trained to probe related topics raised by respondents. All interviews were conducted in the respondents' homes by one of four professional interviewers. Interviews were recorded, transcribed, and entered into QSR-N6 for coding and analysis (Chih, 2008).

Analytic Strategy

We used the constant comparative method, moving iteratively between codes and text to derive themes related to talking, counseling, and psychotherapy (Glaser & Strauss, 1967). Originally developed for use in the grounded theory methodology of Glaser and Strauss, the constant comparative method is a discovery-oriented method that brings out the underlying uniformities and diversities in the data, which facilitates identification of the dimensions of particular categories. Initial coding and theme generation were carried out by the first author (Joo) through immersion in the data and multiple close readings. The third author (Dahlberg) independently analyzed the data and derived themes, which were discussed with the first author. Any disagreement of themes was discussed until consensus was reached. For this article, we began with the aim of trying to understand respondents' conceptualizations of counseling that might shed light on low counseling use. We categorized the transcripts according to ethnicity to compare the responses given by African American and White

¹The interview guide is available on request.

respondents. We focused on specific questions related to counseling and psychotherapy, as noted above. We also focused on sections of the transcripts in which respondents mentioned counseling or psychotherapy spontaneously, without being specifically asked.

Results

The mean age of the 102 participants was 78 years. Seventy-five (74%) of the participants were women. Forty-seven (46%) of the participants self-identified as African American, and 55 (54%) self-identified as White. Thirty-eight (70%) of the White participants and 37 (79%) of the African American participants were women.

In the interview, respondents were asked about “talking things over,” “counseling,” and “therapy,” and whether they thought any of those activities were helpful when coping with depression. When answering questions respondents used the terms for counseling in their own ways. The majority of respondents used the terms *talking* and *counseling*, and fewer respondents used the term *psychotherapy*. Respondents used those terms to express different types of talking. For instance, some respondents conceptualized therapy as a strictly professional activity, whereas counseling and talking were seen as activities that could be performed by both professionals and nonprofessionals alike. In this article we use the term *counseling* to include counseling, pastoral counseling, and psychotherapy.

“It’s a Good Idea to Have Counseling and Talking”

The majority of respondents, regardless of ethnicity (African American men, $n = 7$, 70%; African American women, $n = 25$, 68%; White men, $n = 11$, 65%; and White women, $n = 24$, 63%), stated that counseling is a good method of managing depression and depressive symptoms. The word *good*, suggesting a simple and fundamental belief in the value of talking, was used often by respondents to describe counseling. One African American man said, “Yeah, I think that’s good, to go to counseling.” An African American woman said, “I think it’s a good idea to have counseling and talking, talking and to talk about it.” A White woman said, “I believe the best way to treat depression is to have counseling [in addition to other things].”

The pervasive perception that counseling is good was based on the perceived benefits of talking. Talking was commonly conceptualized as a method of self-expression, a way to “get it out of your system.” Through talking, negative emotions and thoughts that cause stress are expelled. Respondents also spoke about how counseling worked as a way to obtain solutions to problems, getting “a different slant on things,” and “help[ing] you think the problem through.” One White woman said, “Yeah, I think it’s good, very good. Talk about things and let it out. Don’t hold them in, let it all out and then you feel better, or they can help you [with] what’s bothering you.” Even among those who believed in the value of counseling however, willingness to actually use counseling was variable, regardless of the ethnicity of the respondent. One said, “I’ll go for that”; another said he might recommend it to someone else because “some people need counseling and everything,” but would not consider it for himself. One White woman said, “I don’t know if it would help me, but I know some people it does help.” Some respondents said that counseling would be suitable only if their depression became severe and coping alone was not possible. An African American man

said, “I, if I got, well, I hope I don’t, but if I got to the point where I couldn’t control it or couldn’t help myself, I would seek counseling.” A White man said, “Well, I think sometimes you have to get to a point where you need outside help.”

Professionals Are Too “Straight”

Both African American and White older adults expressed a common reluctance to talk to a professional about personal and emotional matters. Most respondents conceptualized counselors as “someone very caring, empathetic, good listener, warm”; however, most respondents expressed fears of rejection and concern about not being received sympathetically by them. Pejorative terms such as “strangers” and “them people”—suggesting people who are distant, unsympathetic, and untrustworthy—were used to describe professionals. One African American woman complained that professionals were too “straight,” impersonal, and formal. She described her experience with professionals as cold and distant, whereas what she wanted was a counselor who was emotionally responsive and caring:

In the first place, a good counselor would be a good listener and have a sort of a joyful ... they would spread a little joy or something, you know, instead of being so professionally straight, you know? If they would tell you little things to do, that would cheer you up instead of being professional.

