Treating the Aged in Rural Communities: The Application of Cognitive-Behavioral Therapy for Depression

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Many rural communities are experiencing an increase in their older adult population. Older adults who live in rural areas typically have fewer resources and poorer mental and physical health status than do their urban counterparts. Depression is the most prevalent mental health problem among older adults, and 80% of the cases are treatable. Unfortunately, for many rural elders, depressive disorders are widely under-recognized and often untreated or undertreated. Psychotherapy is illustrated with the case of a 65-year-old rural married man whose presenting complaint was depressive symptoms after a myocardial infarction and loss of ability to work. The case illustrates that respect for rural elderly clients’ deeply held beliefs about gender and therapy, coupled with an understanding of their limited resources, can be combined with psychoeducational and therapeutic interventions to offer new options. © 2010 Wiley Periodicals, Inc. J Clin Psychol: In Session 66:502–512, 2010.

Keywords: rural; aging; depression and aging; psychoeducational therapy

Given the increasing proportion of the population of older adults and changing demographics, health professionals must be prepared to assess and treat clients who are often much older than the populations they worked with in their training. Several psychotherapies have proven effective in working with older adults (Culverwell & Carol, 2000). The controlled research and our clinical experiences confirm that most older adults are well-suited to cognitive and behavioral therapies utilizing a collaborative, explicit goal setting, and acknowledgment of their strengths. Within this approach (or any other psychotherapy), it is useful for therapists to consider what adaptations might be important to make therapy especially responsive to the concerns style of older rural clients. In addition, therapists would do well to utilize a biopsychosocial model in working with older rural adults, in which they plan treatment with awareness of interdisciplinary principles and resources.

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In this article, we describe the changing demographic profile of older adults with particular attention to rural elders. Next, we review probable adaptations of psychotherapy for the aged in rural communities. We present a clinical illustration of CBT with an elderly rural man and outline with recommended clinical practices.

Older, Rural Adults

The population of the United States is growing older and becoming more ethnically diverse. According to Census Bureau projections, the number of persons aged 65 years and older will increase from 35 million to 66 million by 2030 and to 82 million by 2050, a figure accounting for 20% of the entire population (U.S. Census Bureau, 2000). This “gerontological explosion” will also occur across groups of minority elders, whose respective population sizes will nearly double by 2050 (U.S. Census Bureau, 2000).

Rates of growth of ethnic minority elderly are expected to exceed those of whites within the next few decades. Ethnic minority populations are projected to increase from 5.7 million (16.4%) in 2000 to 8.1 million (20.1%) in 2010 and then to 12.9 million (23.6%) in 2020. Between 2004 and 2030 the white population 65 and over is projected to increase by 74% compared with 183% for older minorities, including Hispanics (254%), African Americans (147%), American Indians, Eskimos, and Aleuts (143%), and Asians and Pacific Islanders (208%; Administration on Aging, 2006).

Twenty-five percent of the older adult population lives in rural areas (National Advisory Committee on Rural Health and Human Services, 2004). Rural elders are increasingly becoming isolated. The proportion of the older adults in rural counties is higher than in urban areas primarily as a result of younger populations moving to larger urban areas. Along with the out-migration of younger populations, there is an immigration of retired elderly. Thus, many rural communities are aging more rapidly (Ham, Goins, & Brown, 2003). Retirement communities, primarily in coastal regions, experienced a rate of total population increase of 28.4% from 1990 to 2000 (Johnson & Beale, 2002). There was a rapid growth of the older population moving to the rural areas of the West and Mid-Atlantic regions, mainly for retirement. However, the growth of the older population slowed or stopped in many areas in the Great Plains, Corn Belt, and lower Mississippi Delta (Whitener & McGranahan, 2003). Although retiree migration does increase populations and local tax bases, studies find that it does not increase per capita income, nor contribute to increased economic stability (Ham, Goins, & Brown, 2003).

Rural elders are one of the greatest at-risk groups for experiencing mental health problems (Chalifoux et al., 1996; Bischoff). In many rural communities, there are no psychosocial services to meet the needs of the rural elderly. Many frail elderly depend on family members to help with long-term care needs associated with activities of daily living and household management.

