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Help-Seeking for Depression in Rural Women: A Community Portrait

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Help-seeking for Depression in Rural Women: A Community Portrait

A dissertation submitted in partial fulfillment of the requirements for the degree of
Doctor of Philosophy at Virginia Commonwealth University.

By

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I want to dedicate this project to my grandparents, Dr. Walton and Lucille Mitchell. In their roles of primary care physician and community nurse, they devoted over forty years to the health care of my home community. Further, my grandfather had a special regard for the importance of the role of nursing and was the first Virginia physician to affiliate with a nurse practitioner in his rural practice.

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ABSTRACT

HELP-SEEKING FOR DEPRESSION IN RURAL WOMEN: A COMMUNITY

PORTRAIT

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This study was conducted with fourteen participants who lived in a rural Virginia

community. The focus of the study was exploration of the nature of the experience of

depression and of help-seeking for depression in one rural woman and in her community

social network. The need for exploration of the community social network was

influenced by the DeFacto Services Model of Rural Mental Health, which emphasized

the influence of community factors in making decisions to seek mental health care.

Findings of the study included the following themes, which related to the nature of

depression: 1) linkage of experiential depression to diagnostic criteria; 2) overcoming

depression using willpower; 3) connection of depression to abuse and violence, and 4)

masking the inner world of depression. The following themes related to the nature of

help-seeking emerged from the data: 1) family role in help-seeking; 2) insider/outsider

status impact on help-seeking; 3) role of family and work functioning in help-seeking,

and 4) role of informal and formal networks in help-seeking. Tentative conclusions were

reached based on the findings that suggest depression and help-seeking may be

experienced in distinctive ways by rural dwelling women in this particular community.

Further research was suggested as a way of understanding more about how rural women

seek help for depression within the context of their own community social networks.

CHAPTER ONE

Overview of the Study

Introduction

Depression is one of the most pervasive, distressing, and costly public health problems in contemporary America and it is the second leading cause of morbidity and mortality worldwide (World Health Organization, 2004). In any given year, major depression affects as many as 14 million American adults, which is approximately 6.6 % of the total population (National Mental Health Association [NMHA], 2003). More than 16 % of Americans – as many as 35 million people in all segments of the population – suffer from an episode of major depression severe enough to warrant treatment at some time in their lives (Kessler et al., 2003).

On the continuum of mood disorders, major depressive episode (MDE) is distinctly different from more common experiences of "feeling blue." MDE is disabling, and if left untreated can be a potentially lethal medical and psychological issue. However, it is also important to note that depression is a common and highly treatable disorder. Once identified, depression can almost always be successfully treated either by psychotherapy, medication, or a combination of both (Satcher, 1999; U. S. Department of Health and Human Services, 2000).

Kessler and colleagues (2003) reported that depression costs employers $44 billion annually in lost productive time. This figure is $31 billion more than the amount lost due to illnesses in people without depression. Major depression can impair a person's social and physical functioning even more severely than serious medical

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conditions such as hypertension, diabetes, or arthritis, and can result in disability and significant loss of income (American Psychiatric Association, 2000). Perhaps the most important outcome of depression is the human suffering imposed on individuals grappling with the malady and on their families and friends. This suffering can be expressed through difficulty with interpersonal relationships, financial hardships, disability, and in some cases, even suicide.

Women in general are at higher risk of depressive disorders due to genetic factors, sex hormones, life stress and trauma, interpersonal relationships, and cognitive styles (American Psychological Association, 2002); McGrath, Keita, Strickland, & Russo, 1995). Women in the United States are at least twice as likely as men to experience a major depression and the risk of depression may be as much as three to four times greater for certain subgroups of women who are young, unemployed, and poorly educated. The age of most frequent onset occurs during the childbearing period of 25 to 44 years (Agency for Health Care Policy Research, 1993; Hauenstein & Boyd, 1994). Depression is also the leading cause of disease burden among females ages five and older worldwide (Murray & Lopez, 1996).

Women living in rural areas may be especially vulnerable to depression due to a number of social and psychological barriers germane to "country dwelling" (Bushy, 1990, 1994). It is noteworthy that the population of rural women who may be especially vulnerable to depression are also a group that may be quite reluctant to seek help from formal or informal networks (National Institute of Mental Health [NIMH], 2004).

Despite the wide range of effective treatments and interventions that are currently available, a large percentage of rural women with depression still do not seek or receive help from any source.

Since depression remains unaddressed in significant numbers of rural women, it is important that researchers and clinicians gain a better understanding of the processes and influences that affect decision making about seeking (or not seeking) help for their depressive symptoms. Therefore, the exploration of how rural women with depression perceive and express help-seeking for this mental health disorder is a significant area for investigation (Hauenstein, 1994, 1996, 1997).

This study employed the design of qualitative description in exploring the unique story of one rural woman's help-seeking experience for depression, along with complementary descriptions of other members of her community social network. The decision to include members of the social network was guided by the belief that rural women have unique issues and concerns which are experienced inextricably within the context of a complex community social network (Fox, Merwin & Blank, 1995; Hill,1988).

Orienting Theoretical Framework

The theoretical framework selected for this study was the DeFacto Mental Health Services Model developed by investigators at the Southeast Virginia Rural Mental Health Research Center, a research center affiliated with the University of Virginia (Fox, Merwin, & Blank, 1995). The DeFacto Model was developed for application in the rural south and includes in its framework the naturally occurring network of helpers available

in rural communities, including both formal and informal helping networks. This model of rural mental health care emphasizes that understanding the culture of rural residents, how physical and mental health are identified and described, and how help-seeking decisions are made, are all critically important to understanding the defacto mental health system; that is, the system that rural persons access most naturally when confronted with a psychological problem.

Hill (1988) suggests that when people are ill, they make decisions based on their existing knowledge as part of their cultural model of the world. Therefore, in order to understand help-seeking behavior, an examination of culture and structure at a community level is mandatory. At this micro level, the differences between the assumptions and culture of formal and informal health care systems and those persons seeking help can be understood by describing beliefs, attitudes, and behaviors, along with the structure and function of rural communities. Because of the fit between the DeFacto Mental Health Services Model and the purposes of this inquiry, the model was chosen as a theoretical framework to guide the study.

Purpose

The purpose of this study was to describe and understand how rural women perceive and express help-seeking for depression in rural communities. This was accomplished through the use of a qualitative descriptive method providing prolonged engagement with one depressed woman residing in a rural community and also engagement with key informants representative of the social network of the community in which she lived. Exploration of the woman's social network was viewed as vital to

understanding the process of help-seeking for depression from both individual and community perspectives as is consistent with the DeFacto Mental Health Services Model described previously.

The community social network representatives were identified based on input from the primary informant and available information about the formal and informal networks of mental health care and support services in the community. The inclusion of these representatives helped to better understand the potential influences that could shape the pattern of help-seeking in this rural community. The researcher collected, synthesized and re-presented data from one rural woman with depression and from other key community informants who could influence her unique experience of help-seeking for depression.

Research Questions

The central research questions of this study were as follows:

1. What was the nature of depression as perceived by a rural-dwelling woman and members of her community social network?

2. What was the process of help-seeking for depression as perceived by a rural-dwelling woman and members of her social network?

Foundational Terms

Depression in Women

Though depression can be defined in a variety of ways, most of the psychiatric and clinical literature in the mental health field utilizes the diagnostic taxonomy, *Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV-TR)*

(American Psychiatric Association, 2000). In this manual, diagnostic criteria are described in relation to the degree of interference with daily living, as evidenced by the inability to carry out usual activities and role functions. More specifically, a positive diagnosis of major depression results from the individual meeting a designated threshold of behavioral indicators for a specified duration of time.

In order to make a positive diagnosis, at least one of the indicators of depressed mood or loss of interest or pleasure in usual activities must be present during a 2- week period. Additionally, five or more of the following criteria (representing a change in previous level of function) must also have been present during the same 2-week period: 1) weight loss or gain; 2) changes in sleep patterns; 3) changes in psychomotor activity; 4) fatigue and energy compromise; 5) feelings of worthlessness or excessive guilt; 6) concentration impairment or ambivalence; and, 7) ruminations about death or suicide or a specific suicide plan or previous attempt.

In this study, the *DSM-IV-TR* criteria were used as a complementary way of understanding the woman's personal descriptions of her own experience of depression. These were not imposed in a strict fashion or used as the primary inclusion factor. While the *DSM-IV-TR* checklist was completed by the key informant (the woman with depression) and her responses reached diagnostic threshold for major depression, these data were utilized as one way of understanding her experience in relation to a widely accepted, standardized diagnostic tool. It is important to note that the primary definition of depression for this study was in no way standardized. The woman's self-definition of her unique experience of depression, grounded within her personal story, was viewed as

foundational since *DSM-IV-TR* diagnostic criteria can fail to fully capture the uniquely personal expression of depression as a lived experience. Perspectives of the community social network were viewed as complementary in understanding how women with depression seek help in the context of this particular rural locale.

Help-Seeking

The initial conceptualization of help-seeking used in this study was guided by the following definition: an individual's ability to actively inquire about and to request help for a mental health need (Fisher, 1996). Defining attributes of this definition included: 1) active, rather than passive event; 2) inquiry outside of the self; 3) assistance or aid sought; and, 4) mental health need as perceived by the person seeking help. A key element of the initial conceptualization of help-seeking was the nature of inquiry outside of self. This definition of help-seeking was viewed as an interpersonal process, which occurred in connection with others, rather than an internal intrapersonal process. Introspection and self-reflection were viewed as important antecedents to the action of help-seeking. However, the process of intrapersonal reflection was viewed as a separate concept that was necessary, but not sufficient, for engagement in help-seeking for depression. In the context of this study, the interpersonal process of help-seeking was influenced by and occurred embedded within the context of the community social network.

Rural Dwelling

Distinctions between the terms urban/rural and metropolitan/non-metropolitan are used in the literature as parameters for geographic description and population density.

Urban/rural categorizations refer to locations and population density, while metropolitan/ non-metropolitan categorizations are determined by population density or adjacency to a city or other dense residential population (U.S. Department of Agriculture, 2004). These descriptive categories are useful in identifying service delivery areas and in establishing standardized geographic boundaries for research purposes. However, these categories do not capture the individual character of the social networks in specific communities.

In this study, the research site was deemed rural as defined using geographic population measures. Specifically, terminology employed by the U.S. Bureau of the Census was used. These standards define rural populations as being ones in which fewer than 2,500 residents live or as having an open countryside terrain. The study setting met both of these standards. In comparison, urban populations are designated as areas including a central city and its closely settled territory, which has a combined population of at least 50,000 (Office of Rural Health Policy, 1994). Although population measures validated the research site as a rural area, the descriptive stories of the research participants were used to fully describe and define what rural meant in this individual community setting.

Community Social Network

The fundamental proposition guiding this study was the assumption that decisions related to help-seeking by rural women with depression were influenced by their own personal perceptions, along with the perceptions of other key people in their community social network. In this study, some of the members of the social network who were interviewed included family, friends, health care providers, law enforcement personnel,

and social services workers. These community members were selected by the key informant. Other community members, such as staff in the women's resource center and the county extension agent, were included at my suggestion, with agreement by the key informant. The decision to include these participants occurred at decision points during the data collection phase. This issue will be described more fully in the discussion of results in Chapter 4.

Significance of the Study

Although female to male ratios for prevalence of major depression vary from one study to the next, the rate for women averages at least two times the lifetime risk for depression as compared to their male counterparts (Agency for Health Care Policy Research, 1993; American Psychiatric Association, 2000). In 1995, the American Psychiatric Association appointed a task force that was charged with implementing an extensive review of the current knowledge related to the experience of depression in the population of women; this was to include review of theoretical conceptual work, as well as research findings. The product of this huge work effort was production of the publication *Depression in Women: Risk Factors and Treatment Issues* (McGrath, Keita, Strickland, & Russo, 1995). This work represented one of the most comprehensive synthesizing works on the topic of women's depression to date.

One of the most important findings of the American Psychological Association National Task Force on Women and Depression was the need to place the appreciation for and interpretation of any exploration of women's depression within a biopsychosocial context.

"Understanding the complexities of women's higher risk for depression requires understanding the interaction of women's biology with their environment. It requires clear definitions of depression and of the biological, psychological and social variables used to predict it. Most of all, it requires understanding the social construction of women's biology…" (McGrath, Keita, Strickland, & Russo, p.7,1995).

This emphasis on the biological, psychological, and social components of the experience of depression provides one of the major foundational tenets of the work. Because of my particular interest and experience in rural settings, the orientation of this inquiry focused on contextual cultural factors.

Summary

The issues of availability, accessibility, and acceptability of rural mental health services warrant immediate attention from researchers, practitioners, and educators (U. S. Department of Health and Human Services, 2003). In order to make existing and future services more acceptable, it is critical to understand the local cultural experiences that comprise the tapestry of everyday, ordinary life in rural communities. Thus, the purpose of this study was to describe and understand how one rural woman and her community social network perceived and expressed help-seeking for depression.

CHAPTER TWO

Review of the Literature

Statement of the Problem

It is widely recognized that depression is one of the most serious public health problems in contemporary America and throughout the world (Murray & Lopez, 1996; Satcher, 1999; U.S. Department of Health and Human Services, 2000). Depression is twice as prevalent among women than men in the United States and in most countries and ethnic groups across the globe (Kessler, 2003; McGrath, Keita, Strickland, & Russo, 1990; NMHA, 2004; Nolen-Hoeksema, 1990). The population of women living in rural communities throughout the United States is especially vulnerable to experiencing depression (NIMH, 2004). Further, these rural women who are particularly reluctant to seek help for depression are significantly influenced by their community social networks in making decisions about whether or not to seek help (Bushy, 1993; Hauenstein, 2003). The purpose of this literature review is to highlight some of the most significant findings to date in the exploration of how rural women seek help for depression in the context of their community social networks.

Significance of Depression

Depression is among the most prevalent of all psychiatric disorders (American Psychiatric Association, 2000; Gotlib & Hammond, 2002; Satcher, 1999). Because of this prevalence, depression is sometimes referred to as the "common cold" of psychiatry. Current estimates indicate that 20% of all Americans will experience a clinically significant episode of depression at some point in their lives. Depression is also a highly

recurring disorder, with over 75% having more than one depressive episode or experiencing a relapse of depression within two years of recovery (Keller & Boland, 1998). Depression has been associated with greater disability care, higher medical costs, and non-adherence to medical regimens, as well as to increased morbidity from medication misuse and/or abuse (Katon & Sullivan, 1990).   It is widely acknowledged that the consequences of depression are tremendous at both personal and societal levels.

Suicide, which kills approximately 30,000 Americans annually, is one of the most tragic and devastating consequences of depression (Jamison, 1999). The World Health Organization estimated that suicide was the cause of death in 1.8 % of the world's 54 million deaths in 1998. In ranking the causes of death worldwide by gender, suicide ranked second as the cause of all deaths in women and fourth in men. Up to 15% of patients with depressive disorders severe enough to warrant hospitalization eventually die by suicide at some point in their lives (Agency for Health Care Policy and Research, 1993). It is noteworthy that all of these statistics are likely underestimated, because suicide is chronically underreported. This underreporting occurs because some people who commit suicide disguise their actions and because those left behind do not or cannot acknowledge the reality of the suicide. By any standard, suicide is a significant national and worldwide public health problem that imposes tremendous suffering on the person who commits suicide and on those left behind.

Another result of depression at the individual level is the often negative impact on interpersonal relationships. Many of the symptoms of depression act as barriers to the quantity and quality of interpersonal relationships with family, friends, employers,

coworkers, and others. A few of the depressive symptoms that may directly or indirectly affect interpersonal connections are loss of interest or pleasure in activities, withdrawal and social isolation, irritability, and ruminations of dread or impending doom. Until the depressed person seeks help, the family and social networks of the individual often grow weary of the unremitting nature of these symptoms. Others may even feel that the depression is actually under the individual's personal control and that the depressed person could "snap out of it" or "think positively" as a remedy for the depression. Not only is the divorce rate higher among people with depression (Wade & Carney, 2000), but the children of depressed parents may be at elevated risk for psychological difficulties (Gotlib & Goodman, 1999). At every juncture, depression has a significant impact on the interpersonal relationships of the affected person and the affiliated social network.

