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Clinical Geropsychology: Treatment and Research Approaches With Rural Older Adults

Natalie D. Dautovich PhD a, Kristy D. Shoji MA a, Ashley M. Stripling PhD b & Joseph M. Dzierzewski PhD c

a Department of Psychology, University of Alabama, Tuscaloosa, Alabama, USA
b School of Psychological and Behavioral Sciences, University of West Florida, Pensacola, Florida, USA
c Geriatric Research, Education and Clinical Center, Greater Los Angeles Veterans Affairs Medical Center, Los Angeles, and the David Geffen School of Medicine, University of California, Los Angeles, Los Angeles, California, USA

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Clinical Geropsychology: Treatment and Research Approaches With Rural Older Adults

NATALIE D. DAUTOVICH, PhD and KRISTY D. SHOJI, MA
Department of Psychology, University of Alabama, Tuscaloosa, Alabama, USA

ASHLEY M. STRIPLING, PhD
School of Psychological and Behavioral Sciences, University of West Florida, Pensacola, Florida, USA

JOSEPH M. DZIERZEWSKI, PhD
Geriatric Research, Education and Clinical Center, Greater Los Angeles Veterans Affairs Medical Center, Los Angeles, and the David Geffen School of Medicine, University of California, Los Angeles, Los Angeles, California, USA

The proportion of older adults in rural settings continues to increase, with the proportion of older adults greater in rural versus urban areas. Rural elders often have greater mental health needs but live in areas with the greatest shortages of mental and behavioral health services. Furthermore, cultural barriers to treatment exist with a lack of understanding of rural older adults’ cultural context contributing to a hesitation to seek help by rural elders. The current article will explore characteristics, need for treatment and research, barriers to delivering treatment and conducting research, public policy, and clinical implications related to the mental health needs of rural older adults.

KEYWORDS interventions, mental health, older adults, public policy, research, rural

Rural America is often idealized as consisting of idyllic vistas and unspoiled pastures. Unfortunately, the reality for many rural older Americans consists of unmet mental health care needs (American Psychological Association, 2002). The present review explores a variety of barriers to treatment and research...
with older rural Americans. Additionally, public policy issues and clinical implications related to serving the mental health needs of older rural adults are presented. As the next generation of clinical geropsychologists is trained to meet the needs of aging Americans, there is a need to better understand the unique strengths and challenges experienced by those residing in a rural context.

CHARACTERISTICS OF RURAL AMERICA

There are many definitions that have been proposed for the term “rural.” The definition of areas as rural and urban is important given that how these areas are defined influences what statements can be made about people living in these areas (Rural Policy Research Institute [RUPRI], 2009). Two well-known definitions come from the Office of Management and Budget (OMB) and the Census Bureau (National Advisory Committee on Rural Health & Human Services [NACRHHS], 2008). The OMB classification, which is the most commonly used definition of rural areas, categorizes counties as metropolitan, micropolitan, or non-metropolitan, with only non-metropolitan areas considered rural. This county-based approach may be problematic due to the fact that most counties contain both rural and urban areas. In contrast, the Census Bureau identifies Census blocks as either rural or urban based on population density and numeric thresholds. The Census approach may be problematic because the boundaries do not align with cities and towns, making it more difficult to understand trends and conditions, and to appropriately target resources as needed (RUPRI, 2009). These divergent definitions result in identification of a greater number of people as rural using the Census definition as compared to the OMB definition (NACRHHS, 2008).

Other definitions proposed for rural and urban areas include Urban Influence and Rural Urban Continuum codes (RUC; USDA Economic Research Service, 2013) intended to further define rural and urban areas, and Rural Urban Commuting Area (RUCA) Codes based on commuting flow. RUC codes are made up of 10 distinct categories, with metropolitan areas defined by size and non-metropolitan areas defined by degree of urbanization and their proximity to urban areas (Nance et al., 2002). RUCA codes are determined using census tract-level demographic information in combination with work commuting data to define 33 categories of census tracts, which can be useful for identifying rural areas in metropolitan counties and urban areas in non-metropolitan counties. Both the size of a town and its functional relationship with adjacent areas is used to determine the appropriate category, which can range from core urban centers to small rural communities (Hart, Larson, & Lishner, 2005). For example, a small town with a large number of people commuting to a nearby urban center would be classified
differently than a small town where the majority of people commute to other nearby small towns.

