CHARACTERISTICS OF HELPING RELATIONSHIPS
FOR EMOTIONAL DISTRESS: OLDER
ADULTS’ PERCEPTIONS

by

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ABSTRACT

Characteristics of Helping Relationships for Emotional Distress:

Older Adults' Perceptions

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Geriatric depression reduces older adults' quality of life, yet few will seek formal help. Older adults often seek help for emotional distress from informal helpers, which appears to have a therapeutic benefit for them. This qualitative study was designed to investigate older adults' perceptions of helping relationships that they used when faced with emotional difficulties or concerns, characteristics that facilitated their approaching helpers, and what they perceived as helpful in those relationships. This study also looked at older adults' perceptions of professional mental health practitioners and barriers to seeking help.

Semistructured qualitative interviews were conducted with 8 older adults between the ages of 78-91, all of whom were participants of the Cache County Study on Memory, Health, and Aging. All participants had been identified in previous interviews as depressed according to study criteria. The interviews took place in the participants'
homes and the participants were asked about their experience seeking help with emotional difficulties or concerns.

Participants in this study reported using informal helpers (e.g., family and friends) more than formal helpers. Characteristics of those from whom help was sought were consistent with the literature on the therapeutic helping alliance, and included understanding, caring, trust, acceptance, and availability. Behaviors that were found to be helpful included listening, problem solving, normalizing, and understanding. Older adults generally did not trust or have confidence in professional helpers. Overall, the participants preferred working through emotional concerns on their own or with the help of family and friends. This study supports the literature concerning older adults’ use of social support networks for emotional support and provides suggestions for both informal and formal helpers as well as implications for policy and research.

(148 pages)
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There are numerous individuals that made this project possible. There were eight dedicated older adults in the community willing to talk to me. There were three incredible professors who bent over backward to help me reach deadlines and encouraged me along the way. There were two supportive parents who may have questioned whether I would make it through, but never let it show. There were two awesome friends who were my legs in Logan. And there were five cohort members who cheered and waved happy fingers in my behalf.

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CHAPTER I
INTRODUCTION

Following World War II, the soldiers returned home, settled down, and began building the postwar nation (Maples & Abney, 2006). The returning soldiers married and what followed is considered the “baby boom” era: a time period known for the highest birth rate in the history of the United States (Maples & Abney). Seventy-five million children were born during the 18 years spanning 1945 to 1964, which means the first of the boomers will begin turning 65 in 2010 (Polivka & Salmon, 2003). The next 20 years will see the largest population of adults over the age of 60 in United States history. Policy makers, scholars, and community service providers are all looking to the future of the baby boomers and are predicting, planning, and preparing for the impact this aging population will have on the American society.

Problem

Research has shown that those approaching old age have lived in a context far different from previous cohorts (Curtis & Dixon, 2005; Weiner & Goldberg, 2003). Differences in family structure, medical advances, mandatory retirement, and social definitions of old age have created a context substantially different from other generations (Curtis & Dixon; Rowe & Kahn, 1998; Weiner & Goldberg). Many older adults remain employed, spend hours volunteering, and pursue many leisure activities (Weiner & Goldberg). Rowe and Kahn define successful aging as a “low risk of disease, ... high mental and physical functioning, and active engagement with life” (p. 38). Yet
successful aging according to this definition is threatened by geriatric depression. Among older adults there exists a segment of the population that experiences depression. Prevalence statistics show that 3% to 7% of older adults experience depression in late life (Steffens et al., 2000). However, it is estimated that only 20% of older adults with depression are treated (Cole & Dendukuri, 2004). Those individuals not treated become a concern because adults who experience depression symptoms are at risk for poorer physical functioning (Blazer, 2003; Eastwood, 2002), dementia (Blazer; Eastwood; Ownby, Crocco, Acevedo, John, & Loewenstein, 2006), mortality, and suicide (Alexopoulos, Bruce, Hull, Sirey, & Kakuma, 1999). This concern is not only for the individual who suffers increased health and mental problems, but for families and society that pay for increased health care costs, as well as the loss of a loved one.

There are a variety of options available to individuals suffering from depression, including psychopharmacology, and psychotherapy (Joiner, Pettit, & Perez, 2002). Research has shown the efficacy of psychopharmacology coupled with psychotherapy for the treatment of depression in older adults (Blazer, 2003; Ebmeier, Donaghey, & Steele, 2006; Vitt, Edenfield, & Lynch, 2002; Woods & Roth, 2005). However, of the few older adults who seek help for depression, even fewer see psychotherapy as an option (Blazer; Woods & Roth; Zivian, Larsen, Gekoski, Knox, & Hatchette, 1994). While some older adults may prefer medication, there are some that may be reluctant to take them because of side effects, costs, and interactions with other medications they take. Although typically less accepted by older adults, psychotherapy is non-chemical with no-risk of drug interaction. Among mental health professionals, the usefulness of psychotherapy for
older adults has generally become accepted (Curtis & Dixon, 2005; O’Rourke & Hadjistavropoulos, 1997; Taylor et al., 1999; Woods & Roth) and psychotherapists anticipate that as the baby boom generation moves into retirement these older adults will make increased use of psychotherapy.

Older adults have different concerns and life experiences than individuals in earlier life stages (e.g., failing health, caregiving, bereavement, increasing family and financial struggles, societal stigmatization, and social isolation; Katz, 2002; Silverman & Prigerson, 2002). These complex factors unique to older adults emphasize the importance of professional helpers (e.g., physicians, clergy, and psychotherapists) becoming aware of the aging population and their unique needs (Curtis & Dixon, 2005).

In previous generations, older adults have not used formal psychotherapy for depression or other emotional concerns. More frequently, they have turned to their social support networks for help. Cummings, Neff, and Husaini (2003) found that older adults’ positive perception of emotional social support acts as a protective factor against depression. Socioemotional selectivity (Carstensen, 1995) theory proposes that across adulthood, the motivation behind forming and maintaining friendships changes, moving from information seeking toward emotional regulation. Based on this theory, older adults value emotion regulation more than information seeking; thus, it is assumed that social support among older adults impacts symptoms of depression. Looking at the relationship between older adults and what they consider useful in confidants and supportive figures can inform our knowledge of how formal or informal helpers might enhance the helping alliance with and be more helpful to older clients.
The helping alliance, or the bond that a client feels with a therapist, has been found to be one of the most important factors in therapeutic outcome (Sprenkle & Blow, 2004). It is the alliance rather than the models or interventions used that appears to make the largest difference. Factors such as trust, empathy, warmth, and respect are key in fostering alliance, and thus therapy effectiveness and outcome (Blow & Sprenkle, 2001). The majority of research on the helping alliance has been conducted with working-age adults and older adults from over a decade ago. The question arises as to whether this research on younger populations and previous cohorts can be generalized to contemporary older adults with their unique challenges and perspectives. The lack of research on the helping alliance with current older adults leaves this question and others like it unexamined.

Purpose of the Research

The purpose of this research was to investigate the perspectives on helping relationships, both formal and informal, of older adults who had been identified as depressed in earlier interviews of a larger parent study. The current study was conducted through qualitative analysis of data from face to face interviews with a sample of older adults who had experienced symptoms of depression to examine what they found helpful in relationships when dealing with emotional problems and concerns. The aim of the research was to find themes that illuminate the type of helping relationship that is most beneficial for formal and informal helpers to construct when helping an older adult. It is also possible that the findings can help formal helpers know how to reach the older
population, break down stereotypes and barriers, and help this underserved population.

Definitions

For the purposes of this study, the following definitions will apply: Social support refers to a relationship in which there is an intended benefit for one or both of the participating parties (Rudkin & Indrikovs, 2002) including both emotional and instrumental support. Older adults are those 65 years old and older. Helping alliance encompasses the unique relationship between a helper and help-seeker, incorporating the help-seeker’s affective experience and perception of the helper’s empathy and understanding (Gaston, 1990). Informal helpers are friends, family, lay-clergy members, and other untrained individuals. Formal helpers are trained clergy, physicians, and mental health professionals (e.g., psychiatrists, psychologists, therapists, and counselors).
CHAPTER II
REVIEW OF LITERATURE

This chapter outlines previous research in the areas of interest to this study. Research has looked extensively at geriatric depression: its etiology, prognosis, and phenomenology. The literature examines risk factors for depression and the impact that depression can have on the individual's physical and mental functioning. With the upcoming increase in the older population of this country, it is increasingly important to understand the factors related to geriatric depression.

One of the major questions that can be asked is who older adults go to for help. The typical help-seeking behavior for older adults was important to this study. Research has shown that older adults go to different individuals for different types of help (Stolar, MacEntee, & Hill, 1993). Support for emotional problems and depression often comes from close family members and friends. These relationships may serve as protective factors and may impact the course of the depression.

The literature on older adults and social support increases our understanding of the different roles friends and family provide to the individual. It is possible to assume that the roles of friends and family are closely linked with the factors that older adults find helpful. Social support is closely linked to depression as a protective factor.

Within the framework of formal psychotherapy there is extensive research on the helping alliance and factors that are helpful for improved mental health. This literature informed this project because it is possible that factors that are helpful in formal relationships may also be helpful with informal helping relationships.
This chapter reviews current literature on geriatric depression: its demographics, risk factors, prognosis, and protective factors. This review is followed by a review of help-seeking behavior of older adults, to whom they go for emotional help, and barriers that keep them from seeking help. The social support network of older adults is not only a protective factor against depression, but it also is one of the sources to which older adults turn when they are seeking help. The research on social support is summarized in preparation for a discussion on its relation to depression and recovery. Finally, research on the helping alliance is recounted as a foundation and comparison for the possible outcomes of this research.

Depression

Definition and Prevalence

Joiner (2000) argued that depression is a persistent and recurrent mental illness that is incapacitating, costly, chronic, and potentially lethal. The prevalence of depression appears to be increasing worldwide. Seligman (as cited in Joiner) presented an important age-related phenomenon connected to the prevalence of depression. In 1998, a person 70 years of age had a 1-2% lifetime chance of experiencing depression. Seligman reported that a person in his or her 50s had a 3-4% lifetime chance of experiencing depression in 1998. This pattern continued for younger ages with those in their 30s having a 6% lifetime chance of depression. Joiner labeled this increase in prevalence a "looming epidemic" (p. 224), claiming that when the teenagers of 1998 reach their 70s, their lifetime prevalence of depression will be 20%. It is clear that the predicted future
prevalence of depression is rising.

Depression is one of the most common mental health disorders for older adults (Smyer & Qualls, 1999), and it is often underrecognized, underreported, and undertreated (Parashos et al., 2002; Webber et al., 2005). Depressive symptoms and dementia often look similar in older adults (Birrer & Vemuri, 2004), making it more difficult for physicians and caregivers to distinguish between cognitive decline and depression. Lack of concentration or memory deficits are symptoms of depression that can be confused with expected age-related memory problems (Insel & Badger, 2002). These similarities make it difficult to accurately diagnose the symptoms. There also appears to be a cohort effect, with older adults feeling that depressive symptoms are shameful (Yang & Jackson, 1998) and that they should be able to fix things without help (Switzer, Wittink, Karsch, & Barg, 2006). These cohort effects may also be augmented by gender stereotypes found in a study of young adults in which the researchers (Sigmon et al., 2005) found that men were less likely to report symptoms of depression if their anonymity would be compromised by a possible followup. Underreporting was also found in a study with probable Alzheimer’s patients who reported significantly fewer symptoms of depression as compared to their caregivers’ observations (Moye, Robiner, & Mackenzie, 1993). Whether it is gender, cohort effects, cognitive decline, or not recognizing the symptoms, the result is the same: older adults with depressive symptoms do not receive the assistance they need to help them recover and improve their quality of life.

The commonly used term depression can be further subdivided into a continuum of depressive symptoms (Lasser, Siegel, Dukoff, & Sunderland, 1998). A major
depressive disorder (MDD), as outlined in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (American Psychiatric Association, 2000), is the most acute on the continuum. Approximately 1-6% of community-dwelling older adults experience a major depressive disorder in a given year (Joiner et al., 2002; Steffens et al., 2000). The estimated rates are somewhat higher for institutionalized older adults (6-25%; Joiner et al.; Smyer & Qualls, 1999). Slightly lower on the continuum is dysthymia, a low grade chronic experience of depressive symptomology with dysphoria or depressed mood lasting at least two years, occurring at a rate of 2% in community-dwelling older adults and 16-30% in those residing in institutions (Joiner et al.; Smyer & Qualls).

The majority of older adults do not meet the diagnostic criteria for a major depressive disorder or dysthymia; however, they experience high rates of depressive symptoms or subsyndromal depression at a rate of 20-30% in both community-dwelling and institutionalized older adults (Joiner et al., 2002; Smyer & Qualls, 1999). Subsyndromal depression is based on the presence of one core depressive symptom (e.g., depressed mood or loss of interest) coupled with one to three additional symptoms (Blazer, 2003). Thus, subsyndromal depression on one end of the continuum has similar but fewer symptoms to MDD on the other end of the continuum. Research has shown that without early intervention, subsyndromal depression often progresses through the continuum into MDD (Coryell, Endicott, & Keller, 1991; Hybels, Blazer, & Pieper, 2001; Kessler, Zhao, Blazer, & Swartz, 1997; Norton, Skoog, Toone et al., 2006).

*Etiology of Depression*

The etiology of geriatric depression is not clearly understood; however,
researchers have identified numerous risk factors including demographic variables, life events, physical illness, and cognitive decline. Demographic variables such as age and gender are risk factors. Women report depression at higher rates (nearly double) than do men (Eastwood, 2002; Steffens et al., 2000). It is unknown whether this reflects a true difference in ratio, inflation due to underreporting by men, or the possibility that symptoms of depression in elderly men are expressed in less detectable ways (Steffens et al.).

Life events including those that occur early in life and more recently are risk factors for depressive symptomology (Bazargan & Hamm-Baugh, 1995; Blazer, 2003; Smyer & Qualls, 1999). For older adults, current life events are widely believed to contribute to geriatric depression (Bazargan & Hamm-Baugh; Blazer; Joiner et al., 2002). Losses are common in later life and the grief process, if not resolved, can progress into a major depressive episode (Silverman & Prigerson, 2002). A review of 11 studies exploring the prevalence of depression after the loss of a partner found that almost 22% of the widowed were diagnosed as having MDD and, compared to control subjects, experienced a relative risk of developing a mood or anxiety disorder ranging from 3.49-9.76 times (Onrust & Cuijpers, 2006).

Cognitive decline is often a risk factor for depression (Blazer, 2003) and often complicates the recognition of symptoms of depression by caregivers (Bellino, Bogetto, Vaschetto, Ziero, & Ravizza, 2000). Alexopoulos and colleagues (2000) found in a study of 58 older adults that losses of executive functioning were associated with increased levels of depression and relapse. Thus, cognitive decline, physical decline, and stressful
life events are risk factors for depression.

Recursive Risk Factors

Physical illness is a major risk factor for depression identified by researchers: approximately 60-85% of depressed older adults report having a physical illness prior to the onset of their depression (Blazer, 2003; Joiner et al., 2002; Smyer & Qualls, 1999), and depression often becomes a risk factor for subsequent physical illness (Blazer). Depression and vascular disease are an example of this recursive process. Approximately 20% of heart attack and 50% of stroke survivors develop depression, and those with depression have increased reports of heart disease (Blazer; Eastwood, 2002).

Decline in functional abilities often accompanies physical illness. As activities of daily living—both basic activities of daily living and instrumental activities of daily living—are restricted, older adults' risk of depression increases (Cummings et al., 2003). Following the decline of the ability to perform activities of daily living, older adults may find themselves in some type of institution (e.g., assisted living, nursing home; Grayson, Lubin, & Van Whitlock, 1995; Lasser et al., 1998). This is also a recursive process because higher rates of depression are reported in institutionalized older adults (Arvaniti et al., 2005; Frojd, Hakansson, Karlsson, & Molarius, 2003; Joiner et al., 2002).

Prognosis of Depression

Geriatric depression also becomes a risk factor for other types of problematic behaviors and conditions. Simon, Ormel, VonKorff, and Barlow (1995) reported that depression and anxiety increased the use of all types (not just psychiatric) of inpatient and
outpatient medical services. Another study of 350 nursing home patients 55 years and older found that participants with depression and anxiety used health care services more frequently than non-anxious and non-depressed residents (Smalbrugge et al., 2006).

Depression is also related to cognitive decline, including a doubling of risk for Alzheimer’s disease (Ownby et al., 2006; Steffens et al., 2006). Depression has been found to be a mental illness that often relapses in older adults (Frojdh et al., 2003; Woods & Roth, 2005).

Severe depression is the main contributor to suicidal ideation and death by suicide (Alexopoulos et al., 1999; Lasser et al., 1998). The rate of elderly suicide in the United States has decreased since 1950; however, the rate is consistently higher for individuals 75 years of age or older compared with other age categories. This high rate of suicide remains consistent for men (35.1 deaths per 100,000) but not for women (National Center for Health Statistics, 2005). In one study, 79% of a sample of older adults 65 years and older who died by suicide in Scandinavia were placed on a depressive continuum ranging from minor to major depressive disorder based on next of kin reports (Waern et al., 2002). Not only does depression increase the risk of death by suicide, but it also increases the risk of death from other causes (Blazer, 2003). In studies controlling for both suicide and severe health problems, the death rate for depressed older adults was elevated compared to non-depressed adults (Baldwin, 1991), which is consistent with more recent findings that depression increases mortality (Frojdh et al., 2003; Penninx et al., 1999). The impact of depression on older adults’ quality of life is profound and leads to the
question of when and how older adults seek help when experiencing symptoms of depression.

Help-Seeking Behavior

Help-Seeking Model

Willis and DePaulo (1991) outlined a pyramid model of help seeking that is logical and has some empirical support. According to this model, the majority of emotional and life stressors are short in duration and minor in magnitude. For these challenges, individuals seek help from family and friends. More persistent problems are taken to clergy or general medical practitioners and, at the top level of the pyramid, specialists are reserved for serious and lasting problems. In 1991, Willis and DePaulo’s model was largely inferential; however, since then, studies have shown that this model accurately represents help-seeking behavior (MacKenzie, Gekoski, & Knox, 2006). This model was used in the current study because it was anticipated that the majority of the help sought by older adults would be from informal sources followed by general medical practitioners, with mental health professionals being used rarely and reserved for challenges perceived to be very serious.