Economic impact is a significant and often underestimated personal and societal consequence of depression. The World Health Organization Global Burden of Disease Study has ranked depression as the single most burdensome disease in the world (surpassing other chronic diseases such as diabetes and arthritis) in terms of total disability among people in the middle years of life (Murray & Lopez, 1996). In an analysis of depression in the American workplace, Greenberg, Kessler, Nells, Findelstein, and Berndt (1996) estimated that the annual salary costs of depression related productivity in the United States exceeded $33 billion. This figure is likely an under representation because it did not take into account the influence of depression factors such as the impact on performance of coworkers, turnover, and industrial accidents, all of which can be more invisible sequelae of depression.

Another economic impact of depression on the American economy was represented in health care costs and the use of health care resources. Total health care costs for treatment of mental illness, including depression, is a major driver of health care inflation and now ranks second only to heart disease in total costs (Rosenchack, Druss, Stolar, Leslie, & Sledge, 1999). Among mental health treatments, SSRIs, the class of antidepressants known as selective serotonin reuptake inhibitors, are a big contributor to cost escalation, accounting for $146 million in prescriptions filled during 2003 (National Public Radio, 2005).

Depression in Women

Definition/Description of Symptoms

The criteria outlined in the *DSM-IV-TR* are the most commonly used by American health care providers in MDE in women and men. Diagnostic criteria outlined in this taxonomy are the same for men and women. MDE is a mood disorder characterized by five or more symptoms during the same 2-week period, which represent a change from previous functioning; at least one of the symptoms must be either depressed mood or loss of interest in activities. In addition to these two requisite symptoms, other criteria may include significant weight loss or gain, insomnia or hypersomnia, psychomotor retardation or agitation, fatigue or loss of energy, feelings of worthlessness and inappropriate guilt, diminished ability to concentrate, and recurrent thoughts of death. Further, in order to make a positive diagnosis of MDE, the symptoms cannot be directly related to a general medical condition, such as hyperthyroidism, and cannot be better accounted for as a part of bereavement (American Psychiatric Association, 2000).

One manifestation of depression, which is common in all of its forms, is physical presentation of symptoms. Expressing depression through bodily symptoms is a process called somatization (American Psychiatric Association, 2000). The *DSM-IV-TR* recognizes three somatic symptoms associated with depression: sleep disturbance, appetite disturbance, and fatigue or loss of energy. However, depression can cause many symptoms. These include headache, diarrhea, dizziness, excessive sweating, palpitations, tinnitus, and nausea and vomiting. Depression is more difficult to diagnose in patients who somatize their symptoms, thus presenting a significant diagnostic challenge to primary care providers (Agency for Health Care Policy and Research, 2003).

Although depressive symptoms in men and women have been found to be similar overall, a few differences in presentation have been noted. Women are more likely to present with atypical or "reverse vegetative" symptoms, such as weight gain and hypersomnia. During interview, women tend to report a greater number of depressive symptoms than men. Most studies have found no gender difference in severity of depressive symptoms or in functional impairment. However, a study by Berndt et al. (2000) reported that women with a history of recurrent depression may develop more severity of symptoms than their male counterparts.

Types of Depression

In addition to MDE, other types of mood or affective disorders classified as depressive disorders include dysthymic disorder and bipolar disorder. Dysthymic disorder is characterized by a depressed mood for most of the day, occurring more days than not. The depressed mood associated with dysthymic disorder must have occurred for two

years in duration before reaching diagnostic threshold. In addition to depressed mood, other symptoms characteristic of dysthymic disorder are appetite changes, sleep/rest changes, low self-esteem, difficulty with concentration and decision making, and feelings of hopelessness. This chronic, but milder form of depression is two to three times more likely to occur in women than men. Nolen-Hoeksema (1990,1998) and Swartz (2005) have described an especially chronic and disabling phenomena, which is termed "double depression." This refractory mood disorder is characterized by ongoing dysthymia, with episodic spikes of major depression that may require acute treatment.

Bipolar disorder is characterized by alternating periods of major depression and mania. Feelings of grandeur or inflated self-esteem, diminished need for sleep, being hyper talkative, racing ideas and thoughts, and extreme distractibility are the major symptom markers for bipolar disorder (Swartz, 2005). Unlike MDE and dysthymic disorder, the prevalence of bipolar disorder occurs at approximately the same rates in men and women. Though dysthymia and bipolar disorder present significant mental health challenges for women, they are beyond the scope of this project.

Subgroups of Women at Increased Risk

As previously noted, women are at least twice as likely as men to develop MDE at some point during their lives, with the greatest differences found in studies conducted in the United States and Europe. Depression was described by Glied and Kofman (1995) as the most significant mental health risk for women of childbearing age. This differential risk emerges during adolescence and may coincide with puberty.

Certain groups of women are at increased risk for major depression. High levels of depressive symptoms are particularly common among women with economic difficulties, lower socioeconomic status, less education, and unemployment; all of these risk factors are over represented among women (McGrath et al., 1990). Women of color are more likely than Caucasian women to share a number of socioeconomic risks related to depression, including racial/ethnic discrimination, lower educational and income levels, segregation in the job market leading to lower status and increased stress, more physically and psychologically demanding jobs, unemployment, poor physical health, larger family sizes, increased marital strife, and unplanned parenthood (American Psychological Association, 2004). Rural women, like women of color, may be at risk for depression due to poverty, lack of education, unemployment, and family size (Hauenstein, 1994, 1996, 2003).

Women's Risk Factors

  Hormonal Factors

Over the years, claims that fluctuations in hormones have profound effects on women's moods have received a great deal of attention in the popular press and in the scientific literature. Parry (2004) asserted that hormonal factors related to the reproductive cycle might play a role in women's increased vulnerability to depression. Further, estrogen and progesterone were identified as affecting neurotransmitter, neuroendocrine, and circadian systems that have been implicated in mood disorders (Young, 2002). For example, estrogen and progesterone were shown to influence the synthesis and release of serotonin and norepinephrine, which are the neurotransmitters

believed to be most influential in causing depression. Kornstein and Wojcik (2000) also reported that medication levels may be altered by hormonal changes associated with the menstrual cycle, pregnancy, or menopause, as well as by contraceptives or hormone replacement therapy.

Fluctuations in reproductive hormones (estrogen and progesterone) are most notable during the menstrual cycle, pregnancy, the postpartum period, and menopause. The luteal phase of the menstrual cycle, which is a period of estrogen and progesterone withdrawal, is frequently associated with depressive mood changes, as well as the onset or worsening of an episode of MDE (Endicott, 1993; Kornstein, Schatzberg, & Thase, 2000). Approximately five percent of women meet criteria for a severe form of premenstrual mood syndrome known as premenstrual dysphoric disorder (American Psychiatric Association, 2000). The essential features of this disorder are markedly depressed mood, marked anxiety, fluctuations in affect, and decreased interest in activities. In order to reach diagnostic threshold, these symptoms must have occurred for most months during the previous year. Parry (1995) claimed that the similarity of this disorder to MDE might indicate a hormonally-based vulnerability to depression in some women.

Although pregnancy is often a time of emotional well being for women, there is no "protection" during pregnancy for new onset depression or relapse of previous depression (Cohen, 2003). Evidence from the few systematic studies of depression during pregnancy indicated that rates of mood disturbance in pregnant women are comparable to those seen in nonpregnant women (Evans, Heron & Francomb, 2001;

O'Hara, Schlechte, & Lewis, 1991). However, Cohen, Viguera and Lyster (2002) found a 75% rate of relapse in women with a history of depression who discontinued or reduced their antidepressant medication during pregnancy.

The postpartum period is also a frequent trigger for the onset of depressive symptoms (American Psychiatric Association, 2000; Nonac & Cohen, 1998). As many as 80% of women experience minor mood symptoms, commonly known as the "baby blues," following the birth of a child. Postpartum depression occurs in 10-15% of new mothers, and the rates are considerably elevated in those with a previous history of MDE. Women who have experienced postpartum depression are at increased risk for future episodes of depression, both in association with and independent of reproductive events.

Menopausal depression was once thought to be extremely common in women. Early editions of the *Diagnostic and Statistical Manual of Mental Disorders* included a special diagnostic category for menopausal depression, labeled involutional melancholia (Nolen-Hoeksema, 1990). Although there remains a common perception that the onset of menopause is a time of significant mood variability, there is little support for an increase in the occurrence of MDE in women experiencing menopause (Kornstein, 2003). However, there is some evidence that the perimenopausal period is a time of increased risk for recurrence of MDE in women with a history of the illness (American Psychiatric Association, 2000). There is also agreement that some minor depressive symptoms common during the perimenopausal period may be influenced by hormones, as well as other life events.

Another hormonal factor that may affect women's vulnerability to MDE is related to thyroid function. Thyroid abnormalities are much more prevalent in women than in men and have been closely linked to depression. Additionally, thyroid dysfunction may play a possible role in both postpartum mood disorder and premenstrual mood syndrome (Whybrow, 1995).

Despite the public perception that female hormones may be one of the major causes of depression, there is no evidence that any causal connection exists. However, it is noteworthy that women with a previous history of MDE may be more vulnerable to a recurrence of symptoms during periods of significant fluctuation in reproductive hormone levels. This vulnerability underscores the need for health care providers to be especially sensitive to mood changes and the need for depression screening during these periods of hormonal variation in women.

Social Factors

How women define and manage their mental health is influenced by a broad range of social factors, commonly called social determinants. In most cultures throughout history, different social roles have been prescribed for men and women. Social determinants influence how women enact these various social roles within the family at home, at work, and in other settings. In contemporary American culture, there are many social determinants that are conjectured to be influential in the higher prevalence of depression seen in women (McGrath et al., 2000; Nolen-Hoeksema, 1990). The social explanations for women's increased vulnerability to depression attribute this

vulnerability to acute and chronic stressors, which women experience more frequently than men.

History of trauma (sexual and physical abuse) was the social determinant most consistently linked to high rates of depression in women (Bolen, 1993; McGrath et al., 1990; Weiss, Longhurst, & Mazure, 1999). Sexual assault and physical assault have been linked both retrospectively and prospectively to depression and post traumatic stress disorder (Nolen-Hoeksema, 2003). One study estimated that one in three women globally had been beaten, coerced into sex, or otherwise abused in her lifetime (Heise, Ellsburg, & Gottemuller, 1999). Most sexual assaults against women occurred first during childhood and adolescence. The National Violence Against Women Survey found that 54% of the women reporting rape also reported having first been victimized before the age of 18 (Strauss & Gelles, 1990; Tjaden & Thoenes, 1998). A meta-analysis of 18 studies of epression and intimate violence found that the mean prevalence rate of depression among battered women was 48% (Golding, 1988).

Behavioral and feminist theories of women's increased vulnerability to depression compared to men often attribute this vulnerability to the negative consequences of women's positions of lower social status and power in contemporary America (Miller, 1976; Radloff, 1975; Seligman, 1975). Because of this lower status and power, women may experience more negative events and have less control over important areas of their lives than men, resulting in chronic strain. Nolen-Hoeksema, Larson, and Grayson (1999) posited that in intimate heterosexual relationships, some women faced inequities in the distribution of power over important family decisions. This was called "silencing

the voice" and may be employed by women in favor of keeping a positive emotional tone in their relationships (Helgeson, 1994; Jack, 1991). The authors noted that in some women, after attempting to voice thoughts or feelings, they still felt that their opinions were not taken seriously and that they were not affirmed or respected by their partners.

In addition to the chronic stressors of traumatic events and power inequity in some relationships, women were also more likely than men to have incomes below the poverty level. Bruce, Takeuchi, and Leaf (1991) found that adults in poverty were twice as likely as others to experience new episodes of depression, while Brown and Moran (1997) reported a rate of depression in low income mothers that was twice that found in the general population.

Finally, the social determinant of work overload was a significant issue for American women. Although women made less money than men, they appeared to work more hours per week than men when all the roles they performed were considered (Nolen-Hoeksema, Larson, & Grayson (1999). Women were often full time in the paid workforce and continue to do much of the traditional work in the home around domestic work and childrearing, particularly in rural families. Additionally, women are increasingly "sandwiched" between caring for young children and caring for sick and elderly family members (also a frequent hallmark of rural families). This work overload can contribute to a sense of "burnout" and general distress, including depressive symptoms (Gove & Tudor, 1973; Hobfoll, 1991; McInTosh, Keywell, Reifman, & Ellsworth, 1994).

Psychological Factors

Psychological explanations for the gender differences in depression have evolved over the last few decades. Early psychoanalytic explanations ascribed women's vulnerability to depression as stemming from masochism and psychological dependency (Deutsch, 1944). In the 1960s and 1970s, women were thought to be more vulnerable to depression because they more often suffered low self-esteem and made self-defeating behavioral attributions (Dweck & Gilliard, 1975; Radloff, 1975). Newer perspectives on gender role development were introduced by authors such as Gilligan (1982) and Brown and Gilligan (1992). These contemporary developmental theorists asserted that during their adolescent years, girls were socialized to play subservient roles to male partners and focused primarily on becoming good wives and mothers. For several decades, a theme in the psychological literature was that women were less assertive than men and more prone to helplessness, both of which contributed to higher rates of depression (Radloff, 1975; Seligman, 1975).

More current psychological explanations of women's increased vulnerability tend to focus on two issues; women's interpersonal orientation and the cognitive style of rumination, or "thinking too much" (Nolen-Hoeksema, 2003). Feingold (1994) claimed that one of the most consistent psychological differences between women and men was their interpersonal orientation. In this view, women were more likely than men to feel strong emotional ties with a wider range of people and to evaluate their roles in relation to others (e.g. as daughter, wife/partner, mother) as central to their self-concepts, to highly value what others thought of them, and to be emotionally affected by

events in the lives of other people. It was suggested that women may not only have experienced potential exposure to negative events by virtue of their broader social networks, but also that women may have experienced more emotional pain (in degree and kind) than men did when these events occurred (Leadbeater, Blatt, & Quinlan, 1995).

Jack (1991) and Helgeson (1994) argued that some women crossed a line from interpersonal orientation to an excessive concern about their relationships with others, which led them to silence their own wants and needs and to feel too responsible for the quality of their relationships. In recent studies using measures that tapped "feeling too responsible," women or adolescents girls scored higher on such measures than men or adolescent boys; higher scores on these measures were correlated with depression (Hegelson & Fritz, 1996). Thus, women were more likely than men to overvalue relationships as sources of self-worth, and interpersonal theories of depression have identified this tendency as a risk factor for depression (Barnett & Gotlib, 1988; Joiner & Coyne, 1998).

In addition to interpersonal orientation, rumination was another psychological factor that could predispose women to vulnerability for depression. Nolen-Hoeksema (2000) defines rumination as the tendency to focus on symptoms of distress, and the possible causes and consequences of these symptoms, in a repetitive and passive manner, rather than in an active and problem-solving manner. Though some rumination may be a natural response to distress, this author maintained that women who ruminate excessively in response to their depression had longer periods of symptoms and were more likely to be diagnosed with MDE.

The gender differences in rumination were reported in both self-report survey and interviews, as well as in laboratory studies in which women's and men's responses to sad moods were observed (Butler & Nolen-Hoeksema, 1994). Studies have shown that when people ruminate in response to depressed mood, their memories of the past, interpretations of the present, and expectations for the future become more negative and distorted (Lyubomirsky & Nolen-Hoeksema, 1995; Lyubomirsky, Caldwell, & Nolen-Hoeksema, 1998). This pattern of increasingly negative and hopeless cognition, which resulted from rumination, was described by Beck (1987) as contributing to development and maintenance of depressive symptoms. The topic of rumination and women's depression was explored in a recent book in the popular press, titled *Women Who Think Too Much* (Nolen-Hoeksema, 2003).

