



Rural Residents' Depressive Symptoms and Help-Seeking Preferences: Opportunities for Church-Based Intervention Development

Addie Weaver¹ · Joseph Himle^{1,2} · Mark Elliott³ · Jessica Hahn⁴ · Deborah Bybee⁵

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Abstract

This study examines rural residents' depressive symptoms, helps seeking preferences and perceptions of a church-based group depression intervention, informing feasibility of adapting evidence-based treatment for delivery in rural churches. A cross-sectional survey was administered to 100 members of 2 churches in a rural Midwestern community; 63 congregants responded. Depression was assessed via the Patient Health Questionnaire-9. Descriptive analyses were performed, and 12.9% of respondents screened positive for depression. Another 25% reported mild symptomatology. Respondents preferred informal help seeking, although reported more openness to formal providers to address others' depression. Results suggest receptivity to church-based treatment. Almost two-third of respondents reported they would consider attending a church-based group depression intervention, 80% would recommend it to a friend in need, and 60% indicated it would benefit their community. Delivering evidence-based depression treatment within church settings may provide a viable option for increasing access to care in this rural community.

Keywords Rural mental health · Depression · Help-seeking preferences · Church-based intervention · Access to mental health care

✉ Addie Weaver
weaverad@umich.edu

¹ School of Social Work, University of Michigan, 1080 S. University, Ann Arbor, MI, USA

² Department of Psychiatry, University of Michigan, Ann Arbor, MI, USA

³ Hillsdale Church of the Nazarene, Hillsdale, MI, USA

⁴ Trinity Lutheran Church, Hillsdale, MI, USA

⁵ Department of Community Psychology, Michigan State University, East Lansing, MI, USA

Introduction

Depression is a significant public health concern, projected to be the second leading cause of disease burden by 2020 (Murray and Lopez 1996). Almost 20% of Americans experience depression during their lifetime, and approximately 7% of adults in the USA have experienced depression within the last year (Blazer et al. 1994; Kessler et al. 1994, 2003, 2005). When untreated, the disorder has devastating effects on work, family and social life (Marciniak et al. 2005; Wang et al. 2003). Despite high prevalence, only one-third of persons with depression seek treatment (Kessler et al. 2005; Katz et al. 1998). Rural Americans experience depression at rates similar to urban residents (Blazer et al. 1994; Kessler et al. 1994; Probst et al. 2006; Wang 2004); yet, rural residents are significantly less likely to receive any mental health treatment compared to urban residents (Fortney et al. 2010; Wang et al. 2005). In fact, despite decades of efficacy research, rural residents are unlikely to receive evidence-based care for depression (Fortney et al. 2010; Wang et al. 2005, 2006; Hartley et al. 1999; Hauenstein and Peddada 2007).

Rural residents face substantial barriers to care, the most significant of which may be the shortage of mental health providers (Gamm et al. 2003; Ellis et al. 2009; Sawyer et al. 2006). Research demonstrates that mental health professionals are concentrated in urban areas of the USA, with 80% of master-level social workers (MSWs) and 90% of psychologists and psychiatrists exclusively practicing in metropolitan areas (Ellis et al. 2009; Sawyer et al. 2006). Given the concentration of mental health providers in urban communities, over 60% of rural Americans reside in designated mental health provider shortage areas (Health Resources and Services Administration 2019).

The mental health provider shortage in rural America has existed for decades and is exacerbated by access challenges, including high poverty and unemployment rates (Proctor et al. 2016; U.S. Department of Agriculture Economic Research Service 2017), high proportions of uninsured or underinsured persons (Eberhardt et al. 2001; National Advisory Committee on Rural Health and Human Services 2014; Newkirk and Damico 2014), and travel burden (Amundson 2001; Gjesfeld et al. 2012; Hogan 2003).

However, even when mental health treatment is available, rural Americans often choose not to seek services. Values emphasizing self-reliance and independence contribute to common beliefs that psychiatric distress is a personal weakness (Buckwalter 1991; Crumb et al. 2019; Hill and Fraser 1995; Rost et al. 2002; Sheffler 1999; Weinert and Long 1987), leading to high levels of shame and stigma (Cheesmond et al. 2019; Crumb et al. 2019; Rost et al. 1993; Stamm 2003). Lack of anonymity may also deter help seeking, as limited social networks make obtaining care without being noticed difficult in rural areas (Rost et al. 2002; Logan et al. 2004; Smalley et al. 2010). Further, rural residents may perceive cultural dissimilarities and distrust between themselves and mental health providers, many of whom are not from the community (Cheesmond et al. 2019; Rost et al. 1993).