Demographics of Help Seeking

Willis and DePaulo (1991) did an exhaustive review of factors contributing to help-seeking behavior, including demographics and social context. The current help-seeking literature confirms Willis and DePaulo’s work. The literature indicates that women are more willing to seek help from formal and informal sources than are men.
(Kushner & Sher, 1991; MacKenzie et al., 2006), although Willis and DePaulo questioned whether this would remain the case if spouses were included as informal helpers. The influence of gender appears to hold true for older adults as well (MacKenzie et al.).

The findings on differences in help seeking with age are mixed. Willis and DePaulo (1991) indicated that there was a decline in formal help-seeking behavior with age. This was confirmed by Alea and Cunningham (2003), who conducted an investigation comparing the help-seeking behavior of 36 young adults (18-23 years) and 36 older adults (67-87 years). Both the control and experimental groups of each age range were asked to complete a series of cognitively difficult tasks and the 18 young adults and the 18 older adults in the experimental groups were allowed to seek help. They found that overall, the older adults in the experimental group were not as likely to ask for help as compared with the younger group, even when the tasks were difficult and they did not perform well. On the other hand, a more recent study found that, when asked about their willingness to seek help from professional mental health providers, older adults had more positive attitudes toward help seeking and were just as likely to ask for such help as younger adults (MacKenzie et al., 2006). However, this study looked at the prospective attitudes of the older adults, which may or may not correlate with actual help-seeking behavior.

Social Context of Help Seeking

The social context of help seeking is salient to the current research. Willis and DePaulo (1991) reported that individuals prefer to ask for help from friends and family.
General literature about help seeking indicates that individuals are more likely to ask for help when the helper is perceived to be similar in status (e.g., similar age, gender, authority; Alea & Cunningham, 2003; Lee, 2002). Willis and DePaulo indicated that social support offers an opportunity for reciprocal helping, in which the help seeker becomes the helper in different situations. This is pertinent when considering the two perspectives of help seeking that are mentioned in the literature: either it is perceived as intentional information seeking or as dependent, incompetent behavior (Alea & Cunningham; Willis & DePaulo). The perception of help seeking as being a sign of incompetence or dependence is a barrier to formal help seeking (DePaulo & Fisher, 1980; Lee; Meltzer et al., 2000).

Willis and DePaulo (1991) reflected that the emotional support help seekers receive from friends and family contributes to informal help seeking. The importance of social support networks in relation to help seeking was confirmed by Phillips and Murrell (1994), who found that older adults who perceived themselves as having strong social support networks sought help more from their family and friends and less from formal sources than those who did not perceive the presence of strong social support networks.

MacKenzie and associates (2006) conducted and reported the most recent study on help-seeking behavior among the elderly. They approached people waiting for passengers in a busy Canadian train station. They asked questions about past use of mental health professionals and prospective attitudes toward help seeking. Their finding that older adults were just as likely to report that they would seek help as younger adults is contradictory to past research on older cohorts. However, their sample of older adults
emotionally and physically healthy enough to travel may be non-representative of older adults with depression. The mixed findings on help seeking warrant continued investigation.

Social Support

Positive perceptions of social support not only influence lower formal help-seeking behavior, but also have been found to be a protective factor against depression (Bazargan & Hamm-Baugh, 1995; Cummings et al., 2003; Silverman & Prigerson, 2002) and have therapeutic value in mental and physical health (Pearson, 1986). The aim of this study was to investigate social support in relation to depression and other life challenges.

Social Support Networks

Social support changes over time and is influenced by a variety of factors. Older adults appear to have fewer members in their social support networks than do younger adults (Doherty & Feeney, 2004). To explain this pruning phenomenon, socioemotional selectivity theory proposes that throughout the life-span, motivation behind forming and maintaining friendship changes (Carstensen, 1991, 1995). There are two central motives that drive the formation of relationships across time: emotional regulation, including the goals of feeling good at the moment and deriving meaning from the experience (Kennedy, Mather, & Carstensen, 2004), and information seeking. According to Carstensen and colleagues (Carstensen 1991, 1995; Carstensen, Fung, & Charles, 2003) it is only the perceived importance of each that changes throughout the life course. According to the authors, when time is perceived as limited, as in old age, attention is
focused on the present and more emotional regulatory goals are pursued as compared to information seeking. Carstensen and colleagues found that interaction rates among emotionally close social partners showed no decrease across time, while less important and unpleasant relationships were discarded. Thus, the decline in social interaction and social network is better described as social selection rather than social withdrawal (Carstensen, 1991, 1995).

Women reported more significant people in their social networks than did men in one study (Antonucci, Akiyama, & Lansford, 1998), although other studies have not found a significant difference (Doherty & Feeney, 2004). Personality, gender roles, and the fact that women tend to live longer than men may contribute to women having more social relationships. The idea that women live longer and are typically responsible for maintaining kinship ties makes logical sense of the finding that family, friends, and other women make up the majority of those named as primary supporters (Doherty & Feeney; Tak, 2006).

Social support is influenced not only by individuals’ being more selective with relationships, but also by contextual and personality factors. Johnson and Troll (1994) found that older adults’ neighborhoods, living situations (Yeh & Lo, 2004), and marital status contributed to their social context. However, Dykstra (1995) indicated that a change in marital status is more salient, a finding that is supported by research on grieving and loss as a risk factor for depression (Williams, 2005). Other factors that contributed to the number of individuals in a person’s social support network included age, personality, and functional ability (Johnson & Troll).
Health and Well-Being

Older adults appear to use different members of their social support networks for different purposes (Stolar et al., 1993). In Stolar and colleagues’ study, participants reported that they most often turned to their friends as confidants, reserving professional medical help for more personal care needs and neighbors for instrumental needs. This study did not include mental health concerns as one of the variables. According to Dykstra (1995), friendships offer emotional rewards to older adults such as love, respect, trust, positive regard, and validation. In a qualitative study, Lansford, Antonucci, Akiyama, and Takahashi (2005) identified themes contributing to enhanced well-being, including elements of being comfortable confiding in others, a sense of support and belonging, and perceptions of being successful, while experiencing the pressure of high demands or control contributed negatively to well-being. These themes varied in significance among the different cultures and genders in their study.

Research has shown that it is the perception of the usefulness of the support rather than some external measure of support that has the most impact on individual well-being (Cummings et al., 2003; Rudkin & Irdrikovs, 2002). Similarly, it is not the number of individuals in a person’s social support network that is important but the emotional support that they receive (Hong, Seltzer, & Krauss, 2001). In another study, O’Connor (1995) found that the quality of relationships rather than the amount of time spent together improved life satisfaction. It is reasonable to conclude that the benefits that older adults receive through social support depends upon their individual perceptions, the quality of the relationships, and emotional and functional support received.
Social support has been researched extensively in relation to the health and well-being of older adults. In the study reported above, Lansford and colleagues (2005) took a unique approach by using a combination of quantitative and qualitative methods for studying cultural differences across the life span regarding social support and well-being. They looked at the impact of both positive and negative interactions. Their results suggest that high levels of positive interactions and low levels of negative interactions are correlated with lower depressed affect, higher self-esteem, and higher self-efficacy.

Dykstra (1995) found that loneliness can be offset by friendship, even with the loss of a spouse or partner. Commerford and Reznikoff (1996) found in a sample of nursing home residents that social support from family was negatively associated with depression, while Bazargan and Hamm-Baugh (1995) found that friends were an important mediator between chronic illness and depression. Social support also appears to impact the physical health of individuals because it can decrease functional disability, which in turn affects depression (Dean, Kolody, Wood, & Ensel, 1989; Fiksenbaum, Greenglass, Marques, & Eaton, 2005; Potts, 1997).

Concerned with focusing solely on positive interactions, researchers have also looked at the impact of negative interactions on older adults’ well-being. What they have found is that negative interactions (e.g., experiences that lead them to feel resentment, shame, or sadness) have a stronger impact on well-being and mood than positive interactions (Rook, 1984, 1990, 2001). Negative interactions are related to unhappiness (Antonucci et al., 1998), psychological distress, emotional and physical health (Rook, 1990), and depression (Antonucci et al., 2002). These findings suggest that not only can
social support be a protective factor, but negative interactions can increase depressive symptoms. According to some research (Jackson, Antonucci, & Gibson, 1990; Rook, 1990) reactions to negative interactions may be moderated by elements of personality such as efficacy, social competence, and internal locus of control.

The current study was designed to gather the words and experience of older adults. This adds to our knowledge of social support and older adults’ unique perceptions of its impact on well-being.

Helping Alliance

The focus of the current research was to qualitatively assess what depressed older adults reported as helpful and not helpful when they approached individuals for help at an earlier point in their lives, and to determine whether those relationships were with friends, spouses or other family members, physicians, clergy, or mental health professionals. This relates directly to the concept of the helping alliance because it was anticipated that themes relating to what was helpful about the reported relationships would be similar to themes of what is helpful in therapeutic relationships in general. Therefore, a description of findings about the helping alliance in relation to formal therapy is offered next.

Historical Overview

The concept of a special relationship between therapist and client was first discussed by Sigmund Freud early in the twentieth century, primarily in the context of transference (Horvath & Luborsky, 1993; Safran & Muran, 2000). Through the work of
others, the concept of the helping alliance was expanded to include factors of rapport, hope, liking, respect, and trust (Gaston, 1990; Horvath & Luborsky; Safran & Muran). Elizabeth Zetzel was the first to argue that the alliance was “essential” to the effectiveness of any intervention (Horvath & Luborsky; Safran & Muran). Since that time, the concept of helping alliance has expanded into other therapeutic traditions. It is reasonable to surmise that similar factors play a role in all helping relationships, both formal and informal.

Helping Alliance as a Common Factor

In the last thirty years, researchers have found that different therapy modalities produce similar change suggesting that common variables across models may be responsible for the bulk of client improvement (Horvath & Luborsky, 1993; Safran & Muran, 2000). Researchers and clinicians alike have been looking for the common elements of successful therapy, of which helping alliance is just one. Client factors such as faith, inner strength, and motivation, and factors outside of therapy, such as fortuitous events and social support, account for 40% of change, and it is said that “the client is the single most potent contributor to outcome” (Sprenkle & Blow, 2004, p. 120). The therapist and the chosen model and interventions account for 15% of positive change, and placebo, hope, and expectancy factors account for another 15%. Finally, the helping alliance accounts for 30% of the change, second only to the client factors (Sprenkle & Blow).

It has been suggested that the alliance is in itself therapeutic (Hyer, Kramer, & Sohnle, 2004). In a meta-analysis of 90 independent clinical investigations, Horvath
(2001) indicated that “it is likely that a little over half of the beneficial effects of psychotherapy accounted for . . . are linked to the quality of the alliance” (p. 366). In a meta-analysis of their own, Lambert and Barley (2001) reported that a crude estimate attributes 30% of therapeutic change to the helping alliance. Influenced by the postmodern concept of reality being a subjective experience (Becvar & Becvar, 1999; Singer, 2005), researchers have found that clients’ perceptions of the alliance and all therapeutic processes contribute most to the effectiveness of therapy (Lambert & Barley; Orlinsky, Grawe, & Parks, 1994).

Elements of Helping Alliance

The result of the common factor debate has been the general acceptance that the helping alliance is a crucial element in successful therapy (Horvath & Luborsky, 1993; Hyer et al., 2004; Orlinsky et al., 1994; Safran, Muran, Samstag, & Stevens, 2001; Trepka, Rees, Shapiro, Hardy, & Barkham, 2004). Carl Rogers (1957) was emphatic that there were several conditions that were necessary and sufficient for therapeutic change, namely, empathy, unconditional positive regard, and therapist congruence or genuineness. Taking a different approach, Edward Bordin identified three components of the working alliance: tasks, bonds, and goals—all emphasizing the collaborative nature of the therapist-client relationship (Horvath & Luborsky). Bordin’s (Safran & Muran, 2000) conceptualization of bonds incorporates an affective quality of the relationship between therapist and client, which fits with Rogers’ concept of necessary and sufficient conditions for change, because both emphasize the client’s perception of being understood, accepted, and respected. Taking the helping alliance to a more broad,
encompassing framework, Gaston (1990) proposed four dimensions of the alliance: (a) the client’s affective relationship to the helper, incorporating both Rogers’ and Bordin’s constructs; (b) the client’s willingness and motivation to work in therapy, which fits with the common factors; (c) the therapist’s empathy, understanding, and involvement; and (d) a collaboration between therapist and client as to overall goals and tasks of therapy. This study focused on these dimensions of the client’s perception of the helping alliance.

There are several elements of the helping alliance that are often noted in the literature. Empathy (i.e., understanding, compassion, and caring) is perhaps the one most often mentioned (Blow & Sprenkle, 2001; Farber & Lane, 2001; Horvath, 2001; Horvath & Loborsky, 1993; Hyer et al., 2004; Rogers, 1957). Greenberg, Elliott, Watson, and Bohart (2001) conducted a meta-analysis of empathy in therapy and reported that this particular construct may account for as much or more outcome variance than any specific intervention. Empathy contributes to the client’s feelings of being understood and safe. Additional factors of the helping alliance mentioned in the literature are unconditional positive regard (e.g., acceptance, respect, warmth, openness, and support; Blow & Sprenkle; Farber & Lane; Horvath; Horvath & Loborsky; Hyer et al.; Rogers; Rosowsky, 1999; Safran & Muran, 2000), mutual trust, confidence, faith, and hope (Blow & Sprenkle; Horvath; Horvath & Loborsky; Rosowsky; Safran & Muran), perceived therapist genuineness (Klein, Kolden, Michels, & Chisolm-Stockard, 2001), and a sense of collaboration (Horvath; Tryon & Winograd, 2001). These factors contribute to a positive alliance, while the lack of or opposite are detrimental to the perceived alliance (Horvath).
Hyer and colleagues (2004) indicated that the importance of the alliance when working with older adults has always been endorsed but has not been widely researched. This can be seen in the paucity of research focusing on the helping alliance with older populations. Gerontologists currently draw their understanding of the helping alliance from literature dealing with younger populations. Klee, Abeles, and Muller (1990) used a sample aged 20-57 and Krupnick and colleagues (1996) used a sample between the ages of 21 and 60. There is a vast array of literature about the helping alliance; however, there is very little directly related to the unique experiences of older adults. Older adults are a unique group with specific challenges that younger adults do not experience, including cognitive and functional decline, and significant social loss due to frailty and death. These types of experiences shape the perceptions of the individual, and because younger adults are less likely to have experienced these, it is inappropriate to generalize their perceptions to older adults.

Considering that the helping alliance accounts for anywhere from 30% to 50% of therapeutic outcome and that it is the client’s perception of the alliance that is most important (Horvath, 2001; Horvath & Luborsky, 1993; Lambert & Barley, 2001), it was hypothesized that the social relationships of older adults may have a similar therapeutic impact. This being true, it was possible to suggest that older adults, when asked about informal help seeking, would mention these factors that are similar to current knowledge of the helping alliance. The current study aimed to explore whether older adult participants in qualitative interviews would report similar factors in helping relationships.
Summary

Depression can be considered a persistent and concerning problem among the elderly. It impacts not only the mental health of the individual but physical health as well. With the anticipated increase in the older population in the next few decades, it is important for researchers, clinicians, and caregivers to understand this unique time period and the effects of depression.

Research has shown the current population and those approaching old age have lived in a context far different from previous cohorts (Curtis & Dixon, 2005; Weiner & Goldberg, 2003). Differences in medicine, technology, and society have created a context substantially different from other generations (Curtis & Dixon; Rowe & Kahn, 1998; Weiner & Goldberg). As old age continues to be redefined, the past literature on older adults, including help seeking, depression, and social support may not apply to the most current cohort. Researchers should continue to confirm the applicability of past information to today’s older adults. Although older adults’ experiences in 20 years are not likely going to be the same as those of current older adults, understanding the current cohort’s experiences may shed some light on factors that may be important as baby boomers reach retirement and older years.

Help seeking among the current population of older adults is not well researched and not specific to emotional challenges such as depression. The available literature suggests that for the majority of emotional needs, friends and family provide the necessary help, with doctors, clergy, and mental health professionals being reserved for more lasting and/or complex problems. The contradictory findings on the willingness of
older adults to seek help needs to be resolved through continued research on their perceptions and attitudes toward help-seeking.

Social support is an alternate way of looking at a part of the informal helping relationship. The reviewed literature indicates that social support networks change across time, and those relationships that are retained provide emotional regulation to the individual. Social support has also been observed as a protective factor against depression if the interactions are positive. When the interactions are negative, they can have a detrimental effect on well-being. This distinction is important to the current literature because negative interactions with informal helpers may not have helped the older adult and, in fact, may have contributed to the problem.

The factors of the informal helping relationship that are perceived as helpful may or may not have similarities to the elements of the formal helping alliance. Factors of empathy, unconditional positive regard, trust, faith, and hope are all mentioned extensively in the literature on helping alliance. The literature on the helping alliance with older adults is lacking. For the most part, it appears that gerontologists assume that these factors are the same across all age groups. This may or may not be the case. This study looks at those factors that older adults report as being helpful and compare those with the formal helping alliance literature.

With the postmodern and constructivist movements, psychotherapy researchers have become interested in perceptions of clients’ experiences with the process of therapy (Singer, 2005). This has led to an increase in qualitative studies that capture the descriptions used by the participants themselves (Singer). Qualitative methods have been
used for other populations and topics including middle-aged adults in therapy (Singer).
However, this type of study has not been conducted on older adults in relation to helping
relationships. The current study examined a group of older adults and their unique
perspectives of the helping alliance in both informal and formal helping relationships,
and thus the results add to our understanding of the older population.

Research Questions

The purpose of the current study was to explore the perceptions of older adults in
relation to helping relationships. Older adults’ unique experiences with help seeking and
social support will add to the knowledge base on how to help older adults with symptoms
of depression. Based on the reviewed literature, the current research included four
research question categories, divided into parts for conceptualization and analysis.

The first research question category is older adults’ perceptions of informal
helpers. This category is divided into four parts:

1. Whom do older adults approach when they experience emotional challenges
   such as depression?
2. Whom do older adults not approach when they experience emotional
   challenges?
3. Why can older adults approach informal helpers?
4. Why can older adults not approach informal helpers?

The second research question category is centered on older adults’ perceptions on
helping behaviors:
1. What do older adults perceive as helpful behaviors in informal helping relationships?