Depression in Rural Women

Thirty percent of all American women live in rural areas, but attention to their unique behavioral health concerns has been largely unaddressed in the professional literature (American Psychological Association, 2000). These rural women face all of the risk factors associated with the population of women at large, along with other unique issues and concerns. While not homogenous in terms of geography, economic base, or demographics, rural women share some common experiences. These include low population density, geographical distance from large metropolitan areas, isolation, and geographic barriers. Other experiences that most rural women share are dense social networks, a culture of self-sufficiency, traditional values, and patriarchal social structures. Often women in rural communities also encounter insufficient transportation

and communication systems, as well as diminished economic and work force resources (Mulder et al., 2000).

There has been very little research concerning how rural women describe and experience depression. Emily Hauenstein's work at the University of Virginia is one notable exception. In fact, this author's experience is the only rural women's research mentioned in the recent popular work by Andrew Solomon (2001), *The Noonday Demon: An Atlas of Depression*. Hauenstein (2003) reported that there are many factors that contribute to making rural women with depression "invisible" in their community and within health care systems. These include fear of stigmatizing attitudes by the community and health care providers, shame, and the impact of poverty. This author's work in a rural Southern Appalachian community confirmed that key informants in the community repeatedly mentioned the unwillingness of rural residents to discuss their mental health problems as the most significant barrier to seeking help for depression. This tendency not to disclose personal information related to depression was especially problematic for rural women. Hauenstein further asserted that what is known about the meanings that rural women ascribe to depression are so threatening that speaking about them is virtually taboo. The author's recommendation was that prior to applying known effective treatments for depression in rural women, it is critical to understand what aspects of the dominant cultural narrative impede discussion of talking about depression and of subsequently seeking help.

Rural Mental Health Issues

Rural America makes up 95% of our nation's landmass and is home to more than 25% of our nation's population. Virginia's population is reported as 30% rural (President's New Freedom Report - Rural Subcommittee, 2004; U.S. Census, 2000). While rural places and people exist in every state and territory of the United States, rural mental health needs are too often not taken into account (U. S. Department of Health and Human Services Rural Task Force, 2002). All too frequently, policies and practices developed in and for people in metropolitan environments are assumed to apply to rural populations. Epidemiologic evidence suggests that the prevalence and incidence of adults with serious mental illnesses, such as MDE, are similar between rural and urban populations (Kessler, 2003). However access to mental health care, practitioners, and delivery systems to provide care, and attitudes and cultural issues influencing whether people seek and receive care, differ profoundly between rural and urban locales (President's New Freedom Commission on Mental Health, 2004).

Despite widespread recognition of the paucity of mental health services for rural populations, little has been done to improve availability to such services. Problems faced in planning mental health service delivery in rural areas include the limited availability of specialty providers, restricted access to available care, and cultural and stereotypic barriers that deter people from seeking care. Increased stigma against those with mental illness has been identified as a characteristic of rural cultures (Howland, 1995; Hoyt et al.,1997). Yet there appears to have been little effort to delineate the nature of this stigma, how it varies from that in more urban areas, what its specific impact is, or how it can be altered or diminished.

Access to services is another barrier to rural persons seeking mental health services. Access reflects more than availability of different types of individual and organizational providers. Access also refers to barriers including isolation of services created by distance from available services, decreased availability of private and community funds to purchase care or to provide transportation, and prevailing cultural barriers to mental health care for minority communities. For women with primary parenting responsibilities, the absence of available childcare when accessing mental health care is a significant barrier. Also, for women who work during the day, public mental health clinics may not have sufficient evening appointment times available.

Merwin, Fox, and Holzer (1994) documented that the rural South was home to fewer specialty mental health providers and trainees as compared to other regions of the country. These authors noted that only in the northwestern United States was there a comparably low density of mental health providers per 100,000 population. Similarly, there were few mental health trainees in many southern states based on *Mental Health, United States* 1990 and 1992 data (Goldsmith et al., 1994).

Psychiatrists and psychiatric nurses are poorly represented in the South and both professions have modest numbers of trainees in the southern states. This scarcity of providers and trainees presents a major impediment to ensuring future access to specialty mental health services for southern residents. It is therefore reasonable to expect that people living in rural, southern areas will have greater difficulty accessing mental health services given lack of providers, the prevalence rate of mental illness, and the well documented difficulty of attracting and retaining specialty providers in rural areas.

In a recently published rural companion to the public health document, *Healthy People 2010,* it was noted that rural people were more likely than their urban counterparts to use primary care practitioners for mental health needs (U. S. Department of Health and Human Services, 2005). Physicians who practiced in rural and frontier areas played an even larger role than those in metropolitan areas (Geller, 1999). This may be attributed to the scarcity of mental health professionals and to the rural stigma associated reluctance to seeing a mental health professional. Treatment of mental illness by primary care practitioners faced a number of constraints, including insufficient mental health training in medical school, limited time for additional education after entering practice, short time for patient evaluations, lack of expertise in and time for counseling and related therapies, and lack of specialized mental health backup (Rural Healthy People, 2010).

There are many interrelated barriers to accessing appropriate mental health services in Virginia. Merwin, Hinton, Harvey, Kimble, and Mackey (2001) described multiple barriers specific to rural areas in Virginia. They found that the most frequently occurring barriers were financial, followed by transportation, an individual's personal resistance to mental health care, the lack of specialty providers, and the limited time for primary care providers to identify and treat mental health problems. Additional concerns related to how patients were identified and treated for mental health problems.

Regarding the provision of mental health care, the interviewees in this study noted problems in under identification of major mental health issues and under addressing identified issues. There were also perceptions that patients were discharged from treatment who were still in need of help. Other respondents highlighted the use of "old

medical models" and a hesitancy to prescribe state of the art psychotropic medications. The lack of mental health providers and the limited availability of staff were also mentioned as barriers, along with stigma.

Help-Seeking

The topic of help-seeking has received little attention in nursing literature, while the process has been of interest to social psychologists for several decades. In a review of the social psychology literature, Gourash (1978) defined help-seeking as any communication about a problem or troublesome event that was directed toward obtaining support, advice, or assistance in time of stress. Thus, the critical attributes contained within this early definition were: 1) communication; 2) problem; 3) support, advice, or assistance, and 4) distress. Gourash noted that much of the existing literature at that time explored the relationship between help-seeking and the social network. The author noted that the social network could affect help-seeking by buffering the experience of stress leading to help-seeking, by providing tangible or emotional aid needed and thus making professional help unnecessary, by acting as a screening/referral agent to professional services, and by transmitting attitudes, values, and norms about professional help-seeking.

Gottlieb (1995) also recognized the importance of the social network in the decision to seek help. This author suggested that the social network functioned as a treatment modality called the lay treatment network. The social network also aided in the help-seeking process by assisting in coping, providing some level of "treatment," and serving as a type of informal self-help group. McKinlay (1980) discussed the relevance

for considering how social networks affected the decision to seek medical help. This work proposed that the social network influenced the expectation of the visit, what the person presented to the provider, and perhaps most importantly, what the person ultimately did after the encounter.

Balint (1957) recognized the role of psychological issues embedded in the decision to seek medical care. These "hidden reasons" for deciding to see a doctor were outlined as follows: 1) upsetting events; 2) social isolation; 3) psychiatric disorder; and, 4) desire for health information. In another analysis, Zola (1973) described the complexity of the help-seeking process by identifying nonphysical triggers that precipitated help-seeking. These included the occurrence of an interpersonal crisis, perceived interference with social/personal relations, and sanctioning or pressure from others to seek medical care. Zola recognized that seeking help for psychological issues could be veiled under the guise of a "doctor's visit." These authors made significant contributions to the existing knowledge base by highlighting the connection between social network and decision to seek help, as well as emphasizing the secondary rationale of psychological help when seeking medical treatment.

Another important phase in the help-seeking literature began to emerge in the 1990s. As previously described, much of the extant literature had focused on linkage between social network, support, and help-seeking. Additionally, much of this body of work had viewed help-seeking as a negative trait associated with high levels of psychopathlogy and deficits in social support networks (Knisely & Northouse, 1994).

With the publication of Rosenbaum's (1990) analysis of the relationship between learned resourcefulness, coping skills, self-control, and adaptive behavior, a very different model was proposed in which help-seeking was conceptualized as a positive coping strategy. Around the same time, Nadler (1990) portrayed help-seeking as a coping resource with multiple potential positive outcomes. The author further described help-seeking as an interpersonal process in which an individual chose to seek assistance from others. It was viewed as the counterpart of self-control or self-regulation and was viewed as no less positive or healthy than a decision not to seek help outside the self.

In reviewing previous literature, Nadler (1990) described two distinctly different perspectives regarding the outcomes of help-seeking. In one model, help-seeking was viewed as inherently exacting psychological costs. These outcomes could include self-threat, because of the sometimes implied inferiority, dependency, and inadequacy inherent in our culture when taking the role of being a recipient of help. Although seeking help does not automatically equate with dependency, deeply ingrained norms of self-reliance in American culture may promote distortion. The other model of help-seeking described the process as an instrumental behavior with potential for positive outcomes. Chief among these benefits were the resultant increased psychological salience and self confidence gained from the success of reaching out interpersonally when intrapersonal efforts at coping had proven insufficient.

Help-Seeking in Rural Cultures

The perception of need for help is the first step in seeking help, and rural residents generally enter care later than their urban peers due to a lower perception of need. This problem may be compounded by the accompanying reality of diminished access to mental health care (New Freedom Subcommittee on Rural Issues, 2004). Empirical studies indicated that lower rates of access to mental health services were directly related to lower rates of availability or supply of mental health providers (Lambert & Agger, 1995).

Current research suggests that perceived need for mental health care in rural areas is so low that even minimal barriers in other areas can prevent someone from seeking help (Rost, Fortney, Fischer, & Smith, 2002). One recommended response to overcoming these barriers is implementation of a marketing campaign to enhance rural residents' knowledge of mental illnesses, treatment options and best practices, and local resources. Rural residents often note that they "couldn't go because they didn't know" and this barrier could be addressed through public education and marketing strategies. However, there is apprehension by some about creating any increase in demand when current resources are often inadequate or underutilized.

Many people in rural areas seek help from informal sources in order to overcome or compensate for their problems (Fox, Blank, & Kane, 1994). The process of seeking help from informal sources of care such as family members, friends, church members, and self-help groups is poorly understood. Additionally, the linkages between formal and informal caregivers have not been fully explored. In a study in which Young, Giles, and

Plantz (1982) interviewed 213 rural persons, 80% of this sample described themselves as active help givers and receivers. These findings suggested that informal help networks might have been underutilized sources of support for linkages with formal caregivers. Hill (1988) emphasized that rural health care systems are superimposed on existing social and cultural systems. Exploration of these social and cultural systems could help strengthen potential linkages between formal and informal helping networks, thereby enhancing workforce capacity of formal caregivers in rural communities.

Many of the identified values and beliefs frequently attributed to rural dwellers may serve as deterrents to seeking help for mental health problems. These include extreme self-reliance, conservatism, a distrust of outsiders, religion, work-oriented, familism, individualism, and fatalism (Bushy, 1992; Hill, 1988; Wagenfeld, 1990). Rugged individualism and emphasis on self-reliance may result in the belief that individuals should work out personal problems independently or with the help of close kinship networks. Further, the stigma concerning help-seeking for mental health problems remains pervasive in many rural communities. Wagenfeld (1990) argued that rural residents' values often precluded seeking help from formal caregivers for mental health problems and, if they did seek formal help, the expectations of caregiver/client were incongruent.

There are many distinct differences between rural and urban cultures that directly impact mental health care and help-seeking. In particular, mental health resources are often sorely lacking or are incongruent with the identified needs of consumers and families. Moreover, rural beliefs and values concerning self-reliance, work, and

community/family connections profoundly affect issues of availability, accessibility, and acceptability of mental health services in rural settings (New Freedom Commission – Rural Subcommittee, 2004). Currently, the range and complexity of these issues offer unique challenges for researchers investigating culturally congruent mental health care.

Summary

Depression in rural women poses one of the most significant public health challenges in current rural health care. Although the most current data indicate a prevalence of depression in rural women comparable to urban women, the issues of availability, accessibility, and acceptability of mental health care remain problematic for rural dwellers, health care providers, and policy makers. The tendency of rural women to seek help later in the course of depression further warrants investigation of help-seeking from formal and informal sources in order to provide culturally congruent clinical services and improve rural health care policy.

CHAPTER THREE

Review of Method

Introduction

The purpose of this research study was to describe how rural-dwelling women

experience depression and help-seeking for depression within the cultural context of rural

community social networks. This was accomplished through the use of a qualitative

descriptive method as described by Sandelowski (2001). The author emphasized that this

method of qualitative description could be influenced by overtones or hues of other

research traditions such as ethnography, phenomenology, or narrative research.

Ethnographic studies typically describe and interpret a cultural or social group or system,

including patterns of behavior, customs, and ways of life (Wolcott, 1990). In this study,

an ethnographic overtone was employed. This decision derived from the community

social network's construction as a cultural concept, foundational to understanding

experiences of depression and help-seeking by one rural woman in her social network.

Specific research questions that guided this study were:

1. What was the nature of depression as perceived by a rural-dwelling woman
   and members of her community social network?

2. What was the process of help-seeking for depression as perceived by a rural
   dwelling woman and members of her social network?

Researcher Assumptions

In exploration of these research questions, it was important to consider personal

assumptions that might potentially influence the research process. Clarification of

potential researcher perspectives was important so that the reader understood the

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researcher's position and any biases or assumptions that impacted the inquiry (Creswell, 1998; Merriam, 1988). In this clarification, the researcher commented on personal beliefs, values, and experiences that could have shaped the approach to and description of the study findings. These beliefs and assumptions were explicated as follows:

1.   There is a distinctly rural culture that is uniquely different from suburban and urban culture. Within rural culture, women often assume more traditional gender roles of major responsibility for homemaking and parenting, position of subordination and diminished power within the family and community, significant concern regarding the opinion of other community members related to decision making, and belief that sharing of "troubles" is best kept strictly within the family and/or a close knit circle of trusted friends.

2.   In rural settings, the importance of being a native is highly valued. The level of social status assigned by the community is most heavily influenced by how long the family has been a rural dweller in that locality. Age, gender, and occupation are also important attributes in assigning power and influence by the community. Men, elders, and professionals are generally viewed as most powerful. Women are often assigned power in relation to the social status of the family patriarch.

3.   Seeking help for depression by rural dwellers is difficult for men and women for different reasons. Men are expected to be "tough" and

seeking help from an outside source is often viewed as a sign of weakness. Women's tendency to share depressive feelings in a more expressive, external fashion than their male counterparts can be minimized as "just being a woman or being overly emotional." Rural women are expected to be controlled, composed, and hard working in enactment of social roles and functions. The community response to emotional concerns is often an admonition to "just get over it, get your mind on something else," or to simply "work harder."

4. The research process is an inherently mutual and reciprocal experience in which the researcher and the participants learn, grow, and expand their perspectives together. Assuming the "expert role" as researcher and/or practitioner can negatively influence the trust necessary for successful relationship building in these contexts.

5. Informal helpers in the community are very important partners in the process of help-seeking for depression. In fact, they can often deter the need to seek help from formal sources. However, when depressive symptoms begin to interfere with daily activities, personal satisfaction, or safety of self/others, then formal treatment may become necessary. This is always best accomplished when the person has input into the choice of available treatments, including the gender of the person providing help.

6.   The researcher's beliefs regarding help-seeking for mental health problems have been shaped by a career of working in mental health settings and doing community service in rural locales. Most recently, the researcher's perspective has been heavily influenced through her role as director of a not-for-profit mental health advocacy organization. This experience has given the researcher a renewed appreciation for the concepts of self-empowerment, self-determination, and hope in formal and informal helping networks.

During the reflection and data analysis of the study, the researcher kept these assumptions present as a part of decision making processes. In doing so, the aim was to separate the researcher's own biases from influencing the findings. However, it is also important to note that the researcher made no claims that this study was value free. Lincoln and Guba (1985) emphasized the following propositions in their foundational tenets of naturalistic inquiry: 1) the relationship between the knower and the known is mutual and inseparable; 2) reality is mutual and simultaneously shaped by the knower and the known and, 3) naturalistic inquiry is value dependent, not value free.