Given these well-established and persistent access challenges, it is imperative to explore non-mental health settings within underserved, rural communities that

could offer evidence-based depression interventions and reduce barriers to care. Literature consistently suggests that gold standard evidence-based treatment for depression, such as cognitive behavioral therapy, can be effectively delivered in non-mental health settings, by non-mental health professionals (e.g., Brown and Schulberg 1995; Hoagwood and Erwin 1997; Rose and Perz 2005; Roy-Byrne et al. 2005), and with the use of technology-assisted approaches (e.g., Andrews et al. 2010; Antonacci et al. 2008; Kaltenthaler et al. 2006). This further supports the need to consider strategies to reduce access disparities outside of specialty mental health settings and providers. However, it is also crucial to understand rural residents' help-seeking preferences and receptivity to potential intervention delivery methods, in order to ensure approaches are acceptable to potential end-users.

In general, Americans experiencing emotional issues commonly seek help from clergy (Chalfant et al. 1990; Wang et al. 2003; Weaver 1995) and rural residents tend to be more religious than urban residents (Braun and Maghri 2004; Chandler and Campbell 2002; Fischer 1982). Therefore, it seems that delivering evidence-based interventions for depression in the church setting may offer a logical, promising way to increase rural populations' access to effective, acceptable care. Only one identified study, conducted in the rural South, has examined rural residents' receptivity to church-based mental health care (Fox et al. 2001). Among this sample of rural southerners with untreated depression, 68% of whites and 93% of people of color stated they would seek mental health services if they were available at church. However, findings of this study have not been replicated in other regions of the country and no identified research has assessed rural residents' receptivity to group depression treatment delivered in the church setting.

This study examines rural residents' depressive symptoms, help-seeking preferences, and perceptions of a church-based group depression intervention. This work informs the feasibility and acceptability of adapting and implementing group cognitive behavioral therapy for depression for delivery in church settings.

Methods

As part of community-based participatory research aimed at increasing access to mental health treatment, researchers and clergy collaborated to administer a cross-sectional mail survey to active members of two churches in a rural Mid-western community between July and November 2013. The Pastor of each church introduced the survey and its purpose to congregants during two Sunday morning worship services. Along with the survey, congregants were provided information regarding the survey's voluntary, confidential nature. The churches administered surveys to 44 and 56 congregants, respectively. Sixty-three of the 100 congregants (63%) completed the survey; with no significant differences in response rates across the 2 churches (63.6%; 62.5%). All study procedures were approved by an Institutional Review Board.

Survey Instrument

The survey included 23 items. Five items assessed the respondents' demographic characteristics. A ten-item depression screen (PHQ-9) was included in the survey to assess respondents' depressive symptomatology. Four items examined respondents' help-seeking preferences and three items assessed respondents' perceptions of church-based group depression treatment.

Demographic Characteristics

Respondents were asked questions about their demographic characteristics, including gender, marital status, race and birth year.

Depressive Symptoms

Survey respondents completed a well-established, widely used screening tool, the Patient Health Questionnaire-9 (PHQ-9; Kroenke and Spitzer 2002) to assess depressive symptoms. The PHQ-9 includes nine items that ask respondents how often they have been bothered by problems commonly associated with depression (e.g., little interest or pleasure in doing things; feeling down, depressed, or hopeless) over the last 2 weeks. Responses for each item range from 0 (not at all) to 3 (nearly every day), with total scores ranging from 0 to 27. Scores greater or equal to 10 indicate probable depressive disorder and scores ranging from 5 to 9 suggest mild depressive symptomatology. The PHQ-9 has excellent internal reliability (Cronbach's $\alpha=0.89$) and test–retest reliability ($r=0.84$; Kroenke and Spitzer 2002). After the nine diagnostic screening questions, respondents are asked how difficult the problems have made it for them to do their work, take care of things at home, or get along with other people.

In addition to the PHQ-9, respondents were asked if they thought anyone in their household was experiencing depressive symptoms (e.g., feeling down, blue, or hopeless).