2. What do older adults perceive as unhelpful behaviors in informal helping relationships?

The third research question category contains questions about older adults' perceptions of formal helpers:

1. Would older adults be willing to see mental health professionals?

2. What reasons do older adults give for not seeking help from mental health professionals?

3. What have older adults found helpful from mental health professionals?

4. Under what circumstances might older adults be willing to seek professional help?

5. What do older adults perceive as being barriers to seeking professional help?

The final research question category deals with other findings contained within the gathered data.

1. What attitude do older adults have in dealing with emotional challenges?
CHAPTER III

METHODOLOGY

The current study was designed to explore older adults’ perceptions of helping relationships when experiencing emotional challenges such as symptoms of depression. The research question categories focus on whom they do and do not approach and why, and what was perceived as helpful and not helpful. The older adults’ attitudes toward seeking help from mental health professionals are also of interest. The qualitative design was ideal for looking at the unique perceptions of older adults about the research questions. This was a single cross-sectional interview design with a purposive sample. In this section, the procedures for sampling, data collection, analysis, and reporting will be outlined.

Sample

This study was designed to tap older adults’ experiences and perceptions of helping relationships. The sample included 8 adults 78 years of age or older. Participants were purposively selected from a larger study of older adults. The Cache County Study on Memory Health and Aging (CCSMHA) was funded by the National Institute on Aging (NIA AG 11-380). The CCSMHA is a population-based epidemiological study of dementia and its genetic and environmental antecedents. In 1995 the CCSMHA invited all 5,677 individuals aged 65 years and older who were permanent residents of Cache County, Utah to participate, and enrolled 5,092 (90%) individuals over an 18-month period (Breitner et al., 1999). Such high levels of participation helped to reduce non-

Ancillary to the CCSMHA, a mixed methods project called the Quality of Life Study (QLS) was conducted in 2004-2005. The QLS was designed to enhance understanding of older adults’ perceptions of the most salient life challenges they were facing, coping behaviors, depressed mood, and social supports to help alleviate depressive symptoms. Eligibility to participate in the QLS was endorsement of depressive symptoms or use of antidepressants for depression in the CCSMHA 2002-2003 interview. A total of 322 participants met one or both of these criteria. Eighty-four individuals were randomly selected from the eligible pool using stratified random sampling by gender, cognitive status (normal cognition vs. mild cognitive impairment), age (above vs. below age 80), and 2002-2003 CCSMHA depression interview (endorsement of depressive symptoms, antidepressant use, or both) with combinations of these stratification variables defining 24 strata. The objective of the QLS was to interview two individuals in each of the 24 strata, or 48 total interviews. However, due to insufficient numbers in some of the strata, the final sample of participants in QLS was 42 individuals.

The sample for the current study was purposively selected from the 42 QLS participants who agreed to be contacted in the future. Participants had endorsed depression in the CCSMHA 2002-2003 interview (i.e., criteria for inclusion in the QLS)
and participated in the most recent CCSMHA interview in 2005-2006. Participants were excluded if they had previously asked to discontinue participation in the CCSMHA or QLS. These criteria excluded 15 of the possible 42 QLS participants. An additional 6 QLS participants were excluded based on their scores of 85 or below on the sensory and education adjusted Modified Mini-Mental Status (3MS) examination (Tschanz et al., 2002). This excluded participants with mild cognitive impairment from the study because such individuals may have had difficulty understanding the interview and/or may have been in prodromal stages of dementia. This exclusion was appropriate due to the retrospective nature of the study. To protect against participant burden, 5 participants were excluded because they were scheduled to be visited by the CCSMHA within 6 weeks of the anticipated interview date. This left 16 possible participants to be contacted.

Of the 16 possible participants, 13 were contacted. Three were not contacted in an effort to keep the gender balance somewhat equal in this study. Of the 13 that were contacted, 2 were unable to be reached to schedule an interview, 1 had moved beyond the geographic area, and 2 refused, 1 because of time constraints and no reason was given by the second. This left 8 participants for the study, which is a 61% participation rate.

The sample included 3 male and 5 female participants. Four of the participants were middle old (78-84; 3 male, 1 female) and 4 were oldest old (85-91; 4 female). All 8 participants were Caucasian and LDS and were living independently in the community. All 8 were long-time residents of Cache County, although one had recently moved a 45 minute drive to be near family. The sample was also homogenous in having been married for many years; however, at the time of the interview, half were widows (4 female).
Overall, the sample was small and homogeneous in the demographics identified in this study.

Instruments

*Interviewer*

The interviewer is a fundamental instrument in qualitative research and researcher bias is inherent in qualitative research (Daly, 1992). The interviewer in this study was the main researcher and master's candidate of this thesis. The interviewer's gender, family, and past life experience influence the questions and interpretations. The interviewer was an unmarried Caucasian female in her late 20s. She was a long time resident of Utah and was a member of the LDS religion. The interviewer was aware of her own feelings and responses to the narrative of the participants and how this impacted ensuing interviews. For example, the longest interview was followed by the shortest interview, mostly because of participant differences, but also because the interviewer was more prepared to curtail narratives that were unrelated to the topic at hand.

The similarities that the interviewer shared with the participants may have created an environment where the participants felt more comfortable relating personal information (Alea & Cunningham, 2003; Lee, 2002). The interviewer was similar in religion (LDS), race (Caucasian), and residence in Utah. These similarities made it easy for the participants to believe that the interviewer understood what they were talking about without feeling it necessary to explain terms or situations. The interviewer also shared a common gender (female) with 5 of the participants, which may also have
encouraged confidence. Alternatively, the differences between the interviewer and participants may have hindered the participants' sharing. The most obvious difference between the interviewer and participants was age. The participants may have withheld information because of the age difference or they may have felt more free to share or pass on their wisdom to an individual from a younger generation. The differences in gender between the interviewer and the 3 male participants may have hindered confidence sharing; it is possible, however, that the men perceived emotion as a feminine quality and felt more comfortable talking about this topic with a woman rather than someone of their same gender.

Prior to the fieldwork for this study, the interviewer was trained by the CCSMHA to conduct appropriate quantitative interviews using scripts and probes when necessary. While working for the CCMSHA during the 2005-2006 CCMSHA interviews, the interviewer met with over 100 older adults, including one of the study participants, which was not anticipated or recognized by the interviewer until she arrived at the participant’s residence. The participant did not indicate familiarity with the interviewer and thus may not have remembered her. During her employment with the CCMSHA the interviewer had the opportunity to talk to many older adults about their life experiences. Although the 2005-2006 CCMSHA interview was structured, the interviewer listened as the participants described different aspects of their lives. This experience prepared the interviewer with skills to interview older adults, including sensitivity to concerns such as sensory impairments and fatigue, and the experience guided the questions and direction of the current study.
The interviewer received training in the Marriage and Family Therapy program at Utah State University (USU). In the program, the interviewer was exposed to literature discussing depression, including its etiology, epidemiology, phenomenology, and prognosis. In the program, the interviewer worked as a psychotherapist with depressed individuals in several settings, including the student clinic at USU, a community agency in Ogden, Utah, and via the internet. In these settings, the interviewer developed skills for being empathic with clients, respecting their experience, and being aware of verbal and non-verbal signals indicating distress or reluctance (e.g., lack of eye-contact). These skills both with in-room and internet clients helped the interviewer to be more sensitive to the emotional state of depressed individuals.

Semistructured Interview

The interviewer administered a semistructured qualitative interview designed by the interviewer with input from the supervisory committee. Using minimally predesigned questions allowed the participants to express their perceptions based on their own experiences. The majority of the questions were open-ended, allowing the participants to talk openly during the interview. This qualitative interviewing process increased internal validity (Huberman & Miles, 1998). The stem questions were based on the literature on social support and help-seeking behavior, and focused on relationships that participants found helpful or unhelpful when facing emotional problems. It was anticipated that the majority of the helping relationships would be informal (e.g., family and friends). The current literature, the interviews, and the participants’ responses served as a foundation for the interviewer to ask in-depth questions on the qualities and responses of those
approached. Using a process common to qualitative research, the interviewer’s field notes and the participants’ narratives were used to shape and direct the questions asked in later interviews in the study, thus narrowing the focus, streamlining the questions, increasing the quality of data, and decreasing the amount of unhelpful data (Gilgun, 1992; Huberman & Miles).

Procedure

Initial Contact

Prospective participants were sent an introductory letter in February or March, 2007 explaining the purposes of the study, interview design, and expected length of the interview. The letter indicated that the interviewer would be contacting them within the next few weeks. All correspondence, including the informed consent, were printed in large font to accommodate visual impairments (see Appendix A).

The interviewer phoned the selected participants and scheduled appointments. The order in which participants were contacted was based on scheduling requirements and conflicts with the CCSMHA with the objective to minimize participant burden across studies. As selected participants refused or scheduled appointments, additional participants were contacted using the same selection criteria. The interviews were conducted during the month of March, 2007.

Setting

All eight interviews took place at the participants’ residences in either the morning or afternoon depending on the preference of the participants. The interviews
were conducted in locations chosen by the participants and were audio-recorded. Participants were asked to choose a place in their homes in which they were most comfortable. It is possible that the participants chose spots not that were most comfortable for them, but that they perceived as more comfortable for the interviewer. Six of the interviews took place in the participants’ living rooms and two at their kitchen tables.

The interviewer met 3 of the participants’ spouses. During two of these interviews, the spouses left when the formal interview began; one spouse decided to join us in the room and in the conversation part-way through the interview. The interviewer handled this by letting both the participant and her spouse know how much time was remaining in the interview. This served as a gentle hint that the spouse understood and he departed until the interview was complete. This interview was the only one that had a person enter the room, which may have altered the responses of the participant, both by the shift in conversation and possibly by the participant’s unwillingness to be completely honest about sensitive topics with her spouse in close proximity. Several other interviews were interrupted by phone calls. During these, the interviewer turned the recorder off and started again with a brief reminder to the participant about what was being discussed prior to the interruption.

With the exception of the interviewer and the recorder, the settings of the interviews were familiar to the participants. Although they had similar settings in prior interviews, it is possible that the both the interviewer and the recorder may have altered the responses of the participants.
Introduction and Informed Consent

After greeting the participant, the interviewer spent 10-20 minutes getting to know the participant. None of the information gained in that part of the conversation was considered data for the purposes of this study. This time was designed to help the participant feel comfortable with the interviewer. The formal interview began with the reading, discussing, and signing of the informed consent (see Appendix B for Informed Consent and IRB approval letter). Two copies of the informed consent were signed by the participants and interviewer, with copies being left for the participants’ records. The informed consent outlined in detail the purpose of the research, those involved, the procedures that would be followed in the interview, and the possible indirect and direct benefits of participation in the research. The informed consent also explained the measures to protect participants’ confidentiality. The participants were identified with the unique ID numbers that were assigned by the CCSMHA to protect their identities in data processing and analysis. Their contact and interview information was kept locked in separate cabinets at USU with access granted only to the research committee and authorized staff. The gathered information was used for research purposes only and no identifying information was included in reports. The informed consent also outlined limits to confidentiality (i.e., duty to warn of imminent harm to self or others, and suspected child or elder abuse). The informed consent also included the possible risks to the participant (e.g., the possibility that someone might gain access to the information stored at USU, and the participant might be uncomfortable with the questions asked). Participants were informed that they could discontinue participation in the study at any
time without consequences relating to their participation in the larger study. The participants were also given contacts and numbers for the Institutional Review Board at USU if they felt that they had been harmed in any way.

**Semistructured Interview**

Once the participant had a chance to ask questions and agree to participate, the interviewer asked two demographic questions and requested a subjective report of health of the participant on a scale from very poor to excellent, which was used to determine the appropriateness of continuing the interview. This was followed by 6 cognitive screening questions as used in the QLS to confirm cognitive capacity to give informed consent (Callahan, Unverzagt, Perkins, & Hendrie, 2002). A score of 4 or more on the cognitive screener was considered appropriate awareness to provide informed consent. Seven of the 8 participants received a score of 6 on the screener, and 1 received a score of 5, indicating that all the participants were cognitively aware.

The interview was digitally-audio-recorded for transcription so the interviewer could focus on the participant and not on taking notes. The interviewer asked the designed stem questions (see Appendix C) followed by probes and additional questions based on the participants’ responses. The interviewer occasionally made reflective summary statements following a participant’s response. These summary statements were to ensure that the interviewer understood the meaning the participant was trying to convey. The interviewer also prompted for certain characteristics or topics that other participants had mentioned, allowing the participant to refute or agree. The start and end time of the interviews was recorded. Interviews lasted anywhere from 32 minutes to 1
hour and 40 minutes. The difference in time depended on the participant’s rate of response and his or her willingness to share stories, whether related or unrelated to the topic at hand.

The introductory question, “In the past 10-15 years, has there been a time when you found yourself struggling with your feelings, maybe feeling down, blue, sad, or confused?” was designed to create the context for the remainder of the interview. The purpose of the time frame was to keep participants’ responses focused on the older adult years and recent situations when they were struggling with emotional concerns. On the few occasions when the participant mentioned struggles earlier in life, the interviewer asked, “what about in the last few years?” to ensure that the context of later life was established.

The stem questions, “Whom did you talk to about your feelings?,” “Whom do you talk to about your feelings now?,” and “Is there anyone you wouldn’t talk to about this?” were designed to gather data to answer the first research question of whom older adults talk to or do not talk to about their emotional concerns. After the first several interviews, it became apparent that the majority of the older adults were talking in the present tense, making the question about whom they talk to currently redundant. This question was eliminated, unless it was obvious that the informal helper they were talking about was deceased. There were also instances where the participant initially offered only one informal helper. In these cases, the interviewer asked whether there was anyone else the participant would talk to. To keep the interviews brief to prevent participant burden, the interviewer limited the participants to three or fewer informal helpers by asking
additional questions about only three identified helpers.

The stem questions, "What was it about [the identified helper] that led you to believe you could talk to them?," "How did you feel when talking with [the identified helper]?," and "What reaction did you get from [that person]?," addressed several of the research questions. Some of the participants talked about characteristics in response to this question while others began to talk about what they found helpful, which addressed another of the research questions. These questions were consistent across the interviews; the interviewer asked, "Is there anything else?" to ensure that the older adult had the opportunity to cover the topic fully. The design of the study allowed the interviewer to offer several suggestions based on literature and previous interviews for the participant to confirm or deny. These probes were often phrased as, "What about feeling accepted, respected, or understood?" At this point, the participants had an opportunity to talk about some, all, or none of the ideas presented.

The questions, "What did [the identified person] do that you felt was helpful?", and "What did [the identified person] do that was not helpful?" were designed to open a discussion about what the older adults felt was helpful and not helpful. The results of the research question of what was helpful came from responses to this question as well as other questions. These questions were not changed or altered across the interviews. One question—"Tell me about your experience talking with them?"—was included to examine when, where, and what was helpful. This question was confusing to the first two participants and was dropped in subsequent interviews.

The questions regarding professional helpers and barriers to help were also
consistent across the interviews. Their placement at the end of the interview was purposeful because it was anticipated that a majority of the participants would not have had experience with professional helpers and that these questions would shift the focus from life experiences of the older adult to hypothetical situations for the older adult to consider.

**Interviewer Influence and Reflection**

The interviewer tried to keep her reactions to the participants’ responses to a minimum. The interviewer often reflected key words verbatim to acknowledge she was listening and encourage the narrative. The interviewer also took occasional notes of things that were of particular interest. Both of these actions may have led the participants to believe the interviewer approved or disapproved of what they said, thus impacting their later responses.

The interviewer kept a record of observations from the interview setting and interview (Manning & Cullum-Swan, 1998). The interviewer also recorded themes, insights, and possible changes to the questions for future interviews. The interviewer used previous interviews to guide the way in which following interviews were conducted. The first interview conducted illustrated a problem with the introductory question of “tell me something about yourself” that allowed the participant too much freedom to stray from the topic at hand. In the following interviews, the interviewer chose to discontinue that question in favor of spending more time prior to the signing of the informed consent building a relationship of trust with the participant. In other instances, the interviewer chose to use the words and language the participant used to describe his or her emotional
struggles. This process was based on the interviewer's experience in therapeutic interviews.

*Data Management*

The recordings were transcribed by the interviewer and the recordings were kept locked in a cabinet at USU to preserve confidentiality until the completion of this study, at which point they were destroyed. The transcripts will be kept indefinitely in a locked office at USU with the 2004-2005 QLS transcripts. The interviewer's notes and reflections were kept with the transcripts until the completion of this study, at which point the notes will be included with the stored transcripts and the reflections will be destroyed.

*Data Analysis*

The interviews were transcribed verbatim and entered into a word processing program by the interviewer. The data were placed in a table that allowed for codes to be entered in a column to facilitate sorting and visual analysis. The qualitative data were analyzed for content using a process described by McCracken (1988): interview transcripts were read twice by the interviewer, the first time for general content and the second to identify themes in the participants' experiences in help seeking. The interviewer read each interview in the sequence in which it occurred, followed by a second reading to identify preliminary themes. A numerical code designed by the researcher was used to easily identify the research question categories addressed and an alphabetical code to identify the themes found within each question category. This code
became more detailed as the analysis process progressed. As each interview was read, identified themes were either matched with responses from previous interviews or placed into categories of their own. This was followed by evaluation of the data for connections within and among the themes. The connections were analyzed for their relationship to the preliminary themes.

During this process, the interviewer consulted with a member of the research committee who had independently categorized the data; similarities were identified and discrepancies were resolved. This process incorporated triangulation by using multiple individuals with different perspectives and strengths to increase the validity of the report (Huberman & Miles, 1998).

After consultation, the interviewer returned to the data and produced final themes within each research question category. The data were read through again to confirm themes and as the interviewer wrote this report, additional adjustments were made when it became evident that themes could be combined for clarity without losing the participants’ meanings.

Validity and Reliability

*Validity*

The validity of this study rests on the experience of the interviewer with the topic and population of interest. The literature reviewed prior to and following the analysis laid a solid foundation for the procedures and results of this study. The interviewer used this foundation to help her conceptualize and understand the participants’ experiences.
Additionally, the interviewer has spent the past several years working with and learning about older adults, depression, and therapeutic processes. All these factors increase the validity of the data collected in this study.