Regardless of the definition of rural America one adheres to, there are general characteristics and trends common to rural communities. According to the 2010 Census Bureau, approximately 19.3% of the United States population is considered rural, and 80.7% is considered urban. In rural areas, there is a trend toward rural populations being made up increasingly of older adults. There are likely two driving forces behind the higher concentration of older adults in rural areas: (1) younger adults migrating out of rural areas to seek employment or other opportunities, and (2) older adults migrating into rural areas for retirement (NACRHHS, 2008). The U.S. Department of Agriculture, Economic Research Service (Jones, Kandel, & Parker, 2007) estimated the concentration of older adults in rural as compared to urban areas to be 15% and 12%, respectively. Disparities between rural and urban areas extend beyond the age of their populations. According to the Rural Poverty Research Institute, 95% of persistent poverty counties in the United States (counties where 20% or more of the county population has lived in poverty for the past 30 years) are found in rural areas. Furthermore, there is a gap in educational attainment, such that people living in urban areas are better educated than their rural counterparts (Jones et al., 2007). In a recent article by Deen, Bridges, McGahan, and Andrews (2012) rural-urban disparities were reported for insurance, with individuals in rural areas more likely to be uninsured, to spend longer periods uninsured, and less likely to seek services when they are unable to pay for them than people in urban areas. Given the higher proportion of older adults, a decreased likelihood to be insured or seek treatment, and the workforce shortage and high turnover rates in rural areas, there is an obvious need for concentrated efforts to improve service availability, quality, and utilization in older adults living in rural communities.

**TREATMENT OF RURAL OLDER ADULTS: NEEDS AND BARRIERS**

The underutilization of mental health services has been well documented in both rural (Cully et al., 2010; Hauenstein et al., 2007) and urban older adult populations (Crabb & Hunsley, 2006), despite evidence indicating a continued high need for services (Maiden & Peterson, 2002; Peterson & Maiden, 1993). In fact, 55% of the 3,825 federally designated mental health professional shortage areas are in rural rather than urban areas (Health Resources and Services Administration, 2013) with acute need noted for specialized populations, including, older adults (American Psychological Association, 2002). Underscoring this need for services is the high proportion and critical nature of mental health problems in rural and older adults (NACRHHS, 2004). Suicide rates, for example, are consistently higher in both older and rural populations when compared to their respective demographic groups.
Treatment and Research With Rural Older Adults

As such, it is no surprise that the overlap of these identities has been referred to as “double jeopardy” (Bull, Krout, Rathbone-McCuan & Shreffler, 2001) and purported as a contributor to a litany of ill effects. In fact, rural older adults self-report a shortage of mental health providers, inadequate and inaccurate diagnosis, a lack of elder outreach, and specialized geriatric mental health treatment, all of which further exacerbate difficulties (Stockdill & Ciarlo, 2000). Although research has documented a trend toward greater help seeking and provision (Maiden & Peterson, 2002), unmet mental health needs continue to exist (Wang et al., 2005).

Researchers have identified a number of distinct and significant barriers to rural geriatric mental health treatment (Sanders, Fitzgerald, & Bratteli, 2008). The most global of these include those related to cultural or ideological beliefs. One noted example is the lack of understanding of rural older adults’ cultural context, which has been estimated to affect areas spanning from funding for services and provider’s attitudes to willingness of older adults to seek services (Sanders, Fitzgerald, & Bratteli, 2008). For example, a lack of understanding surrounding the needs and values of this group could lead to a misappropriation of money and energy based on the attitudes, or worse stereotypes, held by urban trained providers based on urban data. This deficit is due in part to the heterogeneous nature of rural communities whose diversity cuts across geographic, cultural, occupational, economic, and life-style domains (Murray & Keller, 1991; Roberts, Johnson, Brems, & Warner, 2007).