Older adults emphasized the value of an empathic relationship rather than a therapeutic one, and seemed to value nonprofessional types of relationships for talking. One White woman suggested that “semiprofessional” people who work in aging agencies might be easier to talk to, and might be more trustworthy and caring. In addition, the semiprofessional could enable a depressed person to find new relationships:

Let’s say a semiprofessional. I’m not talking about [a] psychiatrist or psychologist. I’m just talking about someone who, like in the office of aging, where they’re used to dealing with older people, and they’re lovely people up there. I think they would do everything they could to draw her out, maybe even kind of tie her up with another person, another woman.

Differences in Familiarity With Counseling

Most respondents had a general familiarity with counseling as a depression treatment. Many of the White men in the study were experienced with counseling and spoke about it in detail. Apart from doctors, who could provide referrals, older White men were aware of different mental health professionals and agencies that provided talking services such a psychologist, psychiatrist, churches (clergy, and so forth), senior centers, and aging organizations. A White man said he would seek a “friendly psychiatrist,” but also was aware of the existence of other counseling providers:

A friendly psychiatrist probably, if you were involved with him before, someone who knew your problems... . A doctor can, should be able to help you You’ll find that in some cases the churches are, have counseling services. In some cases, other social, I can’t, I’m not so sure if there is someone at the adult centers in [name of state].

The White men also discussed issues related to where counseling was available and how it could be afforded, its drawbacks and benefits, as well as how counseling worked. One White man who had had experience with counseling described his conceptualization of how counseling worked:

Well, from my experience with it, I think it was very good. I think it was very, very helpful. And then I realized that those kinds of people don't have to know everything. All you do is just talk and ... a lot of the answers come to yourself. I'll look at, I used to look at him and I'd smile. He'd say, "Ah, you got an answer, huh?" ... and he would say, "Sounds like, sounds good to me."

Based on their personal experiences of counseling, White men suggested that a person should choose a counselor carefully, because professional counselors vary in quality. One White man described his experience with various psychiatrists whom he had seen for counseling;

So, I've been to, actually I've been to a lot of psychiatrists, and Dr. [Name] was, who I went to initially, was outstanding. And then, of course, there were a lot of psychiatrists that aren't real good. In fact, some don't, and they do make you feel worse, so you need a good medical professional psychiatrist that will help.

Compared to White older adults and African American women in our study, African American men possessed the least familiarity with counseling. Many African American men spoke in general terms about the role of counselors as being that of "a nice person" who knew "how to talk to a person." They lacked familiarity with the process of obtaining counseling or how it worked. When asked where they would seek counseling, many African American men mentioned that a person should go to a doctor or a minister in general terms, without mentioning the processes involved in accessing it. One African American man was obviously not familiar with the role of the psychiatrist, and primarily relied on his doctor to refer him, as needed, to a mental health professional:

What you call them, a psychiatrist or, and it's a person you go talk to, isn't it, a psychiatrist? Right, uh-huh. I'd get to my doctors to make an appointment for me, and explain to him that I'm just not feeling up to par, and she would recommend me to a psychiatrist so I can talk to him. Maybe he can help me with whatever is bothering me.

The majority of White and African American women were less familiar with counseling than the White men in our sample, who had more direct experience with counseling and therefore spoke more explicitly about those experiences; however, both African American and White women had a general familiarity greater than African American men. Women mentioned the high cost of counseling, the various professionals who provide it, and the need to choose carefully:

So, it's not that easy, and it can be expensive because you've got to have health care that will take care of it unless you are a state dependent, and social services probably will do it. I was lucky enough to have both.

So you end up going to a, sometimes a psychiatric social worker or a psychologist. Sometimes insurance will take care of it, sometimes it won't. Everybody that's

depressed doesn't have to be psychoanalyzed by a psychiatrist, you know? Sometimes they just need to be in a group or have a social worker know how to direct the conversation and talk, and find out what's going on.