In many rural communities there has been a decline in medical care and home health care. Mental health researchers have found that community dwelling elderly persons with significant symptoms of depression use more general medical services and incur higher health care costs than elders who do not show such symptoms (Ganguli et al., 1995; Unutzer et al., 1997). Many physicians who treat elderly community dwelling individuals have little specialized training in diagnosis or treating the most common mental health problems of older adults. Symptoms of older individuals’ underlying mental health problems are often either ignored,
misdiagnosed, or are simply attributed to the inevitability of the “aging process” and then left untreated (Butler, Lewis, & Sunderland, 1991). Where specialized services do exist, they tend to be concentrated in more densely populated cities and suburban areas. Obtaining mental health services for older people is most problematic in rural areas of the country where there is a general overall scarcity of such services for all age groups and a lack of specialized expertise in diagnosing and treating the mental health problems of the elderly (Buckwalter et al., 1991; McCulloch & Lynch, 1993). Although it is unclear exactly what confluence characteristics of living in a rural area contribute to mental health problems, several explanations have been suggested, including neighborhood or residential stability and its isolating effects, lack of community resources and health services, and diminished family and social support because of migration of younger cohorts to more populated areas.

Adapting Cognitive-Behavioral Therapy for Treating the Rural Elderly

Psychoeducation is a major component of cognitive-behavioral therapy (CBT), and therapy is often framed as a “learning experience” rather than a “psychological treatment.” Thus, clients do not have to be especially “psychologically minded” to benefit. This can be an advantage to the current cohort of older adults, who were raised in an era when psychological principles were not widely disseminated. However, it is noteworthy that older adults may not be as averse to psychotherapy, especially CBT, as our intuition might lead us to expect. Rokke and Scogin (1995), for example, showed that older adults rated cognitive therapy as more credible and acceptable than drug therapy for depression, in direct contrast to frequently voiced expectations that older adults would prefer drug therapy and feel stigmatized when psychotherapy is recommended.

Core elements of CBT remain essential when working with older adults, even those with cognitive or physical impairments. These elements are as follows:

- Emphasis on a collaborative therapeutic relationship, in which the therapist and client develop a mutually responsive, goal-focused working style and the client’s strengths as well as problems are explicitly recognized.
- Recognition of the client’s strengths as well as problems.
- Focus on a small number of clearly specified goals for treatment.
- Placing the emphasis of treatment on change, while acknowledging that understanding or insight may be an important step but is not usually an end in itself.
- Use of psychoeducational methods as a central treatment component, e.g., sharing the treatment rationale, educating the client about techniques to be used.
- Length of therapy established initially, or as soon as feasible, and linking length to the time expected to accomplish particular goals.
- Setting an agenda at each meeting, representing the consensus of the therapist and client about which goals have priority.
- Training in more effective strategies for handling problems as a frequent component of treatment (e.g., cognitive behavioral or interpersonal skills).

There are a few major content differences in therapy with older as compared with younger adults. Older adults have more health problems resulting in functional impairment, and their psychological status is often related to their functional status (Zeiss, Lewinsohn, Rohde, & Seeley, 1996). In addition, older adults may face
obstacles in terms of resources for supporting an adequate quality of life, such as limited financial resources or transportation or the experience of loss of friends or family. The problems older adults face are not all appropriate targets for CBT, but they may be important targets for the services of other health care professionals, such as geriatrists, social workers, and occupational therapists, who can work collaboratively with the CB therapist. Thus, CBT with the elderly often is part of a comprehensive, interdisciplinary treatment.

Because of the emphasis on learning in CBT, it is important to consider possible changes in memory and information processing with older adult clients and to be prepared to adapt therapy according to the specific function of each older client. Cognitive changes can be part of normal aging or can occur with more dramatic brain changes due to trauma or a dementing process. There are enormous individual differences among older adults, so the concerns briefly highlighted below are presented as possible cognitive changes related to aging.

Older adults, on average, show significant age decrements in performance on many kinds of memory functions, such as short term memory, memory span, recall of lists of information, recall of paired-associate learning, and recall of prose material. Because recognition memory is generally not as impaired, older adults benefit from the possibility of reviewing lists or texts, particularly when they can set their own pace for review. Older adults generally do not show poorer ability than younger adults in strategies for making associations, imagery, or extracting main points from prose material. Thus, using bibliotherapy adjuncts or using imagery procedures can be as effective with older adults as with younger adults.

Because of cognitive changes, the pace of therapy may be slower than with younger adults. More repetition of material may be necessary, and processing of new ideas may be slower. Memory aids, such as an audio tape of each session to review at home, may be helpful. It may help to present material in multiple ways, both because of potential sensory loss (poorer hearing or vision, for example) and repetitions provide multiple routes to memory storage. A key phrase for therapists working with older adults is “Say it, Show it, Do it”: when presenting a new idea, state it clearly, write it down, and help the client use the idea in a specific way, applying it to her or his own situation.