Help-Seeking Preferences

Respondents were asked four questions related to their help-seeking preferences. One question asked respondents who they would consider going to for help if they were feeling down or experiencing blue mood, and another question asked respondents who they would recommend to a friend in need of help for the same emotional problems. Respondents were asked to select all of the people they would consider seeking help from or recommend to a friend in need of help from a list that included: family member, friend, neighbor, clergy, primary care physician, mental health professional, and other. Respondents were also asked if they had sought help for emotional problems (e.g., feeling down, depressed, blue mood) in the past. Respondents who endorsed past help-seeking were asked to identify who they reached out to for help from a list that included: family member, friend, neighbor, clergy, primary care

physician, mental health professional, and other. Respondents were asked to select all of the individuals they sought help from.

Perceptions of Church-Based Group Depression Treatment

Three survey questions assessed respondents' perceptions of a church-based small group program focused on ways to help people who are feeling down get better. Respondents were asked whether they thought members of their church could benefit from this type of small group program, whether they would encourage someone who was feeling down or blue to attend, and whether they would attend if they were feeling down or blue. Response options included yes, no, and maybe.

Analysis Plan

Descriptive statistics, including frequency distributions, measures of central tendency, and measures of variation, were used to examine survey responses. Bivariate statistics, including chi-square tests and independent *t* tests were used to assess church-based differences in demographic characteristics and PHQ-9 depression scores between respondents. Bivariate relationships between demographic characteristics (i.e., gender, age, marital status) and PHQ-9 depression scores were also examined for the full sample. As no significant differences were found, these results are not reported.

Results

Demographic Characteristics

Respondents were, on average, 61 years old ($SD=16.4$) with ages ranging from 19 to 97 (see Table 1). Of 61 respondents who answered these demographic questions, over two-thirds were ($N=42$) women and three-quarters ($N=46$) were married. Fifty-seven respondents reported their race/ethnicity, with almost 90% ($N=51$) identifying as white.

Depressive Symptoms

PHQ-9 scores suggest 12.9% ($N=8$) of the 62 respondents who completed the measure screened positive for Major Depressive Disorder (MDD), whereas another 24.4% ($N=15$) experienced mild depressive symptoms (see Table 2). Approximately 29% of respondents ($N=18$) who endorsed at least one depressive symptom indicated their symptoms made life somewhat or very difficult. This suggests that for some respondents, mild depressive symptoms still negatively impacted on their ability to function in everyday life.

Table 1 Respondents' sociodemographic characteristics

	Mean	SD
Age ($N=58$)	60.7	16.4
	<i>N</i>	%
Sex ($N=61$)		
Women	42	68.9
Men	19	31.1
Marital status ($N=61$)		
Single	5	8.2
Married	46	75.4
Living with partner	1	1.6
Divorced	3	4.9
Widowed	6	9.8
Race/ethnicity ($N=57$)		
African American	2	3.5
Asian American	1	1.8
Latino	0	0
Non-hispanic white	51	89.5
Multi-racial	0	0
Other	3	5.3

Table 2 Respondents' depressive symptoms based on PHQ-9 scores ($N=62$)

Score	<i>N</i>	%
0–4	39	62.9
5–9 (mild symptoms)	15	24.2
≥ 10 (probable MDD diagnosis)	8	12.9
Total	62	100

One-fourth of respondents ($N=16$; 25.4%) also reported a household member was experiencing depressive symptoms (e.g., loss of pleasure or interest; feeling down; depressed; hopelessness).

Help-Seeking Preferences

When asked who they would go to for help if feeling down or blue, respondents most frequently endorsed clergy ($N=37$; 59%), family ($N=37$; 59%), and friends ($N=37$; 59%) (see Table 3). Almost 50% indicated they would seek help from primary care providers ($N=30$); though only 22% reported that they would go to mental health professionals ($N=14$). Respondents were also asked who they would recommend to a friend feeling down or blue. Three-quarters of respondents ($N=48$; 76%) indicated they would recommend clergy and 60% reported they would recommend a primary

Table 3 Respondents' help-seeking preferences for themselves and recommendations for others seeking help ($N=63$)

	Family	Friend	Neighbor	Clergy	Primary care physician	Mental health professional
	<i>N</i> %	<i>N</i> %				
Self	37 58.7	37 58.7	2 3.2	37 58.7	30 47.6	14 22.2
Other	27 42.9	30 47.6	1 1.6	48 76.2	38 60.3	34 54.0

care provider to a friend ($N=38$). Interestingly, 54% of respondents suggested they would recommend a mental health professional ($N=34$) to a friend with depressive symptoms. Forty-eight percent of respondents ($N=30$) indicated they would recommend consulting with either a friend or family member to a friend feeling down.