**Reliability**

Consultation with the supervisory committee increased the reliability of the data. Having an outside perspective, one not entirely saturated in the data, provided an additional point of reference to increase the reliability of the interviewer’s perspective. This is a process called triangulation that is often used in qualitative work (Huberman & Miles, 1998).

Reliability in qualitative studies also is established through making the study procedures clearly understood and replicable (Adler & Adler, 1998). The interviewer made clear the sample selection and procedures used in this study. The reasoning and process for making subsequent changes in the interviews were explained. The interviews themselves were designed to be semistructured and therefore it is difficult to outline every variation that existed between them. For some methodologists, this inconsistency between interviews weakens the reliability, while for others, reliability is not as important as the unique experiences of the participants (Adler & Adler).

**Reporting**

In the following chapters, the participants’ responses are discussed in relation to the research questions. Examples from the participants’ narratives with personal identifying information removed are used to support the themes identified. Pseudonyms
are used to maintain the confidentiality of the participants. The 8 names chosen were selected specifically because they were popular baby names in the United States in the 1920s. Variations from the themes are also presented with examples from the participants' narratives. The findings are discussed in relation to the current literature on social support, helping alliance, and help-seeking behavior. Additional literature on the themes that were not previously discussed is introduced.
CHAPTER IV
RESULTS

The eight qualitative interviews produced a vast amount of information regarding not only the participants’ life experience, but also their experiences in talking with others about struggles with their feelings, including feeling sad, down, blue, or confused. The participants had all endorsed symptoms of depression or antidepressant use within the last 10 years.

The information is divided into several research question categories with several questions in each category. The first research question category is older adults’ perceptions of informal helpers. This category is divided into four parts: (a) whom older adults approach when they experience emotional challenges such as depression, (b) whom older adults do not approach when they experience emotional challenges, (c) why older adults can approach informal helpers, and (d) why older adults cannot approach informal helpers.

The second research question category is centered on older adults’ perceptions on helping behaviors. This category is divided into two parts: (a) what older adults perceive as helpful behaviors in informal helping relationships, and (b) what older adults perceive as unhelpful behaviors in informal helping relationships.

The third research question category contains questions of older adults’ perceptions of formal helpers: (a) would older adults be willing to see a mental health professional, (b) reasons older adults give for not seeking help from mental health professionals, (c) what older adults found helpful from mental health professionals, (d)
under what circumstances older adults might be willing to seek professional help, and (e) what older adults perceive as being barriers to seeking professional help.

The final research question category deals with other findings contained within the gathered data. The findings in this category look at the attitude that older adults in this study expressed in reference to emotional and physical challenges.

The findings are arranged sequentially through each of the research question categories with themes that emerged form the interviews for each question discussed along with exemplar quotes from the participants. For convenience and to maintain confidentiality, each of the participants has been assigned a name by which they will be referred to throughout this chapter. The 5 women were named Alice, Betty, Doris, Evelyn, and Frances. The 3 men were named Arthur, Charles, and Donald. These names were selected because they are popular names for individuals born in the 1920s and are in no way connected with the actual participants.

Research Question Category One: Older Adults’ Perceptions of Informal Helpers

Part One: Whom Do Older Adults Approach When They Experience Emotional Challenges Such as Depression?

The participants mentioned a variety of informal and formal helpers. Spouses, children, and other family members were the most often mentioned theme for individuals the participants would approach when struggling with their feelings, feeling sad, down, blue, or confused. Family was the most often reported with friends being a close second.
Friends were mentioned next in frequency with a few other unique responses.

*Family.* The majority of the participants in this study mentioned family members as individuals whom they approached for help when they were struggling, feeling down, sad, or depressed. Six (4 middle old; 2 oldest old) of the 8 participants mentioned their spouses as the people they talked with. All 3 of the men participating in the study mentioned their wives and all were currently married, with one making the statement that his wife “got it up to her ears . . . and then some.” Of the 3 women who mentioned their husbands, one was still currently married and two had been widowed within the last 15 years. The two women who did not mention their spouses indicated that they had been widowed for many years.

The next most often mentioned familial category of informal helpers was children. Four of the 5 female participants mentioned talking with their daughters about problems. Interestingly, all 4 women were among the oldest old. A 91-year-old woman said, “Oh, I can talk to my daughters very easily,” and Doris, an 87-year-old said, “My daughter. She’s really good to listen.” None of the men mentioned their daughters; however, one of the men, Donald, talked about his son, saying, “Well, actually, I can talk to my youngest son better than I can talk to anybody.”

Miscellaneous family helpers such as siblings and grandchildren were also mentioned. Doris talked about her sister with whom she often talked on the phone. She said, “Well, I’d just feel . . . that call was worth it and that would make you feel better.” This same participant talked about a specific granddaughter to whom she felt she could talk.
Friends. Friends was the next most often mentioned category of informal helper. Three widowed females and one married male participant mentioned talking with a friend. An 87-year-old widow said, “Well, I have a friend up here . . . and I talk to her a lot, we have a lot of talks” (Evelyn). Arthur spoke more generally:

You would find someone that . . . would fall into your circle, that you would have confidence in them. And generally it may not be a shrink, it could be just a good friend, who’d give you some good advice.

Self. Three of the oldest old participants answered immediately that they, in the words of one of the participants, talk to “Just mainly myself” (Betty). This finding was unexpected and could be interpreted a number of ways, which is discussed in the next chapter.

Miscellaneous helpers. Several of the participants had unique responses to the question of to whom they talk. One male, Charles, talked about his personal physician and also mentioned his Bishop, a local lay clergy member in the LDS Church: “Oh, I guess I talked to the Bishop a little bit and he was very helpful. He tried to do the best he could.” One female participant’s first response to the question of whom she talks to about her feelings was, “Why, Heavenly Father in prayer” (Frances).

Part Two: Whom Do Older Adults Not Approach When They Experienced Emotional Challenges?

Those individuals mentioned by the participants as those whom they would not approach fell into the same categories as those they would talk to—family and friends. Those friends named were more specifically distant friends or acquaintances.

Family. Family was also mentioned as a group of individuals to whom
participants would not talk. Four of the 8 participants mentioned specific members of their family that they would not talk to about things that were concerning them. Two of the family members mentioned were children, one a sister, and one a spouse. One woman said:

I have four daughters and one son. But I've always tried to make them feel better and they have problems and so they talk to me about them. So, I don't, I don't feel bad enough, or feel like I need to talk to anybody besides my Heavenly Father. (Frances)

The only male that responded with a specific family member suggested that his wife was someone that he could talk to about some things, but not all.

Acquaintances. One of the female participants, Betty, said, “Well, there again, you don’t talk to everybody. You have ... family or close friends. I think everybody has acquaintances that you wouldn’t necessarily bring all your problems.”

Part Three: Why Can Older Adults Approach Informal Helpers?

There were many characteristics that impacted the participants’ willingness to talk with informal helpers. The older adults’ perception of the helper as understanding and caring, as well as a long-established relationship with the individual were all mentioned. Trust, confidence, and admiration were also important characteristics. Finally, the helper’s being knowledgeable, available, and accepting were characteristics the older adults felt contributed to their being able to approach informal helpers.

Understanding. The participants in this study mentioned a variety of reasons they felt they could talk to the individuals they named. All 8 participants mentioned that they felt that the other person understood them. Several participants spoke of the informal
helper as having similar experiences in their life. Speaking of her good friend, Evelyn said:

We had kind of the same problems... We had both lost husbands. [We are] in the same kind of same boat, like to do the same things... I just think that she’s very understanding and I think she’s very knowledgeable because of her profession [as a clinical nurse], very knowledgeable, and she just gives good advice and understanding... She’s very knowledgeable and she’s had so many of the same experiences and we just click... I don’t know, she just understood and was there.

Several of the participants talked about understanding as being similar in personality. One female participant, Alice, said of her daughter, “Well she’s kind of like me.” Charles said he and his doctor “saw eye to eye on a lot of things,” while another male participant spoke of his son as being similar in personality to himself.

Established relationship. Having a comfortable relationship or a long-standing relationship with an informal helper is another factor that participants mentioned. Those participants who mentioned speaking with their spouses also mentioned the long term relationship they enjoyed with them. Charles put it well when he said, “Well, when you’ve lived with someone 55 years, you should be able to talk with them about anything.” The long established relationship contributed to the spouse’s knowing and understanding what the participant was talking about: “She understood quite easy. Quite easy to understand our situation. We’ve been in it together for all these years. And she knew why we got into it and who these people were that we knew about” (Arthur).

Solid relationships were also illustrated through the mention of friendship and long-term relationships. Charles talked of his LDS Bishop: “I don’t think of him so much as an ecclesiastical leader but as a, just as a good, a very good friend.” Frances, the
female participant who spoke of her relationship with God, said that she had “known I could [pray] since I was a little girl.”

Caring. Love, caring, and compassion were characteristics mentioned by 6 participants. One man, speaking of his wife said:

*Charles:* Well, she’s someone I love.  
*Interviewer:* So, because you love her, you can talk to her.  
*Charles:* Yeah, we’re one, we’re one in purpose.

Betty responded, “They’re friendly, their situation, just understanding and caring for each other.” This sense of being cared for and loved was also apparent with Charles who talked about his physician:

He loves people. He loved people. They had a reception for him when he left... the hospital. And I went out there of course, and you’d be amazed at the number of people coming in, patients coming in to see him. Like this other doctor, this surgeon, said, “I’ve never seen anybody that has as many friends as [he] has.”

This same participant spoke of his sense of his LDS Bishop: “He’s very compassionate... with problems. And when it seemed like things were going pretty rough, there’s always an out, and a good out” (Charles).

Trust. Trust was a characteristic that 4 of the female participants and 2 of the male participants talked about. One female participant, Evelyn, said of her friend, “I don’t know, she just understood and was there. We just enjoyed talking to each other. We just have felt good, just felt comfortable and good and trusting.” After listening to a participant’s response, the interviewer occasionally characterized the statement made, to which the participant would agree. This was the case in the following example:

*Betty:* Oh, she is just open, and receptive, and friendly.  
*Interviewer:* So, what does *open* mean to you, so I can understand.
Betty: Well, just open conversations, freedom of speech to each other, confidential.
Interviewer: You know that if you tell her, then George down the street [is] not going to find out.
Betty: Right.
Interviewer: Now, when you said open, you could talk about anything with her?
Betty: I would say so.
Interviewer: And it’s confidential?
Betty: Uh-huh.

Knowledgeable. Four of the 8 participants mentioned the judgment, knowledge, and good sense of the individuals they talk with. Charles said, “That’s what makes me think a lot of him, because he could pick up things that other people, other doctors... just miss.” This was a level of insight that encouraged this participant. Other participants mentioned the good sense of those they talk with. Alice was speaking of her daughter when she said:

Alice: She just seems to have the ability to see through problems.
Interviewer: Wow, that’s a good quality: to be able to see through problems.
Alice: She can either figure it out or say, “Just leave it alone.”

Open and available. The simple fact that these older adults could contact the people who helped them when they were struggling is one of the factors of which half of the participants spoke. Three female participants talked of being able to call and talk with their identified informal helper whenever they needed. Charles, the male participant who was influenced by his physician, said, “He was not one of these doctors that get in, take a look at you, and push you out right quick, either; he wanted to know about you.”

Acceptance. The reaction that the participants expected from the informal helper was also a characteristic that was listed by the participants. Knowing that they could not
upset the other person was a characteristic that made it easier to talk with them. A male participant said:

*Donald:* He’s got a real lot of good common sense. He’s serious. . . . We can have fun anytime but he can get serious. I (pause), you can level with him on anything. Lot of things you can’t talk about with your kids, you know what I mean, it’d shock your kids to death or something like that but [it] doesn’t bother him.

*Interviewer:* So, he doesn’t get ruffled by much.

*Donald:* No.

A female participant had a similar response:

*Alice:* She’s level-headed, she’s quick to think. She’s just an extra special person.

*Interviewer:* What does *level-headed* mean to you?

*Alice:* Level-headed, that’s a good question. I think it more or less refers to the way you react to things.

*Interviewer:* So how does she react to things? If you were to tell her something really sad, or something that was upsetting you, how does she usually react?

*Alice:* She’s usually pretty good about everything.

*Interviewer:* So, you can’t shock her?

*Alice:* Uh-uh

Other participants talked about the ease of being able to converse with the person, that it was “easy” and “natural,” that things did not bother the person, and they did not worry about things.

*Admiration.* Two of the participants talked highly of the person that they confided in. Their responses led the interviewer to reflectively respond:

*Interviewer:* So, it sounds like you admired her.

*Doris:* Yeah, I did. Because she’s just, she did things, and then she’d got along after she’d went and did that. She’d get along just as good as if she’d just sit there at home.

*Part Four: Why Can Older Adults Not Approach Informal Helpers?*

This question is the mirror image of the previous question and it is possible to
look at the reverse characteristics to find those factors that were perceived as hindering the older adults from talking with others. Three of the 5 categories of responses were the mirror image of factors that are helpful: trust, understanding, and expected reaction. Two categories that were unique to this question involved the participants' not wanting to burden others with their problems and wanting to maintain privacy. Overall characteristics of unhelpful informal helpers were fewer in number.

**Burden.** Six of the 8 participants mentioned not wanting the informal helper to be burdened with their problems. All 5 of the female participants and one of the male participants spoke of this factor. Betty was speaking of her children when she said, “Well . . . they are busy. They have their own life. And I, that’s been one of my dreads, is not to be a burden to my family. I do not want that. But you don’t choose when to die.” Doris spoke of the informal helpers’ problems: “Maybe, I think, they got worse troubles than I have. Why should I . . . why should I bore them with what’s the matter with me when it isn’t half as important as what maybe they’ve got.”

**Privacy.** “Well, I don’t know, sometimes I think my feelings are kind of private.” This statement by Charles simply illustrates one of the reasons that some older adults do not share with others. Two males and one female participant spoke of their not wanting to share. Alice added a layer of concern when she said, “Maybe I just don’t want them to know that much about me. If they don’t know that, maybe they’ll like me better.”

**Lack of trust.** Not surprisingly, several participants in this study used a lack of trust or confidence in the informal helper as a reason for not confiding. All 3 of the male participants and 1 of the female participants named this as a reason. Donald said:
Well, I think (pause). I’ve only had about two or three good friends in my life, and I found out the hard way sometime that real good friends will let you down. So I only put my trust in just so many. . . . I like friends but not the bread and butter kind. . . . Not them that, yeah, I won’t buy a guy as a friend, you know, the first ten minutes that I meet. I’ll accept him but not right down . . . to the bottom line. I’ve been disappointed in that a one or [two] times.

This speaks of his own experience with not being able to trust others. Arthur showed his skepticism when he said, “There are some that I wouldn’t rather talk to . . . ‘cause I don’t think they’d understand my point of view, and who they are, I’d rather not give out names.” This theme of lack of trust is the direct opposite of the trust and confidence indicated in the characteristics that helped participants be able to talk with people.

*Lack of understanding.* Understanding was a theme that 3 of the participants mentioned as contributing to their reluctance to speak with informal helpers. Two of the men and 1 female participant talked of this. Arthur summed it up well: “I don’t think they would give me any type of information that would comfort me.”

*Expected reaction.* In response to the question of why they felt they did not want to talk to others, 3 of the female participants talked about the negative reactions they had received from informal helpers. Alice said of her daughter, “She thinks she should run everything, but she shouldn’t. . . . She’d probably fly off the handle. She has a bad temper.” Another woman had a different perspective:

*Doris:* I just don’t talk to [others] a lot, I don’t like sympathy.
*Interviewer:* You don’t like sympathy?
*Doris:* No, I can start bawling. Before I get a lot of sympathy . . . better if I get, if I get so mad that I don’t, then that’s all I do is bawl, if I’m trying to tell somebody about it. . . . I don’t like to get in that position.
*Interviewer:* So, you don’t talk to people who you know will give you sympathy?
*Doris:* I just uh, well, no.

This response illustrates how negative reactions are unique to the individual; what one
may feel is positive may be perceived very differently by another.

Research Question Category Two: Older Adults’ Perceptions on Helping Behaviors

Part One: What Do Older Adults Perceive as Helpful Behaviors in Informal Helping Relationships?

The participants in the study responded with a range of behaviors when asked what they found helpful when they spoke with informal helpers. In several interviews, the interviewer prompted a selection of possible themes or reflectively characterized the participant’s response, which the participants either confirmed or denied. Seven themes of what the helper did were identified. The first two—problem solving and advice giving—were similar, but participants seemed to characterize them differently as illustrated by the following: “She didn’t give me so much advice as it was understanding, and she understood and we just kind of, we talked things out, arrived at answers” (Evelyn). The interviewer defined problem solving as a discussion where possible solutions were generated that helped the participant in making a plan, while advice was specific statements directing behavior. The participants also mentioned normalizing, listening, and encouraging as behaviors in which the helpers engaged. The informal helper’s understanding was not only reported as a reason that the participant could talk with the helper, but also something the helper did. Finally, there was a category of more instrumental help such as shopping, medication, and so forth that was mentioned.

*Problem solving.* Five (4 female, 1 male) of the participants’ responses were grouped into a theme of problem solving. The participants’ responses ranged from the
helpers solving the problem for the participant, simply answering questions, or having a
discussion. A woman said of her deceased husband:

Frances: And we’d talk about it.
Interviewer: Would he give you advice? Would he tell you what to do?
Frances: He’d ask me, what did I think about this or that in what we were talking
about. So that way, I could decide between one or the other or something. But we
always talked everything over before any decisions were made.

Simply answering questions was found to be helpful: “I think she’s always been fair to
answer any questions I had. And if she can’t answer, she’ll say ‘Mother, I’ll get back to
you’” (Alice). One of the male participants who talked with his son similarly indicated
that it was an alternate perspective that he found useful:

Donald: He’d give me the answer, that one way or the other, that I figured it
should come out, you know. It’s not always the way I look at it but at least I can
get a good viewpoint from him.
Interviewer: So, he can see it from your viewpoint, but he offers another one.
Donald: A lot of times he does, most of the time they’re pretty darn good.

Advice. Giving advice was considered specific instructions as to what the
participant should do. The interviewer occasionally prompted possible behaviors that
might be helpful, as illustrated by the following exchange with a female participant:

Interviewer: When you talked to him about things that were concerning you or
some of your sad feelings, did he offer advice? Did he listen?
Alice: Yeah, and usually it was good advice.
Interviewer: And was it helpful to you?
Alice: Uh-huh, it was.