Some older adults become distracted from the main topic during a session because of memory problems and a tendency to be pulled off topic by concrete or tangential associations to words. You may hear an older person start to tell a relevant story, for example, to provide information on a homework assignment, and then get lost in the details and unable to return to the main point. Older people who have this problem benefit from active efforts to keep them focused, including redirecting their attention to the main ideas of a discussion. It can also be helpful to have the agenda clearly visible, for example, on a white board on the wall or on a table between therapist and client.

Because older clients may have trouble processing and storing new information, they may be slow to see the relevance of ideas presented in therapy. For example, teaching an older client to be assertive with the butcher may not generalize to being assertive with a neighbor, an adult child, or the librarian. Each seems like a new situation, and the material may need to be presented in multiple contexts before the older client can be said to have developed a new “skill.” This slows the pace of therapy, but is often essential to helping the client master essential points.

The changes because of cognitive deficits, strengths of the elderly, and the intrinsically interdisciplinary nature of work with older adults are summarized in the
mnemonic *MICKS* to help therapists remember the key adaptations of CBT that should be considered with older clients:

- Use Multimodal teaching.
- Maintain Interdisciplinary awareness.
- Present information more Clearly.
- Develop Knowledge of aging challenges and strengths.
- Present therapy material more Slowly.

Using CBT for Treating Depression in the Rural Elderly

The prevalence rates of major depressive disorder range from 3%–5% in community samples, increasing to 6%–8% in primary care settings, and around 13% in home health care recipients (Bruce et al., 2002). Older adults have a comparable or higher prevalence of minor depression, dysthymia, or significant depressive symptoms compared with younger persons (Blazer, 2002). Data from a number of studies indicate that across the adult life span, the highest depression scores are found among younger adults and persons 75 years and older (e.g., Lewinsohn, Rohde, Seeley, & Fischer, 1991).

Why might older adults experience a high rate of symptoms without a high rate of diagnosed depression? One answer is that older adults often have comorbid chronic medical illness. Depression is often exacerbated by the presence of these comorbid conditions, in particular, heart disease, stroke, diabetes mellitus, and Alzheimer’s disease (Fischer et al., 2003). Older adult patients were more likely to be widowed, have lower levels of education, have fair or poor health, and have three or more comorbid health problems than the younger depressed patients.

Fifteen percent of persons 65 years of age and older live in rural areas (U.S. Census Bureau, 2000). Older adults who live in rural areas typically have fewer resources and poorer mental and physical health status than do their urban counterparts (Guralnick et al., 2003). In many communities, there are limited psychosocial services available to meet the needs of rural older adults. Mental health researchers have found that community-dwelling elderly persons with significant symptoms of depression use more general medical services and incur higher health care costs than elders who do not show such symptoms (Ganguli, Gilby, Seaberg, & Belle, 1995; Unutzer et al., 1999). Obtaining mental health services for older people is most problematic in rural areas of the country where there is a scarcity of such services for all age groups, vices for all age groups, and a lack of specialized expertise in diagnosis and treatment of the mental health needs of the elderly (Buckwalter, Smith, Zevenbergen, & Russell, 1991).

As a result of government initiatives, including the Surgeon General’s Supplement focused on mental health (U.S. Department of Health and Human Services, 2001) and the President’s New Freedom Commission on Mental Health (2003), there has been an increased emphasis on decreasing mental health disparities. Depression has been identified as an area in which disparities are strongly indicated by higher prevalence or disparity in mental health assessment, access, and treatment outcomes for minority elders.

CBT is the most extensively researched psychological treatment for geriatric depression (Scogin, Welsh, Hanson, Stump, & Coates, 2005) and is one of several evidence-based treatments available for use with this population. One of the most
frequently used protocols is that developed by Thompson and colleagues (1995); this particular adaptation of CBT is listed in the National Registry of Evidence-Based Practices maintained by the Substance Abuse and Mental Health Administration. Further information on resources and training related to this protocol is available at http://oaofc.stanford.edu.

