



University of Kentucky
UKnowledge

Behavioral Science Faculty Publications

Behavioral Science

2017

Mental Health Treatment Seeking Patterns and Preferences of Appalachian Women with Depression

Claire Snell-Rood

University of Kentucky, snell-rood@uky.edu

Emily Hauenstein

University of Delaware

Carl G. Leukefeld

University of Kentucky, cleukef@uky.edu

Frances Feltner

Center of Excellence in Rural Health

Amber Marcum

University of Kentucky, amber.marcum@uky.edu

See next page for additional authors

Follow this and additional works at: https://uknowledge.uky.edu/behavsci_facpub



Part of the [Behavior and Behavior Mechanisms Commons](#), [Mental and Social Health Commons](#), [Rural Sociology Commons](#), and the [Women's Studies Commons](#)

Repository Citation

Snell-Rood, Claire; Hauenstein, Emily; Leukefeld, Carl G.; Feltner, Frances; Marcum, Amber; and Schoenberg, Nancy E., "Mental Health Treatment Seeking Patterns and Preferences of Appalachian Women with Depression" (2017). *Behavioral Science Faculty Publications*. 35.

https://uknowledge.uky.edu/behavsci_facpub/35

This Article is brought to you for free and open access by the Behavioral Science at UKnowledge. It has been accepted for inclusion in Behavioral Science Faculty Publications by an authorized administrator of UKnowledge. For more information, please contact UKnowledge@lsv.uky.edu.

Authors

Claire Snell-Rood, Emily Hauenstein, Carl G. Leukefeld, Frances Feltner, Amber Marcum, and Nancy E. Schoenberg

Mental Health Treatment Seeking Patterns and Preferences of Appalachian Women with Depression**Notes/Citation Information**

Published in *American Journal of Orthopsychiatry*, v. 87, no. 3, p. 233-241.

© American Psychological Association, 2017. This paper is not the copy of record and may not exactly replicate the authoritative document published in the APA journal. Please do not copy or cite without author's permission. The final article is available, upon publication, at: <https://doi.org/10.1037/ort0000193>

The copyright holder has granted the permission for posting the article here.

The document available for download is the authors' post-peer-review final draft of the article.

Digital Object Identifier (DOI)

<https://doi.org/10.1037/ort0000193>



HHS Public Access

Author manuscript

Am J Orthopsychiatry. Author manuscript; available in PMC 2018 January 01.

Published in final edited form as:

Am J Orthopsychiatry. 2017 ; 87(3): 233–241. doi:10.1037/ort0000193.

Mental Health Treatment Seeking Patterns and Preferences of Appalachian Women with Depression

Claire Snell-Rood, PhD,

Department of Behavioral Science, University of Kentucky College of Medicine, 141 Medical Behavioral Science Building, Lexington, KY 40536-0086, 859-257-4547

Emily Hauenstein, PhD, LCP, RN, FAAN,

School of Nursing, University of Delaware, 343A McDowell Hall, Newark, DE 19716, 302-831-8602

Carl Leukefeld, DSW,

Department of Behavioral Science, University of Kentucky College of Medicine, 111 Medical Behavioral Science Building, Lexington, KY 40536-0086, 859-323-5308

Frances Feltner, PhD,

Center of Excellence in Rural Health, 750 Morton Blvd, Hazard, KY 41701, 606-439-3557

Amber Marcum, BA, and

Department of Psychology, University of Kentucky, 106b Kastle Hall, Lexington KY 40506-0044

Nancy Schoenberg, PhD

Department of Behavioral Science, University of Kentucky College of Medicine, 125 Medical Behavioral Science Building, Lexington, KY 40536-0086, 859-323-8175

Abstract

This qualitative study explored social-cultural factors that shape treatment seeking behaviors among depressed rural, low-income women in Appalachia—a region with high rates of depression and a shortage of mental health services. Recent research shows that increasingly rural women are receiving some form of treatment and identifying their symptoms as depression. Using purposive sampling, investigators recruited 28 depressed low-income women living in Appalachian Kentucky and conducted semi-structured interviews on participants' perceptions of depression and treatment seeking. Even in this sample of women with diverse treatment behaviors (half reported current treatment), participants expressed ambivalence about treatment and its potential to promote recovery. Participants stressed that poor treatment quality—not merely access—limited their engagement in treatment and at times reinforced their depression. While women acknowledged the stigma of depression, they indicated that their resistance to seek help for their depression was influenced by the expectation of women's self-reliance in the rural setting and the gendered taboo against negative thinking. Ambivalence and stigma led women to try to cope independently, resulting in further isolation. This study's findings reiterate the need for improved quality and increased availability of depression treatment in rural areas. In addition, culturally appropriate

depression interventions must acknowledge rural cultural values of self-reliance and barriers to obtaining social support that lead many women to endure depression in isolation.

Introduction

Low-income women face higher rates of depression than men (CDC, 2010) and higher-income women (Chen, Subramanian, Acevedo-Garcia, & Kawachi, 2005). Economic struggles increase depression by limiting women's autonomy (Chen et al., 2005). Further, women contend with increased exposure to the social risk factors associated with depression, including chronic stress, family care-giving responsibilities, and experiences of trauma (Hauenstein & Peddada, 2007). Less research has focused on the experience of depressed, low-income rural women. Though interventionists increasingly account for the needs of diverse women as they adapt mental health interventions (Levy & O'Hara, 2010; Nadeem, Lange, & Miranda, 2008), low-income rural women have remained largely neglected (Hauenstein, 2003).