Another female participant volunteered a situation with a specific piece of advice she had
received: “Yeah, she always . . . she never failed, she’d always call me up and say, when
I got this, then she said, ‘you’d better go and do what they tell you to.’”

Understanding. Understanding was given as a characteristic that facilitated older
adults approaching informal helpers. However, understanding was also mentioned as something that was perceived as helpful by older adults. Five participants perceived the informal helper as understanding them. A male participant reported: “He just seemed to understand what was going on. And he knew why, he knew why I was feeling that way and he seemed to take care of it” (Charles).

Encouragement. Five of the participants related stories where talking with the informal helper served to distract them, change their focus to a more positive one, and encourage them. Donald and the interviewer had the following exchange:

Interviewer: Yeah, what else does he do that is helpful, when you talk to him about your worries?
Donald: Oh, he tries to make you feel like, “look, tomorrow will be a new day, forget about it, it’ll change, it’ll go away, nothing ever develops, no matter how black it is today it’ll brighten up.” . . . I don’t think he knows any more than I do.
Interviewer: He kind of pumps you up and tries to be positive with you.
Donald: Yeah.

Several of the participants reported that talking with the informal helper about what was going well in the helper’s life had a positive impact on them.

Betty: Well, I’m glad, I’m glad they have a good life. They’ve both got good husbands. And there’s just something to rejoice over.
Interviewer: So, in a way, they help remind you of your blessings in a way.
Betty: Right.
Interviewer: Or the good things in life.
Betty: Uh-huh.

Listening. Five of the participants reported listening as helpful to them when they approached others for help with concerns or problems:

Interviewer: What is it about your friends that lets you know that you can talk with them?
Betty: Well, I don’t know. I just think that everyone has to have a listening ear. I think I’m the same in their lives.
Interviewer: What do they do to help you?
Betty: Just visit. That’s the main thing. Just to have someone.

A female participant and the interviewer had the following exchange in relation to listening:

Interviewer: And what else about praying is helpful for you besides that peace that comes?
Frances: That I know I can talk to [God] about anything and everything. Just the way I could talk to my parents. To me He’s real. Just the way my parents were real. But I have a testimony of it, of His, that I was His child and He knows me... So I know prayers are answered. I know they’re listened to.
Interviewer: Yeah, and both those things help you?
Frances: Yes.

Visiting and frequent contact were also mentioned as being helpful.

Normalizing. Half of the participants reported that the helpers they approached said things that helped them to feel that what they were going through was natural and normal. A participant related the following story of when he spoke with his physician about his depressed feelings:

Charles: He said, “That’s all right. I have the same problem. I’m on an antidepressant, too.” So he said, “I know what’s going on.”
Interviewer: Very natural and normal.
Charles: Been there, done that type of thing.
Interviewer: What else did he do that was helpful when you talked to him about your feelings?
Charles: Well, he just said, “I know what you’re going through.”

Comparing their problems with others’ was another form of normalizing that informal helpers engaged in. Doris said, “She would say, you know, I had nothing to complain about. She’d say, you know, ‘you’re lucky.’... And of course you can look around and see a lot of people worse off than you, you think. So that makes you feel better.”

Instrumental help. Half of the participants mentioned other types of help that informal helpers offer, including simple things such as bringing over catalogs for
shopping purposes, and providing soup for a meal. The participant who spoke with his doctor mentioned that the doctor also provided medication. Instrumental help was mentioned as being helpful provided an interesting link between emotional health and physical limitations.

Part Two: What Do Older Adults Perceive As Helpful Behaviors in Informal Helping Relationships?

The participants’ responses to this question were very limited. The majority said that they could not think of anything that was not helpful. One participant was confused as to whether her children’s questioning her actions was helpful or not as illustrated in the following exemplar:

Doris: They always ask me when I come from the doctor, my daughter and son. And . . . sometimes they’ll get their feelings going; “Why didn’t you do this or ask him that?” or something like that.
Interviewer: Is that helpful, when they ask or they say, “How come you didn’t do this or why didn’t you do that?”
Doris: Well, yeah, I think, well I should have said that, but I didn’t.
Interviewer: Does that help you or does it make you worse? When they ask you that?
Doris: Well, I think, well, if worse is, I shouldn’t, I should’ve done that, that makes you feel worse.
Interviewer: I don’t know: does it?
Doris: I can’t tell. I don’t know if my decision wasn’t as good as theirs or not, you know.

Research Question Category Three: Older Adults’ Perceptions of Formal Helpers

Part One: Would Older Adults Be Willing to See Mental Health Professionals?

The participants’ willingness to seek professional help was mixed. Three of the 4
oldest old women said they would not seek help from a therapist. The remaining female
in the oldest old group said that she might if she felt she needed it. One of the middle old
women agreed:

If it was necessary, I would, but I’ve never, I’ve always felt just talking to
Heavenly Father has helped me. If I had a problem, I would talk to my Bishop but
... I’ve never felt the need of going to a therapist or a psychologist. Like I told
you, [I’m a] psychology major, so I know, I know that they try. I know there [are]
people that are troubled and you have to find out what’s at the bottom of it. And
sometimes it’s a simple thing and sometimes it’s something that they’ve seen and
it’s enlarged in their mind. But if somebody said I should, I wouldn’t mind talking
to [them]. But I’ve never felt the need of it. (Frances)

The 3 male participants all reported that they had seen a mental health
professional at some point and they were not pleased with the experience. Charles was
still required to meet with someone at the Veteran’s Administration to monitor his
medication. Of this experience, he said, “I have to go talk to her every so often in order to
get my medicine replenished. And I talk to her about it and sometimes . . . I end up, uh,
gently brushing it off and finishing it. Not spending that much time with her.”

Part Two: What Reasons Do Older Adults Give for
Not Seeking Help from Mental Health Professionals?

The 8 interviews provided a selection of responses as to why participants were
unwilling to seek help from professional mental health practitioners. Several of the
participants had had experience with professional helpers in the past and provided
specific reasons for their unwillingness. More general responses were also rendered.

The participants listed a variety of reasons that they would not seek professional
help. There was not a category that the majority of the participants mentioned. The
responses ranged from the obvious “I don’t need help” to specific things that they had
experienced when seeking help in the past. The following responses were gathered from a question of why they would not seek help and, from their perspective, why other older adults may not seek help.

*Not needed.* Three of the participants specifically said that the reason they would not seek help was because they did not feel that they needed it. In these cases, the interviewer probed and still the participants maintained they did not need help:

*Interviewer:* Are there any circumstances where you might consider seeing a counselor or a psychologist or something like that?
*Doris:* Well do you think I need one?
*Interviewer:* No. I’m just trying to figure out people’s ideas about them.
*Doris:* Oh. I don’t know. I wouldn’t. ‘Cause, I don’t think I have that, uh, not that it wouldn’t help me, I don’t know, I don’t think I have that many problems that I could go [for].

Feeling like help was not needed was not limited to the participants, but also to their perceptions of their older adult friends. Evelyn said, “All my friends think they know it all already.” One participant characterized older adults as being “head-set” which prompted the following:

*Interviewer:* Too head-set? What does that mean?
*Doris:* Well, I think that they, I’m not going to go get something that I’m not sure I need or something like that, you know.

*Lack of trust.* The theme of trust was evident in those helpers the participants reported they chose to talk to and those they chose not to. Mental health professionals, including psychologists, counselors, and therapists, were not trusted by 3 of the 8 participants. Evelyn said, “Well, like I say, if I thought he or she didn’t have a spiritual feeling, I would, I would not have the trust in them. So I don’t think I would go to them.” A male participant was very specific in his reason for not trusting professional helpers:
Charles: Oh, I’ll have to confess, I don’t think much of psychiatrists ... and what do you call them?
Interviewer: Psychologists?
Charles: Yeah, psychologists. I’m a little biased that way. If you’ll pardon the expression.
Interviewer: That’s okay. I’m curious why?
Charles: Well they call it a science and it isn’t a science. ‘Cause they’re just, in science you think different that way.
Interviewer: They’re looking for evidence?
Charles: A lot of things they call science, not only are they looking for evidence, but in science, you have to set up an objective and through experimentation you have to see if you can prove it.

Age constraints. Two of the participants mentioned being constrained by age-related factors including being too old for help and having too many doctors already.
Both of the participants who mentioned this factor were women. One said, “In this stage of the game, where I’m as old as I am, it wouldn’t make much difference now. ... I’ll just take things as they come and not make a big fuss over anything.”

Independence. Two of the participants reported that they would not see a professional helper because they felt, as Betty put it, “There again, it is your own battle, work through it.” The element of privacy was also found in the reasons against professional help. Arthur, an 87 year old participant, emphasized his view:

I have found in my ... experience with people that a lot of them are that way, they don’t want to talk about it or they don’t want to be trying to think about it, or trying to find a solution, or you know what it is, they’d sooner keep it to themselves. ... I don’t like to talk to people about things I don’t like to talk about.

Not helpful. Two of the participants—one female who had not seen a professional helper and one male who had—reported that they did not feel that seeing a professional would be helpful. Betty said, “I’m sure I don’t know. I don’t think you get a lot of help from them.” And Charles said, “No, talking isn’t enough sometimes. And a lot of the
brain chemistry we don’t understand yet. We don’t understand exactly how the brain works in many cases, either.”

Unknowledgeable. The 3 male participants who reported having seen professional helpers indicated that they felt the helpers were not knowledgeable. The man who still occasionally sees a professional helper had this exchange with the interviewer:

Interviewer: So you don’t, you go to her so you can get your meds but you don’t really find talking with her useful.
Interviewer: Why not? Why isn’t talking with her useful for you?
Arthur: I just don’t think she’s that smart.

Another of the participants, Charles, felt strongly about the medical side of depression:

Well, I’ll tell you, I think the biggest thing was that they didn’t understand the medical part of it, too. ‘Cause, like anything else, you can see a tree in the forest but you can’t see the forest. Then again you can see the forest but not the trees. So you just have to understand what’s going on with people.

Past experience. Two of the participants had specific examples of things that professional helpers did that were perceived as not helpful. Arthur had seen several counselors and was still having his medication monitored said:

You know what, they were always trying to talk about this, oh, what is it? Now that I want to say it, I can’t think of the title they throw on it. Anyway, it’s what they give marines, or army, or people like that have a hard time relating with the military and the problems they have been having now. And it has been driving them crazy, so they’ve had to come to them to talk to them about their problems. This one [counselor], the one that was driving me crazy, he was the one that was trying to push me through on this, and I was trying to step back from it. Cause I didn’t feel that I had, that I had come back with that big of a problem.

The other complaint was that the counselor did not provide the kind of answers that Arthur was looking for. He wanted answers rather than the normalizing that the professional helper apparently was doing.
Part Three: What Have Older Adults Found Helpful From Professional Mental Health Practitioners?

One participant did report something useful he gained from visiting with a professional helper. He said that it was helpful to know that there is someone out there that cares if I’m willing to give the time and talk about whatever it is. . . . And she would take me at a moment’s notice. I could call, and I had some real serious problems. I would sit in the bedroom in there and just, with a blanket over my head, just shaking. And I would call her and ask her if we could get together immediately and generally she would say yes. So I would go down and what her solution wasn’t so much [her words], she was mostly one who would . . . change my medicine around, put me on a different medicine.

Part Four: Under What Circumstances Might Older Adults Be Willing to Seek Professional Help?

The participants in this study talked of when they might seek help from professionals. Several did not know what it would take for them to seek professional help for emotional problems. Two of them mentioned family circumstances and 3 of them mentioned personal problems.

*Family circumstances.* Trouble with family was one of the categories of responses the participants offered to this question. Two female participants mentioned family as a reason to seek help. Alice had this exchange with the interviewer:

*Interviewer:* Under what circumstances might you be willing to talk to a counselor, therapist, or psychologist?

Alice: If it was for advice on . . . something that pertained to family problems . . . something that they would suggest or have me do that would help.

*Interviewer:* The family . . .

Alice: Uh-huh

*Interviewer:* But not for yourself?

Alice: No.

*Personal concerns.* Three of the participants talked about things that would be
serious enough for consultation with a professional helper. One of the female participants had this dialogue with the interviewer:

*Interviewer:* Would talking with a counselor about being sad, would those be feelings that would be acceptable to talk with a counselor about?

*Evelyn:* If they were bad enough, I would. . . . But I don’t think that they are hindering me that much.

*Interviewer:* Okay, so if they were really hindering you, you’d be okay . . .

*Evelyn:* I’d be okay.

*Interviewer:* . . . to go to a counselor about that?

*Evelyn:* To go to a counselor about that.

*Interviewer:* And how could you tell if they were hindering you?

*Evelyn:* I don’t know. . . . If I was, I’m almost there now. I get so tired. I can’t keep up. I don’t know. [I] guess if I was crying a lot, just doing a lot of crying and couldn’t make decisions. . . .

*Interviewer:* That would be . . .

*Evelyn:* . . . a reason.

One of the male participants, Donald, gave no specifics and took it to an extreme when he said:

*Donald:* Life or death maybe.

*Interviewer:* Life or death, but nothing besides that?

*Donald:* Nothing short. I can’t think of anything that’d be tragic enough and that to do it, you know.

Part Five: What Do Older Adults Perceive as Being Barriers to Seeking Professional Help?

Many barriers to seeking help have previously been discussed in those sections dealing with why the participants did not feel they could talk with informal or formal helpers. Responses to the barrier question fell into categories of trusting the helper, the helper’s level of understanding, and not needing help. Two participants added additional reasons of finances and not knowing where to go for the help they needed.

The interviewer asked questions about what could be done to remove those
barriers. The participants' responses ranged from, “I don’t know” to receiving a large sum of money. Only 4 of the participants had a specific response. Charles implied there was not much that could be done when he said, “I think we all have our prejudices that we have that we enjoy having.” Evelyn could see how her family might be instrumental in getting her help; “I think, well, in my situation if your family and your kids were concerned about you—really, really concerned about you—that they, with their help, they would help you get to one. . . . That would be the reason to get me to one.”

Research Question Category Four: Other Findings

Part One: What Attitude Do Older Adults Have in Dealing with Emotional Challenges?

Across the interviews, the participants made statements about coping that they implemented when facing challenges. All 8 participants made statements that illustrate an attempt at being upbeat, looking at the positive, and having hope that things would get better.

It would pass by. . . . It’ll be okay. . . . Well, time and places will change it. (Arthur)

I think you just have to roll with the punches. . . . Roses are coming up everywhere, but they’re not, but you make it feel that way, life is more pleasant if you can look on the good side of everything. (Alice)

I’m usually not struggling too much. Don’t have to put an emphasis on that I don’t think. (Betty)

But I don’t go around moping about it because I’ve got it and that’s, that’s it, you know, I’ve got to just do the best I can. (Doris)

Just understand and realize that this is life and it’s not, that life just has its ups and
downs and you just take them as they come. (Evelyn)

I don’t care who they are but everybody has their down moments and their up moments and so on. They have their problems they have to work through in this life. (Charles)

So, if you talk to people and give them something positive it lifts them up and gets them away from being down. So, I’ve always thought about that in my own life. That, I wake up in the morning and no matter how hard I’m hurting, it has to be a positive, with the help of the Lord I can do this. . . . Think positive and always look up. (Frances)

Maybe that isn’t a good philosophy to follow, I don’t know. Try to do better in my life, you know, that’s the way I’ve run it. (Donald)

These exemplars illustrate the different upbeat statements that the participants made throughout the interviews. One female participant talked often about how she “looks up” and “thinks positive.” She also placed a heavy emphasis on faith in God. She said that “the knowledge that Heavenly Father loved me, that Jesus lives, and that there’s always tomorrow that things always look different” helped her to feel better when she was down.

Summary

Within the eight interviews conducted for this study, a plethora of information was collected and analyzed. The category concerning whom older adults talk and why was covered in great depth. The things those helpers did and what was helpful were also evaluated. The third research question category was the perspectives of older adults’ on professional helpers, followed by a small selection of other findings. Arthur summarized the entire study when he said, “So you can see that if you have the right type of people around you, you could, you can wipe away all the cares in the world.” With these data, it
is possible to begin to draw conclusions about what older adults in this study found useful in helping relationships.
CHAPTER V
DISCUSSION

The purpose of this study was to investigate older adults' perspectives on helping relationships to further our understanding of this population in ways that may increase formal and informal helpers' ability to effectively assist older adults when they are struggling with emotional concerns such as depression. The organization of this chapter parallels the literature review and integrates the findings of this study with the current literature on help-seeking, social support, and therapeutic alliance. This integration suggests that those factors identified by this study are not limited to emotional concerns such as depression, but apply to all types of problems older adults' experience. The following sections will discuss the findings of this qualitative study as well as clinical, policy, and research implications, and limitations.

The characteristics and context of the sample must be considered when drawing conclusions from the data. Therefore, it is important to note that all 8 participants were homogeneous in race (Caucasian), religion (LDS), location (Northern Utah), and living situation (community dwelling). Four of the participants were 85 years and above (oldest old) and 4 were 75-84 years (middle old). Four of the participants were widowed and 4 married to lifelong partners. Thus, the sample can be described as White, LDS, older, and independent.
Help Seeking

Demographics of Help Seeking

Gender. The findings in this study both supported and contradict the literature on the role of gender in help seeking. In this study, all of the participants, including the men, sought help from family members. This is contradictory to research indicating that women are more likely to seek help than are men (Kushner & Sher, 1991; MacKenzie et al., 2006), and, although frequency of help seeking was not a focus of this study, it appears that both genders in this sample were willing to seek help from informal helpers when they felt they needed it. The women did mention seeking help from their children more often than did the men. The men in the study were all currently married, which may account for their having easy access to a confidant. The absence of unmarried males in the sample makes it difficult to make comparisons. However, the 3 men were also the only participants who had experience talking with formal helpers. This finding is unusual and contradicts the research that indicates women are more willing to see mental health professionals than are men (MacKenzie et al.). This finding may have been influenced by military status, because two of the male participants talked of their experiences in the armed forces during World War II and the Korean War. The details surrounding why and when they sought help were not specifically elicited.