No matter how one attempts to naturalize the environment, research is an artificial process and any interaction between people involves sharing of one's own values, beliefs, and ideas (Crabtree & Miller, 1992; Ely, Anzul, Friedman, Garner, & Steinmetz, 1991). Persons are all influenced consciously and unconsciously by previous experiences and perceptions. Sandelowski (1995) noted that the paradox of one's worldview is that it opens up and blinds at the same time. In qualitative research, the aim is not to eradicate

or neutralize values in an effort to make the relationship between the knower and the known dispassionate. It is to raise awareness about how values, experiences, and perceptions enter into the research transaction and eventually help shape the findings. Therefore, explication of researcher beliefs and assumptions at the outset of the project was an important step in planning and enacting the study.

Overview of Method – Qualitative Description

Lincoln and Guba (1985) proposed that there is no hierarchy of paradigms, since the goal of all inquiry is to get at the meaning of the experience. Sandelowski (2000) concurred with this perspective and maintained that the general view of descriptive research as a lower level form of inquiry has negatively influenced the use of this important research strategy by qualitative researchers. This author notes that the critique of descriptive research as the "crudest form of inquiry" (Thorne, Kirkham & MacDonald-Emes, 1997) may have discouraged its use by both quantitative and qualitative researchers.   Wolcott further (1992) proposed that the attitude of devaluing some methods as less rigorous or important has resulted in "posturing" about phenomenologies, grounded theories, ethnographies, and narrative studies that are in fact descriptive studies.

Sandelowski (2000) listed several important features of the qualitative descriptive design. First, it was noted to be an existing categorical, rather than noncategorical method, which was relatively unacknowledged and underutilized. This position departed from the claim that qualitative description is a new, distinctively nursing adaptation of grounded theory, ethnology, and phenomenology (Thorne, Kirkham, and MacDonald-Emes, 1991). A second critical and defining aspect of the method is that qualitative

descriptive studies do not require researchers to move as far from or into the data as interpretive description. Researchers using qualitative description stay closer to the data and to the surface of words and events than researchers conducting ethnographic, grounded theory, phenomenologic, or narrative studies. Third, these studies should not require a highly conceptual or abstract rendering of the data. The valued end product of qualitative description is viewed as inherently sufficient, rather than as a necessary intermediate step toward a theory building inquiry. That is, the descriptions grounded in the words of the participants are valued as having privilege, without imposing researcher interpretation.

Sandelowski (1989, 1993, 2000) proposed that qualitative description should be used unashamedly by researchers whose goal is a comprehensive summary of events and experiences in everyday terms, along with the presentation of the experiences in everyday language. The aim of this study was description of the unique, yet ordinary, experiences and processes involved in depression and help-seeking by women and community dwellers in their rural community social networks. Use of an accompanying overtone or hue was employed in the study to reflect the cultural "look, tone, and feel" of the description and end product (Sandelowski, 2000, p. 337). Since culture has often been constructed as the ordinary, "invisible" enactment of everyday living (Altheide, 1987) an ethnographic overtone was employed during the research. Hence, qualitative description with an ethnographic overtone fit well with the concepts of interest and the expected product in this study.

In summary, Sandelowski reiterated that surface descriptions of the data should not be viewed as superficial, worthless, or trivial. The author viewed descriptions as especially amenable in obtaining direct answers to questions of significance for practitioners and policy makers. The research questions in this study were viewed as having potential value for consumers, practitioners, and policy makers and fitting well with a qualitative descriptive design. Most importantly, the purpose of the study was aimed toward describing and understanding, rather than explaining or interpreting answers to the research questions.

Study Design

Sample

The sampling plan for this study was modified based on events that occurred early in the recruitment phase. In the original sampling plan for the study, the aim was to recruit and interview three to five rural women who had experienced depression. This initial group of women would be asked if they knew other women who had experienced depression and who might be interested in study participation. This method of referral of potential study participants by current study participants is called snowball sampling (Kuzel, 1992). The women in the initial round of interviewing would then be asked to contact their participant referral, with a subsequent follow-up to be made by the researcher. The initial goal was to interview twelve to fifteen rural women who had experienced an episode of depression.

One of the planned recruitment strategies was an article in the community weekly newspaper, featuring an interview by the researcher, which described the research project

and solicited potential participants. After the interview for the newspaper article, the reporter asked if she could participate in the study, saying that she had "lots of experience with depression." Thus, recruitment of the first participant occurred in an unexpected manner.

During subsequent interviews with the first study participant, the need for modification of the sampling plan emerged. As she discussed how she had managed her depression and the processes of seeking help, the role and influence of others in her social network became an area of emerging interest and exploration. She described the prominent role played by her mother on several different occasions when she had decided to seek formal help for her depression. Further, she described the key support role that her network of friends had occupied throughout her experience of depression. She also described how interactions with community members, such as the sheriff, social services worker, and her therapist had been influential within the context of her experiences of depression and help-seeking. Based on the emerging data from conducted interviews, as well as support from the literature, the decision was made to explore help-seeking for depression in the context of the community social network, rather than solely from the perspective of a sample of rural women with depression.

Thirteen participants were interviewed during the course of the study, totaling 35 hours of face-to-face interview time. The first level of data was obtained from the primary informant, (i.e. the rural woman with depression). The second level of data was obtained from 13 members of the community social network who were selected either by

the primary informant, another member of the community social network, or the researcher.

Setting

The setting of the study was a rural mountain community in Virginia. The population was deemed as rural using population measures defined by the U.S. Bureau of the Census and taken from 2000 U.S. Census data figures. The county had a population of approximately 5,000 people (all designated as rural) and covered an area of close to 350 square miles. Census figures reflecting race of householder-by-householder type revealed that 509 families in the county were Caucasian, none were African-American, and five fell within the category of American Indian, Eskimo, or Aleut.

Participant Recruitment

As noted in the previous section describing the sample, the participant recruitment plan was modified early in the course of the study. The original recruitment plan included visits to women's church groups, garden clubs, and extension homemaker clubs, along with placing flyers in grocery stores, beauty salons, and the community's primary care provider's office. Since a newspaper article describing the study prompted the first study participant and subsequent modification of the sampling plan, the above recruitment strategies were not employed.

Data Collection

The primary source of data was obtained from a purposive sample of one woman (between the ages of 25 and 44) who was willing to participate, had experienced depression, had sought help, and lived in a rural community. She had been treated for

major depressive disorder as defined in the *DSM-IV* diagnostic criteria and as described experientially.   The rationale for studying only one gender was based on the marked prevalence of depression in women. All racial and ethnic groups were open to inclusion, although the homogeneity of the population disallowed racial or ethnic variation in the sample.

Morse (1994) emphasized that multiple data sources including interviews, observation, field notes, and reflective writing were recommended in qualitative research studies; each of these strategies was utilized during this inquiry. Minimally structured audiotaped interviews lasting between 60 and 120 minutes occurred in a naturalistic setting of the participant's choice; among these were the participant's home, office, or worksite, and on one occasion, a restaurant.   The initial question offered to the key informant (the woman with depression) was "Tell me what it was like when you looked for help for your depression." Subsequent interview questions emerged based on the reciprocal process that occurred between researcher and participant and on the emerging conversation. Intermittent field notes were taken during the interviews to track the process, note nonverbal behavior, and document hunches. These field notes served as a "backup of data" in the event of malfunctioning recording equipment and to supplement recording of nonverbal data.

Fourteen participants were interviewed during the course of the study, totaling around 35 hours of transcribed interviews. The following table summarizes some of the key elements regarding the participant interviews:

Table 1: Data Sources – Participant Information

Participants	Selection Source	Selection Criteria	Location of Interviews	Length and Number of Interviews
Susan	Self	First hand experience with depression	Participant's home and therapist's office	Four interviews, totaling 15 hours
Ellen	Researcher	County official involved in local women's health policies	Participant's office	One interview, totaling one hour
Jane	Referred by her daughter, Susan	Played important role in help-seeking experience	Participant's home	Six hours of participant observation/ interview
Lana	Susan	Susan's therapist	Participant's office	One interview, totaling one hour
Terry	Susan	Friend	Restaurant	One interview, totaling one hour (not taped)
Johnny	Susan	Susan's social services worker	Participant's office	One interview, totaling one hour
Bob and Jane	Susan	Two of Susan's health care providers	Participant's office	One interview, totaling two hours
Tommy	Susan	Susan's "best friend"	Participant's home	One interview, totaling two hours
Dawn	Researcher	Involvement in community women's issues	Participant's office	One interview, totaling two hours
Connie	Susan and researcher	Director, Women's Domestic Violence Ctr.	Participant's office	One interview, totaling two hours
Barry	Susan and researcher	Susan had interacted with him in dealing with her experience of domestic violence	Participant's office	One interview, totaling one hour

Pam	Researcher	Expertise in local women's health issues	Participant's office	One interview, totaling 90 minutes
Joe	Researcher, Dawn, and Pam	Importance of local church as a community institution in rural settings	Participant's office	One interview, totaling one hour

Participant Protection

Informed consent was obtained from all study participants prior to beginning the first interview. Confidentiality was maintained by the researcher and transcriptionist. Participation in the study was voluntary and the participants were advised that they could withdraw at any time without any negative consequences. Transcripts and tapes were stored in a secure area that could not be accessed by others. All discs, tapes, and transcripts produced during the project will be destroyed at the end of the study. Pseudonyms were used in reporting the findings in order to maintain anonymity and confidentiality of the participants.

Potential risks and benefits were explained in advance. The participants were advised that for certain people, the recalling of depressive experiences could be painful. The participants were assured that the researcher had extensive experience in the role of therapist and counselor as an advanced practice psychiatric nurse. It is noteworthy that the recall of painful memories was not encountered as problematic during the study. Rather, the participants generally described themselves as feeling comfortable and expressed appreciation to have someone listen to their story.

Data Analysis

The preferred data analysis strategy for use with qualitative descriptive designs is qualitative content analysis (Sandelowski, 2000). One such analytic strategy is described by Morgan (1997) as a dynamic form of analyzing verbal and visual data that is oriented toward summarizing informational contents of that data, rather than relying on counting. This author claimed that qualitative content analysis is a credible technique, which is frequently misunderstood and unclaimed by both quantitative and qualitative researchers. Qualitative content analysis was proposed as a viable alternative when the available data and research goals warranted the advantages of content analysis in selecting descriptions answering the research questions and exploring initial patterns in the data.

The researcher was challenged to reflexively interact with the data to accommodate developing insights during and between participant interviews. This reflexivity helped shape foreshadowed questions, highlighted details related to concepts of interest, clarified information already obtained, and informed sampling decisions as the emergent research design took shape (Maykut & Morehouse, 1994; Munhall & Boyd, 1993). Sandelowski (2001) claimed that this strategy was the least interpretive or analytic of the qualitative analysis approaches in that there was no mandate to re-present the data in any other terms but their own (i.e., as grounded in the words of the participants).

Step by step application of qualitative content analysis in this study is described as follows:

1. Interviews were audiotaped by a high quality recorder that did not have voice activation. These tapes were then transcribed by a transcriptionist who the researcher had worked with on previous projects and was found to be professional, accurate, and attentive to confidentiality.

2. Field notes were taken during each interview with an aim of capturing nonverbal data and as a backup in the event of equipment failure. These notes were reviewed soon after the interview observation for clarity and additional comment.

3. After transcription of the interview was received, it was reviewed for accuracy and/or any gaps in the narrative.

4. Multiple readings of the transcript were done with initial readings focused on an attempt to get a sense of the whole in relation to individual interviews.

5. During subsequent readings, phrases and chunks of text were marked, without any attempt to name or understand the meaning. This step was the first move toward a surface rendering of the data (Sandelowski, 1989, 1994, 2004).

6. On the next reading, the two categories, nature of depression and nature of help-seeking, were noted on the transcript with color highlighting. These categories were drawn from the research questions.

7. Salient descriptive quotations were extracted from the transcript text to illustrate and support the categories of experiences of depression and of help-seeking. Themes described in relationship to the two research questions were then derived from multiple readings and analysis of the data. The decision rule supporting

inclusion of each theme was presence of data supporting the theme in at least half of the participants interviewed.

8. Throughout the "play" with the text, field notes were referred back to and notes were made as new impressions emerged.

9. This process was continued until no new insights came forth and then the process was repeated with the next interview, continuing until all interviews had been described with sufficient depth.

10. When all interviews had been reviewed, comparison for common descriptions across interviews was undertaken.

Issues of Trustworthiness and Legitimacy

Credibility and legitimacy of the research were built into the method of grounding observations and descriptions in the actual data. Credibility was further enhanced by data collection within a naturalistic setting. Legitimacy was also enhanced by providing ongoing researcher contact with participants during the duration of the study and by use of the participants' own language in explicating all descriptions. Sandelowski (1993) emphasized that rigor is established concurrently during the data collection and analysis phases of the project, and should never be viewed as occurring at the end of the research.

Concurrent validation, also known as member checking, was considered by Brink (1991) to be the most critical validation procedure in qualitative research. This was achieved through intermittent checking with participants during the interviews for validation of hunches and meanings. In sum, trustworthiness and legitimacy were

maintained by: a) grounding observations and descriptions in the data; b) using multiple methods of data collection; and, c) regular member checking during interviews.

Summary

There is currently very limited information available about how rural women ascribe meaning to the social and cultural factors that influence help-seeking for depression. Hauenstein (2003) asserts that it is important to design local resources and methods of treatment for rural women with depression. Toward this eventual aim, one community in rural Virginia was explored against the cultural and social backdrop related to help-seeking for depression. Because of the cultural context of the study, an ethnographic overtone was employed within the qualitative descriptive design. This warranted the collection and analysis of data by consistently keeping the concept of culture as a lens for understanding.

This qualitative research study employed the method of qualitative description as presented by Sandelowski (2000) and was designed to describe the nature of depression and of help-seeking for depression in the cultural context of one rural community social network. Fourteen participants were interviewed during the data collection phase of the study; data collection methods included interviews and participant observations. Data analysis was done using a qualitative content analysis as described by Morgan (1997). The findings of the study are presented in Chapter Four, with emphasis on the two research questions.

What was the nature of depression as perceived by a rural dwelling woman and members of her community social network?

1. What was the process of help-seeking for depression as perceived by a rural dwelling woman and members of her social network?

2. What was the process of help-seeking for depression as perceived by a rural dwelling women and members of her social network?

CHAPTER FOUR

Presentation of Findings

Introduction

This chapter described the major findings of the study categorized around the two concepts of interest: depression and help-seeking for depression by women within a rural community social network and by her community social network as a contextual backdrop. First, presentation of findings from each participant was described as a foundational step in laying the groundwork for descriptions of themes related to the research questions across all participants. The chapter closed with a summary of themes discovered across interviews with all participants and these themes comprise the major findings of the study. The conclusions were generated using a research design of qualitative content analysis and more specifically a data analysis strategy called qualitative content analysis (Sandelowski, 2001; Morgan, 1997). The findings were supported through the use of accompanying selected quotes, grounded in the words of the participants and illustrative of the findings generated within the study.

Findings from Each Participant

Susan - Primary Participant

The primary participant in the study, Susan, was a Caucasian woman in her early 30s who was currently separated from her third husband. She married for the first time when she was 17 years old and was the mother of four children ranging in age from 9 to 15, all who were from her first marriage. Susan was not a native of the rural community

in which she now lived and described herself as having been "raised in the North." She was a high school graduate with community college training as a dental hygienist. Susan was currently employed part-time outside of the home, worked full time as a mother and homemaker, and received child support from the father of her four children.

During early adolescence, Susan's family relocated to this area from a different section of the country. Her mother and father were both alive and in good health and she described them as a significant source of support to her; they currently resided in comfortable driving distance from Susan. Susan's mother worked in the home and her father commuted to another county where he is a professional businessman. Susan's maternal grandmother and maternal great aunt lived on the same farm property as the parents, and the parents have provided support in assisting them with maintenance of daily activities. Recently, the grandmother's health had declined, with some accompanying cognitive changes affecting self-care ability. Further, Susan's great aunt became unable to live independently and was transferred to a long-term care facility where she had just recently died.