In parts of Appalachian Kentucky, residents reported an average of 6–8 mentally unhealthy days per month (Kentucky, 2015), nearly twice the national average. This high prevalence is mirrored among U.S. rural women more broadly, estimated to range from 38–51% (Hauenstein & Peddada, 2007; Jesse & Swanson, 2007; Price & Proctor, 2009). While Appalachia is celebrated for its distinctive cultural tradition (Keefe & Curtain, 2012), Appalachian women with depression also face increased vulnerability from bearing some of the greatest health disparities and poverty rates in the U.S. (Halverson, Ma, & Harner, 2004).

Appalachian women encounter numerous treatment barriers despite their high incidence of depression. Treatment options for depression in rural areas are fragmented (Merwin, Snyder, & Katz, 2006) because of critical shortages in mental health care providers (Mohatt, Bradley, Adams, & Morris, 2005). In rural areas, mental health is most commonly addressed by primary care providers (Wang et al., 2005), yet their need to respond to multiple health concerns and lack of specialty skills results in the under-diagnosis and treatment of depression (Rost et al., 1998). Stigma related to mental illness and mental health treatment obstruct receipt of treatment (Jesse, Dolbier, & Blanchard, 2008; Simmons, Yang, Wu, Bush, & Crofford, 2015; Thorndyke, 2005) and inhibit recognition of depression (Keefe & Curtain, 2012; Muntaner & Barnett, 2000). In rural communities, family and church may provide many women with close, long-standing relationships, yet the expectation that women care for others and remain selfless often prevents them from reaching out for material and emotional support from these intimate relationships (Hauenstein, 2003; Nelson, 2000; Sherman, 2013).

Yet new evidence indicates a changing landscape of mental health treatment for Appalachian women, prompting us to re-evaluate the role of social-cultural and service-related barriers to treatment among an extremely vulnerable group. Studies show that many rural women *are* engaging in depression treatment, even if this treatment is more commonly pharmacological and less often counseling, and even if their treatment is often fragmented or incomplete (Fortney, Harman, Xu, & Dong, 2010; Zhang et al., 2008). Further, a majority of low-income rural women experiencing depressive symptoms now self-report depression

(Simmons, Huddleston-Casas, & Berry, 2007). Despite these trends which seem to indicate decreased barriers to treatment, mental health disparities remain entrenched.

In summary, the experiences of low income Appalachian women struggling with depression warrant attention given significantly higher prevalence of depressive illness, exacerbated by unmet needs in their communities. In the face of changing community and cultural norms regarding the legitimacy of depression and its treatment, examining these issues allows us a window into how marginalized populations may (or may not) transition into contemporary therapeutic orientations and environments. By re-evaluating the barriers to treatment and recovery, we hope to offer recommendations for improving treatment options in order to alleviate disparities in depression recovery.

Methods

Research Design

A qualitative research design was employed to understand women's experiences of depression broadly and their effects on the use of conventional treatments for depression. Qualitative methods, particularly appropriate for re-appraising existing theory, enabled us to re-evaluate well established theory about rural mental health treatment seeking in a changing social context. Because our goal was to learn about women's understanding of their illness and the reasoning behind their health-seeking behavior, we concentrated on the treatment seeking perceptions and experiences of those rural Appalachian women who identify their symptoms as depression. Drawing on existing literature about rural depression and treatment seeking, we conducted semi-structured interviews on participants' perceptions of depression and their treatment seeking behaviors. We created a codebook derived from theoretical constructs and emergent themes, consulted with project personnel to confirm accuracy, and applied codes to the data.

Sample

Using purposive sampling, a non-probability sampling method used to obtain expertise on the specific phenomenon under consideration (Bernard, 2006), investigators recruited 28 low-income women living in southeastern Kentucky and screened them for depression using the Center for Epidemiological Studies Depression scale (CES-D) (Radloff, 1977). Investigators sought participants diverse in age, employment, family size, degree of religiosity, and treatment history. Throughout recruitment, the team monitored the diversity of these characteristics in the sample from intake questionnaires, and targeted recruitment of groups under-represented based on our knowledge of regional demographics (Pollard & Jacobsen, 2011). Despite the variations in the sample, eligibility criteria about depressive status, Appalachian residence, gender, and income maintained a degree of homogeneity within the sample. In studies conducting semi-structured interviews of relatively homogenous samples, qualitative experts have found that saturation occurs within the first 12 interviews (Guest, Bunce, & Johnson, 2006). While enrollment and interviews were ongoing, the PI read through interview transcripts in order to document themes; when new themes ceased to emerge, concept saturation was reached and we ended recruitment (Bernard, 2006). The majority of themes related to treatment-seeking behavior and hopes for

further mental health resources had been identified in the first 10 interviews, however, we continued enrollment in order to confirm and further explore several themes that emerged as a consequence of women's more open-ended responses to our questions as well as to ensure we had sufficient data to identify novel relationships between the themes. We ended enrollment at 28 participants once we had confirmed (and in some cases, ruled out) that emerging themes appeared beyond single cases, and had sufficient data not only to answer our research questions, but systematically identify how theoretically derived themes appeared in this data.

A total of 61 women aged 20–66 were screened for depression. Of these, 53 were eligible to participate, with 28 women eventually taking part in face-to-face interviews. The limitations of this high attrition are explored in the discussion section below. Recruitment strategies were developed in consultation with our collaborators at the Center of Excellence in Rural Health. A research assistant publicized the study in several venues, including a federally qualified health clinic (FQHC) and social service agencies, and by contacting area health practitioners, substance abuse researchers, community health workers, and our liaisons in area churches. To avoid identifying potential participants with the stigmatizing label of depression, participants were invited to contact research personnel. Upon calling the research assistant, potential participants were screened for their eligibility. Eligibility criteria included income (200% of poverty line), non-pregnant or immediately post-partum, and residence in southeastern Kentucky, an Appalachian sub-region. Depression was assessed with the Center for Epidemiological Studies Depression scale (CES-D); all women with a score over 15 were eligible. A research assistant scheduled eligible women for an appointment in which research procedures were explained and consent was obtained. Participants completed questionnaires and a 1 hour semi-structured, in-person interview. They were compensated \$30 for their time.