The use of this CBT protocol with depressed rural older adults requires consideration of several factors in addition to those mentioned with respect to older adults in general. First, many rural older adults will find twice-weekly or weekly sessions at a clinic-based office setting problematic because of mobility and transportation difficulties. Consideration of in-home or telephone-administered sessions is suggested if such difficulties arise. It is our belief that consistent contact with the therapist and application of the protocol with the use of these nontraditional means is desired above infrequent meetings in more traditional venues. A second common adaptation of CBT that occurs with depressed rural older adults is a greater emphasis on behavioral activation and a lesser emphasis on pure cognitive therapy techniques such as three and five column approaches. As is illustrated in the case study that follows, some older adults find a focus on identification of and engagement in meaningful activities to be more consistent with their beliefs and values, as well as a better match for their educational and cognitive status. A final consideration in the use of CBT with depressed rural older adults, especially those residing in the southern parts of the United States, is the issue of religious and spiritual beliefs (Crowther, Parker, Larimore, Achenbaum, & Koenig, 2002). Many rural older adults are deeply religious and may initially find the application of psychology to their suffering to be antithetic to their beliefs. This is most prototypically represented by clients who express that their lives are “...in God’s hands.” The sensitive and respectful interpretation of this belief into an action-oriented approach to improvement, as represented by CBT, can be a challenging task for therapists working with rural older adults. One approach we have taken with respect to the behavioral activation tasks of CBT is to encourage greater involvement in religious activities (e.g., prayer, listening to the Bible on tape) as a means to increase activation and begin the upper spiral to improved well-being.

Case Illustration

In this section, we present a rural older male client who presented with depressive symptoms. The goal is to illustrate respect for rural elderly clients and demonstrate strategies of CBT for depression in a specific case, with attention to the unique experience of the rural client. We also believe this case illustrates some general principles in recognizing the real-life obstacles older rural clients face in understanding and utilizing mental health services.

Presenting Problem and Client Description

Mr. Black, a 60-year-old Caucasian man, presented to a rural primary care clinic with depressive symptoms after a recent myocardial infarction and loss of his ability to work. Doctoral students in clinical geropsychology provided psychotherapy services 1–2 days per week at the clinic, which was sponsored by The University of Alabama and primarily staffed by a certified registered nurse practitioner (CRNP) and two licensed practical nurses (LPN’s). Mr. Black lived in rural Alabama with his wife, two adult sons, one daughter-in-law, and two grandchildren. He lived in the same rural community his entire life; he possessed 9 years of formal education and
had been married for 40 years. Mr. Black was raised with both his parents; he was the third of seven children. At the time of therapy both of his parents were deceased. Mr. Black had a small, tenuous social support network, comprised primarily of his wife, children and a few friends. He had contact with his siblings but did not consider them to be a major source of support. Mr. Black had a history of nicotine dependence. He indicated that he drank alcohol but did not think he had a problem with alcohol, just cigarettes. In terms of pleasant activities, he reported that he and his friends would get together to fish and hunt prior to the change in his health status. He also indicated that he enjoyed playing with his grandchildren. Mr. Black stated that his wife was very active in the church; while he didn’t attend on a regular basis, he supported church related activities and expressed a strong religious belief system.

Working in construction before his cardiac illness, he had been denied Social Security Disability once and was preparing to reapply. He had no known source of income. Mr. Black had no previous psychotherapy experience and had very limited knowledge of psychological disorders or psychotherapy. Although prescribed Wellbutrin by his primary care provider, the medication was conceptualized as a treatment for nicotine dependence, and he did not think of it as an antidepressant.

**Case Formulation**

Mr. Black was experiencing depressive symptoms because of his recent cardiac illness and subsequent loss of functioning. Working and providing for his family had previously been a large part of his identity, and he was experiencing feelings of worthlessness because of the loss of this role. He also experienced a loss of pleasant events because of his illness, as he was physically unable to do many things he had previously enjoyed (e.g., hunting, fishing). Other stressors experienced were financial strain due to his unemployment, the recent death of a close friend, and family conflict (did not agree with the way his son and daughter-in-law were raising his grandchildren). Mr. Black was deemed appropriate for CBT. He was experiencing negative cognitions that interfered with improvement of depression symptoms (“I’m worthless now that I can’t provide for my family”) and loss of positive reinforcement from his environment (no longer engaging in previously enjoyed activities).

**Course of Treatment**

Mr. Black demonstrated discomfort at a diagnosis of depression but responded well to a conceptualization of depression as a logical and normal consequence of his recent cardiac illness. Moreover, he was receptive to education about the link between physical and emotional health and the need to treat his depressive symptoms to improve his physical health. However, he expressed some discomfort at the terminology “cognitive-behavioral therapy.”