Susan was the eldest of three siblings and had two younger brothers who also resided in this rural community. The oldest brother was married with children and the youngest brother, who has had "learning problems," had moved away from home in the past few years and maintained a separate residence for the first time. He utilized his parents' home as a base for support and visited daily with the mother, assisting her in doing farm and household chores. Though the family was not native to the area, the

practice of intergenerational sharing of homes on the same "family property" was a common practice in rural communities.

Susan reported that she had a very difficult adolescence. She never felt accepted by her rural peers at school and she related that her female peers were especially mean to her - "they thought I was going to take their boyfriends away from them." This social ostracism was a major source of unhappiness and she always felt like an outsider after moving from her previous school and community. She related that her only friend during high school was another girl "who didn't care what they thought about her."

Susan had married three times and was currently in the process of divorcing her third husband. The first marriage occurred near the end of high school and lasted around eight years. She reported that she and her husband "just grew apart" and that was the reason for her divorce. There were two subsequent marriages and she described both of these as having been "physically and verbally abusive."

Ellen – County Official with Local Health Policy Influence

This taped, 90-minute interview was held in the participant's office, which was located in the county government administration complex. Ellen was interviewed because of her potential impact on health care policy and also because she was the first woman to be employed as the county manager. Having a woman in this job was a significant departure from norms in which professional or government jobs were reserved for men. She stressed at the outset of the interview that she "was not sure how she could be of any help." Ellen had grown up in a rural community in far southwest Virginia and had just moved from a rural town in Vermont.

Ellen recounted that the most positive local event in town was the recent development of a Community Violence Task Force, of which she was a member. Currently, the local weekly newspaper had been highlighting public service announcements about the Women's Center for Domestic Violence. Ellen described the role of an insider/outsider mentality: "the natives just sit back and let things go on like they always have. Then they get mad if newcomers express ideas or volunteer to do things. It's a hard system to break into." Ellen described geographic distance as the most significant barrier for rural women trying to seek help for depression. "Things are really spread out…there's not a wealth of services and the driving distance is prohibitive for many folks."

During the course of the interview, Ellen tearfully described her own personal experience with an episode of depression, which left her more sensitive to how disabling and frightening depression can be. While living in rural Vermont, she had been dealing with different stressors, including the geographic isolation of the locale, ethical conflicts in her job as county manager, and other interpersonal challenges.

During a major snow and ice storm, she was trapped in her house for four days: "I couldn't drive anywhere, couldn't get to the mailbox, couldn't do anything." Finally, I decided that I was going outside to get some fresh air and fell, hitting and injuring my head…there was blood everywhere. After that, I had this sense of panic that I had to get out of the house, get out of Vermont… I just kept saying over and over…I've got to get the hell out of here...I was getting more and more depressed."

"I called my mother and shared what I was going through and her response was 'just pull yourself together and be an adult.' I smiled through tears, and responded, 'What does being an adult have to do with this?' I then decided to call a friend of mine who had been through some emotional problems...she reassured me that she understood what I was going through and that it would get better…'but you just can't ignore it.'

"Eventually, I was able to figure out that I was not only feeling trapped by the snowstorm, but was feeling trapped by my life in Vermont. This prompted the beginning of a job search, moving here, and my new job here."

Jane - Susan's Mother

The interview with Jane was scheduled for 90 minutes. Instead, the investigator arrived at Jane's home at 10:30 a.m. and stayed into the afternoon; two hours of this time was audiotaped. Jane was tremendously interested in sharing her experiences through her consummate storytelling. She and her husband shared their home with 13 dogs and a menagerie of other animals and fowl. Jane was not a native of this rural locality. After living in a community adjacent to the site of a nuclear accident, she and her family moved to the most rural area that they could find that was a safe distance from a nuclear power plant. She and her husband had been married over 30 years. She practiced Catholicism and routinely drove over 40 miles to attend religious services several times a week.

Jane was instrumental in helping her daughter seek services for domestic violence. On one occasion, she picked up the telephone book, looked up the number for a domestic violence treatment program, and assisted Susan in making a call for help.

Jane also shared that her husband had recently been the victim of downsizing leaving him out of a corporate job where he had worked for nearly 30 years. This was an unexpected event that negatively affected his self-concept, along with the family's way of life. She described him as having had a "clinical depression" from which he was recovering. Currently, he was employed, but in a job of less status and salary than his previous management role. She also described herself as having been instrumental in "strongly encouraging" him to seek medical care when he became depressed.

Lana – Susan's Therapist

Susan suggested that I accompany her on a visit to see her therapist, saying "you could learn a lot about me from Lana." Lana was an engaging and knowledgeable woman who was interested in the research project and in helping me "get to know Susan better." Lana related that most of her referrals were made by community physicians. She had a collaborative practice with a physician (GI specialist) in the same office building. Lana stressed that 20% of the women she saw in her practice have irritable bowel syndrome (IBS); this demonstrated one way that women internalized their relationship conflicts, which were then expressed through physical symptoms. She informed me that there is a strong correlation between history of abuse, particularly of childhood sexual abuse, and IBS.

She used humor in illustrating some of Susan's current issues and Susan laughed easily and seemed comfortable with this style. One example of the use of humor was the description that Susan and women with similar issues "develop antennae to zero in on inadequate, macho guys, who have antennae to sense which women will buy into the

inaccurate notion that they are 'less than' in the context of relationships." She also talked about Seligman's model of learned helplessness as related to women with depression and anxiety. She portrayed this as a trap in which "women feel secure in their misery, rather than trying the misery of insecurity."

She noted that in Susan's case, what initially looked like an episode of depression, was more akin to post traumatic stress disorder "as the layers were peeled back." Lana emphasized that inquiring about a history of violence and abuse was a routine part of her initial assessment interview. She further stressed the importance of dealing with the issue of abuse and violence head on and throughout the course of the therapy. However, she acknowledged the difficulty of women sharing such sensitive personal experiences. Because of the threat of sharing this kind of experience, Lana initially framed abuse inquiries in more oblique ways, such as, "Tell me about the last time in intimacy that you were forced to do something unpleasant."

Lana described Susan as minimizing her level of personal threat/danger and clarified that during the separation period, "her husband has been stalking her…stalking is a pretty serious thing." One of the therapy assignments that Susan had been working on was reading the popular book, *The Gift of Fear* (Becker, 1998). The thesis of this book was that there are survival signals we often perceive, which are typically minimized or discounted, but that may protect us from violence or even save our lives. Susan related that she was "really enjoying the book…I'm learning a lot of things and it validates that I'm not crazy or hysterical…in fact, my radar is pretty good."

Terry – Susan's friend

This interview was scheduled for an hour and occurred in a restaurant near the participant's place of employment. When calling to arrange an interview appointment time, Terry indicated that it was more convenient to meet someone other than in her home. Since we had not met in person, she gave me a description of herself and left a message with the hostess so that I would recognize her. Because of the public nature of the environment, our interview was not tape recorded and I took detailed field notes and enhanced these notes immediately following the interview.

Terry was a well dressed and well groomed woman who looked to be about the same age as her friend Susan (early to mid 30s). She greeted me with a handshake and introduction and we began by talking in general about the nature and goals of this research project. Terry was very forthcoming and articulate in responding to requests for information. She was a college graduate and had also enrolled in an associate degree nursing program for one year before stopping this course of study.

In preparation for the interview, I formulated the following foreshadowed questions as important to explore: 1) Tell me the story of what your friend did when she was depressed; 2) What was your involvement like in this process; and, 3) What do I need to learn about depressed rural women seeking help for depression? Within this context of inquiry, she willingly provided thoughtful and descriptive information as we ate lunch together.

Like Susan, Terry was a single mother with two daughters, one of whom was the same age as one of Susan's sons. Terry and her daughters lived with her parents and she

described being consistently and conscientiously involved in the role of single parent. Further, it sounded as if she was frequently involved in personal and/or child related activities as she reviewed the upcoming evening's activities: "Tonight, I'll be attending my church women's club and both of the girls will be in soccer clinics – the coach is picking them up for me. I'm usually there myself, because I'm assistant coach of the soccer team." At another point in the conversation, she noted, "I don't usually date much…it wouldn't be fair to the kids." She spoke proudly of her daughters and shared a photograph of them as we talked. She also mentioned that she had a picture of "our kids" (Susan's and Terry's) on her desk at work. At one point she went to the car to get a photo of all of the kids together, but was unable to find it.

She said she had been "best friends" with Susan for about two years and that they had known each other "since the kids were in preschool together." Terry was not a native of the rural community where Susan lives. However, she grew up in a rural town in the north that was similar in its racial homogeneity (almost exclusively Caucasian) to the rural community being studied in this inquiry. These two women also attended the same Catholic Church and their children were involved in many church related activities together. Terry emphasized that Susan's usual pattern of socializing at church stopped during the last abusive marriage and that she had become increasingly isolated in comparison to her usual style of connecting interpersonally.

Johnny – Social Services Worker

Johnny was a Caucasian man in his early 30s. He was not born in the community, but had spent most of his youth in the area, thereby granting him some degree of

"insider" status. He agreed to participate in an interview and I met with him in his office at the Department of Social Services. Initially, I asked him to talk about how rural women in difficult life situations seek help for depression. He emphasized that he is a "generic" social worker with a background in criminal justice, not a psychiatric social worker. He emphasized the role of local family history as a predictor of which families in the community would have difficulties.

He seemed to have a rather definite predetermined notion of what constituted "good" versus "bad" families. In discussing depression among women in the community, Johnny initially asked the investigator to define depression. After hearing the definition of depression according to the *DSM-IV* criteria, he quickly equated depression to a lack of self-sufficiency.   He offered a solution to the problem of domestic violence by suggesting that women victims should be moved to an urban area, where they could have increased opportunity to obtain employment and access a higher level of resources.

Bob and Mara - Community Health Care Providers

This interview was held in the home of Bob and Mara which was in an isolated area, at the end of a dirt road and not maintained by the local transportation department. Originally, the appointment was made with Bob; however, when I arrived, Mara asked if she could join the dialogue, which was welcomed by the researcher. Bob and his wife, Mara, had lived in this rural community for five years and he described himself and his wife as "definitely being outsiders." The tone of his discussion was ominous as he discussed the "evil" at play in the community and the potential peril that was faced by outsiders, due to the Ku Klux Klan and other dangers.

Bob was helpful in describing his perception of women's experiences with depression within this community. He stated that women presented with vague physical complaints of illness instead of labeling their conditions as "depression." Many of the women who presented with depression were in a marriage with an alcoholic husband. In general, women came to him with symptoms of depression at the point at which their behaviors were affecting their ability to work and/or to maintain their home. The women often resisted antidepressant medication due to their belief that the medications were tranquilizers, and therefore, were addictive. There was generally a low level of knowledge about antidepressant medication among this cohort of women.

In contrast to her husband's description of women's depression in his health care role, Mara tearfully shared her own more personal experiences with depression. She focused on the social isolation of the community, perhaps contributing to the high level of what she termed "endemic depression." Mara emphasized a lack of activities or gathering places, such as an exercise facility, as being contributory to isolation. She noted that there was generally little chance for regular face-to-face communication for women if they did not work outside of the home. Since their move here, she had not practiced as a nurse, and expressed appreciation for the opportunity to think and discuss important health care issues.

Tommy – Susan's Friend

Tommy was a male friend of Susan's and they had worked together and known each other for three years. He was referred for interview by Susan who said "he knew her better than anyone else." The interview was held in Susan's home, while she ran errands;

she was not present during any of the interview. Tommy was a Caucasian man in his early 30s, who was eager to participate in the 90-minute interview. During the opening portion of the interview, Tommy shared that he was planning to visit a doctor within the next week to "see what's wrong with this brain of mine." He said that he had experienced his own troubles with depression.

In our interview, Tommy discussed his role in Susan's life. Tommy was married and noted that he and his wife often invited Susan out to hear the band in which he played. During these times, there was a group of other friends (usually at least 10 people) who generally socialized together. He described his belief that he and his group of friends "needed to help get Susan out of the house," and portrayed her social isolation as a prominent feature of her depression.

During the time that I spent in Susan's home, I observed Tommy enacting parenting skills somewhat like a surrogate father with Susan's children. These included comforting one of them when a minor sledding accident occurred, negotiating during a sibling conflict, and giving feedback/reinforcing limits set by Susan for one of the adolescents. In addition to the affective support that Tommy provided, he also helped with instrumental home management tasks, such as car maintenance/repairs, as well as loaning her a vehicle of his own.

Dawn – Community Services Provider

Dawn described her area of focus as bringing family and human development resources and research into the community. She noted the impact of very limited economic resources as a barrier to services for individuals and the local policy level.

"We are living in Appalachia in a very rural, isolated community that has limited to no resources."

She had been instrumental in writing a federal grant to build a child care center; this was the first licensed children's day care center in the county's history. She noted that because of the lack of county funds, there was no local match with the federal dollars drawn and this is unusual in most communities. Further, the local tax base is limited by the federal government's ownership of 54% of the county land mass in National Forest designated areas.

In discussing mental health services for women with depression, she related that the location of services in a city nearly 40 miles away was a significant barrier. "Accessibility of services is a primary issue that left most mental health needs of the local people unmet. Many of the people here are unfamiliar with what mental health services are really about and feel defensive when 'outsiders' are designing and delivering services for us."

Dawn related her belief that the lack of control over so many things in the community resulted in problematic situations and unmet mental health needs. "People often don't have control over their jobs. The men come home and they are determined to have control over something; that often results in domestic violence, which is all about power and control." She described the presence of the Domestic Violence Task Force as a progressive and important step forward for the community and Dawn currently chairs this group. However, she noted that lack of attendance and involvement by county law enforcement officials was a major problem. "Police play such a critical role in dealing

with the problem of domestic violence in the community…they need to be there...I encourage them to come, but they don't seem to make it…something always comes up." In closing the interview, Dawn emphasized her belief that more sources of help are desperately needed in the community. "These women are good women, but they need help and it's just not available."

Connie – Coordinator of Domestic Violence Center

I met with Connie in her office, which was a small space, adorned with pamphlets, posters, and slogans encouraging women's empowerment and promoting positive self-esteem. She began the interview by asking me about VCU and its role in the research. She described in detail her gratitude toward her favorable experiences with the Medical College of Virginia Hospital when one of her children had genetic testing done for cystic fibrosis.

As we began to discuss her role in the community, a complex and disturbing community portrait emerged. She was new in the job, having been there around 6 months, and reported that things were "going relatively well." However, her nonverbal cues and tone of voice did not confirm this. She related that many of the professionals in the community were very uncomfortable dealing with the issue of domestic violence. "This is a good old boy network…there is an attitude by the law enforcement folks…obtaining emergency protective orders are a problem. There are a whole bunch of rules and nobody knows what's what. Referring couples to marital counseling can actually be dangerous, because husbands and boyfriends use Biblical scripture to defend and validate their 'power over' behaviors."

"Domestic violence here is a very serious problem that no one wants to acknowledge. National statistics indicate that one woman dies every nine seconds as a result of domestic violence. It happens here a lot, but it goes unreported...here, it's all about families…who you are…where you came from. Sometimes I feel like I've entered the Twilight Zone." Connie also related that she viewed lack of economic resources, geographical isolation, deeply traditional gender beliefs about the roles of rural men and women (reinforced by some religious teachings), and the lack of knowledge and self-awareness of community law enforcement officials as being the most influential cultural factors keeping the secret of domestic violence hidden and responded to inappropriately".

Connie described the most important aspect of her job as being public education and heightening the public awareness about the nature and extent of the issue. She had done speaking presentations to women's group and says that "They say they can't believe that this is going on so much…but their eyes tell a different story….I'll bet every one of them know a friend, sister, mother, or daughter who has experienced domestic violence firsthand…or maybe they're the one who already knows the story at a personal level."