Procedures

This study was approved by the University of Kentucky Institutional Review Board. Permission to tape record interviews was requested from all participants. The primary author developed an interview guide with broad questions that focused on two key areas: 1) women's experience of depression, including symptoms, its trajectory, effects on their relationships and self-care habits, and 2) their treatment perceptions, experiences, and recommendations for developing depression services. Because depression is extremely personal and heavily stigmatized in the region, the interviewer encouraged women to describe their experiences in a manner that felt comfortable to them, with the interviewer guiding them to answer questions about all key areas. However, the order in which these topics were addressed varied from interview to interview, based on the manner in which the participant shared her experiences (Bernard, 2006; Morse, 2012). Community-based collaborators reviewed the questions to ensure that language was understandable and culturally acceptable. Because little is known about the Appalachian context specifically, the team ensured that new categories in the data would be allowed to emerge by asking open probes during the interviews to clarify the meanings of participants' specific language and to elicit details within their experiences (Bernard, 2006; Hsieh & Shannon, 2005). Interviews

were transcribed verbatim for analysis. Some responses were lightly edited in the final manuscript for ease of reading.

Setting

The primary author conducted the interviews in a private location chosen by participants, which included community health worker offices, the Center of Excellence for Rural Health office (located next to a regional hospital), or participants' homes. For many, the mountainous roads and lack of public transit made it difficult to travel to the interview site. The majority of participants elected against home interviews, citing the desire to step away from social demands and maintain privacy.

Data Analysis

Interviews were reviewed for preliminary analysis of themes, in order to identify principle variables in the interview content (Hsieh & Shannon, 2005). Using a directed content analysis approach oriented toward in-depth analysis of themes already known about a topic (Hsieh & Shannon, 2005), the primary author composed a codebook derived from theoretical constructs about cultural, social, and service-related factors related to treatment seeking (Gibbs, 2008). MAXQDA qualitative data analysis software was used to analyze the interview transcripts and demographics were assessed with SPSS. As the codes were applied to the text during initial coding, the codebook was refined to clarify and standardize code meaning. To improve validity, the primary author solicited feedback on the codebook and preliminary analysis in a follow-up group session with project personnel and staff from the federally qualified health clinic. While our screening procedure asked women to report whether or not they were currently receiving treatment, our case-by-case comparison of participants (Gibbs, 2008) demonstrated that women often had multiple treatment experiences of varying duration. Because the order of the content shared in the interview was guided by the participant, we were able to understand how participants experienced depression and treatment-seeking, which often intertwined women's feelings about treatment, stigma about their symptoms, and efforts to cope within their narratives. Throughout coding, code meaning was refined through writing analytic memos that clarified code definitions, identified conceptual assumptions, and highlighted code variations between participants, furthering reliability. Theoretical propositions about treatment seeking and stigma were compared with how these themes emerged within the data (Hsieh & Shannon, 2005).

Results

Characteristics of the Sample

As shown in Table 1 and consistent with the demographics of the region, most participants were white (96%), had a household income equal to or less than \$20,000 (56%), and had at least one child (89%); these findings are consistent with regional characteristics (Pollard & Jacobsen, 2011). The mean household size was 2.7, with a partner (67.9%), or child younger than 22 (43%) as the most commonly reported household members. Table 2 shows the mean CES-D score was 32 among the women we interviewed, suggesting moderate to severe depression. The sample was evenly split on their current treatment, with half reporting

current treatment and half reporting no current treatment. Roughly one third of the sample (n=10) reported never receiving treatment.

Qualitative Data

We detected four interconnected themes within our data: 1) doubts about treatment among women who did and did not experience it; 2) self- and external stigma about depressive symptoms; 3) efforts to cope without treatment; and 4) recommendations to improve treatment and related services.

1. Doubts about treatment—Though half of our sample was currently receiving depression treatment, some reporting “no treatment” described past treatment. Many had close friends or family who experienced treatment even if they themselves had not. Women reported decision-making about depression treatment tinged with ambivalence, influenced by the uneven quality of available treatment options, particularly counseling; practitioners’ emphasis on pharmacological treatment; and women’s desire for self-sufficiency.

Women reported treatment delays associated with this ambivalence about treatment, presenting for treatment only when depression symptoms were severe. Depression treatment was not viewed an obvious choice. Those women who eventually received treatment often delayed seeking it—sometimes for years--until there were few other choices available to resolve their symptoms and the consequences. Most women who obtained treatment did so after sustained periods of depression, while others sought help to overcome particular crises, like divorce or abuse. Some women sought treatment only after “breaking down” in anxiety or panic attacks, when they could no longer hide their suffering from others, or when they received family encouragement. Rather than pursuing treatment voluntarily, these women finally received treatment when they felt they could no longer fulfill their social obligations as they wanted to.

Women’s treatment perceptions affected their willingness to seek it. Most women were hesitant about counseling. One woman remained doubtful even after many recommendations from friends: “[a therapist] can’t help me; they can’t change anything that’s going on at home.” Other women avoided treatment because it communicated stigma: “I don’t want people to think, well hey, she’s crazy you know.” Among the women who were not using pharmacological treatment, the majority were suspicious of medication. Other women feared medication’s powerful effects: “I’m scared to death to try [antidepressants]...because I see so many people that are on it are just zonked out; they don’t know, they don’t feel anything, they don’t do anything.” In an area with a high rate of prescription drug abuse, many women cited fear of addiction. Because of this fear, even some whose doctors had recommended pharmacological treatment refused it, concluding instead, “I think it’s better off just to be depressed a little bit.” This led women to avoid treatment and engage in self-management of their symptoms.