Age. The literature indicates that as people age, they are less likely to seek formal help (Alea & Cunningham, 2003; Willis & DePaulo, 1991). The results of this study support these prior findings. Three of the 4 oldest old participants reported that they were unwilling to see a professional helper when struggling with emotional concerns. Three of
the middle old participants reported having seen professional helpers but not having had good experiences. From these findings, it appears that the middle old group were at least open to the idea of seeing a professional helper at some point in their past. It is difficult to be confident in this finding because this is a cross sectional, single interview design, and therefore does not measure change in help seeking. It is possible that the difference between the oldest old and the middle old in help seeking behavior may be accounted for by cohort effects rather than age. The oldest old appear to be less likely than younger cohorts to seek help (Alea & Cunningham), which may be the result of the stigma associated with mental health that has existed for much of their lives (Yang & Jackson, 1998). This study also was dealing with retrospective reports regarding attitudes and may not represent actual help-seeking behavior.

Identified Helpers: Informal and Formal

The results of this study support the current literature on help seeking among older adults. It was anticipated that older adults would follow the pyramid model of help seeking outlined by Willis and DePaulo (1991), with the majority of emotional and life stress being discussed with family and friends, more persistent problems being taken to clergy or general medical practitioners, and mental health professionals being reserved for serious and lasting problems. This help-seeking pyramid was supported by this study. The majority of the helpers mentioned fall into the informal category. Spouses and children were mentioned the most frequently with friends also being mentioned by several participants. Clergy members and physicians were mentioned rarely, and professional helpers were talked of only after prompting by the interviewer. The help-
seeking pyramid was illustrated well by an 84-year-old female participant. She talked with God and her husband for the majority of her problems. When asked about seeking help from professionals, she mentioned that she would talk to her LDS Bishop and followed that with a comment that she would see a psychologist if someone felt she really needed it.

It is not surprising that those individuals the participants identified as being informal helpers (e.g., family and friends) were also named as those they would not approach for help. The difference was not in the category of who they approach as much as it was in the reasons for not talking with them.

According to the pyramid model of help-seeking behavior, the middle layer consists of individuals who are not mental health professionals nor are they family and friends (Willis & DePaulo, 1991). This layer consists of religious outreach groups, untrained clergy, general medical practitioners, nursing home staff, and any other individual that has contact with the older adult on a consistent basis. This layer was not specifically inquired after in this study and only 2 participants mentioned helpers that fit in this category; however, this category of helpers becomes important in the identification of depression in older adults, and these helpers often can become the main source of treatment.

The majority of the older adults in the study felt that seeking help from professional mental health practitioners was not something that they would do. Several had seen professional helpers in the past but felt that the experience was not helpful and they would not repeat the process. There were several who said they would go to
professionals if they really felt they needed it; however, they could not clarify how they would know they needed it.

Several of the participants talked about going to see a professional helper if they had family troubles. One participant, when asked about seeing a psychologist, counselor, or therapist, talked about how most of her friends were not married and so they would not need counselors. This seemed to indicate that for this older adult, family troubles were the only reason to seek professional help. If this is a belief that older adults have, it is possible to see why they do not get the help that might benefit them.

Personal troubles were also listed by several participants for seeking professional help, although the qualifications for knowing when they would seek help were vague. The most specific factor mentioned involved frequent crying. The reasons that older adults seek help for emotional concerns from professional helpers was not a specific intention of this study and deserves additional research.

There were several participants who had seen professional helpers. Some factors were mentioned that were perceived as helpful. The older adults indicated that just having someone to talk to was helpful. This corresponds with the collaborative nature of the helping alliance and the life review that is reported to be helpful for older adults (Gaston, 1990; Woods & Roth, 2005).

The responses given to the questions regarding to whom older adults approach for help may have been impacted by several factors over which the interviewer had little control. The interviewer’s introductory statement of “tell me something about yourself” was designed to ease the participants into sharing and to increase their levels of comfort.
This question was broad and, depending on how the participant understood it and responded, could have impacted the remainder of the interview. For example, one participant began sharing a lengthy narrative about her young adult years of which her sister played a part. When the interview shifted into discussing more recent events she frequently mentioned that particular sister as one with whom she talks. It may be that she talked of that sister because of her previous reflections of her early life. This same participant’s responses surrounding this sister may also have been influenced by the death of that sister within the past year. These are both examples of how the interview itself may have produced a context where the participants’ minds were placed in a certain frame, as well as how external influences (e.g., recent loss of a loved one) may have affected the responses.

Social Support

The characteristics of informal helpers found in this study are based on the perceptions of the older adults. Perceptions of clients have been shown to be the best predictor of therapeutic outcome (Cummings et al., 2003; Greenberg et al., 2001; Orlinsky et al., 1994; Rudkin & Irdikovs, 2002). Perception is based on the experience of the individual and can vary greatly from person to person. Thus, the interviewer noted that several participants had a favorite characteristic they mentioned with each of the identified helpers they named as being helpful.

As expected, the results of this study support the literature on social support and helping alliance. Social support is purported to include factors of trust, care, love, esteem,
information, and mutual obligation (Rowe & Kahn, 1998) and a study of young adults found similar factors, including understanding, caring, listening, insight, acceptance, and so forth (Goldsmith, McDermott, & Alexander, 2000). The results of this study fit these factors as will be discussed in greater detail.

The social support literature hypothesizes that as people age, they discard relationships that are not useful to them (Rowe & Kahn, 1998). The socioemotional selectivity theory suggests that as people age, the relationships that provide emotional support are the relationships that are retained. The findings in this study support the retention of emotionally supportive relationships. The majority of the informal helpers named in the data were individuals with whom the participant had long term relationships. Six of the participants talked with their spouses, with whom they had been married for their adult lifetime. The remaining family members identified were children, with whom, obviously, the participant had an extensive history. Even non-familial relationships that were mentioned were of long duration. The friends that were mentioned by the participants had been friends for many years; one female participant said she had been close friends with the person mentioned for “only about 20 years” (Evelyn). These long-term relationships are comfortable and provide an established relationship, often containing the characteristics of caring, trust, and understanding that are addressed later in this paper. These long-term emotionally supportive relationships also provide easy access, because frequent contacts with spouses and children are typical. Friends are also more available than are medical or professional mental health professionals. This easy availability bypasses the barrier of access that is reported with older adults and formal
The participants felt that an established relationship with the helper was useful in facilitating seeking help. It is likely that this prior relationship increased the helper’s ability to exhibit understanding, caring, acceptance, and availability, all characteristics perceived as important by older adults. The older adults’ perceptions that the helper was trustworthy and knowledgeable were also stated as important characteristics. It is possible that all of these characteristics are interrelated. Relationships with individuals that are trustworthy are likely to endure, while other, less secure relationships are discarded. A long relationship may foster increased understanding and love, which reciprocally enhances trust.

The established relationships also provide a setting for a reciprocal relationship between the individuals in which they take turns helping each other. It appears that older adults are more comfortable in reciprocal helping relationships (Rowe & Kahn, 1998; Willis & DePaulo, 1991) and may actually experience health benefits from helping others in return (Walker, Pratt, & Oppy, 1992). Reciprocal relationships were not examined in great detail in this study; however, the older adults’ stated desire to not be a burden to others suggests a desire for balance and is suggestive of a desire for reciprocity and not always being on the receiving end of help rendered, which was mentioned by several participants.

Helping Alliance

The literature on the helping alliance helps to categorize the discussion on why
older adults felt they could talk with identified helpers, and what they found helpful. Gaston’s (1990) four dimensions of helping alliance included the client’s affective relationship, the client’s willingness to work in therapy, the helper’s response, and the collaborative relationship between the helper and client. Concepts of three dimensions were found in the results of this study. The affective relationship is discussed in relation to older adults’ perceptions of why they felt they could approach the individuals they named as helpers.

Research has shown that the perception of support as helpful rather than some external measure of support has the most impact on individual well-being (Cummings et al., 2003; Rudkin & Irdrikovs, 2002). With this in mind, it is simple to make the connection that it is the older adults’ perceptions of help rather than the help itself that matters. This study was specifically designed to look at the older adults’ perceptions of what was helpful in relationships. The responses support Gaston’s (1990) third and fourth dimensions of the helping alliance: the helper’s response and the collaborative nature of the relationship.

Affective Relationship

The client’s perception of the relationship between the therapist and client is central to the affective relationship. Rogers’ (1957) notion of unconditional positive regard is listed as a necessary condition for therapeutic change. Unconditional positive regard includes feelings of being respected, accepted, cared for, and supported. Rogers’ concepts and the current literature related to the helping alliance (Blow & Sprenkle, 2001; Farber & Lane, 2001; Horvath, 2001; Horvath & Loborsky, 1993; Hyer et al.,
suggest several additional concepts that are supported by this study, including support, trust, confidence, and understanding. All of these concepts were mentioned spontaneously by the participants, with the exception of respect, which was mentioned by a few participants only after they were prompted by the interviewer. Therefore, respect was not found to be a characteristic described by the older adults and is thus not discussed in this study.

Understanding. The older adults’ perceptions of being understood by helpers was the main theme found in this study. Not only was it one of the reasons the participants mentioned for why they could or could not talk with helpers, it was also mentioned as one of the factors that actually helped them with their problems. Understanding is part of what the helping alliance literature calls empathy (Greenberg et al., 2001), which is considered necessary for change (Rogers, 1957). The participants in this study felt that their identified helpers understood them, understood their experiences, and that they were like them. The literature indicates that older adults appear to be more comfortable asking for help from individuals who are similar to them in age, status, and gender (Alea & Cunningham, 2003; Lee, 2002). Seeking help from individuals who are similar in age, gender, and status would increase the understanding of age and cohort-related factors that may make it easier for older adults to confide in similar individuals. Children identified as informal helpers are not necessarily similar in age or status; however, in this study, the children identified were the same gender and, for the most part, it is assumed that children would share a similar history with their parents. These similarities may make it easier for the older adult to approach the individual for help.
Understanding was one of the themes that all 8 participants mentioned not only as the reason they could talk with identified informal helpers but also in relation to why they would not talk with other people, including professional helpers. Several of the participants who had seen formal helpers in the past were adamant that the helpers did not understand them or their experiences; another participant indicated that she would want someone who felt similarly about certain things. This desire for a helper who understands is not unique to the older adult population (Hastings, 2002).

Acceptance. The expected reaction from the identified helper signified the acceptance the older adult felt. Older adults named helpers as more approachable who were not shocked or upset by the discussion. Some helpers appeared to have topical limitations (e.g., “I can talk with them about everything except this”). A lack of acceptance was one of the factors mentioned by the participants for not talking with individuals. They did not want the negative reactions they anticipated. These negative reactions (e.g., criticism) hindered the participants from being willing to share their struggles with others. Not only does this support the literature on perceived acceptance in helping relationships, but also the literature that indicates that negative interactions have a negative impact on well-being (Rook, 1984, 1990, 2001). If older adults encounter helpers who react negatively, the older adults may feel rejected and shamed, and that reduces the likelihood of their seeking help in the future, possibly leading to a decrease in well-being and an increase in their depressive symptoms.

Caring. Participants mentioned that one of the reasons they felt they could talk with their identified helper was because they felt loved and cared for, concepts that fit
with the warmth mentioned in the literature (Walker et al., 1992). The results of this study point to a mutual caring relationship between helper and older adult. This corresponds with socioemotional selectivity theory’s assumption that older adults are focused on fostering emotional connections rather than building new relationships with informational sources (Carstensen et al., 2003). A previously established caring relationship is available and certain, while developing a relationship with a mental health professional may be perceived as being for informational purposes only, not important to the older adult, and not a caring relationship as they have with family or friends.

*Open and available.* As mentioned previously, the helper’s being open and available to the older adult was also found to be important to the participants. The older adult’s perception of the helper as being open increases his or her feeling of acceptance and unconditional positive regard (Rogers, 1957). The participants mentioned their ability to talk about anything with the identified helper; how conversations were easy and open with these people. Being able to contact the helper and discuss anything necessary appears to be characteristics older adults appreciate in helpers. This is logical in light of the life-style of the middle- and oldest-old adults. Many of them have several doctors they are consulting for different medical conditions. They may also have other family, community, and social obligations. Concurrently, their bodies are becoming more infirm and basic tasks take longer than before, therefore, accessing formal helpers becomes a barrier to seeking help from them (Yang & Jackson, 1998); thus, having easy access to helpers is important to the older adults.

*Trust.* The older adults in this study talked about trust, not only as a reason why
they could talk with identified helpers but also why they would not talk with other informal or formal helpers. Trust is important in all helping relationships both informal (Rowe & Kahn, 1998) and formal. Research, laws, and ethical codes stress the importance of keeping confidentiality to protect the fragile helping alliance and benefit the client (Wilcoxon, Remley, Gladding, & Huber, 2007). One of the male participants in the current study related a past experience when a friend broke confidence and consequently this participant would not want to share private things with friends. Poor experiences help to perpetuate distrust. This also happened with a female participant who had a bad experience with a medical specialist and now no longer trusts unknown professionals. It is possible that as people age, become more infirm, experience cognitive decline, and find themselves victims of elder abuse, fraud, and other perpetrators, they have more opportunity for negative experiences, thus becoming more hesitant to trust unknown individuals (Yang & Jackson, 1998). These factors are likely to increase older adults’ distrust of professional helpers, and encourage them to continue to rely on trusted informal helpers, such as family and friends.

**Confidence.** Confidence in the helper’s ability to offer help, comfort, and support is tied to the hope and expectancy factors that reportedly account for 15% of therapeutic change across all models of therapy (Horvath & Luborsky, 1993; Sprenkle & Blow, 2004); this also is supported by the current study. The participants indicated that they had confidence in the other person’s ability to help them, that they were knowledgeable, had good judgment, and were level headed. Several of the participants admired or thought highly of the helper, which also increased their confidence in the other’s ability to help.
In contrast, participants mentioned that they did not think professional helpers were knowledgeable and would be able to offer them much help. The findings in this study indicate that it is important that older adults have confidence in those they approach for help with emotional concerns.

The current study supports recent literature on the helping alliance as discussed. The older adults reported that they had long, caring relationships with the informal helpers identified. They felt they were accepted and understood by them, and they had trust and confidence in them. All of these factors contribute to the affective relationship of which Gaston (1990) spoke.

*Helper Response*

Gaston’s (1990) third dimension of helping alliance was identified as the helper’s response. Several of the factors the participants identified as being helpful can be attributed to the response of the helper. The older adults said that having the helper listen and understand them was important to them. Having a positive attitude, offering encouragement, and normalizing their feelings or situations were also listed as being helpful.

*Listen.* As simple as it may seem, older adults felt that listening was helpful to them when they were dealing with a problem. Listening helps to reassure individuals that they are not alone (Moffatt, Mohr, & Ames, 1995). Listening to the individual’s experience is vital to the helping alliance because it is key to understanding and empathy (Graybar & Leonard, 2005) and because it is not possible to have a good affective relationship without listening (Seikkula & Trimble, 2005). Psychotherapy with older
adults often includes reminiscence therapy, a process whereby the older adult can reflect on his or her life (Woods & Roth, 2005). Life review is a structured process in which the entire life span is covered, giving the individual the opportunity to integrate experiences and create a different meaning for life events (Butler, 1963). Life review has been shown to have helped mood and life satisfaction among participants (Serrano, Latorre, Gatz, & Montanes, 2004). This process of life review might occur spontaneously with older adults and their informal helpers. Life review therapy with both the informal caregiver and older adult has been shown to shift the caregiver’s mood in a favorable direction (Haight et al., 2003). This process of reminiscing and listening may have a benefit for both the older adult and the informal helper. Simply having someone to listen to reminiscences about life events may offer needed therapeutic advantages.

**Understand.** Understanding was a large part of what older adults’ perceived as helpful. They wanted to feel that the helper knew where they had come from, and what they had experienced and accomplished. As previously discussed, older adults may find it hard to relate to formal helpers who are unrelated and significantly younger than themselves, because they differ in age, status, and experience. It also becomes possible that if the older adult holds this perception, it will not matter what the helper actually does; the older adult will experience what he or she expects (Cummings et al., 2003; Rudkin & Irdrikovs, 2002). This corresponds with hope and expectancy that, according to the common factors literature, accounts for 15% of therapeutic change (Sprenkle & Blow, 2004). Feeling understood is part of the therapeutic alliance that accounts for an additional 30% of therapeutic change. With these two factors alone, it is possible that
informal helping relationships may provide the elements necessary for therapeutic change.

**Encouragement.** Several of the participants mentioned the utility of having helpers point out the positives in situations and encourage them in the midst of their problems. Many models of psychotherapy include a technique designed to shift focus from a negative to a more positive outlook (Watzlawick, Weakland, & Fisch, 1974). This technique includes looking at the positive, limiting negative thinking, and looking ahead to the future (Amundson, 1996). These skills may be something that informal helpers do instinctively that help older adults to cope and overcome their challenges.

**Normalize.** Several of the informal helpers discussed in this study helped the older adults to feel that what they were feeling and experiencing was normal, whether by pointing out those who were worse off or by having experienced similar things themselves. This process of normalizing was perceived to be helpful to the older adults. Normalizing is a process used in most therapeutic models and has been effective with younger populations (Knox, Hess, Petersen, & Hill, 1997). There are many transitions in life, including caregiving, aging, and loss that the majority of individuals go through (McGoldrick & Carter, 2003). Normalizing those situations allows individuals to shift their thinking in relation to their concerns, seeing them as universal and decreasing anxiety surrounding the situations (Knox et al.).

**Collaborative Relationship**

Gaston’s (1990) fourth dimension of the helping alliance was the establishment of a collaborative relationship. Once again, it is possible to return to a discussion on the
older adult’s perception and expectation of what is helpful in a collaborative relationship. In this study, the results suggest that older adults appreciate relationships that are collaborative in problem solving, advice giving, and support, although their expectations may modify these according to the individual. Several participants appreciated being the recipient of advice and specific suggestions, while others felt this was not helpful. Singer (2005) found a similar dichotomy in a qualitative study with younger adults, with the clients having different desires for helper involvement. It appears that the perspective and meaning the older adult places on the advice giving or problem solving determines how helpful it is (Goldsmith & Fitch, 1997).

Problem solving. The participants felt there was a difference between problem solving or discussing possible solutions, and advice giving. The process of problem solving appeared to be more collaborative with the helpers’ respecting the autonomy of the older adults to make their own decisions. This corresponds with the literature that indicates that most individuals seeking help for emotional concerns benefit more from a collaborative discussion of the problem rather than the helper’s fixing the problem directly for the individual (Goldsmith & Fitch, 1997; Singer, 2005). This appears to apply to older adults as well.