A doctoral student in clinical geropsychology who was completing a practicum saw Mr. Black for 6 sessions at a rural primary care clinic. The therapist was a Caucasian woman in her mid-20’s. Mr. Black reported that therapy was a new experience for him and that he had always felt uncomfortable discussing his feelings in the past, even with close family and friends. He indicated that he generally felt comfortable talking with the therapist, although there were certain things he preferred not to discuss (e.g., his friend’s recent death). Although encouraged to attend sessions weekly, Mr. Black was unable to come to therapy weekly because of limited money for gas. The therapist offered phone check-ins between sessions;
however, Mr. Black had no home phone and limited minutes on his cell phone and was unable to complete regular phone sessions.

Sessions 1 and 2 comprised gathering background information and developing rapport. The therapist provided active listening and support. Sessions 1 and 2 were held 2 weeks apart. Session 3 was held 3 weeks after Session 2. In this session, the therapist introduced the concept of CBT. She also discussed a medical conceptualization of depression as described above. Mr. Black was hesitant but agreeable to the idea of CBT, saying, “I’ll try it, as long as you don’t try to hypnotize me or anything.” Although initially scheduled for 2 weeks after Session 3, Mr. Black called to postpone session 4, which was, thus, held 4 weeks after Session 3. The therapist presented a more detailed rationale for CBT, as well as an overview of future sessions. The therapist and Mr. Black discussed the loss of pleasurable events and prior important roles as major contributors to his depressive symptoms. The therapist also explained the connection between thoughts and feelings, emphasizing that changing maladaptive thoughts could help individuals feel better.

In Session 5, Mr. Black and the therapist discussed possible modifications to previously enjoyed pleasant events (e.g., going to the fishing hole when his son was able to accompany him), as well as new pleasant events (e.g., talking with his grandson about his history).

During Session 6, several weeks later, some initial challenging of unhelpful thoughts was presented. However, the therapist was reluctant to push too hard because there had been too few sessions to develop rapport and Mr. Black’s deeply entrenched beliefs that were also cultural aspects of the community (e.g., A man’s worth comes from providing for his family). Mr. Black showed limited receptiveness to challenging his maladaptive thoughts.

Mr. Black was receptive to increasing pleasant events as a way to improve depressive symptoms. He identified ways to modify previously enjoyed pleasant activities, as well as new activities that he thought he would enjoy. However, actual engagement in pleasant activities was limited. He was less receptive to challenging of maladaptive thoughts and to a cognitive conceptualization in general.

Outcome and Prognosis

Mr. Black failed to attend a seventh session and did not respond to the therapist’s phone calls attempting to reschedule. The exact reasons for termination of therapy are unknown but likely represent a combination of factors, which include financial barriers to attendance, poor physical health, and discomfort with the process of therapy. It is possible that this part of therapy would have been more successful with more frequent sessions and a higher number of sessions overall. Unfortunately, the federal grant enabling doctoral students to provide psychotherapy services in Mr. Black’s area expired a few months after his last session, with limited other opportunities for mental health treatment. Only a community mental health center provided therapy services in the area, and only group therapy was available. It is unlikely that Mr. Black would have sought services at that facility because of the stigma associated with mental health treatment and the discomfort with discussing his feelings in a group.

Clinical Practices and Summary

As evidenced in the case illustration, working with rural older adults presents some issues that are relatively unique to this population. First, limited access to specialized
mental health providers is the rule rather than the exception. In Mr. Black’s case, there was very little access to any mental health services much less those with a specialist in mental health and aging. Coupled with the stigma he felt towards such services, a view quite pervasive among rural older adults, a circumstance was created in which his receipt of psychological treatment for his depressive symptoms was quite fragile. Although some might view the fact that he discontinued services after six sessions as an unsuccessful course of treatment, his engagement in this many sessions was against the odds and no small feat; we believe he profited from his sessions. As illustrated by this case, access to services is one of the key, if not the primary, barriers experienced by rural older adults. Providers must make efforts to reduce barriers by providing both traditional office-based services with non-traditional modalities such as home-delivered, telephone-administered, or self-administered treatments. An example of one of these alternatives in practice is the Veterans Affairs Home-Based Primary Care approach, in which psychologists provide mental health services in the homes of mobility-restricted veterans. Another issue illustrated by this case is the deviation from a strictly CBT protocol to a more eclectically oriented, yet evidence-based, approach that included a greater focus on behavioral and reminiscence techniques. These techniques often work well with rural older adults, evidencing lower literacy and diminishment of cognitive resources.

Rural older adults are unmistakably a vulnerable population. Finding ways to aid this cohort remains a challenge for those of us interested in mental health and aging. The rewards of such work include the knowledge that one has gone where few chose to tread.

Selected References and Recommended Readings