In addition to cultural barriers, rural older adults often find themselves caught in an infrastructure that contributes to the underutilization of services. Ziller and colleagues (2006; 2010) documented those living in rural areas are more likely to lack adequate health care coverage or have any coverage at all thus, contributing to high out of pocket costs, making mental health care unaffordable, and often resulting in the choice to forgo needed mental health care services. Furthermore, despite noted mental health needs, individuals in rural settings are more likely to receive psychopharmacological versus behavioral treatments, less likely to see a provider in person, and have fewer visits within a year compared to urban counterparts (Ziller et al., 2010). These treatment differences are due in part to environmental concerns faced by both rural clients and providers. Geographic barriers, such as greater travel distances, travel time, and both private and public transportation difficulties, further serve to obstruct service access resulting in underutilization (Brems, Johnson, Warner, & Roberts, 2007; Pepin, Segal, & Coolidge, 2009; Roberts, Johnson, Brems, & Warner, 2007).

Contributing to the infrastructure shortages are barriers specific to personnel. An Institute of Medicine report (Eden, Maslow, Le, & Blazer, 2012) on the mental health and substance use workforce for older adults identified a number of barriers to service in a rural setting, namely, the lack of geriatric mental health training and providers. Providers who may be eager to
work with rural older adults face an absence of financial incentives, support, and training (e.g., continuing educational opportunities, in-services; Sawyer, Gale, & Lambert, 2006). Those that do take up the charge confront a number of ethical and professional challenges innate to rural settings including, confidentiality limitations, dual or multiple role relationships, visibility issues, problems in attaining treatment adherence, engaging in informed consent, resource limitations, and burnout (Brems et al., 2007; Helbok, 2003; Roberts et al., 2007).

Compounding the quality care issue is the inadequate quantity of service providers (Eden et al., 2012). The need for increased rural geriatric mental health providers is clear. Holzer and colleagues (1998) estimate the rates of psychologists per 100,000 residents drops from 34.3 in urban areas to 15.4 in the least urbanized areas. Taken together these shortfalls in infrastructure and personnel put greater reliance on already overtaxed providers and contribute to future recruitment difficulties thus, resulting in a vicious circle with the end result being less access to specialized geriatric mental health services for rural older adults (Brems et al., 2007).

Attitudes of rural older adults toward mental health only add to the complexity faced by rural geriatric mental health providers. Researchers have postulated a number of attitudes of rural adults related to decreased help seeking, such as, higher stoicism, less anonymity when seeking mental health care, and higher rates of perceived stigma of mental illnesses (Rost, Smith, & Taylor, 1993; Stockman, 1990). Older adults in rural areas also express less positive mental health services attitudes than their urban counterparts, preferring to seek treatment from primary care physicians for physical rather than mental health complaints despite poorer overall health (Deen et al., 2012; Sawyer et al., 2006). These identified “stigmas” associated with mental health service use, when added to other intrinsic barriers present a daunting image of a population less open to seeking psychological assistance.

**RESEARCH WITH RURAL OLDER ADULTS: NEEDS AND BARRIERS**

As mentioned above, the unmet mental health needs of rural older adults are well documented. Much remains to be understood about how to effectively implement mental health interventions for rural older adults. In fact, a core competency in geropsychology involves developing understanding of how urban versus rural residency may uniquely influence the experience of psychological problems (Pikes Peak Model of training; Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009).

Researchers conducting mental health research with rural older adults may encounter several barriers such as distrust of outsiders, the impact of lower education levels, and challenges obtaining a representative sample. As described in a study of an Appalachian community, a culture of
“insideness” can exist in rural communities leading to a distrust of “outsiders” (Rowles, 1991). Distrust at both the individual and at the systems level can be encountered when conducting research with rural older adults. First, rural participants may be unfamiliar with the research study personnel. Involvement of community members is critical for both the relevance of the research for the community and for the “buy-in” of the community members. Research needs local legitimacy which is often established by developing a relationship with a local intermediary or gate-keeper (Smith, Blake, Olson, & Tessaro, 2002). Second, distrust may exist surrounding formal health care systems where research is typically conducted (Dibartolo & McCrone, 2003).