Advice. Direct advice is a contradiction to a collaborative relationship and can be seen as an intrusion, criticism, or unwelcome. However, it is possible to classify advice with information seeking on the part of the older adult. There are times that it is appropriate to offer advice, such as when consulting a physician about medication. Advice does not necessarily mean that it is followed; in fact, one example given by a
participant was an instance of where she went against the advice of her husband and regretted it. The interviewer did not gather specifics regarding every instance mentioned of advice giving. However, it is possible that some older adults in some situations are seeking information from the helper and advice is appropriate, whereas there are times when listening, understanding, and problem solving are more appropriate.

Support. Support was mentioned previously in relation to the affective relationship. In this study, the participants mentioned support in conjunction with what the helper did that was helpful rather than a subjective characteristic of the helper. Both emotional and instrumental support were mentioned by the participants. Emotional support, the feeling that the helper is there for them and will stick by them, was mentioned in the study. The participants also mentioned instrumental help such as shopping and meals that may have indirectly provided emotional support by acknowledging the older adult as a person worthy of caring for and of understanding for his or her situation.

The three dimensions formulated by Gaston (1990) served to help categorize the results of this study in a coherent and organized fashion. It is clear that the themes and characteristics found in this study support the helping alliance, including the affective relationship, helper response, and collaborative relationship.

Barriers to Seeking Professional Help

Many of the reasons the participants in this study gave for not seeking help from professionals were similar to the reasons they gave for not seeking help from informal
helpers. Two categories of barriers were found: mental and physical. Independence, trust, experience, and understanding are visibly woven into the framework of the results of this study and are classified as mental barriers. Three physical barriers were also identified: age constraints, finances, and not knowing where to go for help.

Mental Barriers

Trust and confidence. Trust and confidence were once again a central issue for the older adults. They did not feel that professional helpers would be helpful to them, which complements other studies on older adults’ views of psychotherapy (Zivian et al., 1994). One participant even distrusted the entire profession because it is “not based on science.” This same participant was not confident a professional helper would know anything about the medical side of things. Other participants in the study also questioned the knowledge of the professional helper.

Understanding. The participants in this study did not feel that professional helpers would be able to understand their experiences. This returns to the discussion on whether older adults would accept emotional help from someone significantly younger than themselves. It is possible that it is easier for older adults to accept instrumental help from younger adults while it is more personal and perceived as an admittance of weakness to ask for emotional help (Willis & DePaulo, 1991).

Independence. Several participants indicated that they felt that they did not need help, that they wanted to deal with their own problems. This may be a reflection of a value for independence and self-reliance that has been taught and reinforced from the early years of this cohort (Schrimshaw & Siegel, 2003; Switzer et al., 2006; Yang &
Jackson, 1998). The older adults in this study appear to be striving to maintain their privacy and independence; they do not want to be a burden to their family and friends. Asking for help may engender shame in older adults (Crossley & Rockett, 2005). Preliminary studies indicate that shame actually is exacerbated by depressive feelings and may be one of the barriers to older adults’ seeking help (Crossley & Rockett). The anticipation of shame and the value of independence appear to be factors that keep older adults from seeking help from professional helpers.

The help-seeking literature indicates that help seeking is perceived either as intentional information seeking or as dependent, incompetent behavior (Alea & Cunningham, 2003; Willis & DePaulo, 1991). The older adults in this study seemed to see help seeking as the latter. Perceiving help seeking as dependent, incompetent behavior would be exacerbated if the older adult were experiencing cognitive decline. The participants were reluctant to burden others with their problems and desired to maintain their privacy. Several of the participants made it clear that they felt their feelings were private and they wanted to take care of the problem themselves. The values of self-reliance and not burdening others may be a reflection of the individualistic society in which we live and may be emphasized by the cohort to which older adults belong (Schrimshaw & Siegel, 2003; Switzer et al., 2006). This is a value that they most likely have embraced their entire lives and instilled in their children, and now hinders them from receiving the help from which they may benefit.

Experience. Three of the participants had past experience with professional helpers. They did not feel they benefited from the experience and that appeared to be a
reason for not seeking help in the future. They gave specific examples of things that they did not like. One wanted more answers, supporting the previous idea that some older adults seek information. Another participant was upset at the professional helper’s pushing a label and agenda on him, which supports the need for a more collaborative approach indicated in the literature. This dichotomy highlights the importance of the professional helpers’ attempting to meet the needs of older adults. If they want answers, helpers might do better to work within that framework, and if they want someone with whom to collaborate, meet them there.

Surprisingly, the older adults in this study did not mention social stigma as a barrier to seeking professional help. Stigma is a barrier noted in the literature on help seeking among older adults (Yang & Jackson, 1998). It is possible that social stigma is a covert barrier that older adults do not often think about or verbalize without prompting. It might be appropriate to view the stigma associated with seeking professional mental health help as built into the construction of our culture and thus not challenged by the majority of the population.

Physical Barriers

Age constraints. The participants in this study talked about being too old, too busy, or too infirm to seek professional help. It is possible that as people age, they expend greater amounts of energy doing smaller amounts of work. This may not only add to discouragement but may make it difficult for older adults to consider breaking from routine and seek professional help. It is also possible that the older adults believe that because they are old, there is nothing to be done to help them.
Financials. Older adults often face limited funds. Increasing costs of medication and health care make it difficult for older adults to consider adding expenses by seeking help from professional helpers. Medicare covers only 50% of the cost of mental health care as opposed to the 80% covered on other medical expenses (Norris, Molinari, & Rosowsky, 1998), thus making mental health care much less affordable. The obvious solution to this barrier was provided by the participant who said that more money would “do it.” Additional solutions will be discussed in the implication sections of this chapter.

Availability. As discussed earlier, the ease of talking with friends and family makes them an attractive option for talking with older adults about emotional concerns with older adults. Not knowing where to find professional help is a barrier for older adults’ getting additional help if they feel they need it. There were no solutions provided by the participants for this barrier; however, potential solutions will be discussed in the following implications sections.

Mental and physical barriers are real and keep struggling older adults from receiving help. These barriers may be the one thing stopping older adults from having a higher quality of life.

Other Findings

Coping Attitude

An unexpected portion of the data centered on the attitude the older adults had in relation to their struggles. All 8 of the participants made statements of hope, encouragement, acceptance, and growth. These statements indicate that although helping
relationships are important, the independent attitude of the individual is also important. Switzer and colleagues (2006) conducted a qualitative study on older adults’ attitudes toward depression and found similar statements of individual responsibility for overcoming depressive feelings. Other studies found that a positive outlook mediated the relationship between physical illness and depression (Bazargan & Hamm-Baugh, 1995; Jang, Poon, & Martin, 2004; Nygren et al., 2004). It is possible that the statements made by the participants were representative of attitudes that mediate life events and symptoms of depression.

It was also noted by the interviewer that the majority of the participants minimized any negative feelings they had experienced. They attributed emotional challenges to being a part of life and something one deals with, learns from, and overcomes. This belief and acceptance of the challenges of life may also contribute to older adults’ not seeking professional help.

Surprisingly, there was only one participant in this study who spoke of faith as being a key to emotional health. Religion and faith have been found to be mediators of life events and depression (Chen, Cheal, McDonel-Herr, Zubritsky, & Levkoff, 2007) even within the CCSMHA population (Norton, Skoog, Franklin et al., 2006). Although all 8 participants were members of the LDS faith, there was not a clear tie to faith as a method of coping, except for one female participant. For this woman, faith was a large part of her ability to cope with the challenges that she faced, including the loss of many family members and physical disability.

In this study, several participants made more positive comments than did others.
The design of the project did not provide a way to compare the level of positive statements with the level of functioning; however, it would interesting to see whether those who are more positive in their general coping comments are better off emotionally or physically than others. Having a positive attitude would be classified with the client factors that account for 40% of therapeutic change according to the common factors research (Sprenkle & Blow, 2004).

*Interviewer Personal Reflections*

Richardson (1998) conceptualizes field notes into four categories: (a) observational, (b) methodological, (c) theoretical, and (d) personal. The first three categories have been incorporated into the body of this work. The last category is often more difficult for researchers to report; in fact, from the perspective of a novice researcher, everything in academic research, from the required writing style to the conceptualization of the project, encourages the removal of personal reactions. Qualitative research has challenged this removal of the researcher from the research and often includes personal reactions in the methods and the report.

The process of designing and conducting qualitative research with a population of older adults was a unique experience. I had experienced interviewing older adults during my work with the CCSMHA in the 2005-2006 structured interviews. The participants in this study had been visited frequently for structured interviews, and a qualitative interview for some researchers is more interesting and for others it is more difficult because they want defined response choices. For myself, as the interviewer, it was both of these. It was much more interesting to converse with the older adults, to hear about
their experiences, and to experience the freedom of not being compelled to follow a
structure. The increase in difficulty came through maintaining the focus of the narratives
without unduly influencing the responses of the participants.

These interviews became a delicate dance between following the participant and
gently guiding the focus. I learned quickly that it was best not to ask questions that open
the door for reminiscing about childhood experiences. This topic would often detract the
conversation for extended periods of time away from the current helping relationships
they may have. However, when the reminiscing was centered on the informal helper, I
learned to listen and follow the participant’s direction.

There were times that I found myself during interviews wondering how anything
the participant said was related to the research question categories. In the first interviews
like this, I found myself getting frustrated with myself and my seeming inability to keep
the participant focused. In one interview in particular, the participant and I spoke for 40
minutes with my wondering how any of this was going to be useful, when suddenly, the
conversation shifted and a whole line of themes was exposed. This was an exciting
interview, one that encouraged and prepared me to be more willing to go with the
participants’ narratives. By the final interview, I found myself being able to do this with
greater ease.

I also found myself wondering how telling these stories was impacting the
participants. The interview questions were about feelings that were negative and
challenging. I found myself wondering if talking about these feelings brought those
emotions back. I have had experience in my own personal and professional life where
thinking and talking about negative things fosters negative emotions. I wondered whether this was the case with the participants. Sometimes, I could not see the direct link between the question I asked and the participants' responses, and I wondered whether the stories the participants told was in some way soothing to them. I knew that reminiscing and life review was therapeutic and I wondered whether the participants were using these techniques during the interview. After formulating this hypothesis, I found myself much more willing to go with the participants' narratives.

I also found that I did not know how valuable the interviews were until I spent time transcribing them and the themes began to emerge. Comparing the emerging themes with the literature on social support and helping alliance created even more momentum as the results confirmed what was already known.

I enjoyed these interviews immensely. I only spoke with 8 older adults. Among these 8, there were stories of shenanigans, sacrifice, opportunity, adventure, love, work, and faith. I laughed with many of the participants, and cried with several. I found myself admiring their courage, sympathizing with their worries, and wondering whether their families appreciated the wealth of experience and knowledge that they have. I appreciated the time they took to speak with me and I treasure the personal things they shared.

During this study, I have had a small taste of qualitative research. I can see the importance of the individual’s perspectives, words, and narratives. This is what breathes life into research, and resurrects the person of both the researcher and participant.
Clinical Implications

The results of this study lead to several implications for professional helpers working with older adults. Several implications will be discussed, including (a) the events leading up to seeking help, (b) the meaning associated with seeking help, (c) old age as a culture, (d) building trust and confidence, (e) life review, (f) fostering the helping alliance, (g) creative delivery modalities, and (h) using informal helpers in the process of therapy.

First, the event leading up to seeking help should be considered. It is probable that before older adults ever enter the office of a professional helper there have been significant events that bring him or her to that place. This may be a tragic event or the older adults may have been compelled by children or family to seek help, which could be accompanied by a certain amount of reluctance on their part. They also may be experiencing mild cognitive impairment that may increase their anxiety and shame at seeking help. In whatever scenario, the professional helper needs to approach the situation with care and sensitivity.

Second, the older adults in this study desired to maintain their independence and, for them, seeking help from a professional helper may be contrary to that desire; for them, seeking help from a mental health professional may be distressing and accompanied by a feeling of failure. Feelings of depression might actually exacerbate these negative feelings, making it even more shameful to ask for help (Crossley & Rockett, 2005). The literature suggests that older adults’ perceptions of helpfulness make a difference. If an older adult is distressed about having to ask for help or is feeling weak
in some way, he or she may not be as receptive to help, which will increase the likelihood that his or her perception and, therefore, his or her experience will be negative in a spiraling downward cycle. The professional helper needs to be aware of the meaning that the older adult may place on asking for help or coming to therapy and be sensitive to his or her perceptions and experience.

Third, mental health professionals should consider the culture of older adults. It is possible to consider older adulthood a culture about which to be knowledgeable, and, as is generally the case with cultural competency, it is important for professional helpers to be aware that they may have knowledge about this culture, but they may not comprehend their clients’ unique experience within that culture (Hastings, 2002). Understanding was a factor that was central to the older adults’ being able to talk to others and to their perceptions of helpfulness. This factor includes older adults’ perceptions that professional counselors understand their experience and where they are coming from. Older adults may have a difficult time believing that a significantly younger professional helper may be able to understand them. Therefore, it would be important for the helper to focus on building a relationship with the older adult to the extent that the older adult feels heard and understood and not to assume expertise, even with older adults in general. Joining with an older adult may need additional time and attention compared to other groups.

Fourth, the results of this study indicate that older adults may not have confidence in the professional helper’s ability to help. The specific examples given by participants indicate that older adults may be entering the helping alliance with expectations of either information seeking or emotional support. Ascertaining their particular expectations
would be a step toward meeting their needs and building their confidence in professional helpers.

Fifth, based on the results of this study and the current literature, life review is a helpful process for older adults (Haight et al., 2003; Serrano et al., 2004). The participants in this study found someone’s listening and being available helpful to them. This implies that older adults may need additional time to reflect and share narratives that may have no clear connection to the current topic. This may be a significant shift from the professional helper’s typical style.

Sixth, the factors that typically are found to be important for the helping alliance are important with older adults as well. Professional helpers should focus on building these factors, understanding that with older adults, trust and confidence may take extra time to grow.

Seventh, mental health specialists should provide professional services in ways that are more acceptable for older adults. Group sessions may be appropriate because they might be more cost effective and provide a setting where the older adults may feel understood by people who have experienced similar life events. However, the lack of Medicare coverage for this type of therapy may hinder the usefulness of this approach. Professional helpers might also consider alternative places for sessions (e.g., in-home services, day centers) that might be more comfortable and inviting for older adults who are reluctant to seek help from mental health experts. Easy access and availability, similar to blood pressure checking sites, may make seeking help easier for older adults.

Finally, the usefulness of the older adult’s natural social support network and
informal helpers has long been established as therapeutic (Pearson, 1986). A formal helper can use this strength to foster and continue progress made in formal therapy sessions. Psychotherapy has been effective with older adults with depressive symptoms, although the process appears to happen at a slower pace (Lasser et al., 1998) and periodic visits across time may be expected (Newton & Lazarus, 1992). Inviting informal helpers to sessions may be appropriate to encourage changes made in session and extend therapeutic impact. This is a resource for therapeutic progress that has not been reported in literature and is mostly unused with older adults that do seek help from formal helpers.

Because older adults use informal helpers before turning to professional helpers, the results of this study can also be useful to educate family, friends, and clergy. Informal helpers often desire to be more useful to older adults who are seeking help. Educating helpers, both formal and informal, about the importance of understanding, listening, and collaboration rather than advice giving as most beneficial for depressed older adults can increase the helpfulness of these informal helping relationships and thus the older adults’ prognosis.

Policy Implications

This study has shown that informal care givers are central to the coping of older adults’ dealing with emotional concerns. For many years, policy makers have debated how to incorporate family helpers into policies for older adults; the results of this study suggest that older adults, themselves, know how they want things to be done (Harlton, Keating, & Fast, 1998). Asking about and supporting their ideas of what is helpful and
how to incorporate their family and friends into their care should be heard, respected, and implemented. To do otherwise is likely to lead to their not utilizing services that might otherwise be beneficial. Because the participants in this study mentioned these factors as being necessary and helpful to them, it may be appropriate to expand these factors to policy makers as well.

The barriers named by the participants and observed by the interviewer are areas that policy could possibly focus on improving. The review of literature showed the prevalence of depression among the elderly and the negative consequences for the individual, the caretakers, and society. Facilitating older adults’ receiving help will benefit everyone from the individual to society. Medicare includes some provisions for mental health care. Part A allows for a lifetime limit of 190 days for inpatient psychiatric stays and Part B pays for 50% of outpatient fees (U.S. Department of Health and Human Services, 2007). Part B includes 50% mental health coverage for psychologists and clinical social workers, but no other mental health professionals that older adults might have access to, such as marriage and family therapists (MFTs; U.S. Department of Health and Human Services, 2005). At the time of this writing, Medicare still did not include MFTs in their coverage (AAMFT, personal communication, May 31, 2007) despite clear evidence that older adults turn to family for help and, therefore, professionals with expertise in marital and family dynamics are logical choices for helping depressed older adults and their families. The limited reimbursement and narrow choices for providers are barriers to older adults’ receiving the help that they need, especially when considered along with the medical expenses older adults typically have. Medicare managed care
specialists add additional limitations on psychotherapy with patients with dementia, or when they consider treatment not medically necessary (Norris et al., 1998). Results of this study lend support to reform of Medicare in order to provide adequate care to older adults who may be reluctant to access traditional health care delivery systems.

The results of this study show that there are similarities between older and younger adults; however, there also are some differences that need to be addressed. There is still a stigma associated with help from mental health professionals or a cohort effect that prevents older adults from receiving the help that they may need, although this may be changing with each generation (Currin, Hayslip, Schneider, & Kook, 1998). Coupled with the stigma associated with professional help, there exists a pervasive prejudice against older adults. Ageism is a unique form of prejudice because most people anticipate joining the population of older adults (Packer & Chasteen, 2006). Ageism perpetuates the perspectives of being “too old” to change and places limitations on the older adult. Ageism is even exhibited by older adults themselves, and they may believe that sadness, infirmity, and cognitive decline are normal parts of aging. They may not believe that their situations can change and that they deserve and can have a better quality of life. Educating older adults about typical mental and physical health may be one way to continue to combat ageism. This education can be facilitated with aging and health care publications and mailings, health fairs, and community outreach programs directed toward the older adults themselves.