The Role of Personal Relationships

The social environment was often mentioned by White respondents as a source of referral, help, and opinions about the effectiveness of counseling, more so than by African American respondents. Many of the White respondents mentioned asking friends or family members for advice regarding where to seek help, suggesting that depression treatments were talked about within the social network. One White man said, "I would probably ask friends, people that I knew that maybe had done it, you know, and ask them where they went and what they did, did they feel it was good." Some White respondents mentioned being involved in activities that would give them greater access to information and resources regarding counseling. One White man who appeared to be involved in the administration of an aging organization said, "Maybe they've asked me a couple times to be a counselor up at the center, senior center, but I'm a member of the ... County Department of Aging. I attend all their meetings." Other White respondents had personal relationships that connected them to the medical and mental health system, making navigation less impersonal and perhaps less intimidating. When asked where she might go for counseling, one White woman said that she would trust a family member in the health care field to give her information about whom she could seek care from: "We have a lovely hospital here ... and they have an outpatient building, and my daughter-in-law is in charge of the Radiology Department there, so she knows all the doctors and I take her word for it."

White respondents described ways in which personal relationships facilitated actual treatment. One White woman described how she identified and referred a friend who was depressed to a psychiatrist who was "a mutual friend" and in the same social circle:

Well my friend [name] was depressed. He had lost his wife maybe five or six years before I started going out with him, and he complained of this depression... I think he missed that life partner. He was emotionally depressed and he needed some counseling, I guess, somebody to talk to figure it out and find out what he could do for himself to keep from being depressed... I finally was able to help him without being too pushy and too bossy to get him to see a mutual friend of ours who had her own in-house service.

White respondents suggested that personally knowing someone who was a mental health provider might influence their perceptions and possibly their behavior. One White man suggested that his negative perception of counseling was kept in check by his daughter's belief in the value of counseling as beneficial:

Well, I'm not much into counseling so, my wife's, my oldest girl is a counselor. She's enthusiastic about it, so I'm very hesitant about saying anything negative about going to counseling. My daughter would say that would be the first thing that she would recommend.

African American older adults' responses were conspicuous for the absence of references to the exchange of information or discussion about resources with other people in their social network about depression care. They most often mentioned relying on their primary care physician for referral, or simply stated that they did not know of people in their social circle who were depressed and receiving treatment:

I don't know. I can't say. I never dealt with anyone to my knowledge that was depressed and for a period of time, you know, in order to find out how they act before and after ... the time they are depressed, so I can't say.

Discussion

Our study findings suggest that among both African American and White older adults, a strong cultural model of counseling as beneficial exists; however, impediments to use are significant and affect older adults differently depending on ethnicity. Older adults in our study valued caring and trusting relationships, and they were skeptical that professional counselors could be counted on to provide such a caring relationship. Also, White older adults mentioned a wide array of social relationships which were used to navigate and access depression care, whereas African American older adults mentioned few social references, if any, through which information and resources about counseling could be obtained. Finally, African American men as a subgroup were relatively less familiar with counseling services than White older adults or African American women. The findings suggest that White and African American older adults share cultural models that might dispose them to seek care; however, the social context of White and African American older adults with regard to seeking depression treatments is quite different. Being in a social environment that facilitates pathways to care might be an important determining factor for treatment access, and might help explain ethnic differences in the use of counseling services.

Before discussing the clinical implications of our findings, we need to consider potential limitations. First, African American respondents, particularly African American men, might have felt a greater degree of stigma and might have concealed information regarding previous experiences with counseling or mentioned fewer personal references far more than White respondents. To mitigate this, the interviews were carried out in the respondents' homes, and interviewers were trained to relate to the respondent in a trusting and culturally appropriate manner. Second, the degree to which the ethnic differences found in this study were because of ethnic or socioeconomic differences cannot be disentangled; however, ethnicity has been shown to be independently associated with mental health service use (Gornick et al., 1996; Greenberg, Brandon, Schoeps, Tingle, & Shull, 2003; Virnig et al., 2004). Third, the sample of African American men was smaller compared to either White men or White and African American women, which might have led to low saturation and thus less variety in themes. Despite this limitation, our findings suggest that there could be an important difference in the way that some older African American men conceptualize and experience counseling. Fourth, we did not have information regarding previous experiences of counseling, which could have affected older adults' attitudes about counseling as beneficial. Finally, although we found differences in how African American and White older adults use social relationships to access counseling services specifically, African American

older adults might use social relationships in different ways not explored in this study to manage depressive symptoms.