Barry - Sheriff

This interview took place at the Community Police Headquarters in the sheriff's office. This room was next to the lobby, where there was a high level of activity and noise by police and rescue personnel. The sheriff was a large Caucasian man in his late 50s. He had been the town sheriff for 28 consecutive years and was dressed in a uniform, carrying a gun. He sat behind the desk for the duration of the interview. Although he agreed to participate in the interview, he said repeatedly that he did not know how he

could be helpful. He cancelled our first interview because of "police business." According to his secretary, however, our scheduled appointment time coincided with his daily lunch break at a local restaurant. Rescheduling of the appointment required persistent follow-up by the researcher.

At the initiation of our interview, Barry described his perception that outsiders are responsible for many of the "problems" in the community. He stated that family members in this rural area help keep the behaviors of other family members in check. He noted that the insider/outsider mentality of "people who grew up here" made it difficult for health care professionals who were not natives to establish their credibility.

Specific to women's help-seeking, Barry discussed the development of the domestic abuse resource center in the local community. Previously, women had traveled over 35 miles to an adjacent city to receive services. Barry emphasized that the increased access and availability of local services for battered women had been quite helpful to local women. However, Barry pointed out that insufficient law enforcement resources (personnel) were still a detriment to documentation of physical injury and evidence gathering. Barry also praised the advent of the women's resource worker in providing a more objective assessment since "she is not a native of the local area." He spoke of the difficulty in his remaining objective because he "knew all the members of the local community who then expected him to take sides in any conflicts." Barry further described the problems of addressing domestic abuse in the community.

In addition to "knowing everyone" and being expected to take sides, he discussed a recent statutory change, requiring arrest in all domestic violence situations that were

reported to law enforcement officials Although he supported the need for arrest in most cases, he lamented the fact that people are "getting wise to the mandate and are not acting in the spirit of the law." The example that he gave was that "a husband, if he can get to you first, will get the warrant whether he is the aggressor or not…because they know what's coming up." Another problem encountered by Barry was that of "cross-warrants," whereby people file a warrant against their spouse as recourse for their being legally charged.

Barry discussed an interesting practice in the community, whereby "locals" frequently own electronic scanners, which monitor the activities of police and rescue personnel. When police or rescue officials were dispatched to a scene, the name of the people involved and the nature of the incident are broadcast over the scanner. During the week prior to our interview, a woman in the community had committed suicide. Barry raised this topic and discussed this incident in relation to women's depression. In discussing female suicides in the county, he said that he had been involved with more suicides in men than women, but had never noted gender differences in method. Barry said that there is no mental health professional available to counsel family members or rescue personnel after a suicide. He stated that he would not want a counselor to come from the city because it might prolong the process of removing the body and cleaning up the affected area. Barry generally contacted the family's minister if they belonged to a local congregation. If the family did not attend church, he also frequently contacted a community minister to provide spiritual comfort and support. Generally, by the time

police officials arrived, family members had already gotten there. Hence, notifying the family was not a usual part of the police procedure post suicide.

Pam – Public Health Nurse

Pam, a Caucasian woman in her late 30s, was a public health nurse in the community who had relocated from an urban area to this rural locality over 10 years ago. The researcher had known her previously over a 10 year period when they worked together in a mental health setting. Her attitude toward the interview was quite enthusiastic and she repeated her support for this project, saying that it was so important to "learn more about rural women and their depression...what can be done."

Pam began the interview discussing her concern about women and depression. In her experience, the pattern began in many of her clients during their adolescent pregnancies. She noted that the county "had one of the highest teenage pregnancy rates in the state….we're trying to do something about that." She believed that "many teenage girls try to get pregnant without realizing the future effects of having a baby." She viewed these young women as often having faulty expectations related to their baby bringing them closer to the child's father. Instead, the fathers often left soon after the birth. This resulted in the teenage mothers having to care for their babies without either the baby's father or their former peer group.

Pam differentiated two groups of women with depression who were encountered in her practice. As part of her role of public health nurse during the post-partum period, Pam performed a mental health assessment of her clients. If there was a past history of mental illness, including depression, and the woman was experiencing distress, a referral

was made to a mental health caseworker who held a weekly half day clinic. This clinic was done by a caseworker from a nearby city and was held in the public health department. Only women below the age of 18 were eligible for these mental health services. If a woman was older than 18, she was required to travel over 35 miles to the mental health center in the nearest city.   For women without a prior history of depression, this process necessitated numerous trips to the nearest city: one trip for an intake interview/assessment and subsequent trips to receive services. Pam felt that more women would use mental health services if there were a local provider, especially one that was part of a primary care practice in which problems other than mental health were treated.

Pam also emphasized the need for more domestic violence services, though things have improved since the Women's Resource Center became available. She commented that women were willing to receive help if someone reached out to them. However, she felt that women felt constrained in discussing abuse, even with female friends, due to the fear that their husbands might find out. She described the experience of a woman who she had worked closely with over a 14 month period. This woman called, saying that she was "afraid that her husband was going to kill her and her children and she wanted to escape." Pam immediately referred the client to a shelter in an adjacent city. This call was Pam's first indication that this client was a victim of domestic violence. Before the call, the woman had denied violence or alcohol abuse in her home.

Pam was a member of the newly formed community interagency domestic violence team. Since the hiring of the women's resource clinician in the past year, Pam

noted much progress in the assessment and referral of abused women to appropriate services. She gave several examples from her clinical practice. She related that most of the women had low self-esteem and felt hopeless, yet they maintained belief that their partner was going to change. Most denied believing that their children were aware of the abuse, along with minimizing the level of violence. Pam related that extended family members often encouraged the women to return to the perpetrator of the abuse, perhaps due to financial resources and to maintain the male's role as provider. She also noted that these women typically had transportation challenges and generally lacked resources, thereby increasing the complexity of breaking the pattern of violence.

Joe – Pastoral Counselor

Joe was a pastoral counselor from an adjacent city who provided counseling services (individual and family) in a local church one day a week. His clinical background was as a licensed professional counselor (LPC), having Master of Education degrees in theology and child and family development. He has been practicing in the community for 2 years and his client load has developed much more slowly than he had anticipated. He attributed this to lack of understanding of his role and resulting low numbers of referrals.

Joe described most of the women he sees as having depression, with accompanying anxiety. The trigger to seeking help was most often the level of interference within home work and family responsibilities.   He related that he often referred women to their primary care practitioner for medication evaluation. He stressed

that he generally doesn't refer to psychiatrists because of the level of suspicion about formal mental health providers in rural areas.

Another observation he shared was that alcohol abuse was a key family issue in most of the women he saw. He viewed the role of male dominance as another significant stressor for rural women. His primary therapy style was use of a cognitive therapy approach, whereby women change their thoughts or cognitions as a way of eventually changing their feelings and emotions. He also stressed the role of spirituality as a means of "giving purpose and providing buoyancy" in the face of the more oppressive aspects of rural-dwelling.

Summary of Findings with Linkages to Data Sources

The following findings emerged as themes during the course of this research. It was important to note that these themes were contextually derived and not aimed toward generalizing to other settings. These themes were described in direct relation to the two research questions, which guided the study. Descriptions of the findings, with supporting evidence from participant interviews and observations, were included.

The research questions were:

1. What was the nature of depression as perceived by a rural-dwelling woman and members of her community social network?

2. What was the process of help-seeking for depression as perceived by a rural-dwelling woman and members of her community social network?

The following contextually derived themes were generated in relation to Question One – nature of depression:

1. Linkage of experiential depression to diagnostic criteria;

2. Overcoming depression using willpower;

3. Connection of depression to abuse and violence;

4. Masking the inner world of depression.

The following findings were generated in relation to Question Two – nature of

Help-seeking for depression:

1. Family role in help-seeking;

2. Insider/outsider status - impact on help-seeking;

3. Role of family and work functioning in help-seeking;

4. Role of informal and formal helping networks in help-seeking.

Nature of Depression

One finding that was demonstrated within interviews, particularly with the key

informant, was the congruence of the experience of depression with diagnostic criteria as

outlined in DSM-IV-TR. It was important to note that the description of the key

informant's personal experience of depression was privileged as related to the

perceptions of others in the community social network. Though the perceptions of the

community social network were viewed as impacting the local collective cultural

description and perception of depression and of help-seeking, community perceptions

were treated as complementary to Susan's descriptions. It was also important throughout

the research process to consistently acknowledge Susan's descriptions of depression as her unique personal story, defined in her own terms and experiences within the community setting.

As previously noted, Susan's experiential description of depression reflected the criteria for diagnosis of depression, as reflected in DSM-IV-TR, which is widely accepted and utilized by medical and mental health providers. Among the symptoms that Susan described were loss of interest in pleasurable things, feeling sad with episodes of tearfulness, feeling worthless or guilty, excessive sleeping, fatigue or exhaustion, social withdrawal and isolation, change in eating patterns, and digestive problems. The most significant, troubling, and frequently referenced symptom by Susan was fatigue. In every interview or contact, she mentioned her fatigue as negatively impacting her usual routine of work and daily activities, and most notably as interfering with the single parenting responsibilities of her four children. The following passage illustrated her experience of fatigue in the context of her role of single parent:

> Before I was put on antidepressants, I just could not get up out of the bed. I could not get up. The alarm would go off in the morning and I knew what time I had to get the kids ready…they'd be late for school. They eat breakfast at school…a lot of times they wouldn't get there in time because I just can't get up. Sometimes they would have to wake me up. They would get up and come in and wake me and finally when I started taking some medicine for that…it's helped some.

During our final interview as we reviewed our time together and worked on closure, the researcher posed the following question: "In a few words, what would you say has been most important about your experience with depression?" Susan's following

response vividly illustrates the impact that the fatigue of depression had on her everyday life:

> Exhaustion. I'm just flat out tired. It wears me out…it honestly wears me out thinking about it and about him (husband). I want to be more energetic like I was before I met him. I had been doing okay before I met him when I was going to the group therapy thing and I was exercising and I was being fit and staying in shape. I gained 30 pounds when I was married to him…just got a case of the "lazies" or whatever you want to call it. I just wanted to sit around and not do anything.

This passage illustrated the degree of impact that Susan's diminished energy and fatigue had on her self concept, baseline functional level, and sense of well being. It also gave a sense of Susan's perceived linkages between her troublesome relationship with a husband who was abusive, her experience of depression, and specifically her experience of being too fatigued to enact her usual roles and functions.

The community social network presented similar descriptions of Susan's experience of depression as those that she described. The most frequently discussed of Susan's depressive symptoms, as perceived by other participants, were fatigue and social isolation. Though Susan mentioned "not enjoying doing things like I used to" her primary focus was more clearly directed toward the impact of lack of energy on her immediate family responsibilities, particularly with her children. This interesting difference in perceptions may have been influenced by the social network's response to the absence of an important member of their informal group.

The importance of Susan's position in her group of friends and the impact of her social isolation was illustrated by this passage from Tom, who she described as her "best friend":

I don't know if you'd call it a support group or not. But I happen to have a lot of friends…they're not the kind of friends that are a friend to your face and an enemy to your back. My friends aren't like that. Susan is an important part of this group and we've all been worried about her…we try to get her to go out and do things like she used to. You see everybody in our particular group or whatever…everybody in our group has their own specific sense of humor and it's all good because even the lamest one of the bunch can come up with the funniest things and it just cracks us up. We're each different, but we help each other out.

Overcoming Depression Using Willpower

The theme of overcoming depression using willpower was a theme that emerged in several of the participant interviews and which was generally supported in the literature on women and depression. An exemplar of this theme was related by Connie, a county administrative official, who spontaneously shared her own personal experience with depression. The focus of the interview with Connie was slated to describe her experiences as a woman in a traditional male job in this rural community, while discussing potential local changes in health care policy. During the first half of the interview, Connie related information about her life, including job and educational history, ethical challenges encountered in her last job, and her intended career path. This information was related in a factual and neutral style, with no obvious affective

connection to the topic. In fact, she had begun the interview by saying several times, "I'm not sure how I'm going to be able to help."

As the researcher talked more specifically about the topic of depression in rural women, Connie became tearful and described a personal experience with depression. This had occurred in her previous home in rural Vermont during an isolating snow and ice storm. This was during a period in life when she was under significant stress related to her job and other interpersonal pressures. After several days of being house bound, she recounted these feelings:

> I began to feel more and more panicked…I felt trapped. Not just trapped in the house, but trapped in my life, in Vermont, trapped in many different ways. I had this sense that I had to get out of here, get out of the damn house, just get out and go somewhere, anywhere. I really didn't know what was happening. I became more and more restless, and upon going outdoors, I fell and hit my head…injured my head…blood was everywhere. I wasn't hurt badly, but that was it…I had to talk to someone, so I called my mother and told her what was going on. I was crying…I'm not usually like that. My mother's response was to "get myself together…to act like an adult and that this would pass." I was furious and hurt…and what did these feelings of anxiety and depression have to do with being an adult anyway? I just couldn't believe what she had said…not what I expected.

The mother's response to her daughter's experience of psychological pain was an admonition to "act like an adult." This advice represented a clear example of the cultural belief that the solution for depression to "just get over it…get your mind on something

else…act responsibly." Further, this passage corroborated the theme of overcoming depression with willpower.

Connie shared that after she talked with her mother, she reached out by phone to a woman friend.

Anyway, later on I called one of my friends who had been through something similar and she reassured me that this would pass, no matter how scary it seemed at the time, it would pass She also told me that I should try to figure out what was causing these panicked feelings…she really understood…she'd been through this before."

Connection of Depression to Abuse and Violence

The discussion of abuse and violence in relation to depression and help-seeking was the most consistent theme and was discussed in some fashion by every participant interviewed. Susan's first hand experience with abuse and violence began in early adolescence when she was raped by two young men who were classmates. At the time, she did not reveal this to her parents or to anyone else. She had begun to explore this issue in therapy during her first marriage, when she began to develop "sexual problems with my husband."

I never told anybody…no, I was just so scared to. I thought well, if I tell my parents, they'll want to take them to court and all this stuff. I thought, "I'm having enough trouble here now as it is, if I take these people to court, oh everybody's going to be against me, then they're not going to believe it…Oh, crazy things that go through your head at that age. That's just what I thought at

the time. I did tell my Mom when I was 23 or 24 years old…my therapist now is really helping me deal with all of this.

Susan described a pattern of being involved in relationships with men who abused her, including her recent husband, who she is separated from. She described her second marriage as being the most violent relationship with nearly constant verbal threats in between actual beatings and other physically violent episodes. The following passage exhibited the extent of the psychological abuse, which she described and discussed during every one of our interactions and interviews:

> We just lived two separate lives in the same house…finally he just quit speaking to me and I couldn't deal with that …stopped speaking to me for three months – for three months solid, he didn't even speak. He would come in from work and go straight to the bedroom, shut the door, he wouldn't come back out until he went to work in the morning…never said a word.   I would feel so anxious and upset when he came home. We were always on edge…the kids, too. We'd better not make any noise, we'd better not bother him and if he walked out of the room for any reason, we'd all just stop and be like…what's he gonna do?...He left for three of the kids' birthdays…just walked out.

Though she described the majority of the abuse as verbal, a recent escalation to threats of violence, including threatening to rape her, had increased her depression, while concurrently prompting her to get a legal separation and obtain a restraining order against him. The following quotes illustrate the

increasingly violent and dangerous nature of the level of threat as perceived by the primary participant, Susan:

If you leave and try to come back to this house, I have enough fire power to stand at the top of the driveway and blow your head off…and if your family decides to try and come, I'll blow their heads off too…He also said, I hope you know if I want sex from you, I'll just knock you out and I'll just take it…I told him, I don't think so, you're talking crazy, just leave me alone, go on back in your room and leave me sleep. I didn't know what he was going to do…I really didn't know. Then he came back and picked me up out of my daughter's bed and threw me down in our bed and said, "you're sleeping in here tonight…I'm not going to bother you" and he didn't.