Women’s hesitations about treatment were compounded by logistical challenges to care. One participant explained how many women remained isolated in this mountainous region: “Some people deep in these hollers, they don’t, they can’t get out like that; they have to beg for rides and pay people gas money.” While some women argued that lack of insurance

coverage and expensive co-pays were a barrier, several admitted that even without these barriers, they would not consider treatment.

Of those women who pursued treatment for depression, most expressed ambivalence about their experiences. With regard to counseling, some women reported that, while counselors listened, they did not offer adequate direction on how to approach the complex situations that exacerbated their depression. For example, one woman repeatedly sought help to deal with depression stemming from an emotionally abusive marriage and fatigue from caring for her sick mother. She complained: “I’ve never been able to find anybody that can help me understand these things.” Another woman described her frustration when a religiously oriented therapist also urged her to find spiritual meaning in her symptoms: “I felt like she was more concerned about trying to get me in church than she was figuring out why I felt like this.” Some commented that the coping strategies practitioners recommended would make them feel uncomfortable because they felt inconsistent with their daily routines and beliefs about coping: “I can’t sit down and do the breathing techniques and the yoga and I don’t, I can’t do that. I have to be moving. I have to have something that’s occupying my mind at all times.”

In a community where ties were intimate, the anonymity and lack of exchange in the therapeutic interaction felt uncomfortable to some. At counseling, one woman described, “[you] go and you sit there for an hour and you tell a perfect stranger or even a person you know fairly well your problems and I don’t know, I’m not throwing off on it; I just think it’s a joke.” Other women felt out of place in a healthcare environment in which their depressive symptoms were interpreted as medical problems to be solved: “I’d rather talk to somebody...that’s not using the big medical terms, that’s talking to me down to earth. They throw out the medical terms and ‘oh, we’ll start you on this medication.’” Instead, she asserted that she sought to be heard: “I said, ‘I don’t want medication,’ I just wanted somebody to talk to.”

For many women, negative treatment experiences have become a problem intertwined with their depression itself. The treatment setting furthered their stigma through negative interaction and deepened their isolation through a lack of access to quality care. The counselors who were available in region, some women felt, are “just real low grade counselors; they’re just not even qualified actually to be doing counseling; they [the administrators] just use whatever they’ve got to put in the slot.” Others argued for the necessity to ensure confidentiality. Describing the local mental health practice as a “laughing stock,” one woman wished for more options, because “everyone that goes there gets talked about.” These poor options—whether communicated through hearsay or personal experience—reinforced women’s understanding that their depression could not be treated by the providers available to them. Furthermore, women commented that inadequate services contributed to their sense of their worthlessness because policy-makers did not deem their needs important enough to address.

Still, a few women had positive treatment experiences and speculated that, without treatment, their depression would have worsened, hinting at potential breakdown or suicide. As one woman noted, “if I hadn’t been going and actually talking to a psychologist [as my

divorce dragged on], I think I'd have probably reached the breaking point." One woman stressed the gains she made through counseling: "I mean I'm a totally different person from...2 years ago." Though some women preferred counseling oriented to problem-solving, others appreciated a forum in which they were allowed to share their feelings.

2. Self- and external stigma against depressive symptoms—Participants hesitated to admit their depressive symptoms to themselves because they internalized the stigma associated with depression. They were silent about their emotional suffering, expressing reluctance to think about it and avoiding it in conversations with others. For example, although one woman had suffered from depression for years, she commented on her reticence to talk about it: "I just really don't want to name it...[I] don't talk about that; [I want to] talk about other stuff." For some women, the desire to suppress depressive feelings emerged from religious faith. "I try not to worry," noted one woman; "The Lord tells you not to worry but sometimes it's hard not to worry." Putting her worry "in His hands," she felt, was a better way to show her faith and learn the meaning in her suffering over time. "Naming" depression was difficult to do even for themselves, explained one woman, who attributed this to a cultural reticence to self-reflect, "Appalachian people have, they're good people but they, they're pretty closed off to themselves." As a consequence, another participant suggested that few women in the region understood their feelings as depression, even if they were miserable.

If women expressed their depressed feelings, they had to contend with others' reactions. In some cases, women explained that family members who heard their feelings might intervene in situations that they wanted to handle independently. In other cases, women sensed that depressive feelings they felt were reasonable would be judged as abnormal. One younger woman, aged 24, felt that others exaggerated her symptoms of depression: "if I had a panic attack, it automatically turned into the world was ending." One woman distinguished between the warmth she felt was common in the region and the limits of what should be shared within those relationships. She explained, "Once you've gained [Appalachian people's] trust, then they'll let you spend the night and fix your supper and you know they're good to you. But psychological things has never been that important." Even women who were not religious feared that they might be judged for their negative feelings. "People are ashamed to ask for help," reasoned one woman, because explaining negative feelings could be read as crises of faith. Though all women emphasized how much suffering they endured because of their depression, many struggled to find outlets to share these feelings, much less accept that their symptoms were not their fault. To avoid being stigmatized by others in addition to their own self-criticism, women found it easier to remain silent.