Our results suggest that older African American and White respondents share the belief that talking is good and that counseling is as effective a way of managing depressive symptoms. Other studies have found that people believe that talking about depression and receiving counseling are good coping strategies (Angermeyer, Matschinger, & Riedel-Heller, 1999). Among various ethnic groups of older adults in Great Britain, counseling was found to be valued as a good method of dealing with depressive symptoms (Lawrence et al., 2006). The cultural model in which counseling is highly valued appears to be pervasive and to transcend ethnic and gender boundaries. At the same time, related cultural models of counseling that could hinder an individual from seeking counseling coexist with cultural models of counseling as beneficial. For instance, respondents in our study viewed professionals as “strangers,” and feared lack of sympathy when talking with professionals. Older adults focused on the need for a sympathetic and caring relationship rather than the formal therapeutic aspects of the counseling relationship, and seemed to prefer nonprofessional relationships for this reason.

Older adults have been shown to hold negative opinions of mental health professionals and to prefer nonspecialty mental health physicians for emotional problems (Thompson & Scott, 1991; Waxman, Carner, & Klein, 1984). African Americans’ distrust of mental health professionals and psychotherapists based on cultural and ethnic differences have been well documented (Cooper-Patrick et al., 1997; Thompson et al., 2004). Our findings suggest that the added impact of the wariness of receiving services from professionals that exists among older adults might add to the distrust based on cultural differences among African American older adults. African American and White older adults constitute a cohort who share a similar history based on age, and thus might have similar views of depression and its management (Currin, Schneider, Hayslip, & Kookan, 1998); however, African American older adults as a group have had divergent historical experiences, which could have influenced the development of distinct cultural models regarding depression and counseling.

Our study findings suggest that the social context of seeking care for depression might be different for sub-groups, namely African American older adults, and African American men in particular. White older adults appear to talk about depression treatments socially, leading to a greater exchange of information regarding resources for how counseling can be accessed. White older adults also seem to have a greater connection to the formal mental health system through personal relationships and family ties, which facilitates access and alleviates the difficulty of navigating an impersonal and complicated mental health system. Additionally, referral of services through personal contacts seems to alleviate the level of distrust of professionals, and facilitates receipt of actual treatment.

African American older adults appear to be part of a social network of relationships in which depression treatments are not talked about, and the various social connections that might exist for White older adults to get information or referrals, or exchange opinions about depression care, do not seem to exist for African American older adults. This difference between African American and White older adults is likely attributable to differences in

socio-economic status as well as racial discrimination in terms of restricted access to professional education for African Americans (Smedley, Stith, & Nelson, 2003). It could also be that social relationships that matter for African American older adults regarding how depression is treated might be located in the religious community, where coping methods such as prayer or church attendance are used, rather than professional counseling, to “treat” depression (Holt & McClure, 2006; Ornelas et al., 2009; Wittink et al., 2009). Even in this case, however, professional mental health treatment continues to be relevant, as African Americans who seek help for emotional problems tend to turn to both formal and informal sectors for help (Neighbors & Jackson, 1984).

Our study findings suggest that the intersection of gender and ethnicity might put African American older men at greater risk of not receiving counseling for depression because of lack of familiarity regarding what counseling is, who provides it, and how to obtain it. Lack of familiarity with counseling might be associated with the lack of personal experience of depression treatment among African American men, but could also be influenced by the interpersonal milieu and the larger community in which they live. Traditional masculine values and gender role socialization have been shown to conflict with cultural meanings associated with depression, and can hinder men from seeking help for mental health problems such as depression (Addis & Mahalik, 2003; Hinton, Zweifach, Oishi, Tang, & Unutzer, 2006). Ethnic minority older men are at particularly high risk of not receiving depression care (Husaini et al., 2002; Unutzer et al., 2003), and African American men are less likely to use professional services than African American women (Neighbors & Howard, 1987). Educational interventions as well as training of mental health care professionals to identify depression among men from minority groups are needed to increase diagnosis and treatment.

Conclusion

Older adults are an underserved population in terms of mental health. Given the strength of the value placed on counseling among African American and White older adults, adaptation of current counseling interventions to diminish conceptual, cultural, and social barriers have the potential to increase use of depression care services. For instance, older adults’ reluctance to speak with professionals and their desire for caring relationships might be overcome by use of paraprofessionals to provide social support, as an adjunct to mental health professionals who are focused on the formal therapeutic relationship. Reframing counseling as a kind of education, consultation, or coaching (Komiya, Good, & Sherrod, 2000) could address older adults’ negative perceptions of professional counseling and increase engagement. Rather than a limited focus on the individual older adult, considerations of the social context could be integrated into depression interventions. Finally, particular subgroups such as older African American men who are less familiar with psychological treatments require greater attention and accommodation when counseling interventions are developed.

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