Researchers may encounter another barrier to research with rural elders in the form of lower levels of literacy and formal education compared to urban older adults. These factors could impact the informed consent process as rural older adults may be less experienced or more distrustful about quasi-legal documents (Kaye, Lawton, & Kaye, 1990). Additionally, more attention may be required by the researcher during the data collection process to ensure that the instrumentation is appropriate and feasible for the rural participants. In addition to problems arising from lower literacy levels, conducting research on sensitive issues such as mental health can pose a problem in rural areas and result in measurement error (Zanjani & Rowles, 2012). Individuals may be hesitant to provide accurate and comprehensive details about an issue that they consider sensitive or private. Lastly, rural older adults may wish to consult with family members and achieve a group consensus prior to participating in a research study (Kaye et al., 1990). As a result, the informed consent process can be prolonged and occur across multiple meetings.

A final challenge to consider when conducting research with rural older adults is obtaining a representative sample. Rural older adults may be spread across large geographical areas, making transportation to participate in a research study burdensome. Additionally, the lower socioeconomic status of some rural elders (compared to urban elders) may be prohibitive for participating in research studies. As a result, the sample obtained could be non-representative and biased towards those with greater means who are less geographically isolated.

RURAL OLDER ADULT PUBLIC POLICY ISSUES

As delineated earlier in this manuscript, rural older adults represent a distinct segment of the aging population—often with unique needs and challenges. As a result, public policy has developed to lessen the individual and societal implications of growing old in rural geographic regions.

Current public policy movements aimed at addressing the needs of rural older adults involve the allocation of significant government resources in the
hope of improving numerous outcomes. Examples of these funding initiatives include: (1) the National Institute on Aging Alzheimer’s Disease Centers have written goals to incorporate programming for rural elders, (2) the U.S. Department of Health and Human Services has an Office of Rural Health Policy in the Health Resources and Services Administration which focuses on key rural health policy issues and administers targeted rural grant programs (Health Services and Research Administration [HSRA], n.d.a), and (3) the National Health Service Corps, among others, offer Loan Repayment Programs to primary care medical, dental, and mental/behavioral health providers while serving in communities with limited access to care, such as rural areas (National Health Service Corps, 2013). The level of commitment to these current public policy endeavors can be judged by the $185 million awarded through grants in 2010 by the Health Resources and Services Administration to improve health care in rural America through funding of rural hospitals, health centers, and local clinics (HSRA, n.d.a).

While there are impressive public policy movements targeting rural health and rural elder health, much disparity remains. Targeted policies aimed at reducing mental and physical health disparities of rural elders are still needed. An example of a public policy area in need of additional attention is minority rural needs. Rural minority members experience mental and physical health problems at higher rates than non-minority members and are likely to live in poverty, and these difficulties are compounded with advanced age (HSRA, n.d.b). Public policy that addresses the needs of rural elders, including ethnic minorities, in the arenas of health education, mental and physical health care needs, health care provider knowledge and sensitivity, and poverty continues to be needed.

**CLINICAL IMPLICATIONS**

The present review has offered an overview of barriers to conducting treatment and research with rural older adults. The stigma associated with seeking mental health care in particular, can form a formidable barrier. Clinicians can take a number of steps to reduce this stigma burden such as having a remote office, a concealed parking lot, or housing the clinic with other agencies (Smalley et al., 2010). Additionally, increasing awareness of mental health and aging issues can serve to reduce public stigma. A recent initiative in rural Kentucky involved focus groups, a community liaison agent, and a television-based social marketing campaign to increase awareness of mental health issues (Zanjani, Kruger, & Murray, 2012). Modifications to cognitive-behavioral approaches to treating depression have been identified to increase acceptability of these treatments among rural older adults (Crowther, Scogin, & Johnson Norton, 2010).