Women described a fraught process between what they knew of their own feelings and what others might come to know of them. Though one participant was critical of others' perceived judgment, she was not sure whether she approved of her depressive feelings either: "You don't want people knowing your business...I don't know, I think it's just, I think I'm probably just plumb crazy." As a consequence, women struggled to hide their feelings, separating themselves from others and putting on a "mask" that hid their depressive symptoms. "I always have a smile on my face," explained one woman. "I come into work like everything's just wonderful and...I mask it." These intrapersonal and interpersonal

processes intertwined over time, so that it was not always clear for whom women were silencing themselves.

3. Efforts to cope without treatment—Participants used a number of coping strategies that both helped them manage their depressive symptoms that may have contributed to their continuation or recurrence. Whether they were engaged in treatment currently or previously, many participants emphasized the importance of their self-sufficiency in promoting their recovery. “Everything [counselors have] said I’ve heard over and over,” complained one woman. As a result, “I can talk myself up and I can talk myself down.” Another woman said, “the counseling goes you know so far and then the rest is left up to me.” She measured her need for practitioner intervention by her daily functioning and adjusted her treatment seeking accordingly.

Others would not consider treatment at all, preferring to focus solely on their own approaches to coping. “Keep going,” was the mantra of many who tried to take each day at a time by taking care of family members and cleaning. Several women described how others had modeled avoiding negative feelings through distracting themselves. “Grandma used to tell me,” one woman said, “pull your big girl pants up and let’s go.” A number of women felt that through reflection and prayer, they could endure the problems that were at the root of their depressive symptoms. For some of these women, it meant refocusing on their agency within problems, rather than trying to ask for change within problematic social relations: “[I] pray that the Lord will help me to deal with them and you know that he will help me, not necessarily them; be what I should be and not so much focus on trying to fix them but fix me.”

Yet enduring depressive symptoms over the long term led women to avoid confronting these problems. One woman explained that she had never considered counseling: “I’m just, well, ‘it is how it is’ and I’ll work it out and it’s good.” Many women felt that their decision to plow through difficulty promoted their independence, which was positively valued in this rural area. As one woman framed it, “I’m one too that don’t like to ask for help. I mean I’ve been through so much and just try to handle it on my own.” Yet over time, she admitted that this autonomy left her feeling strained: “I know now I can’t handle it on my own.” While distraction was a positive coping strategy it could also have negative consequences, because many women sought to avoid depressive feelings entirely.

4. Recommendations to improve treatment and services—When many participants offered their recommendations for change, they began by emphasizing the isolation and hopelessness that resulted from inadequate service provision: “A lot of people around here feel like you know there’s no options. You just deal with it you know.” The consequences of this shortage, explained another, were dire: “If somebody’s out here ready to slit their wrists, they’re not going to wait for an appointment. I don’t know how many people around here that has happened to because there’s no help.” Lack of access to care only deepened the loneliness of those suffering from depression.

A number of women felt they would benefit from more venues for support, such as a women’s center, as well as instruction in coping techniques. Other women pointed to

improvements in their own relationships that could deepen their everyday social resources. There were few to no settings in which low-income Appalachian women could voice their feelings. Pointing to the study interview as a forum to be heard, one woman commented, “I think it would help if there was more people like you that they could you know confide in, talk to, because I’m sure there’s some women out here that don’t have anybody.” Others longed for the ability to express their needs and vulnerability without fear. “What would help the most,” reflected one young woman, “is making people feel like it’s okay to get help.” These suggestions made clear that as much as women were hesitant to confront their feelings and reach out for help, they longed for support that was currently obstructed by stigma.

Participants explained that, during treatment, the issues at the root of many women’s depression—including domestic violence, poverty, and comorbid substance abuse—needed to be addressed in the approach used by care providers. Yet women also suggested avenues beyond services that would make women feel more secure, which in turn would directly lessen their depression. Some of the recommended resources—food assistance, economic opportunities—would ameliorate women’s vulnerable socio-economic position. However, other issues contributing to women’s depression, like domestic violence, carried stigma of their own. Drawing on her own experiences, one woman explained that, “There’s a lot of domestic violence that is hidden under the covers because... They don’t feel that they can be, go in in confidence and talk.” These descriptions echoed women’s discussions of depression stigma, reflecting women’s fear that seeking help in any form would de-value their experiences.

Discussion

With 20% of the U.S. population living in rural areas, rural women are disproportionately affected by depression (Hauenstein & Peddada, 2007; Price & Proctor, 2009) but they often do not receive a full course of depression treatment (Fortney et al., 2010; Zhang et al., 2008). This study has explored the social, cultural, and structural (i.e., service availability, insurance) issues that shape Appalachian women’s treatment seeking behaviors, echoing other studies on rural mental health treatment seeking (Hauenstein, 2003; Jesse et al., 2008). However, unlike large quantitative studies that have systematically identified how rurality, gender, and class separately affect treatment access, our qualitative study illuminates how, for low-income rural women experiencing depression, these factors mutually reinforce their depression. Rural women who are confronted with messages that their feelings are socially unacceptable, bereft of social institutions to address their poverty, and lacking in accessible mental health services doubt the efficacy of treatment to address their difficult circumstances and come to question whether their depressive symptoms stem from a failure of self-control. Our discussion concentrates on three key findings: a) the importance of treatment quality—not merely access; b) how the value of women’s self-reliance in the rural setting is as influential as the stigma of mental health; and c) the need for sensitive interlocutors with whom women can process their feelings.