Susan said that the children had been away from home visiting when the above incident occurred and that this was the triggering event in her decision to seek assistance from the legal system for the domestic abuse. Though she had been confused and frightened about what steps to take, the next day, she took the following action:

Monday I went to file a warrant on him because I decided that was the last straw...I mean he talked about killing me and knocking me out and all this stuff…that's just not going to work…

Though each member of the community social network discussed the prevalence of abuse and violence in this setting, Connie's quotes were selected to depict this theme. As director of the community Women's Domestic Violence Center, she had dealt directly with domestic abuse from a variety of perspectives since coming to the county. She

regularly had interactions with a variety of community stakeholders, including women who had been abused, family members, law enforcement officials, social services workers, and clergy. The degree and extent of community interactions, along with her formal education, training, experience in the field of domestic violence, and her non-native status informed the choice to have her represent a potentially more objective voice within the community social network. In describing the local community perspective related to abuse and violence, she shared the following:

> I think the idea…I think it's hard for people to accept the idea that there is domestic violence here. And I think my presence kind of exacerbates that ideology. So I think it makes it kind of difficult. I've had to be very careful in representation of what I'm doing and be very cautious in that vein. As I said, I think I've probably stepped on a couple of people's toes advocating for clients, but that's my position.

She shared further information related to the community interpretation of domestic abuse in the following passages:

> I think it's partly because it has been accepted behavior for so long. And it's part of the way…those are the things that they saw growing up. And I think it's just real difficult for a lot of folks to acknowledge that that's not acceptable.

Connie also shared an interesting story about how statutes have historically been influenced by cultural attitudes about women and children. She related that the folk expression "rule of thumb" came from statutory language "that was still on the books in some states…North Carolina and South Carolina…still have these laws on the books."

Basically the term rule of thumb came from a law in Colonial times when men were expected to keep their women and children in check, but were prohibited from using a stick for beatings that was bigger around than their thumb."

Finally, Connie shared a personal experience in which a male perpetrator in the community had violated her personal safety by stalking and making threats of violence:

He called me and was making death threats to me. So I ended up charging him and it got really severe. And he ended up serving more jail time. This sickened me. We went to court. It was all heard on the same day – the assault and battery on her (his wife) and then my stalking charges. He got more time over the charge that I brought against him. I'm assuming because I was a professional in the community and it was looked at differently than what he got for what he had done to his wife. I was beside myself. He ended up going to jail. Served two and a half years on a three to five year sentence, something like that. The day he was released from jail, he showed up at my office.

Masking the Inner World of Depression

The transcribed interviews of the key participant and members of the community social network indicated that there was an often masked inner world of experience associated with depression in rural women, which served both an individual and community function. At the personal level, the masking of depression helped hide the secret shame of depression from family, friends, and other community members. At the community level, denial of the prevalence of depression in the local community

supported the larger societal cultural narrative, in which depression is still viewed with significant stigma and prejudice. The dynamics of personal, community, and societal responses to depression, were viewed as similar to the responses to abuse in the perceived need to "keep the shameful secret." Therefore, it was posited that the presence of the "double occurring stigma" of depression and abuse could potentially result in an even greater perception of need to "mask" these experiences, than either of these experiences occurring in solo.

Like the connection between abuse and depression, there was significant discussion of the theme of masking the inner world of depression across participants. However, the following quotation from Pam, the public health nurse interviewed in this study, was particularly descriptive and representative of the information shared by the majority of the other participants:

Women can put on a pretty smile and go out and when they close that door think everything is fine or can make people believe everything is fine. I worked with a woman for some time, and this was what she did with me. I would have never dreamed anything was wrong with that family. And I think the pressure that women have today if you've got children, even if you're married…most of the time you've got two parent working families, you got children…everybody is tired when they get home from school and from work…uh, you know…it's just the pressures are much more severe and I think that feeds into any depression. Because women around here again typically I think see themselves as the strength of the family.

Nature of Help-Seeking

Family Role in Help-Seeking

Throughout this study, there appeared to be an important role that families occupied in the decision making process of whether or not to seek help. The influence of family members on help-seeking took various forms including encouragement, initiation, and endorsement. The theme of the role of family in help-seeking was corroborated by Susan and by most of the community social network members. Susan's mother, Jane was the single most instrumental person who impacted Susan's decision to seek formal help for her depression and emotional response to domestic abuse. Susan described the role of her mother in help-seeking as follows:

> In my last marriage, she set me up in group therapy, said I had to do something to get some help. I went every weekend and really came to depend on that a lot. It was like, I looked forward to it. You know, you get together with all these other women with the same type of experiences and I was in there for almost a year when I met my current husband. I wouldn't have gotten this help if Mom hadn't made me.

During her current depression, Susan said that:

> Mom opened up the telephone book, started looking in the yellow pages and said you've got to get some help. You can't go on this way. I'll help you, I can make the appointment or you can, but you have to get some help

Insider/Outsider Status – Impact on Help-Seeking

The theme of insider/outsider status in this rural community was widely supported by nearly all of the participants, irrespective of their native or non-native status. This theme was also widely supported in the literature on rural culture. During one of the interviews, a participant who was not native to the community referred to someone as "one of yours". It was reported consistently by most participants, that the attribution of insider or outsider status affected everything in the community at a pervasive and invisible level. There was general agreement that this issue affected help-seeking decisions in many ways including the perceived need for help, the decision to seek help inside or outside of the community, and the respect accorded to both formal and informal helpers based on their native or non native categorization. Several participants referred to the "good old boy network" as another expression of the insider/outsider issue. The following quotes provided examples of the strength and prevalence of the insider/outsider theme.

Bill, the community primary care provider, spoke extensively of this issue in a way that reflected his frustration and feelings of being an outsider in a closed community network.

We know that there are getting to be more of us (outsiders) than there are of them and we're a real political threat to the thems and it's obvious that it's becoming more and more a threat. A lot of xenophobia, a lot of it…If these people have a choice between someone who is excellent at something wh'from here and a scumbag drunk whose from here, the scumbag drunk will win that election every time.

He further described his experience of social isolation as a non-native of the area, expressing his perspective as follows:

> They might be nice to you on the street but they ain't going to invite you home. I'm actually treated different from most outsiders because I provide health care. I have a level of acceptance that is significantly better than most outsiders…Privilege is actually a better word than acceptance, because they don't accept me because they know that I'm going to do the right things…like with my computer project that I've done, like putting public access computers in, grants and computers in schools, cell phones and cell phone towers and it scares some people because they know that I'm going to do what I think is the right thing no matter what the political fallout is.

Role of Family and Work Functioning in Help-Seeking

There were preliminary indications from many of the participants in this study that inability to perform usual family and work responsibilities was a frequent trigger for rural women to initiate help-seeking. In Susan's story, she related that compromise in her ability to effectively parent was the single most important reason that she sought help. Other participants from the community social network also reported that Susan's fatigue in particular had sparked concern that "she just couldn't do things with the kids like I usually do," thus providing some linkage between the impact of her fatigue on parenting and her subsequent decision to seek help for depression. Since Susan was the single mother to four children, the inability to participate in their many extracurricular activities

in her usual manner greatly concerned her. The critical nature of her compromised parenting skills is succinctly expressed in the following passage:

> I'd say probably the most important point to me in seeking help would be the fact that I want to be physically healthy and mentally healthy to take care of the children…that's what matters most to me.

Role of Informal and Formal Helping Networks in Help-Seeking

The primary informant benefited by help from both formal and informal helping networks. She was currently engaged in therapy and had previously sought help for her experience with domestic abuse in both group and individual therapies. Another very important level of help and support came from Susan's network of friends. Previous to her current depression, she had maintained a wide circle of friends. These friends had been supportive of and helpful to her throughout the experience of depression, as well as encouraging her to seek help from formal sources as needed. Thus, the two levels of support afforded to Susan by formal and informal helpers were complementary and helpful in distinctive and important ways. The following passage by the county extension agency in charge of women's programs corroborated this theme as an important issue in rural communities:

> These are really good people here…they work hard and they take care of each other. Sometimes they need help that exceeds what their family and friends can provide. That's when psychological help of some kind is needed…but I think these folks are usually distrustful of people coming in from the outside and trying to help….they don't think people outside of the community understand who they

are. What I see as most important is for health care providers and local people in

the community, who are natural helpers, to work together…help each other out.

That seems like the best idea of providing services for rural women with

depression. I think it can really work out, but it won't be easy. If you're not born

here, you're never totally accepted.

Limitation of Findings

The findings of this study should be considered within the context of its

limitations. These limitations included the milieu of a single rural community, the use of

one woman as an exemplary case of depression in a rural community, the non-native

status of some of the key informants, and the use of data from sources that were second

hand observations of the primary informant's experience and other women in the

community. Although one of the participants interviewed was a pastoral counselor, the

issue of the role of the church in rural community life could have been expanded. The

study also is limited by the scope of the qualitative descriptive design that provides

preliminary understandings that may have transferability in relation to its findings and

does not imply causal connections.   However, the credibility of the findings was

enhanced by acknowledgement of assumptions of the initiating researcher, prolonged

engagement with the primary informant and other key informants, the use of member

checking to ascertain the quality of descriptions generated to support findings, grounding

descriptive findings in the transcript narratives, using multiple methods of data collection

(i.e. interviews, field notes, and observations), and examination of themes within

individual narratives and across a network of participants.

Summary

This qualitative descriptive study was aimed at describing the nature of depression and the attendant process of help-seeking for depression with one rural woman and the members of her community social network. The purpose of inclusion of participants representative of the key participant's community social network was to describe the role of culture, as portrayed in personal and professional descriptions from key community informants. The expansion of the interview scope to the social network further provided an ethnographic hue to this descriptive study, which was set against the backdrop of one local community culture. Discussion of findings was presented in themes derived from descriptions grounded in the data, with collaborating quotations used in support of the themes that emerged.

CHAPTER FIVE

Discussion, Conclusions, and Implications

Summary

The central research questions of this study were as follows:

3. What was the nature of depression as perceived by a rural-dwelling woman and members of her community social network?

4. What was the process of help-seeking for depression as perceived by a rural-dwelling woman and members of her social network?

The study used a qualitative descriptive design (Sandelowski, 2000) to address the questions. This design provided preliminary understandings of the nature of depression and help-seeking associated with depression as experienced by a woman living in a rural community. The study sought to capture a holistic descriptive representation of the experience of depression from the viewpoint of being a woman and living in a rural community. The holistic representation was accomplished by the intentional inclusion of a network of community members that placed the woman's first hand account of her depression and help-seeking within the context of a rural social network. Individuals from the woman's rural social network representing the personal and professional spheres of influence in the community were chosen. The approach of expanding the interview spectrum to the social network provided an ethnographic tone to the study by accumulating data through key informants in the local community culture. Selection of key informants for second-level interviews was determined by the primary informant, other key informants, and the researcher in collaboration.

The rationale for including members of the community social network was guided by a theoretical framework, the De Facto Mental Health Services Model, which has been extensively employed by researchers at the Southeast Virginia Rural Mental Health Research Center of the University of Virginia (Fox, et al., 1995). The De Facto Mental Health Services Model was developed for application in the rural south and included in its framework the naturally occurring network of helpers available in rural communities, including both formal and informal networks. More importantly, this model emphasized that understanding the culture of rural residents, including how mental health was described and how help-seeking decisions were made, is critically important in understanding decisions that rural women make related to help-seeking for depression. Understanding the culture from the vantage point of key community informants is viewed as useful information in how the woman decides to seek help from a formal mental health care provider or from an informal source in the community.

The primary method of data collection was systematic interviewing focused on the research questions and expansion to issues and concerns raised by study participants. Complimentary and supporting data collection included observations and field notes. Findings of the study were generated by review and analysis of the transcripts, observations, and field notes and identification of themes within and across participants. The findings were presented in the context of study limitations that included the context of a single rural community, the use of one woman as an exemplary case of depression in a rural community, the non-native status of some of the key informants, and the use of data from sources that were second hand observations of the primary informant's

experience and other women in the community. The study also was limited by the scope of the qualitative descriptive design that provides preliminary understandings that may have transferability in relation to its findings and does not imply causal connections. However, the credibility of the findings was enhanced by acknowledgement of assumptions of the initiating researcher, prolonged engagement with the primary informant and other key informants, the use of member checking to ascertain the quality of descriptions generated to support findings, grounding descriptive findings in the transcript narratives, using multiple methods of data collection (i.e. interviews, field notes, and observations), and examination of themes within individual narratives and across a network of participants.

Discussion of Findings Related to Nature of Depression

Linkage of experiential depression to diagnostic criteria

The primary informant's description of her depression was consistent with the *DSM-IV-TR* criteria used by professional groups to diagnose and treat major clinical depression. This description was to some extent corroborated by the social network of the rural community. It is not clear whether the description provided by participants reflected the actual experiences and observations of depression unfettered by exposure to health care professional viewpoints and to mainstream literature available to the public, and, in the case of professional informants, their educational preparation. However, it is apparent that the primary informant experienced the dimensions of depression as described conceptually by psychiatry to capture a diagnostic representation. There also seems to be an indication that the experience of depression and its interpretation both by the lay public and professionals is inextricably bound to a clinical representation.

Overcoming depression using willpower

There is preliminary support as corroborated by a variety of participants in this study that the belief that depression is something that can be overcome by the sheer willpower of the depressed is prevalent in this particular community. There also seems to be some evidence to support the contention that this belief may be rooted in the cultural values and perspectives of native rural dwellers. However, this study fails to provide definitive understandings of the sources of this perspective because its design was targeted to beginning understandings. There is some indication from study participant's descriptions of depression that this belief about the role of willpower may exert some negative influence or pressure on those who are depressed by implicitly conveying fault to the depressed. Again, the limitations of this study prevent a deeper and more explicit understanding of how this belief may influence issues such as treatment choices and help-seeking.

Connection of depression to abuse and violence

The continuing theme of the connection of depression as preceding or coinciding with the experience of abuse and violence was evident in the narrative of the transcripts of participants. Both the primary informant and the key informants from the social network gave some attention to this connection. The linkage between depression and abuse and violence was represented by some informants as almost self-evident and specific to gender. There was also some indication that that there could be both professional and personal efforts made at covering up abuse and violence and that this covering up might influence how women experienced depression and sought help. However, the design of the study does not support causal connections between depression

and abuse and violence. Further, the complex dynamic relationship that might exist between depression and abuse and violence is not fully explicated in this particular inquiry in relation to this specific community, although the research literature on consequences of violence and abuse in women indicate that depression is a pervasive one.

The masking of inner world of depression

The transcript narratives of the primary informant and key informants provide some indication that there is an inner world of experience associated with depression that might be intentionally masked due to both internal and external biases toward mental illness in general and depression in particular. Some of the external biases appear to be linked to the rural culture of the community in which the participants lived, but there is also literature to support that some form of masking – referred to as silencing of the self (Jack, 1993) – is common with depression across cultures. The study design limits what can be discovered about this phenomenon in that it gives attention to the social network, perhaps at the expense of further understanding the inner experience of depression. Likewise, the use of second hand observations of depression from the vantage point of key informants, in contrast to the primary informant who had first hand knowledge of depression, limits the amount of data generated about inner experience of depression.

Discussion of Findings Related to Nature of Help-Seeking

Family role in help-seeking

There appears from the references within the text of transcripts to be an important role that families take in relation to help-seeking. The influence of family members on help-seeking takes a variety of forms that include encouragement, initiation, and endorsement. The design of the study does not accommodate a deterministic view of

how the family may impact help-seeking. The qualitative descriptions of how family members may influence help-seeking for depression by rural women is suggestive through anecdotal narratives of cases encountered by the key informants in their work, by the primary informant in her own family, and by the self-described role of family members and friends who believe that had some role in the help-seeking of the primary informant. Although the evidence is suggestive within each participant that there is an important role that family members take in help-seeking, there is a consistency across participants that this is the case generally in the community. The design of the study provides preliminary qualitative information and description of family participation in help-seeking, but is limited in providing a detailed explanation of how this influence may play out in terms of success in obtaining the best help.