In addition to increasing acceptability of mental health treatments, initiatives are underway to increase accessibility of services. One initiative
involves efforts to recruit and retain mental health personnel in rural areas. Integration of rural curriculum during doctoral training and through clinical experiences has been credited with recruiting and retaining rural practitioners (Chung-Do et al., 2012; Dyck & Hardy, 2013). The Association of Psychology Postdoctoral and Internship Centers (http://www.appic.org/) lists 37 sites (out of a possible 714 sites) across Canada and the United States that provide training in rural geropsychology. Therefore, training opportunities exist but still remain insufficient for meeting existing demands.

Another approach to addressing the personnel shortages and the geographic isolation facing many rural older adults is the use of electronic screenings and telehealth approaches to treatment. Electronic screenings have shown promise as a preliminary mental health-screening tool in rural areas (Farrell et al., 2009). Telehealth can be useful for addressing many shortages in rural areas such as providing psychiatric consults, access to training and continuing education credits for personnel, follow-up after discharge, prevention, and early intervention (e.g., crisis hotlines, referral, and peer support; National Rural Health Association Policy Position, 2006). For example, telephone administered (Brenes, Ingram, & Danhauer, 2012) and internet based cognitive behavioral therapy (CBT) have been found to be as effective as therapist led CBT (Griffiths & Christensen, 2006), with significant reductions reported in general anxiety, worry, anxiety sensitivity, and insomnia. In a study of the effects of a telepsychiatry intervention in rural Hawaii, preliminary evidence supported the use of telehealth applications both to train practitioners, and to provide patient care (Chung-Do et al., 2012). Despite these promising findings, additional research is needed to compare effectiveness across various administration modes and to gather more detailed information regarding how effective interventions are for specific disorders. Nevertheless, these results suggest telehealth interventions may be a fruitful endeavor for populations where it is difficult or impossible to travel to a hospital or office for treatment. In addition to the fact that there are relatively few controlled studies on the use of telehealth, particularly mental health applications, there is a scarcity of literature on such interventions in geriatric populations specifically. Such research is particularly important given the sensory deficits, and presence of dementia, depression, and delusions in older adult populations (Grady et al., 2011).

There are many possible benefits to the use of telehealth applications in rural populations both to patients and providers including addressing concerns regarding stigma and lack of anonymity of traditional in-office interventions (Dyck & Hardy, 2013). However, there are also possible barriers to the use of telehealth applications, such as funding, personnel training, and space for equipment (Benavides-Vaello, Strode, & Sheeran, 2013). Other concerns raised regarding the use of telehealth have been specific to psychological interventions, such as lack of control over the environment, privacy and confidentiality concerns, difficulty developing a
therapeutic alliance, ethical and legal concerns, appropriate ways to address crises, and treatment provider adjustment to a new mode of treatment (Brenes, Ingram, & Danhauer, 2011). With the increasing use of telehealth approaches by clinicians (e.g., the largest integrated health care system in the United States, the Department of Veteran Affairs, has established an Office of Telehealth Services), guidelines are needed for how to effectively and ethically deliver these interventions. A joint task force formed in 2011 is working to develop telepsychology guidelines that will help psychologists to appropriately address ethical, regulatory, legal, and practice issues related to the delivery of telehealth services (see http://www.apapracticecentral.org).

For researchers committed to working with rural elders, community-based participatory research approaches can help with developing trust with community members and asking research questions that are relevant for the community (Zanjani & Rowles, 2012). Additionally, recruitment strategies can be tailored to fit the community (e.g., advertisements in church and neighborhood bulletins or participation in local health fairs). Furthermore, researchers may need to travel for data collection or use digitalized methods to overcome geographical barriers.

In conclusion, many factors contribute to the under servicing of the mental health needs of rural older adults including underdeveloped infrastructure and insufficient personnel. Furthermore, even if adequate services exist, there are challenges in the form of attitudes of rural older adults towards help seeking. There is a need for (1) culturally competent treatments that are appropriate for rural settings, and (2) research to investigate how rurality may influence the experience of mental health problems in late life. While current efforts to address rural mental health needs through interventions, research, and public policy are to be applauded, much is left undone.

REFERENCES