In contrast to research describing the limited use of mental health care in Appalachia (Keefe & Curtain, 2012; Muntaner & Barnett, 2000) and the tendency of rural residents with

depression to perceive no need for treatment (Fox, Blank, Berman, & Rovnyak, 1999; Jesse et al., 2008); this study shows that many women had knowledge about and experiences with depression treatment. Though half of the women who took part in our study reported no current treatment, nearly all had treatment experiences, were offered medication by practitioners, or were familiar with family members' treatment histories. Our results demonstrate that, of the roughly two-thirds of participants who received treatment in the past or present, the majority had negative treatment experiences that reinforced their desire to manage their depression independently, even when they admitted the inadequacy of those efforts to promote their recovery. In a rural environment where treatment options for depression are fragmented (Merwin et al., 2006) and poverty poses immense barriers to obtaining healthcare, women's treatment trajectories were also fragmented, seeking treatment when their depression prevented them from meeting social demands: they obtained medication, often avoided inadequate counseling, or sometimes abandoned treatment altogether.

Participants agreed that there were inadequate mental health services in the region. However, in contrast to research on rural mental health provider shortages (Mohatt et al., 2005), in both their perceptions and actual experiences of treatment, participants emphasized that provider *quality* was a crucial factor limiting their treatment seeking behavior. Women emphasized that their individual poverty made them vulnerable to depression, but the poverty of the region limited their access to quality treatment options with devastating effects. Negative treatment experiences not only failed to alleviate women's symptoms, but could further women's isolation and convince them that treatment could not be effective.

A number of rural mental health studies have stressed the stigma of depression (Cadigan & Skinner, 2014; Fuller, Edwards, Procter, & Moss, 2000). For these Appalachian women, rather than emphasizing the stigma of depression as a mental illness, women dwelled on their ambivalence about depressive symptoms which they perceived as negative thinking—evidence that resonates more with research on gender and depression. Cross-culturally, women are socialized to suppress their own feelings and desires in order to sustain or strengthen their intimate relationships (Jack & Ali, 2010). Expectations that women show strength instead of seek help can lead women to silence their distress and isolate themselves from otherwise supportive networks (Beauboeuf-Lafontant, 2007; Belle & Doucet, 2003).

In this study, women's desires to control their worries, think positively, and endure hardship resonate with evangelical ideas about wellbeing described by other Appalachian researchers (Goins, Spencer, & Williams, 2011; Keefe & Curtain, 2012). Some women voiced these values in explicitly religious terms, while others used secular terms to elaborate internal control through reflection. Other women were socially pressured to make sense of their struggles through the lens of faith, whether or not it aligned with their own spiritual beliefs. Participants not only took pride in their coping behaviors but also described their fears of being misunderstood, struggles to be positive, and frustration with waiting for change. While our participants identified themselves as depressed, even their increased awareness as individuals failed to protect them from doubts about the legitimacy of their illness. Though many women freely attributed poverty as a cause of their depression, when it came to depression's resolution, they stressed individual responsibility. Women's perception of their

depressive symptoms as their individual struggles, rather than an illness, led them to avoid or delay treatment and strive to control their symptoms independently.

Frequently, rural depression researchers have stressed how women's hesitation to reach out to socially significant others, let alone pursue treatment, is due to distrust and fear that confidentiality will be breached (Coyne, Demian-Popescu, & Friend, 2006; Jesse et al., 2008). While many participants reiterated these points, they outlined additional social dynamics that limited their desire to reach out. Specifically, support people and treatment providers often did not help them to address the complex social situations they attributed as causes of their depression, many of which were caused or exacerbated by their poverty. Women perceived these interactions to neither account for their complex social responsibilities nor their own capacity for self-sufficiency. Women responded to their distrust of others' reactions by attempting to cope on their own. However, not only did women's independent coping styles promote rumination, which could further their negative thinking, but they had no outlet for emotional processing shown to be vital for coping (Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008).

Limitations

The current study's principle limitation is the high rate of no-shows (47%) between screening and study participation. Because socio-demographic data was not collected at screening, it is uncertain whether those women who did not attend their study appointments were distinct from others. One factor limiting the participation of women in this group may have been their higher mean depression scores—potentially indicating that depression severity prevented study participation, as has been the case in other studies (i.e., Mirowsky & Reynolds, 2000). While these women could have shaped the data, nonetheless, the diversity within this sample is appropriate for the questions posed in this study. While diversity of socio-economic status, race, and ethnicity is low in Appalachian Kentucky, our efforts to recruit at multiple sites resulted in as diverse a sample as possible. Attrition in this study underscores the difficulty not only of doing research with low-income rural women which other researchers have stated (Hauenstein, 2003), but also the challenges that are posed by healthcare outreach to these women. The frequency of treatment could be a bias of our sample because we recruited women who identified as depressed, potentially eliminating women with depression who do not identify their illness as such (Alvidrez & Azocar, 1999). It is possible that in a randomly selected sample the number of women with treatment experiences could be lower. Nonetheless, this study suggests that women continue to struggle with the meaning of their depression even as they are aware of treatment options. Future studies should experiment with alternative strategies of accessing this population—such as the phone—that have been used successfully therapeutically (Dwight-Johnson et al., 2011). While the study's generalizability to other rural U.S. areas is limited, we believe that focusing on a geographically distinct population is important to identify trends distinct to a region and to better understand broader rural trends.

Implications

Our study focused on Appalachian women yet holds implications for broader rural populations. Past research on rural women's depression has focused on their lack of

awareness about depression and its treatment and, accordingly, researchers have recommended interventions that reduce the stigma of treatment and increase the role of primary care providers in identifying women's depression. This study underlines past recommendations to improve the quality of rural mental health services and to increase their relevance for the issues faced in this population—not only because of the scarcity of services, but by establishing that negative treatment experiences reinforce the isolation of rural depressed women and limit their future engagement with treatment. In addition to the need to increased social support for rural women with depression (Jesse, Kim, & Herndon, 2014; Seiling, Manoogian, & Son, 2011), our study highlights the gendered norms of communication and paucity of outlets in which rural women can voice their mental health struggles. Mental health interventions for low-income rural women must acknowledge rural cultural values of internal strength, positive thinking, and endurance that lead many women to endure depression in isolation and transform these into assets that women can use to recover from their depression.