Over half of the respondents ($N=35$; 55.6%) indicated they had asked for help for emotional problems (e.g., feeling down, depressed, blue mood) at some time in their life. Respondents who reported seeking help for emotional problems in the past most commonly reported receiving care from primary care providers ($N=21$; 60%) and clergy ($N=20$; 57%). Forty percent of respondents reported seeking help from a family member or a friend, respectively ($N=14$). Approximately one-third of respondents who sought help in the past reported going to a mental health professional ($N=12$; 34%). Only 2% ($N=1$) asked a neighbor for help for an emotional problem.

Perceptions of Church-Based Group Depression Treatment

Sixty percent ($N=37$) of respondents indicated a church-based group depression intervention would benefit members of their community who were feeling down. Two-thirds of respondents (67%; $N=41$) indicated if they were feeling down or blue, they would consider attending a group depression intervention offered at church. Additionally, 80% ($N=50$) of respondents indicated they would encourage a friend experiencing emotional problems to attend a church-based group depression intervention.

Discussion

Our findings suggest depression was a significant problem among our sample. Almost 13% of respondents screened positive for current probable major depressive disorder (MDD), which is approximately double the 12-month prevalence rate (6.6%) for MDD reported in epidemiologic studies (Kessler et al. 2005). Another one-quarter of respondents reported mild depressive symptoms. These individuals are at great risk for worsening, and literature suggests rural residents typically wait until symptoms are severe to seek treatment (Fox et al. 1995; Green et al. 2012).

These findings demonstrate the need for effective, accessible, acceptable treatment in this rural community.

Findings also demonstrate respondents' strong preference for seeking help from informal providers, such as clergy, family and friends. This result is consistent with existing literature suggesting rural residents experiencing psychological distress prefer seeking help from informal networks of care, including clergy, family, friends and neighbors (Fox et al. 1995, 2001). Respondents' preference for informal providers supports existing literature indicating there is still high levels of stigma associated with mental illness within rural communities (Cheesmond et al. 2019; Crumb et al. 2019; Rost et al. 1993; Stamm 2003) and suggests that specialty mental health care may not be an acceptable treatment option for some rural residents. Interestingly, there was a stark contrast between respondents' openness to specialty mental health providers for their own mental health needs and needs of friends experiencing depressive symptoms, with 22% of respondents indicating they would seek help from mental health professionals compared to 54% reporting they would recommend a mental health professional to a friend. This speaks to the need for further investigation around attitudinal barriers to care experienced by rural residents, with particular attention to internal and public stigma.

Given their strong preference for seeking help from informal providers, and clergy in particular, it is not surprising that respondents were receptive to church-based group depression intervention. Respondents believed offering care for depression in the church setting would benefit their community and saw it as a viable option to address their own depressive symptoms. Findings suggest delivering evidence-based depression treatment at no cost within non-stigmatizing church settings may provide an acceptable way to increase access to care in this rural community.

Limitations

This study includes a small, self-selected sample that limits generalizability of findings. Additionally, as all respondents were church members, their religious affiliation may have impacted their responses. Additional research replicating this study within the larger rural community is needed.

These limitations notwithstanding, this study has important implications for understanding mental health needs and identifying strategies for addressing mental health treatment access disparities experienced by rural Americans. First, this study suggests that depression is a significant mental health need among this sample. Findings indicate that almost 13% of this sample screened positive for probable MDD and another 25% reported experiencing mild-to-moderate depressive symptoms that led to functional impairment. Our results demonstrate the importance of engaging rural residents with mild-to-moderate depression, in addition to those with probable MDD, in treatment in order to prevent worsening severity of symptoms and prevent risk of further negative outcomes. Second, findings support existing literature suggesting rural residents prefer seeking help from informal systems of care when experiencing mental health needs. Our results suggest the need for further research focused on the role of stigma as a barrier to care, with particular attention

to examining both internal and public stigma. Finally, this research identifies the church setting as an important potential conduit for delivering evidence-based care and reducing barriers to mental health services in a way that aligns with rural residents' help-seeking preferences. Given the substantial barriers to mental health treatment in rural America, it is imperative for future research to explore existing settings and resources within rural communities that have the capacity to provide evidence-based depression treatment that is accessible and acceptable to rural residents. This study suggests that the church may provide a promising venue to offer no-cost care in a venue that is non-stigmatizing and actually preferred by rural residents. Further research on the feasibility of delivering evidence-based depression treatment in church settings is needed.

Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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