Older adults with symptoms of depression may experience hopelessness and cognitive decline (American Psychiatric Association, 2000), which decrease the
likelihood that the individual will be aware of their own condition and seek help. This study was unusual in that they all participants were able to identify family and friends that they approach when struggling. For older adults who are not as fortunate, this study suggests that trust, confidence, understanding, and established relationships are going to be key in reaching those individuals as well. This increases the importance of using others (e.g., family, friends, religious leaders, medical professionals, and service providers) as gatekeepers to identify and help older adults with symptoms of depression.

Educating informal helpers would be an important step in reaching this older population because they are often the gatekeepers between older adults and professional mental health experts (Karlin & Fuller, 2007). One participant in this study mentioned that her children would make sure she got the help she needed. Surveys show that children often do not recognize signs of depression in older adults or believe that older adults might benefit from mental health therapy (Zivian et al., 1994). Educating caregivers of the symptoms and treatment options for older adults with depression could occur through the popular press, seminars, and other forms of dissemination. It is possible that even after symptoms of depression are identified and professional help encouraged, that the older adult would refuse formal help. Thus, it could be useful to help informal helpers to understand what they can do (e.g., listening, understanding) to help alleviate the older adults' symptoms and distress.

The unique needs of older adults can be the focus of policy for professional organizations. The American Psychological Association (2004) published a series of guidelines for working with older adults. This document includes guidelines having to do
with attitudes, assessment, clinical issues, knowledge, education, and interventions. This is an effort to maximize the effectiveness of clinicians working with older adults and, if they have not done so yet, it would be appropriate for other organizations to follow suit. Although not within the scope of this study, a brief review of the topics of articles in the MFT literature and of workshops presented at annual conferences suggests that little is written or provided on the care of older adults within the context of family therapy. As the population of baby boomers reaches middle age and is facing their own older years' needs as well as providing care for their aging parents and relatives, the AAMFT might consider providing more information to MFTs regarding the special needs of care for this population.

The availability of services to older adults could also be improved through the incorporation of mental health services at nursing homes, assisted living centers, adult day care centers, senior citizen centers, and retirement communities. Extending services to these venues will facilitate the older adult's access to formal helpers (Newton & Lazarus, 1992). This will allow the professional helpers to come to the older adults rather than the reverse. Increasing the awareness of families and physicians that treat older adults to the benefits of psychotherapy for older adults with depression would also be appropriate.

Research Implications

The research implications are numerous. It would be appropriate to look in greater detail at the people within older adults' social networks that are perceived as potential
helpers to evaluate the similarities and differences between the older adult and the helper. Additional questions could be formulated that measure the perceived intensity of emotional problems and to whom older adults approach with them, possibly pinpointing the help seeking pyramid proposed by Willis and DePaulo (1991). Included in this could be additional specifics for what types of problems would encourage older adults to visit professional helpers. There was some indication that the older adults in this study felt that family concerns rather than personal concerns would cause them to seek help from professionals. This finding was not surprising given the heavy emphasis on the importance of the family within LDS doctrine and culture. Examining whether this finding is replicated in other samples of older adults is necessary before further conclusions can be drawn.

Results of qualitative studies often inform research on larger samples of a population. Results of this study suggest items for surveys that would further identify an array of factors (e.g., understanding, trust, caring), thus illuminating the experience of older adults who experience depression in terms of overcoming barriers associated with their seeking professional help. Perhaps a survey would be an appropriate way to identify situations that older adults would find distressing enough to overcome the barriers associated with seeking professional help.

Goldsmith and colleagues (2000) created a multidimensional scale to measure the helpfulness, support, and sensitivity of helpers. Their research found that adults between the ages of 18 and 66 reported similar factors to those identified in this study. Using this
scale with older populations in clinical settings and the community would help to confirm the findings in this study.

The experience of the 3 men in this study who had experience with professional helpers spawned additional questions of what specifically was and was not helpful for them. This study was not designed to examine these in great detail. A clinically-based research design with a population of older adults who had experienced therapy might produce additional information that would be useful for professional helpers. This might also incorporate an experimental design with a control group of older adults, using informed informal and professional helpers. This would add to the basic understanding that this study provides about the helping alliance and what is perceived as helpful and not helpful.

Finally, this study was retrospective in nature. It would be appropriate to conduct research with older adults who are currently experiencing or being treated for depression to confirm that the characteristics and tools found helpful hold true in prospective research.

Limitations

The design of this study included several limitations to the interpretation of results. The sample was small and purposive. The participants were selected for a prior study and were contacted again for participation in this study. They were selected based on a past history of depression, participation in prior interviews, and current availability, with the interviewer’s cognizance of potential participant burden with the parent
CCSMHA and scheduling conflicts. Not only was the sample small and purposive, the sample was also homogeneous, with all the participants being Caucasian, LDS, and living in a primarily rural community. This limits the generalizability of the findings to older adults in this White LDS community. Although appropriate for the current study, qualitative design could be replicated in other communities and with more diverse populations.

The study is also limited by language. Although similar words were used in each interview, it is possible that the participants interpreted those words differently. This is difficult to control in qualitative research because the interviewer tries not to instill her or his perspective into the process by defining the words for the participants. The interviewer for this study attempted to have the participants define the words they chose to use so that she could be sure she understood what they were saying; however, she was not consistent in asking for definitions. This is one area that most definitely could be improved. This limitation is difficult to address because language will always be a limitation, regardless of the research design. The interviewer could continue to ask for definitions to increase the overall understanding of the meaning the participant is placing on the words. Using interviewers of various ages might also provide additional insight as cohort effect on language might be present. Finally, researchers could further triangulate the data by conducting confirmatory interviews, asking the participants to review the researcher’s findings and to confirm or correct the findings related to their own intended meanings. Participant burden prevented the researcher from using this qualitative
research technique in this study, but further research could utilize the participants in this way as helpful co-researchers.

As has been discussed throughout this study, the questions and their impact on the mental set of the participants impacted the results. The interview questions became a limitation as they sometimes were too broad and too open-ended, allowing the participant to reflect far beyond the scope of the interview. This may have impacted how the participants answered ensuing questions. This becomes a limitation because participant bias may have been increased through the questions themselves. This limitation could be addressed through designing questions that ease into the topics yet are focused on the topic in a non-threatening way. This would shape the participants’ thinking toward the topical area, allowing their later responses to be more focused on the area of interest and less influenced by thoughts that emerged through answering previous questions. Although the researcher had experience with interviewing older adults, this factor was not anticipated; the purpose for this study required open questions and probing, thus more room for reflection on the part of participants that could influence responses to further questions. Although the current study included discussion with the research committee who are experienced in qualitative techniques and older adults, conducting several pilot interviews with a sample of depressed older adults would help to refine the interview process, potentially providing more reliable and fewer set-biased responses to questions.

Conclusion

This study contributes to the body of literature concerning social support, help-
seeking behavior, and helping alliance with older adults who have experienced depression. Older adults use primarily informal helpers—family and friends—when they struggle with emotional concerns. Identified informal helpers are those with whom the older adults have had lasting relationships; these relationships are also characterized by positive interactions that the older adult perceives as helpful. The helping alliance that informal helpers create through understanding, listening, and caring were perceived as helpful by older adults and can be used as models for professional helpers. Mental health professionals are not seen by older adults as obvious sources of help for emotional concerns. There was a lack of trust and confidence in the mental health professionals’ ability to help.

The sample and design created certain limitations; however, within those limitations, this study supports the literature and provides areas for future research. The implications of this study are to use the information presented in this work and create relationships where older adults with depressive symptoms and other concerns can receive the help necessary to facilitate the highest quality of life possible.
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APPENDICES
Appendix A

Introductory Letter
Mr. John Fulmer  
123 Memory Lane  
Logan, UT 84321

Dear Mr. Fulmer

Over the past 11 years we have enjoyed much success with the Cache County Study on Memory Health and Aging due to your support and participation. Across time the study has expanded its focus to include healthy aging and life events typical for older adults like yourself.

In 2004-2005 you participated in a smaller related study about how people adjust to life changes and cope with life events. This was a different type of interview where you were given the opportunity to express your experience and point of view openly with the interviewer. We would like to visit with you again and ask some follow-up questions for the portion of our study related to helping relationships.

In the next few weeks you will be contacted by Ms. Allison Rencher who will explain the purpose and answer any questions that you may have. If you are interested in participating, Ms. Rencher will arrange a time and place to conduct the interview at your convenience. The interview will take approximately 1 ½ hours.

If you have any questions, please feel free to call our local number, 435-797-8108. We know you are busy, however, the information you provide will contribute to our understanding of the experience of older adults like yourself. We very much appreciate your help and look forward to talking with you soon.

Sincerely,

Maria C Norton, Ph.D.  
Project Director  
USU Center for Epidemiologic Studies
Appendix B

Informed Consent and IRB Approval Letter
Introduction/ Purpose:
Dr. Maria C. Norton, Dr. Thorana S. Nelson, and Ms. Allison Rencher in the Department of Family, Consumer, and Human Development at Utah State University (USU) are conducting a research study to find out more about older adults’ perceptions and experience seeking help from others. We are interested in your unique experience with social relationships and how they have either been helpful or unhelpful to you during times of stress and emotional struggle. You have been invited to take part because a couple years ago you participated in the Quality of Life Study in 2004-2005, under the direction of Dr. Maria C. Norton and Dr. Kathy Piercy. For this follow-up study we will be interviewing approximately 11 older adults (75 years and older) that reside in Cache County.

Procedures:
If you agree to be in this research study, the interviewer will meet with you in your home or a private place of your choosing. After the signing of the informed consent, the interviewer will ask you 6 short questions to check your memory and concentration. These will be followed by questions designed for open discussion and response from you, with the interviewer asking for more detail when appropriate. This study consists of only one interview that will take approximately 1 and ½ hours, depending on your responses.

Your information will be labeled with a unique ID number. The interview will be audio taped and kept secure in a locked bag during transportation and a locked cabinet at the university. Following the interview, the recording will be transcribed into written form, after which the recording will be destroyed. The transcript will be labeled with your unique ID number and all identifying information in the written transcript will be deleted to maintain confidentiality.

Your participation in this interview is not deemed to be consent to participate in any future interviews of the Cache County Study on Memory Health and Aging or ancillary studies. If/when you are contacted again they
will explain the procedure and you will be given the opportunity to refuse at that point.

**Confidentiality:**
Research records will be kept confidential as required by federal and state law. Only the investigators and authorized staff will have access to the data which will be kept in a locked file cabinet on the campus of USU. After transcription, the tapes with be destroyed and personal, identifiable information will be deleted in the written transcript to protect your identity and maintain confidentiality. The written transcript will be kept with the other transcripts from the Quality of Life Study and kept indefinitely in a locked room on campus for future research purposes.

There is one exception to confidentiality. In the event that the interviewer feels that you or someone else is in serious danger or harm (i.e. elder abuse, neglect) we have an obligation to notify the authorities.

**Risks:**
The risks in participating in this interview are minimal. People may feel uncomfortable or embarrassed with some of the questions and may become tired from the interview. There is also the possibility of people gaining access to personal information; however, this is limited by the security measures in place at the University to protect your information.

**Benefits:**
There may not be a direct benefit to you at this time; however, benefits of this study are for future older adults that may experience life events and stress similar to yours. The investigators will learn more about your unique experience in considering or asking others for help and this may help clergy, physicians, and mental health professionals more fully understand the experience of older adults with similar life challenges and prepare to help them in appropriate ways.

**Explanation & Offer to Answer Questions:**
The interviewer, Allison Rencher, has explained this research study to you and answered any questions you may have had. If you have other questions or research-related problems, you may reach Dr. Maria C. Norton at (435) 797-8108. You may also contact the IRB (Institutional Review Board for
the protection of human participants at USU) at (435) 797-1821 for further information on your rights as a research participant.

**Voluntary Participation:**
Participation in this research study is completely voluntary. You may refuse to participate, refuse to answer any question, or withdraw at any time without consequence or loss of benefits to you or any member of your family at USU.

**IRB Approval Statement:**
The IRB (Institutional Review Board for the protection of human participants at USU) has reviewed and approved this research study. If you have any questions, concerns about your rights, or feel you have been harmed in any way by this study, you may contact the IRB at (435) 797-1821.

**Copy of consent:**
You have been given two copies of this Informed Consent. Please sign both copies and retain one copy for your files.

**Investigator Statement:**
“I certify that the research study has been explained to the individual, by me or my research staff, and that the individual understands the nature and purpose, the possible risks and benefits associated with taking part in this research study. Any questions that have been raised have been answered.”

Dr. Maria C. Norton  
Principal Investigator  
(435) 797-1599

Dr. Thorana S. Nelson  
Principal Investigator  
(435) 797-7431

Allison Rencher, Research Assistant  
(435) 797-7430
**Signature of Participant:**
By signing below, I indicate that:

- I have read this consent form and have had an opportunity to ask questions and am satisfied with the answers.
- I understand that my information will be kept confidential as required by law.
- I am voluntarily participating in this study and that I may refuse at any time.

<table>
<thead>
<tr>
<th>Participant’s Name</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interviewer’s Name</td>
<td>Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>
TO: Maria Norton
   Allison Rencher

FROM: True M. Rubal-Fox, IRB Administrator

SUBJECT: Characteristics of Helping Relationships for Emotional Distress: Older Adults' Perspectives

Your proposal has been reviewed by the Institutional Review Board and is approved under expedite procedure #7.

There is no more than minimal risk to the subjects.

This approval applies only to the proposal currently on file for the period of one year. If your study extends beyond this approval period, you must contact this office to request an annual review of this research. Any change affecting human subjects must be approved by the Board prior to implementation. Injuries or any unanticipated problems involving risk to subjects or to others must be reported immediately to the Chair of the Institutional Review Board.

Prior to involving human subjects, properly executed informed consent must be obtained from each subject or from an authorized representative, and documentation of informed consent must be kept on file for at least three years after the project ends. Each subject must be furnished with a copy of the informed consent document for their personal records.

The research activities listed below are expedited from IRB review based on the Department of Health and Human Services (DHHS) regulations for the protection of human research subjects, 45 CFR Part 46, as amended to include provisions of the Federal Policy for the Protection of Human Subjects, November 9, 1998.

7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.
Appendix C

Semistructured Interview
Date ______ Start Time ______

Demographics

Gender: M F
Age: ______
Are you currently: Married Widowed Divorced Never Been Married
Some people have good days and bad days, how would you say you are feeling today:
Excellent Good Fair Poor Very Poor

6 Item Screener (Callahan et al., 2002)

I am going to ask you some questions to check your memory and concentration. There are three words on this card that I would like you to remember. Please say the words aloud while you read them, then I will take the card away and have you repeat all three words. (hand the participant the card)

Record the number of tries (up to 3) to remember the words.

<table>
<thead>
<tr>
<th>Apple</th>
<th>Table</th>
<th>Penny</th>
</tr>
</thead>
</table>

Remember the three words because later I will ask you to repeat them.

<table>
<thead>
<tr>
<th>What year is it?</th>
<th>Correct</th>
<th>Incorrect</th>
<th>Refused</th>
</tr>
</thead>
<tbody>
<tr>
<td>What month is it?</td>
<td>Correct</td>
<td>Incorrect</td>
<td>Refused</td>
</tr>
<tr>
<td>What day of the week is it?</td>
<td>Correct</td>
<td>Incorrect</td>
<td>Refused</td>
</tr>
<tr>
<td>What were the 3 words I asked you to remember?</td>
<td>Apple</td>
<td>Correct</td>
<td>Incorrect</td>
</tr>
<tr>
<td></td>
<td>Table</td>
<td>Correct</td>
<td>Incorrect</td>
</tr>
<tr>
<td></td>
<td>Penny</td>
<td>Correct</td>
<td>Incorrect</td>
</tr>
</tbody>
</table>

Score: out of 6

RECORD CONTEXTUAL FACTORS OR ANY SENSORY IMPAIRMENTS

If score is equal to or less than 3 proceed to the interview asking introductory questions. If score is greater than 3 proceed to the full qualitative interview.
Qualitative Interview
Quality of Life Study, Follow Up

I’d like to thank you for your willingness to meet with me today. To begin I’d like to ask you to tell me about yourself.

As you look at your life what is a challenge that you feel that you succeed at facing?

1. In the past 10-15 years has there been a time when you found yourself struggling with your feelings, maybe feeling down, blue, sad, or confused?

2. Whom did you talk to about your feelings? You do not have to give me a person’s name, their relationship to you will be enough.
   a. List all persons, if more than three ask:
   b. Of these people who were the most helpful?

3. What was it about ________ that led you to believe you could talk to them?
   a. Possible prompts or probes:
      i. Personality factors of the help-giver
      ii. Age and duration of relationship
      iii. Past experience
      iv. Confidence in the relationship
      v. Trust

4. Tell me about your experience talking with them?
   a. Possible prompts or probes:
      i. When?
      ii. Where?
      iii. How?

5. What reaction did you get from ________?

6. What did ________ DO that you felt was helpful?
   a. Possible prompts or probes:
      i. Advice
      ii. Listened
      iii. Gave another perspective
      iv. Made it seem normal
      v. Brainstormed for possible solutions

7. How did feel when talking with ________?
   a. Possible prompts or probes:
      i. Understood
ii. Respected  
iii. Cared for/Supported  
iv. Accepted  
v. Safe  

b. If more than one person listed in #3: repeat 4-8 for each individual named.

8. What about currently? Who do you talk to about your feelings now?

9. What did __________ DO that was not helpful?

10. Was there anyone that you talked to that was not helpful?

11. Is there anyone you wouldn’t talk to about this?  
What has kept you from telling another person? 

a. Possible probes or prompts:  
   i. Didn’t want to be a bother  
   ii. Felt judged/worried about what they would say  
   iii. Didn’t want to admit that I need help/ could do it on my own  
   iv. Didn’t think it was a big deal  
   v. Didn’t have anyone/isolated  
   vi. Past experience

12. There are many types of people that we talk to about our feelings. Would you consider talking to someone like a psychologist, counselor, or therapist? Why or why not?

13. Under what circumstances might you be willing to talk to a psychologist, counselor or therapist?

14. What do you think are some barriers that keep older adults like yourself from getting the help they might need with emotional concerns?

15. What could be done to remove some of these barriers?

If there was one thing that you would like others to know about how to succeed with life’s challenges what would that be?

I would like to thank you for your time and your thoughts. Is there any feedback on the interview or questions that you have?

End Time_________