References

- Alvirez J, Azocar F. Self-recognition of depression in public care women's clinic patients. *Journal of women's health & gender-based medicine*. 1999; 8(8):1063–1071.
- Beauboeuf-Lafontant T. You Have to Show Strength: An Exploration of Gender, Race, and Depression. *Gender & Society*. 2007; 21(1):28–51.
- Belle D, Doucet J. Poverty, Inequality, and Discrimination as Sources of Depression Among U.S. Women. *Psychology of Women Quarterly*. 2003; 27(2):101–113.
- Bernard, HR. *Research methods in anthropology*. Lanham, MD: Altamira Press; 2006.
- Cadigan RJ, Skinner D. Symptoms of depression and their management among low-income African-American and White mothers in the rural South. *Ethnicity & Health*. 2014; 20(3):293–308. [PubMed: 24892732]
- CDC. Current Depression among Adults -- United States, 2006 and 2008. *Morbidity and Mortality Weekly Report*. 2010; 59(38):1229–1235. [PubMed: 20881934]
- Chen Y-Y, Subramanian SV, Acevedo-Garcia D, Kawachi I. Women's status and depressive symptoms: A multilevel analysis. *Social Science & Medicine*. 2005; 60(1):49–60. doi: <http://dx.doi.org/10.1016/j.socscimed.2004.04.030>. [PubMed: 15482866]
- Coyne CA, Demian-Popescu C, Friend D. Social and Cultural Factors Influencing Health in Southern West Virginia: A Qualitative Study. *Preventing Chronic Disease*. 2006; 3(4)
- Dwight-Johnson M, Aisenberg E, Golinelli D, Hong S, O'Brien M, Ludman E. Telephone-Based Cognitive-Behavioral Therapy for Latino Patients Living in Rural Areas: A Randomized Pilot Study. *Psychiatric Services*. 2011; 62(8):936–942. [PubMed: 21807834]
- Fortney JC, Harman JS, Xu S, Dong F. The association between rural residence and the use, type, and quality of depression care. *The Journal of Rural Health*. 2010; 26(3):205–213. [PubMed: 20633088]
- Fox JC, Blank M, Berman J, Rovnyak VG. Mental disorders and help seeking in a rural impoverished population. *International Journal of Psychiatry in Medicine*. 1999; 29(2):181–195. [PubMed: 10587814]
- Fuller J, Edwards J, Procter N, Moss J. How definition of mental health problems can influence help seeking in rural and remote communities. *Australian Journal of Rural Health*. 2000; 8(3):148–153. [PubMed: 11249402]
- Gibbs, GR. *Analyzing qualitative data*. London: Sage; 2008.
- Goins RT, Spencer SM, Williams K. Lay Meanings of Health Among Rural Older Adults in Appalachia. *The Journal of Rural Health*. 2011; 27(1):13–20. [PubMed: 21204968]
- Guest G, Bunce A, Johnson L. How Many Interviews Are Enough?: An Experiment with Data Saturation and Variability. *Field Methods*. 2006; 18(1):59–82.

- Halverson, JA., Ma, L., Harner, EJ. An analysis of disparities in health status and access to health care in the Appalachian region. Washington, D.C: Appalachian Regional Commission; 2004.
- Hauenstein EJ. No comfort in the rural South: Women living depressed. *Archives of Psychiatric Nursing*. 2003; 17(1):3–11. doi: <http://dx.doi.org/10.1053/apnu.2003.6>. [PubMed: 12642882]
- Hauenstein EJ, Peddada SD. Prevalence of major depressive episodes in rural women using primary care. *Journal of health care for the poor and underserved*. 2007; 18(1):185–202. [PubMed: 17337807]
- Hsieh H-F, Shannon SE. Three approaches to qualitative content analysis. *Qualitative Health Research*. 2005; 15(9):1277–1288. [PubMed: 16204405]
- Jack, DC., Ali, A. *Silencing the self across cultures: Depression and gender in the social world*. Oxford University Press; 2010.
- Jesse DE, Dolbier CL, Blanchard A. Barriers to seeking help and treatment suggestions for prenatal depressive symptoms: focus groups with rural low-income women. *Issues in Mental Health Nursing*. 2008; 29(1):3–19. [PubMed: 18214775]
- Jesse DE, Kim H, Herndon C. Social Support and Self-Esteem as Mediators Between Stress and Antepartum Depressive Symptoms in Rural Pregnant Women. *Research in Nursing & Health*. 2014; 37(3):241–252. [PubMed: 24797585]
- Jesse DE, Swanson MS. Risks and Resources Associated With Antepartum Risk for Depression Among Rural Southern Women. *Nursing Research*. 2007; 56(6):378–386. [PubMed: 18004184]
- Keefe, SE., Curtain, L. Mental Health. In: Ludke, RL., Obermiller, PJ., editors. *Appalachian Health and Wellbeing*. Lexington: University of Kentucky Press; 2012. p. 223-250.
- Kentucky, FfaH. Mentally Unhealthy Days (per month), 2008–2010 - County Group. 2015 [Retrieved January 26, 2015] from <http://www.kentuckyhealthfacts.org/data/topic/map.aspx?ind=52>.
- Levy LB, O'Hara MW. Psychotherapeutic interventions for depressed, low-income women: A review of the literature. *Clinical Psychology Review*. 2010; 30(8):934–950. doi: <http://dx.doi.org/10.1016/j.cpr.2010.06.006>. [PubMed: 20678834]
- Merwin E, Snyder A, Katz E. Differential Access to Quality Rural Healthcare: Professional and Policy Challenges. *Family & Community Health*. 2006; 29(3):186–194. [PubMed: 16775468]
- Mirowsky J, Reynolds JR. Age, Depression, and Attrition in the National Survey of Families and Households. *Sociological Methods & Research*. 2000; 28(4):476–504.
- Mohatt DF, Bradley MM, Adams SJ, Morris CD. *Mental health and rural America: 1994–2005*. US Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy. 2005
- Morse, JM. The implications of interview type and structure in mixed-method designs. In: Gubrium, J.Holstein, J.Marvasti, A., McKinney, K., editors. *The SAGE handbook of interview research: The complexity of the craft*. 2nd. Thousand Oaks, CA: SAGE Publications; 2012. p. 193-206.
- Muntaner C, Barnett E. Depressive symptoms in rural West Virginia: labor market and health services correlates. *Journal of health care for the poor and underserved*. 2000; 11(3):284–300. [PubMed: 10929469]
- Nadeem E, Lange J, Miranda J. Mental health care preferences among low-income and minority women. *Archives of Women's Mental Health*. 2008; 11(2):93–102.
- Nelson M. Single Mothers and Social Support: The Commitment to, Retreat from, Reciprocity. *Qualitative Sociology*. 2000; 23(3):291–317.
- Nolen-Hoeksema S, Wisco BE, Lyubomirsky S. Rethinking Rumination. *Perspectives on Psychological Science*. 2008; 3(5):400–424. [PubMed: 26158958]
- Pollard, K., Jacobsen, LA. *The Appalachian region in 2010: A census data overview*. Washington, D.C: Appalachian Regional Commission, Population Reference Bureau; 2011.
- Price SK, Proctor EK. A Rural Perspective on Perinatal Depression: Prevalence, Correlates, and Implications for Help-Seeking Among Low-Income Women. *The Journal of Rural Health*. 2009; 25(2):158–166. [PubMed: 19785581]
- Radloff LS. The CES-D Scale: A Self-Report Depression Scale for Research in the General Population. *Applied Psychological Measurement*. 1977; 1(3):385–401.