Insider/outsider status - impact on help-seeking

It is clear from the data sources in this study that there is a culture in this rural community, consistent with other studies of rural communities, that categorizes dwellers as outsiders and insiders or referred to professionally as natives and non-natives. The findings suggest that there may be a connection, that is often invisible yet pervasive, that might influence help-seeking for depression by rural women in this community. Natives appear to be afforded a status of privilege ascribing to them certain knowledge and expertise about depression grounded in the reality of living life that is not ascribed to professionals who do not have the background of living in this rural community. There is, perhaps, a tentative proposition in the narratives that the help given by natives may be more inherently valuable than that given by non-natives, or minimally that it may be perceived as such. This may in turn influence from whom the individual may seek help

and to whom the individual may be directed for help. The impact of this categorization on help-seeking in contrast to other factors is not fully explored in this study due to its limited scope.

Role of family and work functioning in help-seeking

There is some suggestion from the narratives of the participants of this study that inability to perform roles in relation to family and to work may be a key initiating event or point in the decision to seek help. In some cases this may come about through self-realization and others it may be recognized by family and friends and pointed out to the woman who is depressed. There is also some anecdotal evidence to tie this feature of help-seeking to the values of this rural culture regarding work ethic and family responsibilities. There is also some implication that the rural culture may perceive and women living in this culture may accept a particular standard of what warrants the act of reaching out for help. Again, the data provided gives very tentative and incomplete support for these suggestions albeit that there is corroboration across some participants. It is also not clear to what extent this is a uniquely rural phenomenon given that the design does not compare cultures.

Role of informal and formal helping networks

There is corroborating evidence across the participants of this study that there are formal and informal helping networks at play for women experiencing depression in this rural community. These networks appear to work in a complementary fashion often providing different forms of help – personalized from friends and family and professional from healthcare providers – that offer the depressed woman a wider variety of resources for support than either alone. The study did not provide an opportunity to more deeply

understand and explicate the nature of these forms of help and how they may interact specifically. The findings suggest that there is somewhat of an individual and collective acceptance of the value of both forms of help available in this particular community. This finding is interesting in light of the previous finding that suggests the tendency to mask the inner experience of depression. It suggests that, perhaps, the inner world can be mediated through the informal helping networks. However, this is a highly speculative proposition given the design of the study and the limited depth of inquiry into this particular area. The study does not fully elucidate the variety of forms of informal helping but suggests that some forms work in conjunction with formal helping to provide a more comprehensive approach to depression for the woman living in this rural community.

Conclusions

The following conclusions can be drawn from the study based on the findings presented. These conclusions are related to the experience of depression and help-seeking in the context of one woman and one particular rural community in which the study was conducted.

1. For the primary informant in this study, depression was experienced in a way that is consistent with the diagnostic conceptualization of depression as a disease and members of the community social network in which this woman resides relate to depression from a disease-perspective, particularly professionals. It is unclear whether or not the description of depression from these narratives is shaped by the exposure of participants to professional and public discourse on depression.

2. The proposition that depression may be overcome by willpower was a common belief that existed in this community according to study participants. This proposition lies in juxtaposition to the consistency between the experience of depression and its clinical representation by professionals.

3. Participants viewed abuse and violence as either preceding or coinciding with depression in many women living in this rural community. The complex dynamic relationship between depression and abuse and violence was not explicated. Abuse and violence were perceived to contribute to the need to cover up depression by many women.

4. Women in this rural community were viewed as masking an inner world of depression that was fostered by the value-orientation of self-sufficiency in the culture.

5. It is not clear whether the experience of depression is distinctive for women living in this rural culture or others. There is some indication that it may not be although the study did not focus on a comparison of cultures. There is some suggestive evidence that the values, beliefs, and practices of rural communities may influence how women deal with the experience of depression that could influence tendencies to describe it in certain ways. For instance, in spite of the view of depression as a disease, the orientation toward self-reliance may create a perception of the nature of depression as something that can be overcome. In contrast, perhaps the widespread publication and sharing of information about the prevalence of depression as a clinical entity may transcend cultural differences in rural and urban populations contributing to describing it as a disease.

6. The family plays a vital role in encouraging, initiating, and endorsing help-seeking for depression as experienced by women in this rural community. The dynamic connections of family and help-seeking are not explicated fully within a rural context although families are generally viewed as more central according to the literature on rural communities.

7. A tentative proposition may be advanced that help provided by natives of this community is viewed as inherently more valuable for women experiencing depression who live in the community. This may influence choices made by rural dwelling women about whom to go to for help.

8. A critical factor in the decision to seek help by women who are depressed and living in this rural community may be perceived or real ability to function effectively at home and at work. Whether or not this perspective relates to some standard related to beliefs about work or a rural work ethic are unclear.

9. Formal and informal helping networks exist for helping women with depression in this rural community and often perform complementary functions in assisting these women. There is some indication that informal help may serve to mediate the tendency to mask depression by rural women in this community allowing them to seek help. However, data and design limit any substantive conclusion.

10. The factors and forces that are at play in help-seeking for depression by rural residing women in this community are not categorically distinctive based on the culture in comparison to non-rural cultures. However, participants of the study in this community revealed some contextual elements that appear to influence help-

seeking. There is indication from the literature that women who are depressed, in general, may describe help-seeking in similar ways.

Future Implications

Research

The research study raised a number of important questions that would warrant further investigation:

1. What are the factors that may influence how women think of depression and characterize it in relation to rural cultures? In what ways, if any, has the availability of information across urban, suburban, and rural cultures related to clinical depression influenced how women perceive their depression experience?

2. What role does the notion of inherent willpower that might overcome depression play in the treatment of depression in rural communities? What are both positive and negative consequences of a belief in inherent willpower in understanding and seeking help for depression? What type of relationship exists, if any, between the concepts of willpower and empowerment?

3. While depression in women has been linked to abuse and violence in a number of systematic investigations, what role does the health professional play in connecting these phenomenon and providing treatment responsive to any special needs of women whose depression is grounded in abuse and violence?

4. In what ways does masking the inner experience of depression inhibit effective treatment in rural women? What are the most effective treatment approaches that account for the particular ways in which rural women mask their inner experience of depression?

5. What are the distinctive patterns of help-seeking for depression engaged in by rural women and how do these compare with those of urban or suburban women? What are the most effective strategies to mobilize help-seeking in rural women who are depressed?

6. In what specific ways do the role of family, the perceived abilities to carry on family and work functions, and the insider/outsider status of helpers influence help-seeking in rural women who are depressed?

7. What are the distinctive qualities of informal and formal helping networks that make them attractive and effective for rural women who are depressed? In what specific ways are these two forms of help complementary in effecting positive changes associated with depression in rural women?

The study also suggests particular methodological implications for future research. The study attempted to capture in a holistic way the experience and nature of depression and help-seeking in rural women using a qualitative descriptive design (Sandelowski, 2000). While the study provided some preliminary information about these topics in relation to one woman and one rural community, further investigations with a variety of different designs may be needed to further explicate the nature of depression and help-seeking in particular rural settings. Lincoln and Guba (1985) propose that well-designed naturalistic inquiries such as this one have the potential for transferability across similar contexts and thus the importance of specifying everything a consumer of a research report would want to know in order to understand the findings.

Other types of studies would extend the breadth and depth of knowledge associated with the focal areas of the investigation. For example, a discourse analysis of

the narrative texts associated with mental health, depression, help-seeking, and women within a rural culture may uncover deeper meanings associated with these experiences in a rural community. Phenomenological studies of meanings associated with willpower, masking of inner experience, and insider status might be useful in uncovering the salient feature of meaning that contribute to perceptions of depression and help-seeking within rural communities. Critical feminist studies would elucidate the ways in which women's voices are apparent or disguised in relation to depression and help-seeking in rural communities. Quasi-experimental studies could test theoretical propositions while evaluation studies and intervention studies would provide information about the efficacy of treatment approaches for depression in rural women.

Goals of future research regarding depression and help-seeking for depression should focus on "giving women a voice" in all aspects of their lives. Rural women should be included in research in meaningful ways, from the formulation of research questions, to the collection and analysis of data, and the dissemination of research findings. Research methods that privilege rural women's knowledge and experience, for example using focus groups and participatory action research, should be employed. There is also a need to use research knowledge about women's health care to inform curricula development, rural mental health care practice, and development of rural health care policy.

Education/Practice

Any projected implications of this study alone for education and practice would be highly speculative. However, when this study is considered in the context of other research findings related to women's experiences of depression and treatment of

depression in rural and non-rural settings, there is some support to consider further exploration of education and practice strategies. Educators and practitioners may want to consider and evaluate their assumptions about distinctions and comparisons of urban, suburban, and rural communities in relation to mental health and women's lives. For instance, there could be more informative ways of understanding the rural context and its relationship to mental health experiences by using strategies that invite students and practitioners to consider the voices and perspectives of native and non-native women as well as professional helpers of rural communities. Health care practitioners may want to consider the ways in which informal and formal helping networks could be combined to provide for more effective treatment approaches.

Another very important audience for targeting public education about mental health issues is the local citizens in rural communities. Health education has always been recognized as an important part of the health care system, but mental health education, along with promotion and prevention approaches were seen as potentially useful in reducing stigma and increasing knowledge about mental health and mental illness. The exploitation of informal helping networks in rural communities for public education may be a critical component of success.

Public Policy

Likewise, the projection of potential public policy implications is highly speculative from the vantage point of this single study. However, combined with other literature in the field of rural mental health, the findings offer some suggestive possibilities for how we use information to shape public policy. For instance, there could be better attempts by policy makers to shape public policy using information from a

variety of sources that are both professional and non-professional constituents within rural communities. Also, focus group strategies could be employed specifically to capture the hidden dimensions of depression and help-seeking in relation to mental health. Development of public policy without including the voices of rural people is destined to fall short of desired accessibility and acceptability of services. Rural people should be at the table and included in real and meaningful ways as rural health policy is developed.

What this study suggests is that there are a variety of professionals and non-professionals in this particular community who have some meaningful impact on how depression is conceptualized and managed as an experience of women. The meanings associated with depression and help-seeking are informed by certain cultural beliefs and attitudes. What this study did not explore was the ways in which public policy may also be informed by these beliefs and attitudes. It would be important for public policy research to explore the narrative texts of mental health policies in particular rural communities to systematically uncover connections between culture, policy, and practices associated with depressed women.

Summary

This qualitative descriptive study of the nature of depression and of help-seeking from the perspective of a rural woman and her social community network resulted in several preliminary findings that warrant further review and examination. Findings may have potential meaningfulness to similar community contexts. Tentative conclusions were reached based on the findings that suggest depression and help-seeking may be

experienced in distinctive ways by rural dwelling women in this particular community but warrant further explication through additional research. Education, practice, and policy implications are highly speculative based on this single study. However, the findings offer some support, when coupled with existing literature, to consider the voices, issues, and concerns of rural depressed women and their social community networks in developing responsive education, health care practice, and public policy.

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Appendix A
(Informed Consent)

INFORMED CONSENT FOR PARTICIPATION IN A STUDY OF RURAL WOMEN: WHAT DID YOU DO WHEN YOU WERE DEPRESSED?

This is to certify that I, _____, voluntarily consent to participate in a study on what rural women and others in their lives do about depression. I understand that the principal investigator is Dr. Richard Cowling, a faculty in the VCU School of Nursing. The co-investigator is Vicky Fisher, who is a nurse doing her dissertation at the same school.

During the study, I will be interviewed on audiotape and asked to describe what I did during my experience of depression. At the end of this research project, these tapes will be destroyed. This interview will consist of a series of questions and will be scheduled for 60-90 minutes. This will take place in my home or another place of my choice. I will not receive any reimbursement for participating in this study.

Participation in the study may benefit others by helping them to learn more about how they can manage depression. However, participation in this study will not provide direct benefit to me. For certain people, the recalling of depressive memories may be painful. In the event that I need help with recalling these experiences, a treatment referral will be made.

In the event of physical and/or mental injury resulting from my participation in this research project, Virginia Commonwealth University/MCV Hospitals will not provide compensation. If injury occurs, medical treatment will be available at the MCV Hospitals. Fees for such treatment will be billed to me or to the appropriate third party insurance.

My identity will be treated with professional standards of confidentiality. Any specific information that I request to be kept confidential when the researcher talks to others in my life will not be shared with them. The researcher will be talking to these people about general impressions of identified themes and patterns that are important to my experience of depression. The information in this study may be published, but my name will not be revealed. There will be no cost for participation in this study.

Participation in the study is voluntary and I will receive a copy of the consent form. The researcher will answer any questions I have about the study. I am free to withdraw my consent and stop participation at any time. If I decide to withdraw from this study, I should contact Vicky Fisher at 1-800-860-6000 (a toll free number). I can also contact Dr. Richard Cowling at (804) 828-0521.

I understand that if I have any questions about this study, I can call Ms. Fisher or Dr. Cowling. If I have any questions concerning my rights as a research participant, I can contact the committee on the Conduct of Human Research at (804) 828-0868.

Research Participant _____ **Principal Investigator**_____
Witness (if available) _____**Date** _____

Appendix B
(Informed Consent)

INFORMED CONSENT FOR PARTICIPATION IN A STUDY OF RURAL WOMEN: WHAT DID YOU DO WHEN SOMEONE YOU KNEW WAS DEPRESSED?

This is to certify that I, _____, voluntarily consent to participate in a study on what rural women and others in their lives do about depression. I understand that the principal investigator is Dr. Richard Cowling, a faculty in the VCU School of Nursing. The co-investigator is Vicky Fisher, who is a nurse doing her dissertation at the same school.

During the study, I will be interviewed on audiotape and asked to describe what I did when a person that I knew was important to me experienced depression. At the end of this research project, these tapes will be destroyed. This interview will consist of a series of questions and will be scheduled for 60-90 minutes. This will take place in my home or another place of my choice. I will not receive any reimbursement for participating in this study.

Participation in the study may benefit others by helping them to learn more about how they can manage depression. However, participation in this study will not provide direct benefit to me. For certain people, the recalling of depressive memories may be painful. In the event that I need help with recalling these experiences, a treatment referral will be made. In the event of physical and/or mental injury resulting from my participation in this research project, Virginia Commonwealth University/MCV Hospitals will not provide compensation. If injury occurs, medical treatment will be available at the MCV Hospitals. Fees for such treatment will be billed to me or to the appropriate third party insurance.

My identity will be treated with professional standards of confidentiality. The researcher will be talking to other research participants about general impressions of identified themes and patterns that are important to my experience of depression. Any specific information that I request to be kept confidential from other research participants will not be shared with them. The information in this study may be published, but my name will not be revealed. There will be no cost for participation in this study.

Participation in the study is voluntary and I will receive a copy of the consent form. The researcher will answer any questions I have about the study. I am free to withdraw my consent and stop participation at any time. If I decide to withdraw from this study, I should contact Vicky Fisher at 1-800-860-6000 (a toll free number). I can also contact Dr. Richard Cowling at (804) 828-0521.

I understand that if I have any questions about this study, I can call Ms. Fisher or Dr. Cowling. If I have any questions concerning my rights as a research participant, I can contact the committee on the Conduct of Human Research at (804) 828-0868.

Research Participant_____ **Principal Investigator**_____

Witness (if available)_____ **Date** _____

Vita

Vicky Mitchell Fisher was born on March 17, 1954, in Roanoke, Virginia, and is an American citizen. She graduated from New Castle High School in 1972. She received an Associate in Applied Science from Virginia Western Community College in Roanoke, Virginia, in 1975. She pursued a Bachelor of Arts in English Education at Virginia Polytechnic and State University in Blacksburg, Virginia, from 1979-80. In 1992, she received her Bachelor of Science from Virginia Commonwealth University in Richmond. She also received her Masters of Science from Virginia Commonwealth University in 1994. Her 30 year career has been spent as a clinician, educator, and advocate in the field of mental health nursing. She is certified by the American Nurses Credentialing Center as an Advance Practice Registered Nurse (APRN) in psychiatric mental health nursing. She is a member of the honor societies Sigma Theta Tau and Phi Kappa Phi. Currently, she works as a mental health advocate and public educator in her role as Executive Director of the Mental Health Association of Virginia.