- Rost K, Zhang M, Fortney J, Smith J, Coyne J, Richard Smith G Jr. Persistently poor outcomes of undetected major depression in primary care. *General Hospital Psychiatry*. 1998; 20(1):12–20. doi: [http://dx.doi.org/10.1016/S0163-8343\(97\)00095-9](http://dx.doi.org/10.1016/S0163-8343(97)00095-9). [PubMed: 9506250]
- Seiling, SB., Manoogian, MM., Son, S. “I Don’t Know How We Would Make It”—Social Support in Rural Low-Income Families. In: Bauer, JW., Dolan, EM., editors. *Rural Families and Work*. Vol. 1. New York: Springer; 2011. p. 157-183.
- Sherman J. Surviving the Great Recession: Growing Need and the Stigmatized Safety Net. *Social Problems*. 2013; 60(4):409–432.
- Simmons LA, Huddleston-Casas C, Berry AA. Low-Income Rural Women and Depression: Factors Associated with Self-Reporting. *American Journal of Health Behavior*. 2007; 31(6):657–666. [PubMed: 17691878]
- Simmons LA, Yang NY, Wu Q, Bush HM, Crofford LJ. Public and Personal Depression Stigma in a Rural American Female Sample. *Archives of Psychiatric Nursing*. 2015 doi: <http://dx.doi.org/10.1016/j.apnu.2015.06.015>.
- Thorndyke LE. Rural women’s health: A research agenda for the future. *Women's Health Issues*. 2005; 15(5):200–203. doi: <http://dx.doi.org/10.1016/j.whi.2005.07.004>. [PubMed: 16165004]
- Wang PS, Lane M, Olfson M, Pincus HA, Wells KB, Kessler RC. Twelve-month use of mental health services in the United States: Results from the national comorbidity survey replication. *Archives of General Psychiatry*. 2005; 62(6):629–640. [PubMed: 15939840]
- Zhang, Z., Infante, A., Meit, M., English, N., Dunn, M., Bowers, KH. *An Analysis of Mental Health and Substance Abuse Disparities & Access to Treatment Services in the Appalachian Region*. Washington, D.C: Appalachian Regional Commission; 2008.

Table 1

Demographic Characteristics of Study Sample

Characteristics		Percentage		
Race	White	96		
	Black	4		
Marital Status	Married/Partnered	54		
	Separated/Divorced	18		
	Widowed	3		
	Never Married	25		
Household Income	Below \$10,000	25		
	\$10,000–\$20,000	31		
	\$20,000–\$30,000	22		
	\$30,000–\$40,000	11		
	\$40,000 and above	11		
Insurance (could check more than one)	Private	11		
	Company	32		
	Medicare	14		
	Medicaid	36		
	Veterans	3		
	No insurance	7		
Employment	None (retired, unemployed)	43		
	Employed	57		
			<u>Mean</u>	<u>Std. Deviation</u>
	Length of time living in region (years)	33	15	
	Age	40.5	13.3	
	# of children	1.4	1	
	# people living in household	2.7	1	
	# of years of education completed	13.8	2.5	

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Table 2

Depression & Treatment Status of Participants

Screened Eligible for Study*	Mean CES-D Score**	Receiving Treatment	No Current Treatment
Participant (n=28)	32	14	14
No Show to Interview (n=25)	46	19	6

* A total of 61 women were screened, of whom 53 were eligible to participate.

** A score >15 is considered depressed; the maximum score is 60.

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript