UNDERSTANDING MENTAL HEALTH EXPERIENCES OF ADULTS 50 YEARS AND OLDER LIVING IN THE SIMILKAMEEN: A QUALITATIVE STUDY USING PHOTOVOICE

by

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Abstract

Background: Mental health is a major health concern in Canada. As the population ages, adults aged 50 and over will represent a larger proportion of Canadians with mental health concerns. This population is also increasing in size in rural areas; yet, there is a paucity of literature regarding the experiences of older adults with mental health concerns in rural areas.

Research Design: This thesis addressed: What are the experiences of adults aged 50 and over with a mental health concern in a rural community in British Columbia? Community A was a rural town in the southern interior of BC. The thesis used critical social theory and interpretive description and data were collected using photovoice. Cameras were provided to eight participants aged 50 and over who had experienced a mental health concern and who lived in Community A. They photographed meaningful parts of their lives and shared photos in individual interviews. Interviews were conducted using a semi-structured interview guide.

Findings: Five themes were identified using constant comparison. For the first theme, mental wellbeing, participants unveiled eight facets of wellbeing: personal qualities, hope, spirituality and gratitude, nature, routine and productivity, medication, substance use, family, and isolation. For the second theme, losses, participants described how they were affected by the loss of abilities, friends, family, lifestyles, and thoughts regarding death. The third theme, stigma, was experienced internally and publicly. The fourth theme was services and supports. Participants identified barriers to support, as well as negative and positive experiences when they accessed services, and the importance of informal supports. Finally, participants’ mental health was influenced by their environment (home, finances, community).

Discussion: These themes existed in tension with one another. While participants had ways of caring for their wellbeing, these strategies were inhibited by stigma. Stigma was the underlying
factor for many of the complexities uncovered. Isolation, poverty, and access to services were all related to stigmatizing experiences. Additionally, participants’ personal histories often influenced their coping strategies, and their ability to reflect on their mental health needs. Themes informed recommendations made for policy development, education, health services delivery, and future research.
Lay Summary

Mental health concerns are increasing for adults aged 50 and over, particularly due to an aging population. This population is also increasing in rural areas, with little information about their experiences with mental health concerns. This thesis sought to understand the experiences of adults aged 50 and over who have mental health concerns and who live in a rural area. Adults in this age group experience significant transitions affecting mental health (e.g., chronic conditions, retirement). Eight participants with a mental health concern took part in this study. Participants were given cameras, and used them to take pictures that documented meaningful parts of their lives. They then selected their most significant photos. These photos were discussed in individual interviews. Participants met with the researchers to review the results and agreed with the themes identified. Key themes included: care for wellbeing, stigma, losses, their environment, and services and supports.
Preface

This thesis is original, unpublished work by the graduate student Lauren Airth. Supervisors, Nelly Oelke and Carolyn Szostak, as well as supervisory committee members, Shirley Chau and Kathy Rush, provided direction for editing, formatting, and wording of this thesis. The graduate student identified the methodological design under the direction of her supervisors. The graduate student contacted potential participants, led educational meetings, conducted interviews, analyzed data, and led the member checking meeting. This study was granted approval by the University of British Columbia Okanagan’s Behavioural Research Ethics Board and Interior Health Authority’s Research Ethics Board [H18-00652].
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Finally, I would like to thank the loved ones in my life for supporting my academic pursuits. I know my goals are not always easy to understand.

Thank you to the Canadian Nurses Foundation as well, for the generous scholarship that has helped fund my studies.
Dedication

This thesis is dedicated to my Gran and Papa, who believed that home was synonymous with the beautiful simplicity of rural, northern living.
Chapter 1

Introduction

This chapter introduces this thesis’ study topic, which asks the question: What are the experiences of adults aged 50 and over who live with a mental health concern in Community A, British Columbia (BC)? The term, older adults, refers to people who are 50 years of age and over. Internationally, there is a growing understanding of how mental health affects one’s ability to thrive. Nationally, the Mental Health Commission of Canada (MHCC) acknowledges the integral part mental health plays in holistic wellbeing evident in the publication of numerous reports and strategies (MHCC 2012; MHCC 2015). There is some understanding, yet an under-representation, of older adults’ mental health in the literature. The global population of people 50 years of age and over is expected to almost double, and in Canada, similar growth is expected (Smetanin et al., 2011; World Health Organization [WHO], 2016). It is apparent there is much to understand about the mental health experiences of this growing population. Some influential factors for the mental health of this age group include common experiences such as retirement, new diagnoses, and changes in income (Cotter & Gonzalez, 2009; Hao, 2008; Pollard, Ray, & Haase, 2014; Rubio-Aranda et al., 2012). Moreover, older adults with mental health concerns in rural communities live with unique factors that affect their wellbeing (Kulig & Williams, 2011). Some of these factors include the population sizes of their communities, socioeconomic status, and social supports (Kulig & Williams, 2011). Therefore, this study seeks to address the knowledge gap around the experiences of older adults living with mental health concerns in rural areas, specifically in the southern interior of BC, Canada.
**Background**

**Mental Health**

Presently, 20% of Canadians live with a diagnosable mental health disorder (Government of British Columbia, 2017; Smetanin, et al., 2011). This major health concern fits with international trends; mental health disorders are currently the leading cause of disability around the world (WHO, 2014). It is estimated that “the total cost to Canada’s economy incurred by mental health problems and illnesses is currently well over $50 billion annually, or nearly $1,400 for every person living in Canada in 2016.” (MHCC, 2017, p. 16). The MHCC has adopted the WHO’s definition of mental health problems, which describes such disorders as a cluster of symptoms causing impairment related to one’s thoughts, feelings, behaviours, and relationships (MHCC, 2012; WHO, 2017). Whether one has a diagnosis or not, mental health fluctuates between illness and wellness for all people. The MHCC (2012) also uses the WHO’s (2017) definition of mental health, “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to their community” (p. x). Mental health can be influenced by the environment, personal resilience, biology, lifestyle, and other factors (Pollard et al., 2014).

Although many of the causes of mental distress are beyond personal control, 40% of Canadians living with a mental health disorder report feeling stigmatized because of their illness (MHCC, 2015). Stigma can be experienced in discriminatory behaviors, such as bullying, through stereotypes presented in the media, language used by the public, or through the internalization of negative beliefs about one’s diagnosis, amongst other factors (Corrigan, Druss, & Perlick, 2014). The number of Canadians living with poor mental health is expected to grow.
by 2041, at which point it is conceivable that more people will experience discrimination related to their mental health (MHCC, 2016).

Regarding the increase of Canadians with mental health concerns, Smetanin et al. (2011) state,

…the numbers of Canadians with a major mental illness is expected to increase by 31.1% within the next 30 years and will eventually affect over 8.9 million Canadians annually, accounting for approximately 20.5% of the total population of Canada. This increase is primarily driven by Canada’s population growth, wherein the number of Canadians is expected to increase from 34.5 million in 2011 to 43.4 million in 2041, a 26.4% increase (p. 124)

The MHCC (2012) has identified six strategic directions to address the mental health needs of Canadians: “promotion and prevention, recovery and rights, access to services, disparities and diversity, First Nations, Inuit and Métis, and leadership and collaboration” (p. 4-5). To pursue these strategic directions, the MHCC (2012) called for increased opportunities to collaborate with people experiencing mental health concerns. The MHCC (2015) followed through with these recommendations, as seen in their review of mental health indicators for Canadians. The rating given to each indicator was composed of various stakeholders’ opinions, including those who have experienced a mental health concern (MHCC, 2015).

There is a need for research that addresses the impact of mental health concerns on the wellbeing of different age groups. As people age, different age groups experience vastly different life changes with a variety of ways of coping and understanding these transitions that depend upon their development, health, life experience, and other factors. Further research related to age and mental health could lead physicians to assess patients in a holistic manner, where the
importance of both mental and physical wellbeing is acknowledged in an age appropriate context.

**Older Adults’ Mental Health**

Adults aged 50 and over currently represent 38% of Canadians, and by 2041, due to the predicted growth of this population, they are expected to be most affected by mental health concerns of all age groups in Canada (Smetanin et al., 2011; Statistics Canada, 2016). The complexity of aging further complicates how older adults live with their mental health concerns (MHCC, 2012); mental health concerns in this age group are compounded by the number of remarkable changes that occur during this time of life. One of the most common transitions is retirement; by age 60, more than 30% of people are no longer working full time (Hao, 2008). Leaving the workforce can allow retirees to pursue other leisure activities or spend more time with friends and family. However, the loss of regular social interaction and productivity that workplaces provide and have been shown to improve psychological wellbeing and decrease the incidence of mental illness (e.g. depression, anxiety), may be detrimental (Hao, 2008). Besides retirement, people in this stage of life face higher rates of chronic illness, financial loss, and functional declines and associated loss of independence (Cotter & Gonzalez, 2009; Pollard et al., 2014; Rubio-Aranda et al., 2012). These factors have a direct correlation with the development of mental illness (Varcarolis, 2017). For older adults who develop depression or a different form of cognitive decline, there is often a false belief that these health concerns are a normal part of ageing (Muir-Cochrane, O’Kane, Barkway, Oster, & Fuller, 2014; Sanders, Fitzgerald, & Bratteli, 2008).

By 2050, the world population of adults over 60 years of age will grow from 12% to 22% (WHO, 2016). Similarly, in Canada, this same population is expected to increase from 20.4% to
30.3% (Smetanin et al., 2011). It is critical to develop a health care system that can support their mental health. The need for research is highlighted by the fact that older adults’ risk of developing a mental illness increases to 40% by the time they reach 90 years of age (Smetanin et al., 2011). Additionally, deaths by suicide in the older adult population in Canada - 10.4 per 100,000 - have remained consistent for several years, and men over 85 years of age represent the most suicides – 29 per 100,000 (MHCC, 2015, p. 54). Because these rates have not decreased, the MHCC (2015) has flagged older adult suicides as a high priority to address. Presently, society and the healthcare system hold ageist beliefs that result in older adults being given minimal information about their physical and mental health conditions and whose recoveries are under-estimated (Varcarolis, 2017). This may, at least in part, explain why older adults feel negatively about accessing mental health services despite the positive outcomes that these services have been demonstrated to produce (Corrigan et al., 2014; Loch, 2014). To alter the course for older adults’ mental health, exploration of how their environment (living situations, access to resources, relationships, etc.) impacts their ideas, beliefs, and feelings needs to be conducted.

**Rural Older Adults’ Mental Health**

Presently, 19% of Canadians are living in rural areas (Statistics Canada, 2015). Rural communities are defined as “the population living in towns and municipalities outside the commuting zone of larger urban centres (i.e., centres with a population of 10,000 or more)” (Du Plessis, Beshiri, Bollman & Clemenson, 2002, p. 8). In rural Canada, 16.4% of the population is made up of seniors; however, by 2025, it is expected that this percentage will increase to 18.6% (Moazzami, 2015). Within BC, the population of older adults has increased to the greatest extent
in rural communities (Moazzami, 2015). Unfortunately, older adults in these areas face worse health outcomes than their urban counterparts (Kulig & Williams, 2011).

Rural areas are under-serviced and difficult to staff, which means specialist services, such as psychiatrists or centres for older adults’ mental health, are often unavailable (Brenes, Danhauer, Lyles, Hogan & Miller, 2015; Sanders et al., 2008). Ultimately, this means any older adult who needs and is interested in accessing mental health services may need to travel a considerable distance. This creates another issue, as access to transportation for many older people living in rural areas is challenging (Brenes et al., 2015; Muir-Cochrane et al., 2014; Sanders et al., 2008). Furthermore, the widely held rural value of self-sufficiency conflicts with the idea of seeking assistance to obtain transport, which may delay or prevent treatment (Kitchen Andren et al., 2013; Muir-Cochrane et al., 2014).

Since there are few specialist resources, older adults become reliant on their general practitioner (GP) or nurse practitioner (NP) to screen for mental health concerns and provide adequate support, regardless of their training (Bocker, Glasser, Nielsen, & Weidenbacher-Hoper, 2012; Kitchen Andren et al., 2013; Muir-Cochrane et al., 2014). Although this can be a typical expectation of GPs or NPs, when there are no specialists to refer older adults to for the specific type of care they require, this level of care is added to the GPs’ or NPs’ workload. They may not have the same tools specialists have access to or the ability to schedule appointments long enough to meet their patients’ mental health needs (Bocker et al., 2012; Muir-Cochrane et al., 2014). In cases where mental health services are provided in rural areas, some older adults are too embarrassed to be seen attending appointments, as they do not want to be stigmatized (Brenes et al., 2015; Kitchen Andren et al., 2013; Muir-Cochrane et al., 2014; Stewart, Jameson, & Curtin, 2015). Therefore, services provided by general community agencies, such as churches
or seniors’ centres, can be more successful in providing support (Brenes et al., 2015; Kitchen and Ren et al., 2013).

In addition to the experience of stigma, older adults in rural areas often have lower education levels than their urban counterparts (Dautovich, Shoji, Stripling, & Dzierzewski, 2014; Kaufman, Scogin, Burgio, Northland, & Ford, 2006). Rubio-Aranda et al. (2012) found that rural older adults with lower education levels were more likely to experience depression. Also, the mislabeling or disregard of mental health concerns may also be associated with the system’s failure to provide materials at an appropriate literacy level, when considering the lower education levels in many rural towns (Dautovich et al., 2014; Kaufman et al., 2006). It is crucial that rural older adults’ perspectives of mental health be explored so appropriate services can be established and communities can provide better support. Furthermore, raising the awareness of mental health issues can also contribute to decreasing stigma.

**Study Location**

This research study was conducted in a small town in the Southern Interior of BC that will be referred to as Community A. This community is surrounded by rivers, lakes, and mountains. Many of its residents frequently access a larger town nearby for healthcare appointments, which is approximately 110 kilometers away and takes about an hour and a half to drive to in a car (Google Maps, 2018a). Sometimes residents need to travel even further to a larger city, to access specialist services, which is approximately 160 kilometers away (Google Maps, 2018b). In a reliable vehicle in good weather, this trip takes a minimum of two hours. However, during colder seasons, when snow and ice affects the road conditions, these drives can take two to three times longer. In some extreme cases, such as blizzards or rock slides, roads in and out of Community A will be completely closed.
In 2016, the population of Community A was just under 3000, an increase of 6.4% from 2011 (Statistics Canada, 2017). Of this rural population, slightly fewer than 1600 people were 50 years of age or older making up 55% of Community A’s population (Statistics Canada, 2017). Based on data for all age groups in Community A from 2011, 8% of residents identified as Indigenous, there were no new immigrant populations, and 1.7% of residents were part of a visible minority group (Provincial Health Services Authority, 2019). These demographics align with Kulig and Williams’ (2011) discussion, which describes rural Canadian towns as having a smaller proportion of immigrant populations. The general population had an employment rate of 49.7%, and 82% of the population qualified as low income (Statistics Canada, 2017). The most common industries for workers were sales or service industries, the trades, and different management roles (Statistics Canada, 2017). In terms of available healthcare services, this town has a community health centre that offered nursing services and a hospital (Interior Health, 2018). Previously, there was a drop-in mental health centre, which had been closed; recently, a mental health clubhouse opened as a replacement but it requires referrals from health care providers which can be a barrier compared to drop-in services (Interior Health, 2018).

The mental health of rural older adults can be difficult to maintain for many reasons. Geographic isolation, financial difficulties, and a lack of services play a role in this situation. Additionally, the stigma many rural older adults feel when they try to address their mental health acts as a significant barrier. These factors and more are apparent in Community A, especially with the large percentage of older adults living there. Additionally, the very high poverty level magnifies the difficulties faced by older adults living in this community. The combination of these demographics make Community A an ideal place to investigate how rural older adults’ lives are affected by their mental health concerns.
Significance of Study and Outcomes

It is anticipated that this study will contribute to the understanding of the mental health experiences of rural adults aged 50 and over living in the Southern Interior of BC. It has provided members of a vulnerable population with the opportunity to share their experiences and give voice to their perspectives as community members with a mental health concern through photovoice and the planning of knowledge translation (KT) activities. As results are disseminated, it may continue to contribute to feelings of empowerment for participants and others who identify with the participant profile. Through KT activities, there should be a decrease in misinformation and increase in understanding and awareness of the mental health experiences of this population. The research has the potential to contribute to a reduction in stigma as well. Ultimately, this can lead to better outcomes for individuals with mental health concerns as well as communities overall.

Finally, this study has the potential to contribute to service providers’ informed decision-making for the care of adults aged 50 and over with mental health concerns in rural communities. As the size of this population continues to grow, it is critical to understand the kind of care they need to improve their quality of life and decrease the burden on the healthcare system (Smetanin et al., 2011).

Summary

This chapter has outlined the major concepts for this study’s research question: What are the experiences of adults aged 50 and over who live with a mental health concern in Community A, BC? Rural older adults’ mental health has been acknowledged nationally and globally as an area in need of more in-depth exploration. This chapter has provided an overview of what will be discussed throughout this thesis, to address this knowledge gap. Chapter 2 provides a more
robust look into the literature that discusses the current beliefs, views, and trends regarding rural older adults with mental health concerns, which has informed the research question. Following the literature review, Chapter 3 discusses the philosophical underpinnings and methodology of this study, outlines the methods, and reviews ethical considerations. Chapter 4 describes the results of this research study. Finally, Chapter 5 discusses how the results of this study contribute to the current literature, and recommendations for policy, health services delivery, education, and future research in this area of study are provided.
Chapter 2

Literature Review

This chapter provides an in-depth exploration of the current literature related to the mental health of adults aged 50 and over living in rural areas. The literature reveals many common influences of rural older adults’ mental health, including: stigma, personal beliefs and attitudes, social isolation and loneliness, geographic isolation and transportation, financial stress and poverty, service access, and misinformation. Additionally, supportive factors are discussed. For this chapter, and throughout the study, the terms specialty or specialized refer to service providers who concentrate their study and practice in mental health

Search Strategy

A literature search was conducted to examine the mental health experiences of rural adults aged 50 and over. Searches were conducted in CINAHL, Medline, PsycINFO and Google Scholar online databases, using database specific search terms as well as field search terms with Boolean operators AND and OR. Controlled headings in the online databases were variations of rural, older adult, and mental health. Field search terms were used due to the specificity of the term older adults as well as mental health to garner more accurate results (see Appendix A for a full list of search strings used in each database).

Inclusion criteria were English language, peer-reviewed articles published between 2006 and 2017. This timeframe was chosen due to the changing field of mental health and relevance of current beliefs and practices. Exclusion criteria included books, dissertations, and articles that examined the impact of medical disorders on mental health. Articles relating to very specific cultures or ethno-cultural groups and countries with vastly different economies, cultures, and health systems (such as articles focusing on rural villages in China) were also excluded to ensure
applicability to the population of Community A. Such literature would not be as generalizable to the rural older adults in this study, especially taking into account the demographics of Community A. Additionally, this literature was excluded to better understand the current state of mental health for rural older adults in geographical areas and cultures comparable to Community A. This meant considering health systems and the meaning of rural context. According to Kulig and Williams (2011), rural towns’ cultures and social norms are considerably diverse; the experiences of rural residents, whether or not they immigrated to Canada, will vary between communities.

Discipline-based database searches resulted in 68 articles for review. Google Scholar was used to facilitate the inclusion of all applicable literature in case there was pertinent literature not included in the discipline-based databases. Google Scholar led to an additional 19 articles. Of these 87 articles, two duplicates were removed. After an initial screening and review of abstracts, there were 12 articles included for a full text review. In addition, there were two reports and two articles found outside of this literature review, through discussion with the research team, that were included due to their relevance to the study. This brought the final number of articles and reports reviewed to 16.

**Mental Health Related Experiences**

The purpose of this literature review was to gain a greater understanding of the mental health experiences of adults aged 50 and over in rural communities. Whether or not a person is living with a mental health concern will influence their paradigm; those living without a mental health concern may not understand certain perspectives that are inherent to those who struggle with their mental health. This means many systems and communities operate from a mindset that may not consider key factors for those with mental health concerns. The taken for granted norms
of life without a mental health concern can be exposed through the experiences of those living with mental health concerns. Moreover, those in rural communities can perceive socio-cultural norms considerably differently than their urban counterparts. Therefore, it is crucial to explore the subjective experiences of older adults with mental health concerns in rural communities to gain a better understanding of this population.

**Stigma**

Stigma was a common theme in the articles reviewed. The Merriam-Webster (2018) dictionary defines stigma as “a mark of shame or discredit,” (p.1) which in this context refers to the negative perceptions surrounding mental health. More specifically, the terms *social stigma* and *self-stigma* are widely used. Social stigma is the way people discriminate against those with mental health disorders through words, behaviours, or prejudicial attitudes (Corrigan et al., 2014). Self-stigma is when those living with a mental health disorder internalize these negative messages and perceive themselves in a negative manner as a result (Corrigan et al., 2014).

Brenes et al. (2015) outlined the consequences of stigmatizing attitudes:

Stigma (as well as discomfort in talking about personal problems) is associated with decreased use of mental health care among older adults, and lack of belief in the efficacy of treatment has been associated with decreased mental health care among older adults with severe anxiety or depression (p. 1175)

Sirey and associates (2001, as cited in Stewart et al., 2015) also noted that stigma predicted the cessation of treatment in older adults with depression, despite it having no impact on treatment discontinuation with younger people. In contrast, endorsement of less stigmatizing beliefs about mental health services and positive views regarding psychiatric help were associated with earlier access to services (Stewart et al., 2015).
Stigma was more prevalent in smaller communities, and even worse for older adults and men in these locations (Kitchen Andren et al., 2013; Oelke et al., 2016). Hayslip, Maiden, Thomison, and Temple (2010) noted that rural older adults were less open to accessing mental health services and had less of an understanding of what mental health was. These negative views toward mental health service use were associated with greater stigma (Dautovich et al., 2014). Because of these negative feelings, rural older adults preferred to see GPs for treatment of their mental health concerns (Dautovich et al., 2014). This population wanted to remain anonymous and maintain mental wellness privately. A lack of anonymity in rural communities was another barrier to accessing mental health services (Kitchen Andren et al., 2013; Muir-Cochrane et al., 2014; Stewart et al., 2015). Brenes et al. (2015) noted that personal beliefs about help seeking were the most common barrier to achieving wellness for rural older adults. Interestingly, Panazzola and Leipert (2013) also found that when rural older adults overheard urban adults share negative opinions about rural living, it increased stigma for the rural older adults.

**Personal Beliefs and Attitudes**

Aside from mental health-related stigma per se, the evidence indicates rural older adults see the need for treatment as a sign of weakness because it contradicts the rural value of stoicism (Muir-Cochrane et al., 2014). According to the Merriam-Webster (2017) dictionary, to be stoic is to be “indifferent to pleasure or pain”. Many rural older adults value the independence associated with this way of being (Kitchen Andren et al., 2013). In rural communities, stoicism has been the traditional way of coping with mental health concerns and it is difficult for community members to challenge this status quo (Kaufman et al., 2006). Self and social stigma alongside these values can result in a sense of failure or shame for rural older adults who seek assistance for mental
health (Kitchen Andren et al., 2013; Brenes et al. (2015) reported that 40% of respondents experienced embarrassment and worry over what others would think when they accessed mental health services (see also Judd et al., 2006 as cited in Muir-Cochrane et al., 2014). In contrast, those who had sought help for mental health concerns previously or who scored higher on an openness to experiences survey perceived fewer barriers and were more open to seeking and receiving help (Hayslip et al., 2010).

Negative self-concept also impacted the ability to maintain mental wellbeing; many participants had grown up in an era where self-care was interpreted as selfish (Panazzola & Leipert, 2013). Some Indigenous participants touched on the lasting impact of residential schools while other participants reflected on being under-valued in different contexts (e.g., family discord, being bullied in school), which caused them to believe they were not worthy of care (Panazzola & Leipert, 2013). Adults who felt negatively about themselves in this manner were less likely to engage in positive activities, which resulted in their feeling progressively worse (Scogin, Morthland, DiNapoli, LaRocca & Chaplin, 2016). This emotional distress was compounded by feelings of hopelessness that further prevented older adults from pursuing positive or redeeming activities (Scogin et al., 2016). Other traumatic experiences and overall stress also contributed to poor mental health (Oelke et al., 2016; Rubio-Aranda et al., 2012).

Social Isolation and Loneliness

The connection between social isolation and maintaining mental wellbeing is highly apparent in the literature. Many older adults specifically identified loneliness as a major concern (Evans et al., 2017; Oelke et al., 2016; Panazzola & Leipert, 2013; Rubio-Aranda et al., 2012). Rubio-Aranda and colleagues (2012) identified that the “protector effect of social relations in depression is weaker in the elderly who feel alone independently of the influence of other
sociodemographic variables.” (p. 12). This intense feeling of loneliness can be increased by retirement, children leaving the home, and/or the loss of a spouse either through death, divorce or the transition into assisted living (Panazzola & Leipert, 2013; Rubio-Aranda et al., 2012). Loss of a spouse was significant for heterosexual women, especially as women have a longer life expectancy than men (Panazzola & Leipert, 2013).

In rural communities, there were simply not enough volunteers or organizations to address these social needs (Evans et al., 2017; Oelke et al., 2016). Additionally, this diminished the likelihood of older adults with a mental health concern having access to advocates who could assist them in the navigation of a complex health system (Evans et al., 2017). Often older adults did not have a driver’s license or family nearby to address these concerns (Panazzola & Leipert, 2013). Factors such as businesses shutting down, poor infrastructure, and inadequate resources in rural areas further reduced rural older adults’ sense of wellbeing and increased their sense of isolation (Panazzola & Leipert, 2013). Studies showed that the increase in social isolation and loneliness was positively associated with higher rates of mortality (Benavidez, 2017).

**Geographic Isolation and Transportation**

On a larger scale, geographic isolation also had a major impact on rural older adults’ wellbeing. Specifically, Kaufman et al. (2006) and Muir-Cochrane et al. (2014) discussed the complications of access and use of transport in these rural areas. According to Bocker et al. (2012), 67% of older adults in their study were travelling more than 50 kilometers to access mental health services that could meet their needs. This is common in rural areas where there is a lack of specialized mental health care services (Bocker et al., 2012; Brenes et al., 2015). When home care was offered, it was common for navigation issues to prevent out-of-town specialists from reaching clients due to poor street markings (Kaufman et al., 2006). Furthermore, many
rural areas did not have public transit or had transit that was inaccessible for older adults due to mobility concerns (Evans et al., 2017). Because of this isolation, lack of services and transportation issues, older adults are frequently unable to access much needed care (Crowther, Scogin & Johnson Norton, 2010; DiNapoli, Pierpaoli, Shah, Yang & Scogin, 2017; Kaufman et al., 2006).

**Financial Stress and Poverty**

Financial stress was frequently cited as a barrier for rural older adults who tried to access mental health services or who needed money to maintain their mental health in other ways (e.g., gym memberships, aromatherapy, musical instruments) (Stewart et al., 2015). According to the MHCC (2017), in BC, there are higher unemployment rates and lower average earnings in rural communities. Rural older adults also had fewer financial resources and benefits, and less insurance coverage than their urban counterparts (Dautovich et al., 2014; Kitchen Andren et al., 2013).

This financial disparity meant that in the rare case where mental health specialist services did exist in rural areas, it was questionable how much of the population could afford to use them, if they were not charged for the service such as when they were offered through a health authority (Hayslip et al., 2010; Kaufman et al., 2006). Oelke et al. (2016) found similar results in a Canadian study; the cost of specialist services was still a barrier, even with the public health coverage in BC. Services such as counselling, art therapy, music therapy, or other forms of treatment are most often privately funded, which is why they contribute to financial strain, especially for older adults on a fixed income. Bocker et al. (2012) found that 67% of respondents were unable to access mental health services due to the associated expenses they would incur, which aligns with other authors’ findings (see Brenes et al., 2015; DiNapoli et al., 2017). These
associated expenses went beyond the cost of the services themselves to include transit costs (e.g., gas, parking), the need for overnight accommodation, or items therapists recommended their patients purchase.

Kaufman et al. (2006) also noted how a lack of essential items for daily quality of life prevented people from focusing on maintaining mental wellbeing. This has put many people in the position of having to choose either food, shelter, or medication. Economic instability in many rural communities has led to this overarching effect on mental health (Panazzola & Leipert, 2013). Impoverished living conditions have also made it difficult to offer low barrier treatment, such as in-home cognitive behavioral therapy (CBT) (Kaufman et al., 2006). In these cases, poverty can result in unresolved structural issues, and providers can deem a property too unsafe to enter (Kaufman et al., 2006).

Service Access

As discussed, many rural communities lack specialized mental health services (Crowther et al., 2010). In America, 55% of areas with a mental health professional shortage were designated as rural (Health Resources and Services Administration, 2013, as cited in Dautovich et al., 2014). The practical issue of access to treatment options worsened when the focus was narrowed to older adults’ mental health (Bocker et al., 2012; Crowther et al., 2010; Dautovich et al., 2014; Kaufman et al., 2006; Muir-Cochrane et al., 2014). There was a concerning lack of trained professionals in this area (National Ageing Research Institute, 2009 as cited in Muir-Cochrane et al., 2014; Kitchen Andren et al., 2013). Ultimately, this shifted the burden of care back to the primary health care sector (Bocker et al., 2012).

The most common way of coping with mental health concerns, possibly due to a lack of options, was an increased reliance on GPs, including the expectation of diagnosis and treatment
(Bocker et al., 2012; Stewart et al., 2015). Family doctors were mentioned numerous times as a gatekeeper to treatment and resources. Older adults felt comfortable and favoured addressing mental health concerns with a GP in many cases (Kitchen Andren et al., 2013). Bocker and associates (2012) found that 80% of their respondents who were 50 years of age and over felt there was enough information from their family doctor in combination with community supports to manage symptoms of depression. Most respondents in Kitchen Andren et al.’s study (2013) felt people should speak to their GP as soon as clinical depression arose, although there was a group that encouraged discussion with members of one’s social circle first given their accessibility and trustworthiness.

For some older adults, there was a fear of and mistrust in the health system (Muir-Cochrane et al., 2014). Bocker and colleagues (2012) helped to explain some of this fear and mistrust, as they found that less than 40% of general health care providers felt physicians spent enough time with older adults experiencing depression. Furthermore, over a third of rural respondents in one survey reported that they avoided going to the doctor when they thought something was wrong, physically or mentally (Spleen, Lengerich, & Vanderpool, 2014). Once an older adult with a mental health concern gained access to a physician in a rural area, which was challenging in and of itself, older adults then worked through what was described by more than a third of them as complicated pathways (Brenes et al., 2015).

The complicated pathway to a specialist was pursued by people seeking mental health services, despite only half of older adults, who, in one study, felt resources were adequately set up to meet their mental health needs (Bocker et al., 2012). Complicated referral pathways started with a combination of long waitlists, poor availability, and poor communication (Brenes et al., 2015; Evans et al., 2017; Oelke et al., 2016;). Amongst these issues existed onerous paperwork,
services operating over-capacity, long distances to specialty clinicians, and the separation of offices for physical health from offices for mental health (Brenes et al., 2015; Hayslip et al., 2010; Muir-Cochrane et al., 2014; Oelke et al., 2016).

This separation of physical and mental health treatment acted as an additional barrier for older adults with comorbidities that fell in each category and those who experienced stigma (Muir-Cochrane et al., 2014). In addition to the use of family doctors for mental health concerns, many study participants advocated for the use of multi-disciplinary clinics where specialist mental health services and GPs could be in one office (Kitchen Andren et al., 2013). Stigma was heightened when it was obvious someone was going to an office purely for mental health needs (Muir-Cochrane et al., 2014).

The lack of collaboration between agencies, health care providers, and community members was also identified as a problem (Muir-Cochrane et al., 2014; Oelke et al., 2016). Once older adults overcame denial and/or fear of a mental illness and chose to navigate this path, they reported a lack of perceived seriousness from the health care providers they encountered in the end (Bocker et al., 2012). These inefficient referral pathways complicated treatment, which resulted in people being unsure of how to access treatment in the first place (Muir-Cochrane et al., 2014).

**Misinformation Surrounding Older Adult Mental Health**

During healthcare interactions, it was common for the mental health concerns of older adults to be dismissed or misdiagnosed (Bocker et al., 2012; Crowther et al., 2010; Kaufman et al., 2006). The National Ageing Research Institute (2009, as cited in Muir-Cochrane et al., 2014) stated “ageist behavior is common in medical settings, including a tendency to patronize and listen less to the views of older patients, order fewer diagnostic tests and attribute symptoms to
age, rather than treatable conditions.” (p. 764). The lack of training in older adults’ mental health led to providers’ assumptions that clients’ symptoms were a normal part of the ageing process; clinicians failed to promote quality of life in these instances through diagnosis and treatment of challenging symptoms (Dautovich et al., 2014; DiNapoli et al., 2017; Muir-Cochrane et al., 2014). In these common situations, diagnoses, such as anxiety, were found to be confused with medical conditions or what was deemed a “reasonable” fear (DiNapoli et al., 2017). This phenomenon was also seen with GPs who prioritized physical health assessments over mental status exams during office visits, which underscored the belief that older adults’ mental health was irrelevant (Muir-Cochrane et al., 2014). This tendency to disregard mental health, ultimately, led to more problems for clients (Muir-Cochrane et al., 2014).

Rural older adults also did not receive adequate education regarding their own mental health. This was evidenced, in part, by the low use of services in comparison with the prevalence of symptoms and diagnoses (Bocker et al., 2012; Crowther et al., 2010). Some of the mental health concerns described were poor stress management and the belief that late life depression was normal (Bocker et al., 2012; Kitchen Andren et al., 2013). Bocker et al. (2012) found that 87% of respondents reported their health as good or better than good but only 10% reported not having a chronic condition, which may translate to a lack of understanding of wellbeing. Limited knowledge about what constitutes a mental health concern acted as another barrier to timely access for much needed treatment (DiNapoli et al., 2017; Muir-Cochrane et al., 2014).

There also seemed to be a lack of clarity on how to best address mental health concerns. Brenes et al. (2015) and Dautovich et al. (2014) found that respondents did not want to speak to a mental health professional, as they did not trust outsiders or believe that treatment would work. Related to this, participants in another study were torn between seeking professional help as soon
as depression appeared versus turning to friends and family first (Kitchen Andren et al., 2013). Finally, rural older adults with religious convictions were more likely to process their mental health concerns by engaging in religious practices than discuss them with a health care provider (Kaufman et al., 2006).

**Supportive Factors**

In addition to the difficulties faced by rural older adults with mental health concerns, supportive factors were identified. Both spiritual and non-spiritual older adults reported that clergy were helpful supports for counselling and referrals to mental health assistance (Bocker et al., 2012; Kitchen Andren et al., 2013). In addition to church workers, older adults noted that basic services in a community – such as grocery stores, pharmacies, banks, and seniors’ programs – had a positive impact on their mental health (Panazzola & Leipert, 2013). Social and community supports, personal characteristics, and the resources of respondents influenced this belief (Panazzola & Leipert, 2013). Brenes et al. (2015) also found that adults 80 years of age and older reported fewer barriers than those between 60 to 79 years of age. More positive attitudes toward mental health treatment were associated with personal characteristics of coping and resilience, involvement in hobbies, a sense of belonging, and openness to new experiences (Hayslip et al., 2010; Panazzola & Leipert, 2013). In this instance, Panazzola and Leipert (2013) used the definition of resilience given by Tugade, Fredrickson and Barrett (2004), which is “the ability to bounce back from negative events by using positive emotions to cope” (p. 1).

**Summary**

Rural older adults encounter numerous difficulties on a day-to-day basis as they strive to maintain their mental wellbeing. The exploration of this topic leads to the identification of several pertinent barriers: stigma, personal beliefs and attitudes, loneliness, geographic isolation,
transportation difficulties, and a lack of financial stability. There are many issues under the topic of service alone, including: difficulty accessing care, complicated referral pathways, difficulty accessing specialists, and misinformation regarding older adult mental health. Researchers also identify helpful factors that mitigate these hardships, such as: community-based supports who older adults can confide in, the personal characteristics of older adults (e.g., resilience, openness to new experiences), and services a community can offer in general.

Statistics show that 20% of people aged 55 and over suffer from a mental health concern, but it is likely that there are more older adults with mental health concerns who have been misdiagnosed or who have not accessed treatment (Department of Health and Human Services, 2001, as cited in Kaufman et al., 2006). Muir-Cochrane et al. (2014) described how misdiagnoses or a failure to recognize when older adults struggled with their mental health resulted in increased and longer hospital admissions as well as earlier admissions to residential facilities. These implications may also be affected by the lower education levels found in many rural towns, as resources may not be accessible for all older adults (Dautovich et al., 2014; Kaufman et al., 2006).

These issues are more critical in a community like Community A, where the proportion of older adults is much greater than the Canadian average in rural communities. Furthermore, the proportion of the population in the low-income bracket is staggeringly larger than provincial and national averages. This results in a preoccupation with meeting basic needs – even, at times, having to decide between food, shelter or medication. In these instances, mental health concerns do not take priority and there are not enough social services to assist with improving quality of life. All of this is compounded by social isolation.
It is clear from this review that living with a mental health concern in a rural community as an older adult can be a difficult experience; one that is impacted by both internal and external factors. However, there is a paucity in the literature regarding rural older adults’ experiences; rather, much of the literature focuses on service delivery. Without understanding their experiences, changes made will continue to act on the assumptions of outsiders and not on the experiences of the population. Therefore, this study seeks to understand what it is like to live with a mental health condition in a rural British Columbian town by asking the question: What is the mental health experience of adults 50 years of age and over living in Community A, in BC who have experienced a mental health concern?
Chapter 3

Methodology

As the previous chapter highlighted, mental health is affected by countless elements in rural communities. To appropriately address the needs of older adults living in rural areas, it is essential to understand their unique experiences to inform leaders in healthcare, community stakeholders, and community members. This chapter outlines the goals, philosophical underpinnings, and methods for the study. Additionally, it introduces members of the research team.

Context of the Study

The aim of this study was to explore, through the photovoice method, the mental health experiences of adults 50 years of age and over who had mental health concerns and who were living in Community A, BC and the surrounding area. This thesis emerged from a larger study that had three objectives. The objectives were: 1) to understand the mental health-related experiences (e.g., stigma, rural living) of these individuals; 2) to ensure this marginalized population had control in the documentation and sharing of their mental health-related experiences through visuals and interviews; and 3) to develop, in conjunction with participants, appropriate KT approaches so they could share their photographs and stories. Objectives 1 and 2 were addressed in this thesis. However, parts of the third objective were addressed throughout this thesis (see Figure 1 for how this thesis fits within the larger study).

This study was conducted as thesis work in the Master of Science in Nursing program at the University of British Columbia, Okanagan (UBCO) campus. The larger study began with a focus group in which a subset of the participants identified prominent themes related to their experiences with mental health concerns in a rural community. These themes were: giving or
receiving help, a lack of services and supports, and aging. Aging also had three subthemes: what is next, illness, and chronic pain. Demographic information was also gathered at this focus group (see Appendix B for the demographic questionnaire used). Six days after the focus group, a photovoice education session was held, which marked the beginning of this thesis study’s components (see Appendix C for an outline of what occurred during this session, and Appendix D for the photovoice training pamphlet given to participants). The themes identified during the focus group provided a framework for participants to use as a guide during the gathering of photographs. The data collection for this thesis involved participants’ photo taking and individual interviews. The thesis also included analysis of the data collected. Once preliminary themes were identified, a member checking meeting was held with participants. The larger study then continued to determine and conduct KT activities.
The Research Team

Lauren Airth is the Master of Science in Nursing student who was the lead researcher for the photovoice component of the study. She is also a Registered Nurse who works in mental health. The graduate student’s research supervisors were a part of the research team; Dr. Nelly Oelke works in the School of Nursing at UBCO, and Dr. Carolyn Szostak works in the Department of Psychology at UBCO. Sharon Evans is the president of the South Okanagan and Similkameen Mental Wellness Society, a retired Registered Psychiatric Nurse, and has participated in previous photovoice studies. Karen Fulton is a Registered Nurse in Community A working in mental health. Finally, Nola Mensch, a community member, joined the research team to provide representation of community members’ perspectives in the research processes. Ms. Mensch is an older adult living with a mental health concern in Community A and is well connected in the community.

Theory and Methodology

Philosophical Underpinnings

Critical theory provided the philosophical underpinnings for this research. Ontologically, this theory focuses upon the inherent power imbalances in society that need to be addressed, which in this case was the power mentally well people typically have over people with a mental health concern (Weaver & Olson, 2006). A key part of critical social theory is the idea that each person should be able to determine or define their own experiences outside of traditional authority figures’ definitions (Zou & Trueba, 2002). Historically, critical social theorists have focused on the oppressive effects of privileged groups who strive to maintain a society in which they continue to benefit and thrive while the needs of the marginalized are overlooked (Zou & Trueba, 2002). In the context of this research study, critical social theory helped the researchers
identify each participant’s experience as they defined it and uncovered how underlying power structures have minimized the needs of this group.

Additionally, critical theorists describe knowledge created as inherently political (Weaver & Olson, 2006). There has been an increase in the number of images and messages people receive daily through social media, radio, television, print media and more, all of which spread messages that are generally crafted by privileged groups (Zou & Trueba, 2002). Through this constant stream of messaging, political agendas and stereotypes have the potential to become embedded in each person’s narrative and become taken for granted. However, when knowledge is created collectively through the exploration of marginalized groups’ experiences, the meta-narrative has the power to change direction in their favour (Zou & Trueba, 2002). In this study, taken for granted truths have been clarified by participants and the themes that emerged from this study will have a role to play in the politics of the community through community stakeholders, care providers, and community members.

Epistemologically, this theory emphasizes reflection and action on knowledge created, which places importance on both the process and outcomes (Weaver & Olson, 2006). It is essential to act on the knowledge created when working as a critical theorist to counteract the “cultural pedagogy” (Zou & Trueba, 2002, p. 95) established by society’s elite. This was pursued through the methodology and data collection methods.

**Methodological Design**

Interpretive description methodology was used for this study. Interpretive description’s epistemological underpinnings define reality as complex and subjective, and this methodology requires knowledge to be developed from multiple realities in data collection, like the praxis emphasized by critical theory (Thorne, Kirkham, & O’Flynn-Magee, 2004). Ontologically, the
knowledge created must address a clinical need or assumption, which in conjunction with critical theory, can address inequities and create change (Thorne et al., 2004). Interpretive description was developed specifically for health care and will be used to guide stakeholders’ (such as health care providers, advocates, community service operators, etc.) decision-making regarding the complicated reality of rural older adults’ mental health (Thorne et al., 2004).

Interpretive description also lays the foundation for political action. For this study, knowledge was generated to empower and care for rural adults aged 50 and over who have experienced a mental health concern. The concept of empowerment was used as it is understood in relation to critical social theory; that is, the abstract idea of power exists for certain groups based on historical hierarchical structures, and the idea of empowering a historically oppressed group requires an abstract transference of this power (Kuokkanen & Leino-Kilpi, 2000). To support this process, participants became partners in the research process, as outlined throughout this chapter.

Based on the epistemological and ontological foundations discussed above, interpretive description was a suitable methodology to address the research objectives of understanding, emancipation, and awareness. Consistent with the underpinnings of critical theory, interpretive description provided recommendations for change using the political knowledge created (Weaver & Olson, 2006). Critical theory strengthened the use of interpretive description by giving a political, emancipatory foundation to the findings and recommendations.

Data collection worked to emancipate participants through photovoice, which maintained meaningful coherence with study goals, paradigm and methodology (Tracy, 2010). Photovoice is a method that helps participants “identify, represent and enhance their community” (Wang, 1999, p. 185) through photographs and stories, while acknowledging multiple, subjective realities
(Plunkett, Leipert & Ray, 2013; Wang & Burris, 1997). This method aligns with both critical theory and interpretive description as it operates from the concept of the knower and the known being inseparable (Thorne et al., 2004; Wang, 1999; Wang & Burris, 1997; Weaver & Olson, 2006; Zitomer & Goodwin, 2014). Additionally, it aligns with the underpinnings of the chosen theory and methodology as it works to address the assumption of inequity for rural older adults (Wang, 1999; Wang & Burris, 1997).

**Reflexivity**

Reflexivity is an integral part of qualitative research, as the researcher acts as the tool for interpretation and their context, beliefs, and experiences can influence how findings are explained (Cruz & Higginbottom, 2013). The graduate student engaged in reflexivity through discussions with study team members and introspection (e.g., journaling, counselling). She identified as a heterosexual, cisgender, white Canadian woman. She also identified as a spiritual person with a Christian lens and as a feminist who had experienced depression and anxiety. The graduate student had several relatives who lived as older adults in a rural area of Northern BC, but the graduate student was raised in the southern interior of BC. Additionally, she had lived abroad for two years in Zambia and New Zealand.

The graduate student recognized her privilege in being able to travel, work and pursue post-secondary education, identifying as a middle-class citizen. As a white, heterosexual, cisgender woman, the graduate student also recognized the opportunities afforded to her because she operated in a society that catered to these identities. During the course of conducting research for her thesis, the graduate student worked as a Registered Nurse in acute care mental health, a clinical assistant teaching mental health to undergraduate nursing students at UBCO, a counsellor at UBCO, and a research intern for the larger study this thesis was conducted within.
The graduate student was also aware of how these roles were associated with privilege, and how her various titles and other privileges could influence the power dynamics in her research.

Prior to beginning the research, the graduate student explored her values and beliefs regarding rural older adults’ mental health. She valued transparency about mental health concerns and advocacy for the improvement of resources. She believed living with a mental health concern was a multi-faceted experience. However, in the context of rural older adults, the graduate student believed this population led quiet lives and coped with mental health concerns through medication or seeing their GP. She believed social assistance programs were available for older adults who chose to engage with these systems to seek support for their needs. However, she also believed it was more difficult to access resources in rural areas. As an RN, the graduate student had become accustomed to interacting with older adults with mental health concerns on a professional level in which her own emotions or life, generally, did not intermingle.

**Objectives**

The first objective of this study was to understand the participants’ mental health experiences through photovoice. A focus group was conducted to generate potential topics for taking photographs. Russinova, Mizock, and Bloch (2018) found that by using photovoice they were able to explore in-depth aspects of stigma for people living with serious mental illness. Understanding was enhanced by captions the participants wrote or dictated to accompany their photographs and through individual interviews (Wang, 1999; Wang & Burris, 1997).

The second objective was to engage in a process with this population that was marginalized – due to the “over-lapping stigma” (MacCourt, 2008, p. 6) of both ageism and having a mental health concern – to document and share their mental health experiences through
photographs and captions. This second objective addressed the foundations of critical theory by having a population that is marginalized address their experience of social inequity using their own voice (Weaver & Olson, 2006). Ensuring power was placed in the participants’ hands to determine what images and words represented their stories meant that knowledge created was an accurate representation of life as an older adult with a mental health concern in this rural area. Additionally, Becker, Reiser, Lambert, and Covello (2014) discuss how photovoice can work to “decrease the existing power differential between professionals and persons who seek mental health care and to genuinely engage the voices and expertise of these individuals” (p. 189). This unique data collection strategy allowed participants to express their stories in a way they had not had the opportunity to before, which proved to be a fulfilling, educational, and powerful experience.

Ethics: Risks, Strategies and Benefits

Photovoice, as with all qualitative research, comes with inherent risk because of its intimate approach. To mitigate these risks, there was ongoing consultation with the graduate student’s supervisors, thesis committee, and study team members. This study only began once it was approved by the UBCO Behavioural Research Ethics Board (REB) and Interior Health Authority’s REB; ethics approval was received June 13th, 2018 [H18-00652].

One possible risk was that participants in the study could have their mental health concern(s) exposed through photo presentations, which could be harmful due to stigma and/or discrimination. Another risk was that photographs could be reused inappropriately or for profit, and participants and researchers risked legal implications if permission was not received from photo subjects. There was also potential for participants to disagree with researchers about the use of their photographs. To mitigate these risks, researchers used a detailed consent process.
Participants determined how their stories were told and chose which photographs would be part of the data analysis. Consent forms were provided that indicated that the photographs were to be used for the research project only (see Appendices E and F for these consent forms). During interviews, participants also signed forms which gave the researchers permission to collect photographs not selected by the participants for analysis, but that were still part of the study (see Appendix G). Further, at the member checking meeting, participants signed a release form that described possible uses of their selected photographs. This was a very detailed consent form, wherein participants documented their release of specific photographs for specific uses and outlined how they wanted to be given credit for these photographs (see Appendix H for this photo release document). Also, participants have kept the rights to their photographs to prevent misuse (Creighton et al., 2017).

Furthermore, education was given in the information session for participants on privacy law, to protect against intrusion, exposure, false representation, and unethical profit (Wang & Redwood-Jones, 2001). During this meeting, participants were provided with separate consent forms for photo subjects, so if they took a picture of someone else or their property, they were able to obtain their consent and use the photo (see Appendix I for this form). These forms were provided to address any privacy concerns potential photo subjects had.

Additionally, knowledge created from this study was political and participants engaged in intense discussion with others and explored their own beliefs (Weaver & Olson, 2006). There was also potential for re-traumatization throughout the photovoice process (Creighton et al., 2017). The potential for this was discussed in the initial meeting with participants and the graduate student encouraged participants to identify a plan for self-care during the data collection process and specifically on the day of each person’s scheduled interview. A list of trained mental
health professionals and mental health resources was provided to participants during individual interviews to mitigate these risks (see Appendix J for the list of resources handed out) (Creighton et al., 2017).

There have also been direct benefits to participants in this study. They have gained or expanded upon photography skills and were gifted the cameras at the end of the study to thank them for their participation. Additionally, participants were given an honorarium for sharing their expertise and time. For the first cohort, this honorarium totaled 100 dollars, and for the second cohort, the honorarium totaled 90 dollars. The first cohort received an extra 10 dollars for their participation in the focus group. Otherwise, all participants received 20 dollars for the photovoice education session, 40 dollars for their individual interview, and 30 dollars for the member checking meeting. Moreover, participants reported therapeutic benefits as a result of participating in this study. In conclusion, the findings from this study may lead to better care and support for rural older adults with mental health concerns, which can decrease the burden on the health care system as this population grows, as well as increase awareness.

Methods

Sampling and Recruitment

As recommended by Thorne et al. (2004) and to address the research question, purposive sampling was used to identify eight participants. “To allow for practical ease and in-depth discussion, seven to ten people is an ideal group size” for photovoice (Wang, 1999, p. 187). Additionally, for qualitative research, smaller sample sizes are suggested to promote the rich description of findings (Thorne et al., 2004). The study was open to people 50 years of age or older who self-identified as having mental health concerns, regardless of whether they had been diagnosed with one. The research team sought out participants of any gender, sexual identity, or
ethnicity. All participants lived in Community A or the immediate surrounding rural area. We sought maximum variation in our participants to contribute to rich descriptions of this population’s experience, to increase understanding of these experiences from a variety of perspectives, and to increase transferability (Sandelowski, 1995).

Recruitment began following the confirmation of the research team and ethics approval. HCPs used the recruitment script and permission to contact form to discuss the study with older adults who had mental health concerns and who the HCPs thought may be interested (see Appendix K for the recruitment script and Appendix L for the first cohort’s permission to contact form). Generally these older adults were clients of the HCPs; however, it was made clear that the older adults’ decision to participate in the study would not impact their care. Nine interested people were identified in this manner; they signed the permission to contact forms and these were forwarded to the graduate student. The graduate student contacted each of these people, eight of whom confirmed interest in attending the focus group. One person did not answer or return calls from the graduate student and did not join the study. One to two days before the focus group (see Figure 2 for a timeline of the study), two people informed the graduate student they did not want to participate based on the fear of their mental health concerns being exposed. Another person had confirmed their interest and participation but did not make it to the focus group and did not return phone calls following the session. The focus group began with five participants, and four chose to continue with the study, with the other person declining to continue based on scheduling conflicts.

This attrition prompted the use of other recruitment strategies to increase the sample size. Recruitment posters were placed in the library, grocery store, family doctors’ office, and
Figure 2. Study Timeline. This figure details significant dates throughout the study.

Community A Family Services meeting area (see Appendix M for the poster used for recruitment). The graduate student also reached out to workers from a Community Services Society, an organization that ran the seniors’ mental health community clubhouse in Community A. This led to the recruitment of two more participants (see Appendix N for the version of the permission to contact form used with the second cohort to reflect differences in time commitments). Another potential participant was identified by a HCP and one other person contacted the graduate student stating they received the student’s information from another participant and was interested in being a part of the study. Unfortunately, the latter person was unable to participate due to their schedule.

The research team proceeded with booking another photovoice education meeting for the second set of three confirmed participants (see Appendix O for an outline of what occurred at this meeting). On the day of the meeting, one of the participants brought along a friend who was
interested in participating and who met the criteria, bringing the total number of participants in the second round of recruitment to four. These four participants completed data collection and individual interviews, resulting in a total of eight participants. Due to logistical issues, recruitment did not continue until data saturation occurred, when no new information can be found (Morse, 1995). However, themes identified in early interviews aligned with themes that arose in later interviews, demonstrating common experiences.

**Data Collection and Quality Strategies**

To begin the study, an information session with participants was held to introduce project goals, community partners, and timelines; for the first cohort this session occurred in conjunction with the focus group (an outline of the meetings can be found in Appendix C for the first cohort and Appendix O for the second cohort). The second cohort’s information session occurred in conjunction with the photovoice education session. Participants signed consent forms during the information sessions (see Appendix E for the first cohort’s consent forms and Appendix F for the second cohort’s consent forms). All participants were given training regarding the use of cameras, ethical implications of photo-taking, and how to store data during the photovoice education session (Becker et al., 2014, see Appendix D for the document given to participants at this meeting). All sessions occurred in private meeting rooms at Community A’s General Hospital; the privacy of these rooms and the presence of research team members facilitated rapport building (Becker et al., 2014).

At the photovoice education session, each participant was given a digital camera and time was allowed for participants to become familiar with the equipment and to practice taking multiple photographs and using different angles. At this session, it was suggested participants take no more than 100 photographs during data collection to simplify the selection process for
themselves. Participants were provided with journals and encouraged to keep notes as they took photographs, so they could reflect on their thought processes related to the photographs during the one-on-one interviews. Participants also signed up for individual interview times from two to five weeks after the information session depending on participants’ preferences and researcher/participant availability. Subsequently, participants spent two to five weeks taking photographs that represented their experiences as an older adult with a mental health concern in Community A, being mindful of privacy laws (Wang & Redwood-Jones, 2001). Some participants took photographs sporadically between the photovoice education session and their individual interview, while others took photographs right up until the day before their interview.

Once participants finished taking their photographs, they were asked to select five to 10 of their most meaningful and significant photographs to share in their individual interview. This was explained in the initial meeting and reinforced during an interview reminder phone call two to three days prior to each person’s interview. During this photo selection process, they were also asked to write captions to accompany the photographs. Interviews were completed by the graduate student and took place in private meeting rooms at Community A’s General Hospital. Participants were informed they would have up to two hours to discuss their chosen photographs. Ultimately, the recorded audio portion of interviews lasted between 45 minutes to an hour and 54 minutes, with the average interview lasting one hour and 14 minutes (n = 8). Additionally, field notes were taken by the graduate student.

The interviews followed a semi-structured interview guide (see Appendix P for the full interview guide). The interview guide was based on the “SHOWeD” method for photovoice discussed by Wang and Redwood-Jones (2001) which asks: “What do you See here? What is really Happening? How does this relate to Our lives? Why does this problem or strength exist?
What can we Do about it?” (p. 562). The questions in the interview guide helped the interviewer gain insight into the experiences of participants and addressed critical theory and interpretive description by asking how participants thought action should be taken on an issue (Thorne et al., 2004; Weaver & Olson, 2006). Photographs were accompanied by captions written or dictated by the participants to provide another layer of understanding and another set of data to analyze. Similar to other qualitative approaches, critical social theory was addressed in that participants were the ones creating their own narrative, rather than relying on people or groups who historically hold power to dictate participants’ needs (Zou & Trueba, 2002). Additionally, exploration of how to meet those needs is a critical part of interpretive description (Thorne et al., 2004). At the end of each interview, participants signed forms which gave the researchers permission to keep copies of photographs they did not select for the interview process (see Appendix G for this permission form).

**Data Analysis**

First, all audio recordings and field notes were transcribed verbatim. Transcription was done by the graduate student (n = 5) and a confidential transcription service (n = 3). Possible identifiers were also omitted from these transcripts. Then, all transcripts, field notes, and captions were imported into NVivo11™. Due to compatibility issues in NVivo 11 software, it was not possible to upload the photographs for analysis; thus, they were analyzed manually.

The graduate student manually analyzed the photographs numerous times, considering the context of the interviews, and determining major and minor themes for each photo. The data were analyzed inductively using constant comparison to remain congruent with paradigmatic and methodological foundations (Dye, Schatz, Rosenberg & Coleman, 2000). Themes were analyzed and coded accordingly as they emerged (Dye et al., 2000). Categories evolved as new themes
arose through analysis of the individual interviews, photographs, captions, and field notes. By analyzing data in this manner, categories were made to fit the data rather than having data forced into pre-determined categories; this also placed the determination of themes in the participants’ control through their interviews and photographs (Dye et al., 2000).

The themes emerged through an initial analysis, and the data underwent four refinements through reading and re-reading of the data by the graduate student (Dye et al., 2000). The initial themes were re-explored through NVivo11™ and were coded and re-coded as different themes emerged or became clearer. This also involved the re-organization of themes. Additionally, themes underwent refinement with a final round of analysis to determine the final themes. Gender differences were explored throughout the data analysis; previous research has shown that different genders have different mental health experiences (Becker et al., 2014; Creighton et al., 2017; Russinova et al., 2018).

**Rigour**

Rigour for this study was established using Lincoln and Guba’s (1985) evaluative criteria of the trustworthiness of a qualitative study. The first criterion was credibility, which reflects the extent to which the knowledge created is believable (Lincoln & Guba, 1985). This was established by maintaining an audit trail throughout the research process, in the form of detailed and timely field notes and checking in with the research team (Tracy, 2010). Credibility was also established through the software package used to store data, NVivo11™; this software allowed the graduate student to organize data into categories as they emerged. Additionally, experts in qualitative research and mental health care workers were present on the team. Triangulation was also pursued through the perspectives of the research team and analysis of multiple forms of data (i.e., photographs, captions, and interview data) (Koch & Harrington, 1998). Member checking
occurred in the final meeting with participants, where they confirmed the themes identified by the graduate student were true to their experiences.

The second criterion was transferability, defined as demonstrating how the findings were applicable in other contexts (Lincoln & Guba, 1985). This was established through the thick description of findings in Chapters 4 and 5 of this thesis. Presenting findings in this way will ideally provide adequate information for the audience to determine how the results can be applicable to their setting. Additionally, the criteria for research study participants assisted in recruiting a more diverse sample, which led to greater transferability (Zitomer & Goodwin, 2014).

The third criterion was dependability, which focused on replication of the study results (Lincoln & Guba, 1985). This was established through checking in with the research team and comparing the process and findings with results of the literature review. The data collection and analysis process were described in detail earlier in this chapter.

The final criterion was confirmability, which ensured findings were true to respondents’ experiences and free from researcher bias (Lincoln & Guba, 1985). The research team members reviewed categories established through analysis and determined prominent themes in the final refinement of data, using multiple perspectives (Dye et al., 2000). As recommended by Thorne et al. (2004), the findings have been substantiated by team members who are experienced in mental health care. The graduate student also engaged in regular reflexivity to maintain awareness of how her beliefs and values could potentially influence her engagement, through journaling and meetings with her supervisors and thesis committee. Triangulation, member checking and the audit trail also assisted in confirmability.
Knowledge Translation

Integrated KT occurred throughout the research process to produce more relevant findings, and remain congruent with interpretive description (Graham, 2015; Thorne et al., 2004). By involving knowledge-users in the process, there is also a greater chance of the uptake of findings and informing policy development in Community A; this will help to create the tangible change critical theory strives for (Graham, 2015; Weaver & Olson, 2006). Evans’, Fulton’s, and Mensch’s involvement in this study assisted with integrated KT. Their qualifications align with Thorne et al.’s (2004) recommendation to have experts involved in the study to confirm that findings align with assumptions for services and supports. In initial meetings amongst study team members, knowledge-users and researchers agreed upon data access and expected commitments to foster relationship and ensure success of the project (Graham, 2015).

End-of-study KT occurred in a way that resonated with participants, which gave them control and maintained sensitivity to how they wanted their stories told. End-of-study KT activities were completed as part of the larger project. Previous photovoice studies have successfully resonated with community members and stakeholders when results were presented through a website, photobook, and/or gallery night (Becker et al., 2014; Plunkett et al., 2016; Russinova et al., 2018; Wang & Burris, 1997; Wang & Redwood-Jones, 2001). Using creative approaches such as these help to reach a wider audience (Graham, 2015). Participants in this study chose to collaborate with the researchers to create postcards with their photographs and paraphrased stories to raise awareness of their experiences, strengths, concerns, and available community resources. A blog was also created to feature photographs, quotes, and paraphrased stories to explain the study’s findings. A link to this blog was placed on the postcards.
Additionally, a photo exhibit with 17 photographs occurred at a community centre in Community A for one month. The first day of the exhibit included an open house event for the public.

The graduate student, in collaboration with the research team and thesis committee, will be developing a paper based on this study’s findings for publication in a peer-reviewed journal. Furthermore, the graduate student presented on patient-oriented research methods used in this study via a poster presentation at the British Columbia Support Unit conference in October 2018. She also gave an online presentation on patient-oriented research during Interior Health’s Research Week. Knowledge will continue to be disseminated in this way and expand on the findings which will inform policy and assist providers to make necessary changes to address the needs of rural adults aged 50 and over with mental health concerns.
Chapter 4

Results

This chapter reviews the results of the photovoice study that asks what it is like to be an older adult with a mental health concern in a rural community. Six key themes were identified in the analysis of the data: the photovoice experience, caring for mental wellbeing, losses, stigma, services and supports, and environment. These themes are discussed in detail in the following sections of this chapter, moving from those that are more personal to those more external on social, structural and system levels. The headings of each theme are strengthened by the addition of quotes from the participants. Quotes also identify the theme in participants’ words, maintaining meaningful coherency with philosophical underpinnings and methodology. Participants’ identities are protected using pseudonyms for direct quotes. However, photographs in this chapter are identified exactly as participants requested in their photo release consent forms. Many of the photographs are taken exactly as participants found the subject or scene, but some participants chose to stage certain items to communicate specific aspects of their experiences. Photographs in this thesis are a mix of these two styles. Finally, some photographs have been edited to remove overlying date stamps or identifiers.

Demographics

Eight participants completed the study. The self-reported ages ranged from 61 to 83, with a mean age of 68 (n = 7); one participant chose not to disclose their age. There were more women (n = 6) than men (n = 2). Most of the participants identified as Caucasian/White (n = 6). The marital status of participants ranged from people who were no longer in a relationship (n = 5) to people who were in a long-term committed partnership (n = 3). Participants no longer in a relationship were either widowed, divorced, or separated. Education levels varied; participants
had completed some post-secondary education (n = 2), completed high school (n = 3), or had not finished high school (n = 3). All but three participants were retired (n = 5). Participants’ income outside of typical employment was a combination of income assistance for people with disabilities, Canada Pension Plan (CPP) for retired persons, or sick leave. These different types of compensation resulted in three different annual income levels reported: <$25,000 (n =3), $25,000 to $39,000 (n = 2), and 40,000 to 59,000 (n = 3).

Participants reported a variety of physical health concerns (e.g., hypothyroidism, arthritis, cancer). As described in the study criteria for participation, the participants could self-identify as having a mental health concern. Six of the eight participants reported a diagnosed mental health disorder, including mood disorders, concerns related to trauma, anxiety disorders, and suicidality. Everyone in the study had experienced a mental health concern at some point in their lives.

**Photovoice Experience**

*“It made me aware that you can feel better by looking around.”* – Noreen

At their interviews, participants were given the opportunity to discuss how they felt about the photo-taking portion of the data collection. Some participants experienced negative feelings when different photo subjects reminded them of troubling parts of their past. Participants reflected on how their personal histories were an integral part of what they had to share. Reflections included how the world operated when they were younger and the ways the world had changed, as well as traumatic experiences throughout their lifetime – such as abuse or chaotic home environments – which had a lasting impact on participants’ mental health and their ability to cope with stress. Participants also reflected on the despair they felt when they were experiencing a mental health crisis and how they chose to cope when they were struggling.
Peggy described this process of reflection as “disturbing but that, that’s just the way it is for me, my life.”

Some participants were struggling at the time of their interview, due to a decline in their mental health or a challenging home environment. These circumstances led to a heightened awareness of their stressors because they wanted to document what was provoking a decline in their wellbeing. Mental health concerns also prevented some participants from documenting everything they had hoped to; at times, they did not have the energy it took to photograph their experiences. Others worried about whether they were following the process correctly.

Despite the challenge of photo-taking at times, participants also expressed that it had been a positive, therapeutic experience, in enabling them to discuss significant parts of their lives and to feel heard in doing so. It allowed them to reflect on their mental health and the positive influences on their state of mind. Sylvia felt that exploring her mental health concerns through photography helped her see “the bigger picture.” Sigrid shared how her increase in self-awareness could lead to more informative conversations with her GP, stating “now that I’m going to the doctor, I can explain it to him a bit better, you know, what it is that makes me like that.” Overall, every participant expressed gratitude for being involved in the study and felt it was a positive experience.

Mental Wellbeing

“You learn to be resilient and actually become stronger” – Sylvia

Many of the participants selected photographs that highlighted ways they had cared for their mental health, or parts of their life that made it difficult to maintain wellbeing. These influentional factors varied slightly between participants. However, there were several major
categories that these elements fell under: personal qualities, hope, spirituality and gratitude, nature, routine and productivity, medication, substance use, family, and isolation.

**Personal Qualities**

The way participants viewed themselves impacted and was impacted by their mental health concerns, particularly for participants who identified as women. Additionally, their self-concept was significantly impacted by their past (e.g., abusive relationships, bullying, successes and failures). Several women noted that, when they felt like they had acted poorly in a social situation, they had a hard time letting go of it. Focusing on these interactions often led to guilt and sadness. Rose reflected on her response to past situations in which she had been treated poorly, “I just try to let it roll off my back” and continue to be kind to people. This was difficult but participants continued to try to approach things with strength and the belief they were a valuable person regardless of how others treated them. “I don’t let that take me down. It’s not going to take me down. Because I still have my roots,” (Noreen). Similarly, Peggy remarked, “You get tired of always trying to be what someone else wants you to be. You just say to hell with it you know this is me and if you don’t like it, beat it,” (see also Figure 3).

*Figure 3. No Matter What’s Piled on You, You Can Still Grow. Photographer: Nola. Used with permission.*
Despite these challenges, participants often expressed pride and amazement over what they had survived. Rose reflected, “I was pretty gutsy to survive out in the streets like I did.” Participants recognized they had developed resilience through difficult circumstances; “My friends are dead and I’m still sticking it out. And I smile a lot,” (Peggy). Other participants though, were just beginning to discover their own strength: “you don’t always have to be a victim. You learn to be resilient and actually become stronger by putting into place and utilizing the uh tools there,” (Sylvia).

Hope, Spirituality and Gratitude

Hope, spirituality, and gratitude helped participants build resilience, and were often linked to each other. Participants described life without hope as being scary and it often preceded thoughts of suicide or the use of substances.

Not another hour, I was going to go absolutely insane and slit my neck or my wrists, like it was just that bad. So, so, so totally hopeless, like there’s just nothing, no light at the end of the tunnel whatsoever. And never could be (Peggy)

The opposite was also true; participants who had hope had more energy to make healthy decisions. They described knowing things would improve, and that negative circumstances were not permanent. Participants who had experienced crises but were able to thrive because of hope, felt it was important to help others who were struggling with their mental health to have faith in a better future. These participants spoke about the importance of reaching out or identifying what they needed to take care of themselves and find hope (see Figure 4).

Practicing gratitude was common for participants; expressing thanks for the good things in their life helped them feel more positive and connected. “I think that’s another thing, to be
grateful. That helps people with depression," (Sigrid). For participants to be thankful, they reflected on how it was necessary to be open to good things around them (see Figure 5).

Figure 4. Take the Step Forward. Photographer: Beth. Used with permission.

Figure 5. Peace. Photographer: Anonymous. Used with permission.

Interestingly, participants shared that they were able to be grateful for their current situations because they knew how much worse things could be; the contrast of hopelessness in the past with pleasant circumstances at the time of their interviews expanded their ability to be grateful.

One place where participants found hope was in spiritual communities. Spiritual communities, such as churches, were also another form of social connection and support for
participants (see also Services and Supports – Informal Supports). Individual spiritual practices also played a vital role in participants’ lives. “God plays such an important part in my life right now . . . I’ve been really working on my belief and my faith and . . . I couldn’t stay alive without it,” (Peggy). Prayer, meditation, and reflection helped participants work through difficult emotions and strengthened their ability to express or feel love and forgiveness (see Figure 6). Spiritual practices also helped participants feel rested and make healthy decisions. Occasionally, participants’ beliefs led them to feel guilty, but they went on to believe they were forgiven, and that beauty could come from bad situations.

![Image](image.png)

*Figure 6. God’s Help. Photographer: Anonymous. Used with permission.*

For spiritual and non-spiritual related practices, solitude provided similar benefits. Time alone allowed participants to rest but also to critically reflect on their life and identify unmet needs, determine what had helped them, or make plans. Peter described one of his favourite places to retreat to, “There’s no, no road noise and deadly quiet you know, thick trees, everything is wild, so ya it’s the place to relax.” Being away from crowds gave participants control over their environment without having to consider others’ needs or opinions and helped them feel safe.
Nature

Spending time outside was one of the most common ways participants cared for their wellbeing, especially for the men in the study. Caring for plants was described as fulfilling and rewarding. “It’s uh, rebirth. When you got all your flowers out, things are lookin’ good.” (Stuart). Seasonal changes also helped participants; it marked the passing of time and the changes in weather were “invigorating,” (Sigrid). Peter described swimming in a favourite lake, “You know I guarantee there’s something in there that’s healing, healing qualities . . . I feel like a million dollars when I come out.” The forest was identified by numerous participants as a quiet, peaceful place to retreat to and consider difficult decisions they had to make. For multiple participants, the convergence of two rivers in town represented complicated, internal debates regarding their mental health and wellbeing (see Figure 7).

Figure 7. Decisions. Photographer: Debe Hooper. Used with permission.

Pets were also discussed by many participants as a unique and important part of their life. When asked what participants enjoyed about having an animal in their home, they reflected on the “unconditional love” (Noreen), loyalty and sense of calm the pets provided (see also Figures 8 and 9). Additionally, some participants admired the resilience of their pets and felt inspired by this quality. Participants felt better about themselves when they were able to care for an animal
as well. Marlene wrote a poem about her pet, “A lick and a kiss good morning, a rub and a kiss goodbye, sets my heart a soaring and my day flies halfway by.” Participants felt it was important to find other ways for people to engage with animals, if they were not able to have a pet.

**Routine and Productivity**

Although most participants were retired, they strived to maintain a routine in which they could be productive. Some participants reflected on how being employed was fulfilling, but that
Employment was not necessary to feel fulfilled if their life had other people in it and hobbies to pursue.

*I feel really uh, I don’t know, useless and it disturbs me if I don’t accomplish something.*

*I’ve gotta have something to do . . . each day when I wake up or I feel really bad about myself. Ya. That’s important to me* (Peggy)

What qualified as productive varied from person to person (e.g., pursuing hobbies, maintaining a household, volunteering). Participants also reflected on the importance of balance; too many commitments led to feeling overwhelmed and being unable to do anything. One participant reflected on this phenomenon by sharing that rest could be a productive pursuit in itself; prioritizing one’s needs was a different but equally valuable goal.

Exercise routines were an example of how participants felt productive, improved their mood, and provided them opportunities to socialize. “And I really enjoy it [exercise classes]. I love it . . . like, I don’t like to miss it. That’s kind of my fun thing that I do,” (Sigrid) (see also Figure 10). Caring for their physical health was easier for participants who lived close to areas that encouraged movement, such as well-maintained trails, and for participants without physical

*Figure 10. My Fun Time. Photographer: Anonymous. Used with permission.*
limitations. In addition to exercise, some participants altered their diet or took supplements to try and improve their mental health.

**Medication**

Participants had mixed feelings regarding medications for their mental health. Marlene described having to take medication as “bondage, like being bound to the pills.” Participants sometimes struggled to find the right medication for their mental health concerns, which discouraged them from wanting to try new treatments. Weight was addressed by several participants as a negative side effect that made them feel “unrecognizable” (Peggy). This change in appearance also resulted in bullying from friends and family that made participants feel badly about themselves. However, once participants found an effective medication, the benefits were worth the side effects; the right medication helped participants overcome the challenges of their mental health concern and improved their quality of life. “But if it wasn’t for the medication, God only knows where I would be right now,” (Rose).

**Substance Use**

Participants had vastly different relationships with substances. Some participants reported that they had never struggled with addiction and did not feel well informed on the topic. For these participants, they wanted to know more and find ways to support people struggling with addiction. Other participants commented on how using substances made them feel, and they recognized that it resulted in a worsening of their mental health concern. Still other participants remarked on how they felt like their loved ones’ substance use strained their relationship and saddened and isolated the participant.

For participants who used substances – previously or currently – they often began using as a result of family influence. Additionally, participants used substances to numb their distress
associated with traumatic memories. “I tried everything until I found the one thing that didn’t make me think or have to remember what happened” (Rose). Peggy described her use as a survival tactic, “Using drugs saved my life, you know, ya, and it did for years and years. I could never have survived another day without it sometimes.” Participants who used substances understood the potential for physical damage and knew that there were different options to cope. However, participants felt bound to their substances.

Relying on substances left participants feeling socially isolated. Being in a small town, they often felt stigmatized for their drug use, even when they were sober. When participants entered sobriety, they were sometimes hesitant to try different treatment approaches, or disagreed with treatment approaches. However, once they collaborated with the care team to find a treatment that worked for them, they thrived. One negative aspect of sober treatment options in a small community was the lack of anonymity. There was a desire for improved sober living supports, to ensure anonymity and provide life skills to address their psychosocial needs.

Despite their sobriety, participants continued to perceive they had the label of somebody who used substances. Reputations such as this made it difficult for participants to stay sober, as they were pushed back into social circles where they were accepted for their history. However, the longer participants relied on substances, the more difficult they found it to achieve mental wellbeing through sobriety or with other coping skills.

Family

Many participants described how important their family members were for helping them cope with their mental health concern(s). When study members’ loved ones encouraged participants in a way that made them feel respected, they were motivated to engage in services and to take care of themselves. Family members also provided practical support, helping with
things like yard work or providing a safe space to live, when participants could not do this themselves. Time with family created space for participants to be social in an environment where they felt valued. When participants were healthy, helping family members increased the participants’ wellbeing as well.

However, participants also described negative aspects of their family relationships. Growing up with family members who used substances drove participants’ beliefs that substances were a normal way of coping with negative emotions. Some of these negative emotions were born out of the way participants’ families treated them. Peggy recalled, “my family would joke that I was short, fat, and ugly. Slower than molasses running up a hill in January . . . the running joke. It really, really hurt me . . . I always thought I was fat and ugly, unattractive, unacceptable, and unwanted.”

There were many stories around feeling neglected, misunderstood, and hurt by family as older adults as well. Rose reflected on having to leave a family living situation, “I was rather pissed off and still am, actually, to end up here alone.” There was a desire for more relationship with their family members, but participants were saddened when the desire was not reciprocated. Peter reflected on his relationship with a family member.

Every time I say something, he barks at me . . . and he disagrees about just anything so I just, I just ignore it . . . I’d like to help him but I really can’t, I try to you know but it just never turns out

Participants also found that interacting with family members who were going through a difficult life transition caused them stress.
Isolation and Loneliness

Participants described feeling lonely and wanting to find people to relate to, and thus would push themselves into uncomfortable social situations. Sometimes participants felt drained thinking about socializing, and this or other mental health concerns kept them from fully engaging with others. The effort participants put into socializing left them feeling more mentally depleted and saddened afterwards. Participants also felt as though mentally well people in the community did not want to engage with them (see Stigma). This perception magnified participants’ sense of isolation.

Social anxiety or fear related to previous losses prevented participants from engaging in social relationships. Some participants hesitated to reach out because of racial prejudice they had experienced but still wanted to connect with leaders in their cultural community. For participants who did have friends they could reach out to, participants felt their friends did not always understand. “Sometimes you just think you’re fighting the battle alone,” (Noreen) (see also Figure 11). Spending time alone meant that participants had less opportunity to establish social supports, and therefore felt like they had fewer people to rely on.

Figure 11. Empty. Photographer: Nola. Used with permission.
Losses

“She just thought a little visit to the hospital, and she never got back. That’s kind of...sad.” – Peter

Participants had experienced a variety of losses that further impacted their ability to maintain mental wellbeing. They experienced changes in their physical and mental abilities, which meant that participants could no longer engage with the world as they used to. They also mourned lifestyle changes that were often due to the loss of friends and family.

Abilities

Participants felt a sense of loss within themselves. “I get frustrated with uh physical challenges that I have that puts me on the shelf as well, I don’t feel I have as much to contribute as I’d like to,” (Sylvia). A shift in participants’ abilities changed the way they interacted socially, how they viewed themselves, and the coping mechanisms available to them. Peter discussed how beneficial it used to be to hike to different areas around town, but was saddened by not being able to do so any longer (see also Figure 12). Having to be mindful of their bodies’ limitations made participants feel older; they would sometimes let changes have a detrimental effect before they asked for assistance.

Figure 12. Refuge. Photographer: Herb. Used with permission.
The loss of coping strategies – such as hiking, doing yardwork, or house cleaning – worsened participants’ mental health. They described feeling like they could not multitask like they used to, which further limited what activities they could be involved with. Socially, participants felt their opportunities were limited because they did not have as much emotional energy to give to volunteering, socializing, or being a part of important events. Participants were also impacted by their partners’ decline in physical health as it caused participants to take on more tasks and led to more stress. Some participants also worried about potential future losses, and what that would mean for them.

Death

Thoughts related to the loss of participants’ own lives were also discussed. They wondered when their own death might be and if anybody would memorialize them. They wondered how soon they might be gone, and what would outlive them in their surroundings. A few participants had contemplated or attempted suicide, and felt death was a way out of negative circumstances. Similarly, other participants’ spiritual beliefs led them to view death with a sense of relief as well, because of what they expected in the afterlife. Participants were often unsure how they felt about their own death but did not readily express fear or sadness.

Former Way of Life

Participants also grieved how their life used to be. Peter reflected on former social connections, “you know when I moved [to Community A] it was a busy place, kids all over the place. Now they’ve all disappeared” Participants were also saddened by how younger generations seemed less interested in them. “You know they use computers more so than anybody . . . they’re faster . . . they know things I don’t know so they’re much quicker. But on the
other hand . . . I know things they don’t know,” (Peter). Numerous participants reflected on how quickly it felt like things were moving and how they wanted life to slow down.

Retirement also caused participants to miss spending time with like-minded people. For Rose, the loss of work was so significant both emotionally and financially “that’s another reason why [she] tried to commit suicide.” Financial difficulties and changes in relationships also caused participants to mourn the loss of their former homes. Other participants felt loss over their former ways of life, not because of what they no longer had, but because of what they could not change. Peggy discussed what she lost through childhood trauma and how it led her to feel like she would “always [be] on the outside, looking in.” As participants’ own health and the health of those around them changed, they also grieved visions they had for the future that were no longer possible (see Figure 13).

![Despair](image.png)

*Figure 13. Despair. Photographer: Denice Schmidt. Used with permission.*

**Friends and Family**

When participants lost friends, through death or being cut out of the friends’ lives, it increased feelings of isolation. “I’ve had two really close friends kill themselves...and that’s a lot because I’ve only had three close friends . . . ya I protect myself from people, I don’t have a
lot of trust in people because of it,” (Peggy). Participants described the sadness they felt when they lost friends and the subsequent realization that they had fewer social supports to process those emotions with. Losing friends sometimes meant disconnecting from activities that reminded participants of difficult memories, “haven’t been fishing I think in . . . the license plate on that is three years old,” (Stuart, see Figure 14).

Figure 14. Yesterday and Beyond. Photographer: Anonymous. Used with permission.

The loss of family also had a significant impact. Grief over deceased partners was an ongoing process, where participants felt like the devastation of their loss continued to impact many of their decisions. Participants who had lost partners to separation struggled with similar feelings. The death of other family members (e.g., parents, siblings) left participants grief-stricken as well. Several participants felt regret over how they navigated those relationships when their family members were alive (see Figure 15). In other cases, participants’ family members had chosen to remove participants from their lives, which left participants feeling abandoned and inadequate. Overall, the loss of family forced participants to explore their identity
outside of those relationships and left a lasting impact.

Figure 15. Memory of my Mother. Photographer: Herb. Used with permission.

Stigma

“You don’t measure up” – Peggy

Participants’ identities were impacted by negative beliefs, stereotypes or behaviours expressed by residents of Community A related to participants’ mental health concerns. Peggy expressed frustration over stigma,

what you don’t all see is that they’re all mentally ill, all of us have . . . issues . . . they just come out in different ways. Some are more acceptable than others. Is what it amounts to.

I don’t know why mine are so unacceptable, who I am is not very acceptable

Some participants felt stigma was perpetuated by the invisibility of their mental health concerns; nobody else knew what the participant was experiencing unless they voiced it, and even then, disbelief was expressed, or participants were misunderstood. When participants were transparent, and it caused a negative reaction, they were less likely to be open about their mental health concerns in the future.

Participants felt that stigma was greater in a small community where they were judged for their reputation rather than who they were. Several participants felt ostracized, describing how
some community members wanted to stay away from “people like that,” (Peggy). Because of these behaviours, participants felt it was easier to spend time alone; “Ya, cause if you’re alone then you don’t have to deal with others’ opinions or saying things bad about you or whatever the case may be,” (Noreen). Spending time alone further isolated individuals with mental health concerns.

Participants’ friends and family also acted in stigmatizing ways by discouraging participants from seeking treatment, believing that the mental illness was either not severe enough or not real. Peggy described not meeting her family’s expectations, “You don’t measure up. You measure out.” Furthermore, stigma from HCPs was felt through not being given enough time, being given diagnoses or treatments that participants did not agree with and feeling judged on their experiences.

Shame was more prominent in participants who used substances. “Socially, it’s not acceptable these days, so it’s just another reject type label I’ve put myself under,” (Marlene). Participants felt some community members thought, “Hopefully they’ll just go away, you know, ‘we don’t see you, we don’t hear you,’” (Peggy) in regards to older adults who used substances. Perceived attitudes such as these led to further isolation of participants; they wanted to use substances without feeling judged and, therefore, felt forced to be alone when using. However, participants described a sense of connection with other substance users who understood these stigmatizing experiences. Although participants felt strongly about how they should not be judged, they also expressed judgement towards others, including themselves (see Figure 16).

Self-stigma was evident as a result of the judgement participants experienced. “It’s hard for me to remember that I am a worthwhile person and will always have many things to offer others in my lifetime and that my addictions have not been writing the rest of my life,” (Peggy).
Feeling like they did not have enough to offer was more common for participants who identified as women. Participants expressed disappointment in themselves for not being able to cope differently.

Ageism was expressed by people in the participants’ lives and by the participants themselves, with the latter being more common. Peter described an interaction with his GP and how he felt judged because of his age.

*I saw my doctor two days ago, [they] can’t find anything wrong, but about my driving license you know [they] always mention ‘well what will you do if you lose your memory?’ and I think to myself, I don’t know why [they do] that*

When discussing their own age, several participants were self-deprecating, associating aging with negative qualities. A few participants also felt they had no future, and as though “*time [was] running out,*” (Peter).

“*More awareness of how widespread and how common mental illness is nowadays*” (Peggy) was something participants felt strongly about; there is a need to decrease stigma and increase understanding of older adults’ mental health. Noreen suggested “*a lot of people in*
[Community A] should think before they talk, they should watch what they’re doing, pay attention more, and don’t say things that are negative about other people when those people aren’t around.” They felt this could be achieved by bringing in mental health speakers, offering courses, or using poster campaigns (see Figure 17). Some participants identified themselves as mental health advocates and expressed “I want to tell people it’s okay, you can live with this.” And later expanded, “stand up for people, for issues that need help,” (Noreen).

![Image](Figure 17. Think Before You Do Anything. Photographer: Nola. Used with permission.)

**Services and Supports**

“They’re trying to help do something positive for you and for others.” – Marlene

Services and supports were brought up frequently by the participants, who had diverse opinions and experiences. Multiple participants found it difficult to access services or were unaware of services. For participants who were involved with formal community programs (e.g., regular meetings with service providers), they found there was not always adequate support. Other participants reflected on positive interactions they had with the healthcare system. Participants also discussed the importance of seeking help aside from health care services through informal supports, such as friends, family, and pets.
Barriers to Accessing Services and Supports

Participants identified multiple factors that made it difficult to access services and supports. One major barrier was when their basic needs (e.g., food or shelter) were not being met; they did not have the time, money, or energy to explore mental health resources. Peggy described struggling to meet her needs, but not being sick enough for hospitalization:

...you know if you have to struggle, you’re already struggling to the point of annihilation when you’re going in to ask for help because most people don’t even go in to ask for help. And then when you get to that point of asking for help then if you gotta struggle and battle and fight to, to get some reasonable access, you know, happening, then people just give up

Some participants in these circumstances continued to decompensate until they required acute care services (see Figure 18). Once in hospital, they were connected to a group of HCPs for follow up after discharge. Participants spoke about the importance of advocating for themselves when interacting with HCPs to get the care they required before deteriorating to the point where they were unable to advocate for themselves.

Figure 18. Endless Fight for Help. Photographer: Denice Schmidt. Used with permission.
For participants who had attempted to stay connected with a support service, they reported multiple issues (e.g., large amounts of paperwork, personality clashes). One common concern was how busy the mental health workers were, and that additional qualified workers were needed (see Figure 19). In some cases, participants hesitated to engage when employees of the support service had not reached out to the participant to tell them about the service.

In some situations, participants chose not to access supports. Numerous women in this study wanted to control how their mental health needs were viewed or discussed and who they relied on. Participants reflected on how they were not transparent about their needs, stating “what I’m doing there is just masking how I truly feel,” (Rose). They also described not wanting to bother individuals in their support systems – “I don’t want to share it. I think I choose to be alone. I don’t want to burden somebody, that’s probably more realistic, is I don’t want to burden somebody with my problems.” (Noreen).

There was also a lack of knowledge about available mental health resources. This lack of knowledge was evident when multiple participants were surprised by the resources identified on the resource handout sheet given to them in their interview (see Appendix J). Participants also felt like Community A and what it had to offer had been under-estimated. “[Community A] does have facilities [but] . . . Why would we? [Community A is] just this little small community.” (Noreen). Participants felt this assumption led to a lack of awareness of available mental health resources; people did not know there were resources to access. Participants suggested services
and supports (e.g., the mental health clubhouse, the crisis line) should be advertised in public spaces such as the post office, newspapers, or via pamphlets at community events.

Further, a lack of awareness about participants’ own mental health affected their ability to identify the appropriate resources at the appropriate time (see Figure 20). Participants described feeling “not as I should be, kind of thing” (Sigrid) but not knowing how to describe those signs and symptoms. Sylvia stated:

... [I] don’t know where to start as far as how do I figure out where I am, how do I get out of what I’m in . . . who do I go to, uh what do I do, do I pull in a friend, do I go to my doctor . . . I don’t know where to start

Consequently, participants felt badly about themselves for not functioning better. Recognizing this knowledge gap, there was a desire for more mental health education in the community; some participants had taken courses previously and thought education sessions (such as ones offered through churches; see Figure 21) would be helpful for themselves and the community. To offer those courses, participants noted there would need to be more qualified instructors brought into the community.

Figure 20. Where Do I Go from Here? Photographer: Beth. Used with permission.
Negative Experiences

Some participants shared situations where they had successfully accessed support, but it did not meet their needs. When engaging with HCPs, participants did not always feel their concerns were addressed or that they were given the opportunity to collaborate on health care decisions. In some cases, participants felt their HCPs lacked knowledge and were uncomfortable with the topics of mental health and addiction. Participants were also frustrated with the lack of time HCPs had for older adults. Furthermore, participants felt worse about the services when they were required to fill out large amounts of complex paperwork. Having to fill out paperwork drained participants’ mental energy, when they already felt depleted, which was often why they were trying to access the service they needed to fill out paperwork for.

Therefore, participants suggested that workers should be more accessible, the steps involved to access support should be minimal, and it would be helpful if workers would reach
out to participants to notify them of resource options. Additionally, participants thought organizations like Canadian Mental Health Association (CMHA) or British Columbia Schizophrenia Society (BCSS) should have a physical presence in their community to support educational and awareness initiatives. With local organizations like these, there would be potential resources such as “wellness clinics for your mind” as Noreen put it. These organizations could also provide space for subsidized counselling services, which participants thought would be helpful.

Positive Experiences

In this study, every participant had a positive story to share about a HCP in their life. This included the involvement of local organizations that helped participants meet their practical needs (e.g., shelter, mobility aids) so that they could focus on their mental health. Some of the most valuable experiences were interactions with HCPs who were welcoming and nonjudgmental, and made participants feel safe and heard when they were vulnerable. Marlene compared supports to the bark of a tree (see Figure 22):

Figure 22. Togetherness. Photographer: Anonymous. Used with permission.
And that tree, the bark of the tree, it just represents the strength I do have and the protection of that bark to the core of the tree where, like, people in the [mental health clubhouse], my nurses, people in the hospital . . . all of the positive people that I know in this town, they’re part of that tree, they’re part of the bark that protects me

Participants also found formal groups beneficial; groups where other members had experienced similar struggles and could empathize and offer recommendations that were most helpful. This included spiritual communities; churches were seen to be a source of support, strength, and knowledge. Additionally, services offered through the Seniors’ Centre were a helpful resource and an important part of some older adults’ lives.

Informal Supports

Participants identified numerous informal ways of supporting their mental health. Having casual conversations in public helped participants feel connected and valued; they desired more places where they could meet and have positive conversations or share their interests with people who would listen. Participants also enjoyed spending time conversing with other generations. Marlene discussed the idea of a visitation program or finding a way to bring older adults and children together, stating, “Ya, I’d like to be the leader. Let’s go visit old people!” When in social situations, participants emphasized the importance of kindness. Peggy discussed the idea of having a campaign, “help myself feel better by helping someone else feel better.”

Friendships and positive family relationships helped participants feel cared about and less alone, especially in situations where loved ones understood the participants’ mental health concerns. These positive connections were enhanced when participants’ friends shared the same values and beliefs. Friends who understood the participants’ struggles encouraged participants to seek help when the friends noticed their mental health declining. It “comes down to someone else
being open and saying what it’s done for them or that we love you enough, we want, people want you to . . . get better” (Sylvia; see also Figure 23).

Figure 23. I’m Still Standing. Photographer: Nola. Used with permission.

However, participants also noted the importance of social boundaries. They discussed the need to make healthy, positive choices about their friendships, otherwise these relationships started to have a negative effect on participants’ mental health. As Noreen noted, “some people choose to be pessimists . . . and if you surround yourself with people like that then that cloud’s gunna get real, real big and it’s gunna be harder to see the light so you have to distance yourself from that.” Guarding themselves against these social situations also meant being aware of their energy; being with certain people drained participants’ energy and did not leave enough for them to take care of themselves. Solitude served as a retreat from overbearing situations or personalities (see Figure 24). This also meant recognizing when helping others was causing them harm; some people had taken advantage of participants’ kindness.
Participants identified their home environments, financial situation, and community as factors that impacted their mental health. There were many unique features to uncover about the community’s culture, specifically related to the size of the population. It was not surprising that finances were a major theme in this community as well, given 82% of the population in Community A qualifies as low income (Statistics Canada, 2017). Furthermore, the size and location of the town, as well as participants’ income, influenced their housing options.

**Home Environment**

For participants who had less financial stability, they were often in living situations that caused them stress. These stressful situations included hostile neighbours, a lack of control, and disorganized environments. Participants struggled to find safe, affordable rental units. Marlene described this reality:

*I was freezing to death. All I had was, like, coats all over me and blankets piled high and I was shivering trying to dial the number of the crisis line and I finally got a hold of*
[provider] and she got me into the [motel] for the weekend just to thaw me out because I was near frostbite.

Participants in situations such as this found it difficult to care for their mental health when their basic needs were not being met.

Participants also described items in their living environments that had a negative impact on their state of mind. These items included: medication, substances, belongings of deceased loved ones, and unfinished projects. “Just a reminder of my illness, it’s all beside me. Every morning I wake up and every night I go to bed beside it,” (Marlene, see Figure 25). Some participants felt their home environment kept them from inviting people in because of shame around how their home appeared, or a need to maintain control and safety. When participants were struggling with their mental health, they found it difficult to maintain a comfortable home environment.

![Organized confusion](image)

*Figure 25. Organized confusion. Photographer: Anonymous. Used with permission.*

In contrast, those who lived in a safe, stable environment in which they had control found that it helped them maintain their mental wellbeing (see Figure 26). Peter described the joy it brought him to maintain his household, stating, “You can repair things, build things, I mean think of all the things you can do for yourself.” Regarding their environment, men especially
valued stoicism; taking care of their homes and yards independently brought them happiness (see Figure 27). Stuart preferred to take care of his property by himself, elaborating, “well I feel like I don’t owe anything to anybody.”

Figure 26. Antique Furniture. Photographer: Anonymous. Used with permission.

Figure 27. Wind Power. Photographer: Herb. Used with permission.

Finances

Some of the mental health resources available to participants were dependent on finances. Participants who lacked financial stability were unable to explore resources beyond those covered by the public health system. Others shared how they felt grateful they could afford medication, supplements, private counselling, or to pursue hobbies that brought them joy (see
These same participants expressed concern for those who were unable to afford these resources.

Poverty was compounded by having a mental health concern; participants reported that their mental health prevented them from being able to perform the tasks necessary to acquire and keep a job. Other participants identified a lack of jobs in Community A as a contributing factor, stating “there’s the mine and there’s the mill then there’s the pellet plant and uh other than that,” (Stuart). In some cases where participants had been able to find employment, a change in their health status led to the loss of the job, which, in turn, led to a decline in their mental health. Participants identified the Food Bank as an important community resource to assist people in these difficult financial situations. One participant also suggested the development of a community system in which people contribute to help pay for medication when older adults cannot afford necessary treatment (see Figure 29).

**Community Culture**

Participants’ mental health was affected by numerous complex aspects of rural living. Noreen had moved from a larger city and described how in Community A, “it is so small you see
Figure 29. As a Community We Would Like to Help You. Photographer: Beth. Used with permission.

everything.” Many participants agreed with this sentiment, stating things such as “I know pretty well everybody. Everybody seems to know me.” (Marlene). This lack of anonymity made many participants feel like they had established “a reputation” (see: Stigma). Some participants felt trapped by their reputation of having a mental health concern and felt they would not be accepted into certain social circles because of it. This sense of judgement was expanded upon; “I think things are really cliquey, and people cling to each other.” (Peggy). In contrast, participants described feeling welcomed and cared about because of their physical health concerns.

Summary

This study revealed numerous important topics to take into consideration when it comes to older adults with mental health concerns in a rural community. Participants spent a lot of time reflecting on the ways they supported their mental health. It was important for them to establish routines and be productive, which included exercising and pursuing hobbies. Personal characteristics influenced how they chose to cope with their mental health concern. Independently, participants found that hope, spirituality, and gratitude helped them focus on the things that mattered and gave them strength to move forward.
There were challenging aspects of participants’ lives as well. Almost all participants had experienced public and self-stigma related to their mental health concerns. At times, participants’ families also stigmatized the participants. Additionally, participants found it difficult to maintain quality of life when they had experienced significant losses.

In their community, participants’ financial status and housing options were limited by the local economy and their own abilities. Services and supports were also influenced by the size of the town and the available resources (e.g., spaces, trained workers). At times, these resources were difficult to access because of limited capacity or a lack of awareness. However, all members of the study had had positive encounters with HCPs at some point. Aside from formal services, participants also felt supported by social relationships.

The older adults in this study made numerous recommendations. They felt it was important to advocate for their mental health, both publicly and in their personal interactions. Participants also noted how older adults’ basic needs should be met to allow them to focus on their state of mind. To support people when they are ready to take this step, participants recommended an increase in the available resources. Finally, participants wanted to see a decrease in stigma and an increase in awareness of what it was like to be an older adult with a mental health concern, and how to support them.

Overall, participants felt being a part of this photovoice study was beneficial. Many of these findings align with the current landscape for older adults’ mental health. However, there were also some unique aspects to this study. The next chapter will explore how these results are aligned with the literature and recommendations for practice and further research.
Chapter 5

Discussion

A photovoice study was conducted in a rural community in the southern interior of BC. The objectives of the study were: 1) to explore the experiences of adults aged 50 and over who live with a mental health concern in Community A, and 2) to engage in a process with this population that is marginalized to document and share their mental health experiences through photographs and captions. This thesis was part of the larger overall study and addressed these two objectives. However, the larger study had a third objective, which did influence parts of this thesis. The third objective was to develop, in conjunction with participants, appropriate knowledge translation (KT) approaches so they could share their photographs and stories.

This chapter considers the inter-relationships between themes identified in Chapter 4 and how these results fit within current research. The key themes identified were: the photovoice experience, caring for mental wellbeing, losses, stigma, services and supports, and the environment. The implications of these findings are discussed. Furthermore, recommendations are made for policy, service delivery, education, and future research. This chapter also addresses the strengths and limitations of this study.

Caring for their Mental Health

During the interviews, participants talked extensively about those aspects of their life that influenced their ability to maintain wellbeing. Hope, spirituality, and gratitude were enmeshed in discussions around personal ways of engaging with their mental health. These topics were reflected through photographs of nature, of spiritual symbols that gave participants strength, photographs of themselves, and of Christian literature. The importance of hope was highlighted by Scogin et al. (2016) who discussed the detrimental impact of hopelessness. Participants in
Community A resonated with the hopelessness Scogin et al. (2016) identified, but they combatted this feeling through spirituality and gratitude practices that incorporated intentional time reflecting inward on purpose, strength, or healing. Participants in this photovoice study used Christian-based spiritual and Indigenous practices, both in solitude and in groups, to address their mental health concerns; these findings echo what has been said about strong adherence to spiritual practices in the literature and how older adults feel supported by their faith communities (Kitchen Andren et al., 2013; Kaufman et al., 2006; Bocker et al., 2012). When participants in this photovoice study practiced gratitude, they were able to combat negative symptoms of their mental health concerns. The psychological benefits of viewing situations through the lens of gratitude supports evidence from Emmons and Crumpler (2000), who identified that gratitude is a pillar of many religions. The results of this current study, related to hope and spirituality, contribute to the literature on this topic. Further, the results, in conjunction with the literature, imply that it is beneficial for older adults to explore their spiritual beliefs. These results also emphasize how gratitude is practiced in a spiritual context, and how gratitude and spirituality can be incorporated into older adults’ lives to counteract the experience of hopelessness.

Solitude provided similar benefits; time alone allowed participants to reflect inward, feel rejuvenated, and focus on their personal needs. Solitude was highlighted through photographs the participants took of different places they enjoyed spending time alone in nature. The benefits of solitude, as it applies to all age groups, has been acknowledged in the literature (Long & Averill, 2003). In agreement with Long and Averill’s (2003) discussion, participants in the present study found that critical reflection on their emotional, spiritual, and mental health helped them address parts of their lives that were not evident, or that they could not give attention to, in a superficial context. Furthermore, Toyoshima and Sato (2018) explored the tension between solitude and
loneliness in older adults. These authors concluded that older adults maintained wellbeing through solitude as a way of processing and adapting to their changing lifestyle (e.g., smaller social circles, death of friends and/or spouses). The present study’s findings challenges the narrative that time alone is purely negative and lonely. It also contributes to the discussion around how healthy, intentional solitude, perhaps in partnership with spiritual and gratitude practices, can facilitate understanding and processing of deeper spiritual and emotional needs.

Being in nature was another way participants coped with their mental health concerns. Time spent outdoors helped participants ground themselves and feel in touch with their environment, which they described as healing. Participants engaged with nature in numerous ways (e.g., hiking, walking, yardwork, gardening). Photographs of rivers, forests, walking trails, yards, and gardens were shared while participants described the joy these areas brought them. This finding was congruent with the literature that describes how being outdoors and engaging multiple senses (e.g., hearing animals, smelling plants) helps to improve general mood (Berman et al., 2012; Franco, Shanahan, & Fuller, 2017; Oh et al., 2017; Song, Ihei, Park, Lee, Kagawa, & Miyazaki, 2018). Research has also found that horticulture therapy introduces additional benefits (e.g., physical activity, socialization) (Chan et al., 2017). The relationship between overall wellbeing and connectedness to nature has been discussed at length in the literature. The literature has also considered the negative impact of spending substantial amounts of time in man-made environments (Maller, Townsend, Pryor, Brown, & St. Leger, 2006). The consistency of these findings highlights the importance of combining nature with older adults’ mental health care. It can be assumed that this way of coping has been taken for granted, given that current treatment modalities offered in the public healthcare system occur indoors and with minimal interaction with nature (e.g., plants, fish tanks).
Many of the participants spent their time outdoors being physically active. Physical health maintenance as it relates to mental health was reflected in some of the literature reviewed in Chapter 2 (Kitchen Andren et al., 2013; Panazzola & Leipert, 2013). Hayslip et al. (2010) noted that rural older adults had worse physical health than their urban counterparts, and Rubio-Aranda and colleagues (2012) commented on how detrimental changes in physical capacity increased symptoms of depression for older adults. These findings reflect the important relationship between physical and mental health, which some participants in the present study also recognized; they expressed how taking care of their physical health directly improved their mood. The importance of physical health was shown through photographs of running shoes, rakes, and walking trails.

This experience was congruent with studies that have shown that exercise is comparable to the beneficial effects of medication when treating mild to moderate depression (Knapen, Vancampfort, Moriën, & Marchal, 2014). Women in the present study elaborated on how physical activities were even more beneficial when they fostered social relationships (e.g., going for a walk with a partner, going to exercise classes with friends). Some participants were unable to reap the benefits of physical activity that they used to enjoy because of changes in muscle tone or flexibility.

However, these changes do not have to prevent older adults from receiving the antidepressant effects of movement; video games that require the players to move their bodies allow older adults to exercise in different, more accessible ways and still gain the mental health benefits (Chao, Scherer, & Montgomery, 2015). These findings highlight how physical health maintenance can impact rural older adults’ overall wellbeing. Furthermore, it is important to
offer various, unique ways of caring for physical health in rural communities to encourage older adults to stay active.

Furthermore, participants identified losses related to their mental health (e.g., multitasking, social energy, physical ability) as inhibiting. Losses, including elements of their former lives, made it difficult for participants to engage with past coping strategies (e.g., hiking, mindful practices, social connections, employment). Being unable to use former coping strategies made participants feel worse. Participants shared this through photographs of mobility aids, or areas they could no longer hike to. Furthermore, traumatic loss prevented them from critically reflecting on their spiritual, emotional, or mental health needs; reflecting on these needs sometimes meant recalling traumatic histories and experiencing the distressing emotions associated with traumatizing events. Panazzola and Leipert (2013) noted a connection between older women who had lost partners and other social connections in the community with feelings of loneliness. When participants experienced these types of losses, they were unsure how to recover or alter their lifestyle to meet their mental health needs. It is crucial for older adults to find ways to process their losses in order to form new identities and establish healthy lifestyles based around these changed identities. However, opportunities to process loss in a healthy way are limited in rural communities with a paucity of care providers, particularly specialists for older adults’ mental health and grief therapy.

Many participants found their identity, or were able to feel good about themselves, by having projects or routines. Purpose was often found when participants felt they were a part of something bigger (e.g., being in nature, spiritual practices) or they accomplished various tasks (e.g., an exercise class, yardwork). Panazzola and Leipert (2013) noted the importance of hobbies for older women in rural areas. Additionally, Oelke et al. (2016) discussed that when
rural older adults felt a lack of purpose, it contributed negatively to their mental health. These findings have relevance within the context of retirement, and highlight the importance of identifying existing opportunities that encourage older adults to stay productive. Furthermore, these findings show the importance of maintaining or altering their routines when they encounter loss, as previously mentioned.

Participants did not always understand the relationship between these aforementioned facets of wellbeing nor did they have the language to describe it. This knowledge gap has been noted by numerous authors who have found that this gap resulted in older adults suffering for longer than necessary; they could not always articulate what helped improve their mental state (Brenes et al., 2015; Kitchen Andren et al., 2013; Bocker et al., 2012; Kaufman et al., 2006; Hayslip et al., 2010; Muir-Cochrane et al., 2014; Stewart et al., 2015). One participant in the present study shared this feeling through a photo of tangled branches (see Figure 20). In some cases, this knowledge gap meant participants used coping strategies that supplied a tangible, fast-acting solution for distressing emotions, such as substances. Participants who used substances reported their use or curiosity often began in childhood, before other coping strategies could be fully understood or enacted. Without a full understanding of the connections between coping strategies and changes to their mental health, older adults could not appropriately identify when it would be most helpful to enact healthy strategies. Furthermore, it may be difficult for rural older adults to advocate for themselves, or to decrease stigma and increase understanding of their mental health experiences if they do not have the language to explain these connections. It is possible that rural older adults have not been given the opportunity to receive education on this topic because old age is seen as a time of life when rest or retirement should be celebrated, and intentional learning is not promoted as part of ageing.
**Stigma**

Numerous participants in the present study experienced stigma - related to substance use, mental health concerns, and age. Each participant discussed their unique experiences of stigma. Women in the study expressed negative self-concepts related to their appearances (e.g., wrinkles, weight) and personalities when they shared photographs of themselves. The lack of value and low self-worth for women has been discussed in the literature; privileged groups set standards, through popular culture, for how different genders should look, and negative associations are made around those who do not meet these standards (e.g., sagging skin, stretch marks) (McBride, 2017). In contrast, men associated their value with their ability to complete tasks (e.g., taking care of the yard, building items for their homes), which they elaborated upon when they shared photographs of their yards or parts of their house they had built. More commonly, women had a difficult time fostering self-worth and engaging in positive activities. Negative self-concept was due, in part, to trauma or bullying in the past from family members or partners, and/or at the time of the study from family members, partners, or community members. During these experiences, participants perceived that they were being mocked, and that they were socially excluded by privileged groups because of their characteristics. The effects of bullying from others had woven shame and inadequacy into participants’ narratives. Stigmatizing experiences, in which participants were considered inferior because of their age, mental health concern, or coping strategy (e.g., substance use), further impacted how they viewed themselves. Participants internalized negative messages and believed they were unworthy of care, did not belong because of their mental health concern, or had mental health concerns that were unimportant. These findings strengthen existing knowledge in the literature about older adults’ negative self-concept and mental health (Panazzola & Leipert, 2013; Scogin et al., 2016).
There are serious implications related to this internalized stigma. Participants in this study self-isolated and would not reach out for help because they believed they did not deserve support. Negative self-concept also prevented participants from fostering social relationships as they did not believe they had anything to offer or that they fit in. Subsequently, they continued to feel badly about themselves as there was no other person or activity in their life to challenge this mindset. Isolation worsened their mental health and continued this cycle. These findings align with the influence of self-stigma on wellbeing as discussed by Stewart et al. (2015) and Rubio-Aranda et al. (2012). Importantly, Livingston and Boyd (2010) noted “a higher level of internalized stigma is associated with lower levels of hope, empowerment, self-esteem, self-efficacy, quality of life, and social support.” (p. 2157). These findings describe what participants identified when discussing ways of caring for their wellbeing. Therefore, the experience of self-stigma makes it incredibly challenging for rural older adults to engage with influences that would help them overcome self-stigma, and to engage in ways of improving their self-worth and mental health.

Some participants felt such dislike for themselves or their histories that they felt the need to disconnect from their own minds, bodies, or realities by using substances. There was a strong connection between using substances and stigmatizing experiences, which drove participants further into isolation. When participants used substances in isolation, they reported it increased their sense of shame and loneliness, as well as the risks associated with using substances alone (e.g., overdose). These findings of stigmatization and isolation related to substance use aligned with a recent report on substance use and aging in Canada by Flint, Merali, and Vaccarino (2018). These researchers found that, because of ageist beliefs of HCPs, older adults were not screened or supported for substance use concerns (Flint et al., 2018). If older adults use
substances in isolation and are not screened for substance use concerns by their HCPs, they do not receive the support they need to engage in harm-reduction or sobriety. When older adults are not able to access support because of stigma, isolation, and ageism, their substance use continues to wreak havoc on their mental health and can result in death. Death was discussed both as suicidal ideation and accidental death due to an overdose or complication of substance use.

Additionally, participants expressed ageist views about older adults, more so than reporting ageist behaviours from others. The reason for this was discussed by Ayalon and Tesch-Römer (2017), who remarked on the internalization of negative messaging around ageing from privileged groups through popular culture. They discussed how these attitudes begin at a young age and as people get older, they see themselves in a negative light. In a recent Australian study, researchers found ageist behaviours towards people 60 years of age and over resulted in worse mental health for the older adults (Lyons et al., 2017). Negative stereotypes and messages around aging decreased older adults’ self-worth and altered the way HCPs viewed this population (Muir-Cochrane et al., 2014; Varcarolis, 2017). When internalized ageism and public ageism are considered alongside the stigma older adults experience related to their mental health concerns, it reinforces their lack of value on a deeper level.

The participants’ sense of value was also influenced by their interactions with HCPs, which participants reported were not always positive. When they did not feel valued by those they reached out to, they were less likely to be open about their mental health concerns in the future. This aligns with studies that have indicated stigma as a major reason for why people chose not to engage with mental health services (Brenes et al., 2015; Stewart et al., 2015). When participants in the present study felt they could not be open about their mental health concerns, they were more likely to struggle in isolation and decompensate to the point of hospitalization.
Participants reflected on this through photographs of hospitals and ambulances. This phenomenon reinforced the perception that help was only available when participants were in acute distress, and not when they were seeking support to maintain their wellbeing, which further discouraged rural older adults from discussing their concerns and pursuing early intervention.

Participants felt they had established a reputation in which the community judged them for their mental health concern or how they coped with this problem. Men in the study hesitated to identify with having a mental health concern because of this judgement, which prevented them from reaching out for help or reflecting inward to identify their needs. Similar concerns were echoed by Panazzola and Leipert (2013), who found that older women frequently felt ignored. This feeling of being ignored co-existed with the feeling of being known by the entire community in rural areas, due to smaller population sizes. A lack of anonymity in rural communities contributes to the risk of public stigma (Dautovich et al., 2014; Hayslip et al., 2010; Kitchen Andren et al., 2013; Muir-Cochrane et al., 2014; Oelke, et al., 2016; Stewart et al., 2015). This interaction of stigma and shame could be defined as social exclusion, where privileged groups may have acted as gatekeepers and prevented marginalized groups from having the same opportunities (Gordon, Davey, Waa, Tiatia, & Waaka, 2017). This gatekeeper mentality could also apply to people in positions of authority, such as HCPs (Gordon et al., 2017). A substantial amount of the literature has documented stigmatizing experiences for rural older adults with mental health concerns, suggesting there needs to be a more concerted effort to find ways to decrease this damaging phenomenon (Corrigan et al., 2014; Kitchen Andren et al., 2013; Oelke et al., 2016; Stewart et al., 2015).

However, many participants in this present study became resilient, intentionally and/or in response to, stigmatizing experiences. Participants who were resilient and wanted to advocate for
themselves had overcome the negative messaging previously discussed but recognized resilience was an ongoing process; they had to continually act as their own support and remind themselves of their value. Participants shared these experiences through photographs of nature, for example, where trees had survived challenging conditions. Panazzola and Leipert (2013) discussed the benefits of resilience in older women and how this characteristic helped the women cope with negative situations. Shih (2004) discussed how stigmatized individuals become resilient; members of stigmatized groups devalue areas of society where they experience prejudice and put more emphasis on areas where they feel appreciated. This could mean devaluing parts of the healthcare system where privileged groups dictate what is acceptable and do not leave room for the experiences of groups that are marginalized. Furthermore, resilient individuals who had experienced stigma foster qualities, such as being more assertive or adapting different personas, that help them survive stigmatizing situations (Shih, 2004). This was reflected by participants in the present study who valued interactions with people who understood their mental health needs. Resilience appears to be a necessary way for populations that are marginalized to challenge what is most valued by privileged groups and to invest in areas of society which are more valuable and beneficial for them. This may translate to older adults with mental health concerns rejecting conventional treatment modalities used and encouraged by privileged groups.

The Complexity of Isolation

As described, stigma, changes in lifestyle, and social withdrawal often resulted in isolation; participants felt more comfortable alone as they did not experience judgement from others or fear their mental health concern would be exposed. However, loneliness was a common problem for participants, and they wanted to find a way to socialize without the tension of stigma. One participant showed this through a photo of several empty chairs, and a small bus in
the background, as they explained they knew there were people there but they were not sure how to access them. Some of this loneliness was due to intrinsic losses; as discussed, participants described the loss of mental (e.g., multi-tasking, tolerating large groups or strong personalities) and physical abilities (e.g., completing physically taxing tasks). These losses limited their ability to be a part of some social groups or activities that they used to enjoy. Often, this meant a loss of coping strategies, which resulted in a decline in participants’ mental health.

Loneliness has become a public health emergency across numerous countries, including Canada, for those 50 years of age and over (Davidson & Rossall, 2015). Feeling lonely has been shown to increase mental health concerns, such as depression, and to have just as negative an effect on overall health as smoking or obesity (Davidson & Rossall, 2015). Social interactions for older adults are integral to their wellbeing, but these relationships are also complex, because of the many transitions that occur in older adults’ lives (e.g., changes in housing, marital status, health, income) (Davidson & Rossall, 2015). The results from the present study aligned with those of Davidson and Rossall’s (2015), suggesting older adults do not know how to navigate social relationships in conjunction with their life transitions, and find it simpler to be alone than to reach out. However, it is important to note, as outlined in the study’s results, solitude can also be used as a means of coping with the loss of social supports. Attention must be paid to the extent of solitude and its balance with spending time with others.

Participants in this photovoice study were reliant on social relationships to combat their loneliness; this is consistent with research that has identified friendships as an important supportive factor (Panazzola & Leipert, 2013; Kitchen Andren et al., 2013; Rubio-Aranda et al., 2012). However, the literature does not discuss the intricacies of these relationships and how the attitudes of older adults’ friends could affect them. Establishing healthy boundaries and fostering
optimistic conversations were found to be necessary qualities for a relationship to be beneficial. Participants in the present study found that spending time with people who did not respect their values, beliefs, or interests was detrimental to their mental health. The benefits for the older adult population of having control over social relationships is an important finding in this study and others (Werner-Seidler, Afzali, Chapman, Sunderland, & Slade, 2017). Furthermore, participants found that spending time with pessimistic people made it more difficult to thrive. However, some participants were unclear as to how they could establish healthy relationships, and continued to foster negative relationships as they felt these were better than being alone. This phenomenon may also be due to privileged groups practicing exclusion through stigma and bullying, which would prevent older adults with mental health concerns from accessing different groups for social support. Results from this study build on previous literature to identify the importance of the intricacies of older adults’ social relationships (Werner-Seidler et al., 2017). These intricacies are tied to experiences of loneliness (e.g., choosing not to spend time with pessimistic people) or worsening mental health (e.g., choosing to spend time with negative people to avoid loneliness).

Participants also described extrinsic stressors that precipitated their loneliness, such as retirement or children moving out, that are similar with stressors reported previously (Panazzola & Leipert, 2013; Rubio-Aranda et al., 2012; Oelke et al., 2016; Evans et al., 2017). Not living in close proximity to families, or families not communicating due to a variety of reasons, led some participants to feel their family had abandoned them or treated them as an outsider. This contributed to feelings of loneliness that often led to depression as corroborated by the literature (Rubio-Aranda et al., 2012). Research has also shown that older adults who feel valued by their families and communities are less likely to experience suicidality (Yur`yev et al., 2010). These results highlight the need for older adults to feel involved in their families’ lives; however in
rural settings, this can be complicated by geography, financial ability to connect (e.g., internet, travel), or changes to older adults’ cognitive abilities.

Being excluded by the people they loved or having lost loved ones, affected participants’ sense of identity. They wanted to make new connections and thrive but found this difficult when their experiences were often clouded by grief. In contrast, having healthy relationships with their family strengthened participants’ sense of identity and ability to be confident in themselves and their decisions. Positive family relationships were reflected in one photo of a deck that the participant’s children had helped them build, with numerous flower pots, including plants that family members had given the participant. Positive family relationships, in turn, enhanced their mental health and provided them a safe space where they felt like they belonged and were understood (Panazzola & Leipert, 2013; Kaufman et al., 2006).

**Rural Living**

Participants in this study discussed their life in Community A and how its social norms and economy affected them. Within the community, they lacked anonymity and felt they had developed a reputation, being known only for their substance use or mental health concern, which was a challenging aspect of rural living. One participant used a photo of a cloudy sky to describe the anonymity they desired; they wanted to be hidden behind a similar veil. An “everybody seems to know me” mentality prevented participants from forming the social relationships they desired. When participants perceived community members believed the participant to be a certain way and interacted with them accordingly, participants struggled to reconcile who they were, or were striving to be, with who privileged groups in the community thought they were. The lack of anonymity and the resulting public stigma in rural communities aligns with findings from Kitchen Andren and colleagues (2013) as well as Dautovich et al.
Additionally, the small population size limited available options for social supports. The experience of isolation was compounded by the difficulty of travelling in and out of Community A due to limited public transportation, the cost of personal transportation, and the challenging roads.

Participants also noted positive aspects about living in a rural community. They appreciated the quiet lifestyle or how they were able to escape troubling histories in other cities to establish a peaceful existence in Community A. Living in this rural community provided easier access to nature as well. Typically, older adults in rural communities value the opportunities for community involvement, familiarity, and social supports this lifestyle offers (Carver, Beamish, Phillips, & Villeneuve, 2018). As discussed, these aspects exist in tension with some of the struggles this study’s participants have faced, such as stigma, isolation, and the impact of losses.

**Poverty**

Importantly, participants felt their basic needs (e.g., food, shelter, medication) had to be met before they could focus on their mental health; basic needs influenced participants’ ability to maintain their wellbeing. An inadequate diet, being precariously housed, or not being able to afford necessary medication resulted in their mental health decompensating. One participant demonstrated this through a photo of their bedroom, as they explained the disorganization and piles of medication as a reminder of why they lived in a chaotic environment, and as the label(s) they had been given. The significance of poverty is discussed throughout the literature (Kaufman et al., 2006; Oelke et al., 2016; Dautovich et al., 2014; Rubio-Aranda et al., 2012). When participants in the present study were unable to acquire essentials for living, they found themselves caught in a vicious cycle. As they struggled to meet their needs, their mental health
decompensated, making it even more difficult for them to meet their needs, which further affected their mental health. Poverty was compounded by the difficulty participants had in obtaining a job because of their mental health concern. Participants were not always comfortable or confident navigating community resources that could meet their needs, because of public and self-stigma. Furthermore, because of the size of the town, there were not always community supports to turn to, including affordable housing. High levels of poverty in rural areas may relate to the lack of mental health support services; if there is nobody to support older adults’ mental health, they cannot reach a place where they are well enough to maintain financial stability.

Financially, participants were impacted by the local economy and lack of employment opportunities. Most participants were unable to afford private mental health services to address their concerns, a common issue for rural older adults (Kaufman et al., 2006; Hayslip et al., 2010; Oelke et al., 2016; Bocker et al., 2012). One reason participants in this present study were not able to afford private services was because there was a paucity of such resources in Community A. As such, they had to take on significant travel costs to find this kind of care, as discussed in the literature (Bocker et al., 2012; Brenes et al., 2015; DiNapoli et al., 2017; Muir-Cochrane et al., 2014). The present study’s results support the MHCC’s (2017) report that financial disparity is linked to rural economics. In contrast, participants in this photovoice study who felt financially stable could establish a lifestyle that incorporated activities or environments that helped their mental health. For example, one participant shared a photo of their deck, where they liked to start every morning with their partner. Financially stable participants also did not have the added stress and uncertainty related to affording the necessities of life. Furthermore, older adults with higher incomes have been shown to stay more socially involved, which may relate to having the resources to give back to the community or afford different activities (Davidson & Rossall,
Despite extensive literature on how poverty exists for rural older adults with mental health concerns, it continues to be an issue that needs to be addressed.

**Engaging with Mental Health Services and Supports**

As described above, poverty significantly impacted participants’ ability to access services and supports. If participants needed to work, they had difficulty accessing supports during business hours, and if participants had insufficient income, they could not afford to travel to larger centres to receive specialized care. Other notable barriers to accessing mental health services are significant wait times to see the limited number of providers, and an unwillingness to be associated with mental health services. Because of these barriers, almost all participants had seen their GP for their mental health concern, although not exclusively (e.g., mental health support worker). This phenomenon is, in part, a result of the specialist service gap (Bocker et al., 2012; Stewart et al., 2015). It may also have been related to the lack of awareness of local mental health resources; participants underestimated the resources available to them, and reported feeling like others in the community made the same assumption based on their small population, which resulted in community members not knowing there were resources to access.

Negative outcomes related to a lack of HCPs trained in rural older adult mental health was echoed throughout the literature (Bocker et al., 2012; Crowther et al., 2010; Dautovich et al., 2014; Kaufman et al., 2006; Kitchen Andren et al., 2013; Muir-Cochrane et al., 2014; Oelke et al., 2016). The lack of specialized providers or training for general HCPs was potentially reflected by participants who reported a lack of confidence in the system because of how they had been treated or the inadequate care they felt they had received. As previously discussed, when some older adults did not feel adequately supported, they turned to substances to cope.
This corroborates Oelke et al.’s findings (2016) that substance use is a possible by-product of there being inadequate services to support older adult mental health in rural areas.

Participants expressed a lack of confidence in the system alongside frustration with under-staffing and confusing referral processes. This finding adds support to an already comprehensive body of literature on the topic (Bocker et al., 2012; Brenes et al., 2015; Evans et al., 2017; Hayslip et al., 2010; Muir-Cochrane et al., 2014; Oelke et al., 2016; Spleen et al., 2014). Muir-Cochrane and colleagues (2014) found that when older adults were unable to engage with primary health care services, it led to more hospitalizations to access support. Participants in the present study used photographs of the hospital, an ambulance, and an “emergency” sign to demonstrate how often they had been in this position. Bocker et al. (2012) found that a third of their participants were unaware of all the community resources available to them, but it was not highlighted as a significant concern. The Canadian Mental Health Association (2010) has also highlighted a need to improve awareness of older adults’ mental health services in all types of communities. However, some of the participants in this photovoice study felt there was a substantial lack of awareness regarding services and that this prevented older adults from overcoming difficult symptoms of their mental health concern.

Some participants had successfully accessed resources and had positive encounters. For participants who were able to use the healthcare system, they noted the helpfulness of HCPs who used active listening and were nonjudgmental and welcoming. Muir-Cochrane and colleagues (2014) also found the attitudes of HCPs to be an important component of positive interactions. Such experiences with HCPs may relate to older adults’ need to foster optimistic or healthy conversation. These relationships also worked to offset the experiences of stigma, and to help participants understand their mental health concern as something they could work with rather
than something that controlled them. Participants also found that casually meeting with other older adults who had mental health concerns positively affected their mental state; they felt less alone. Moreover, when they witnessed other older adults with similar diagnoses thriving, this helped participants see their own potential and discover other ways to cope with their mental health concern. When participants took part in regular mental healthcare activities, it also promoted productivity, and enhanced their wellbeing in multiple ways.

**Reflection on Methods**

The first objective of this study was to understand participants’ mental health experiences through the photovoice method. Photovoice has the capacity for participants to identify broader key themes in response to the research questions. Using the SHOWeD method for conducting interviews with the participants provided opportunities that deepened the graduate student’s level of understanding of participants’ experiences, which is congruent with what other photovoice researchers have found (Russinova et al., 2018). Participants documented meaningful experiences related to their mental health using photographs and in the follow-up interviews they went well beyond the key themes identified in the initial focus group; every photo and story was unique to each participant and what they considered an integral part of their life. The photovoice method was successful in eliciting observations, experiences, and linkages about how participants manage their mental wellbeing that reflected their unique experiences, and voices. For example, the participants shared the importance of being with nature as a benefit to their mental health, a finding that was not evident in the literature review (i.e., Chapter 2) or a factor previously considered by the researcher. By exploring the participants’ experiences through photovoice, themes arose that were true to participants’ experiences and not based on the graduate student’s bias.
The results presented in Chapter 4 reflect the depth of understanding of the participants’ experiences with a mental health concern. Importantly, participants confirmed that the graduate student’s analysis aligned with their experiences. By addressing this objective, themes were unveiled that might assist HCPs, mental health advocates, and other stakeholders to provide improved care to rural older adults. Additionally, other older adults can use the results to explore their own experiences around mental health and wellbeing. Some will be able to identify with these themes while for others, these results will provide insights to support older adults with mental health concerns, particularly those who live in rural communities.

The second objective was to engage in a process with this population that has been marginalized to document and share their mental health experiences through photographs and captions. This objective was met throughout the data collection period. Participants photographed the parts of their lives that related to their mental health. For some photographs, the content and message were concrete, while others were abstract and metaphorical. The titles for each photo and the way participants chose to elaborate on their photographs enhanced the understanding of the results and gave participants an opportunity to share their stories.

Through documentation of their experiences, participants felt they had the power and ability to collaborate with their HCPs to improve their care; they felt like they could use their photographs to understand themselves or explain their needs to others (e.g., friends, neighbours, HCPs). Collaborating with HCPs in this manner may help participants feel empowered and lead to more effective care for participants and others with mental health concerns. The process of participants using their photographs to take a more informed approach to their care is described by Becker and colleagues (2014) as engaging “the expertise of these individuals” (p. 189). The participants in this study were true experts, as they were able to inform the research team on the
lives of rural older adults with mental health concerns. Furthermore, to help share participants’ photographs and stories, end-of-study KT activities are being undertaken as part of the larger study.

End-of-study KT will occur in a way that resonates with participants, and the research team will strive to give voice to participants and maintain sensitivity to how they would like their stories told. Previous photovoice studies have successfully resonated with community members and stakeholders when results were presented through a website, photobook, and/or gallery exhibition (Russinova et al., 2018; Plunkett et al., 2016; Becker et al., 2014; Wang & Redwood-Jones, 2001; Wang & Burris, 1997). Using creative approaches, such as these, help to reach a wider audience (Graham, 2015). Participants in this study chose to use postcards that included their photographs and paraphrased their stories, as well as a photo exhibit at the community centre.

Throughout the research study, the graduate student reflected on how her values and beliefs influenced her understanding of the experiences shared, and how interactions with the study sample changed her worldview. It was important for her to understand this influence, as her mindset affected the interpretation of the findings. The graduate student found that her ability to remain neutral and disconnected as an RN did not align with critical social theory, nor was it beneficial to establishing rapport with study participants. It was necessary to be vulnerable about her lack of understanding regarding their experiences, to be open about parts of her story that might influence her understanding, and to allow herself to feel invested in their lives.

Initially, it was difficult for the graduate student to understand why older adults would not reach out for help or critically reflect on their own mental health concerns. However, as the graduate student reflected on the impact of stigma in a small town and the pain of numerous
losses, she began to understand why some older adults had a difficult time being vulnerable or trusting others. Additionally, the graduate student’s ageist beliefs were exposed and deconstructed when she got to know the participants personally and how they coped with their mental health concern. She was surprised by how vocal some participants were, the complexity of feeling valued, and the amount of activity necessary to feel well. However, as she reflected on what she knew to be true for the mental health of other age groups, she began to see how this was still applicable later in life. Similarly, she had not considered how substance use would affect this population. However, the graduate student began to understand that substance use was equally relevant to older adults as it was for other populations. She established empathy for the hardships rural older adults endured when they had a mental health concern, but also admiration for the situations they had overcome and the ways in which they had become their own support. Throughout the study, she felt privileged to be let into private areas of the participants’ lives and invested in addressing their concerns.

**Strengths and Limitations**

The strength of this study is reflected in multiple ways, one of which was the diverse perspectives and experiences of the sample, including their various mental health concerns and the acuity of these concerns. There were large differences between income, education levels, and relationship status amongst the participants. Men and women were both represented as well. Furthermore, to strengthen the rigour of this study, the graduate student strived for transparency in describing the methods used. Alongside transparency, transferability was pursued through the rich insight and descriptions provided into the lives of older adults with mental health concerns in a rural community. This rich insight was reflected through the use of constant comparison. Participants confirmed that this form of analysis accurately brought forward their strengths and
concerns, increasing confirmability. This study was also able to retain all participants (n = 8) from each of the cohort photovoice education sessions through to the member-checking meeting.

The participatory approach taken in this study further strengthened the findings. Participants took the lead on data collection, confirmed and expanded on analysis and interpretation of the data, and helped determine end-of-study KT activities. This approach ensured participants had a sense of ownership over the project, and that findings would be true to their strengths and needs. Participatory methods also enhanced the understanding of how to address the clinical gap for this population, which is integral to interpretive description (Thorne et al., 2004). By having participants, rather than system operators, identify gaps in the system, the true experiences of rural older adults with mental health concerns were exposed. Additionally, the findings identify areas that should be improved in the system. Furthermore, this is one of few studies that has sought to understand the experiences of adults 50 years of age with a mental health concern, and who are living in a rural community.

However, there were limitations to this study as well. Men represented a smaller proportion of the sample (n = 2), although this is consistent with samples in other rural mental health and photovoice studies (Creighton et al., 2017; Oelke et al., 2016). Some participants found that the symptoms of their mental health concerns prevented them from documenting everything they had hoped to. Similarly, physical limitations prohibited participants from taking all their desired photographs. In this sample, most participants identified as Caucasian (n = 6). While the lack of ethnic diversity reflects the demographics of Community A, it may also have been due to recruitment methods (Provincial Health Services Authority, 2019). The researchers could have sought out leaders of minority groups in Community A, and discussed with these leaders how different minority populations would feel about being involved in this study. These
discussions did not occur due to the time constraints of this thesis project. Additionally, this study sought a broad representation of experiences, being mindful of the community demographics. While a variety of recruitment strategies were used (e.g., snowball sampling, posters in numerous public spaces), almost all participants were recruited through HCPs (n = 7). Therefore, most participants had accessed mental health services in some capacity.

**Recommendations**

This chapter has illuminated the complex relationships between some of the major findings of this study. As part of critical social theory, action based upon the findings of this study needs to be taken (Weaver & Olson, 2006). The recommendations that follow are based on what has been discovered through this photovoice study, including recommendations made by participants themselves. As identified by the participants in this study, they often felt they would decompensate to the point of hospitalization because their needs were not met by the system as it currently exists. This outcome costs the public system significantly more than if participants had accessed community-based and out-patient services. Policy, health services delivery, education, and future research have all been taken into consideration and recommendations have been made based on the content of this thesis.

**Policy**

Participants felt that rural communities need to hire more HCPs trained in rural older adults’ mental health. Participants struggled to access services or find a care provider with whom they felt comfortable and understood, and there is a clear need for more HCPs based on the lack of resources in rural areas (see Engaging with Mental Health Services and Supports). To address this need, health authorities should revisit policies around the number and type of service providers required in certain areas, based on the number of older adults in that region. The need
for more HCPs in this area of practice is supported by the literature (Kaufman et al., 2006; Hayslip et al., 2010; Oelke et al., 2016; Bocker et al., 2012). Non-financial incentives, such as housing or better work conditions, should be used to attract and retain HCPs for rural older adult mental health (Humphreys, Wakerman, Pashen, & Buykx, 2009).

**Health Services Delivery**

An integrated health services delivery approach should be used to address rural older adults’ mental health concerns. Health and social services could be offered in centres that also offer educational courses, de-stigmatizing events (e.g., posters and speakers as determined by the population), and resources on food, housing, and subsidized medication programs. Each of these services would help to address major concerns of participants (e.g., basic needs being met, stigma). Such an integrated services centre would also give older adults a place to connect with one another, which older adults in this study desired. Muir-Cochrane et al. (2014) and Kitchen Andren et al. (2013) recommended similar integrated services delivery approaches, and Oelke et al. (2016) noted the concerns around a lack of collaboration between agencies, which an integrated services centre could address. This model could also be enacted with a team that traveled between rural communities and addressed older adults’ mental health needs out of designated spaces in different towns. This would address affordability concerns and transportation issues, as well as the lack of local mental health services.

HCPs should also facilitate the coordination of casual meeting groups for older adults in various settings in the community, such as the seniors’ centre or coffee shops. Here, older adults could establish social connections in safe spaces with like-minded individuals where they would feel supported, heard, and understood. These types of groups would assist in addressing the
significant isolation found to be a concern in the present study and in the literature (Panazzola & Leipert, 2013; Rubio-Aranda et al., 2012; Oelke et al., 2016; Evans et al., 2017).

To promote involvement with the groups and foster relationships, it would be beneficial to have peer advocates within each group who reach out to other older adults. Advocates may promote a sense of ownership over the groups, give older adults control of how the groups run, assist with feeling productive, and increase the likelihood of attendance. These groups could incorporate different forms of exercise or spending time outdoors. These groups could also promote gratitude practices, exploration of spiritual beliefs, and hope, which were reported by participants to be powerful ways of maintaining wellbeing. Inter-generational activities to establish relationships between younger people (e.g., students) and older adults would also foster socialization and promote value for older adults, as discussed by participants. This could be established through partner programs with the local school district and the Seniors Centre, or local mental health groups. This could also work to decrease stigma and ageism with younger populations.

Education

Training and continuing education should be provided for free to those who are working in, or plan on working in, an area related to rural older adults’ mental health. More education would enhance HCPs’ informed care decisions and decrease the stigma, ageism, and frustration participants have reported with the system. This would also address the specialist service gap identified by numerous authors (Bocker et al., 2012; Crowther et al., 2010; Dautovich et al., 2014; Kaufman et al., 2006; Muir-Cochrane et al., 2014).

Public awareness raising initiatives (such as Seniors Mental Health First Aid through MHCC, 2019) should be introduced at low or no cost in rural communities to combat
misinformation and stigma regarding older adults’ mental health in an accessible way.

Community education such as this would address concerns and recommendations made by participants. Furthermore, stigma has been acknowledged as a significant barrier to care and is a major concern in the literature (Hayslip et al., 2010; Kitchen Andren et al., 2013; Oelke, et al., 2016). Stuart (2016) notes that the experience of people with mental health concerns and those with stigmatizing beliefs vary between communities; therefore, it is important to develop initiatives that address each community’s specific needs.

Finally, programs should be introduced in undergraduate health and social development programs to further decrease stigma and ageism, and to generate interest in the field of rural older adults’ mental health. Curricula could address stigma and ageism, and encourage students to think critically about location and age influences on mental health. This could also draw more HCPs into this under-staffed area and would address concerns raised by Lyons et al. (2017) as well as participants’ feelings of being misunderstood by HCPs.

Future Research

An intervention study should be conducted to test and evaluate support groups (as outlined above) to determine if they are effective in addressing rural older adults’ needs for socialization and understanding by peers. Throughout the development, testing, and evaluation, a patient-oriented approach should be taken to empower the population and ensure buy-in and establish meaningfulness. Patient-oriented approaches are supported by the Canadian Institutes for Health Research and these approaches have shown great success with research studies and interventions (Fergusson & Monfaredi, 2018).

Initiatives should also be developed and tested to reduce stigmatizing beliefs and attitudes of those in rural communities who do not live with a mental health concern. With this
understanding, educational or de-stigmatizing initiatives could be developed to address the issue of stigma for older adults with mental health concerns in rural areas on a larger scale. The importance of such initiatives was discussed by the MHCC (2014) that described a number of factors that influence mental health stigma in the older adult population.

Research should also be conducted on how the beliefs, values, and attitudes of the friends of older adults with mental health concerns impact their relationships and their mental health. There is a lack of literature on this topic. Furthermore, this was identified as a significant factor in maintaining wellbeing for the participants in this research study.

Finally, research should be conducted to explore the experiences of sub-groups within the population studied. For example, the experiences of rural older adults who use substances to cope with distressing emotions should be explored further. Participants expressed dissatisfaction with how substance use is addressed in rural communities. Additionally, gender differences should be explored to see if they impact mental health experiences/needs differently and whether services need to accommodate these differences.

**Conclusion**

This thesis asked the question, “What are the experiences of older adults with mental health concerns in rural areas?” A photovoice study was conducted in the southern interior of BC with eight participants to answer this question. There were six major themes: the photovoice experience (how being involved with the study impacted participants), mental wellbeing (factors that impacted older adults’ ability to care for their mental health), losses (including physical, emotional, and mental), stigma (public, self-stigma, and ageism), the environment (rural living, finances, home environment), and services and supports (barriers, negative experiences, positive experiences).
Dissemination of the results of this study may facilitate increased awareness in Community A of the experiences of adults aged 50 and over living there with a mental health concern. This may assist in reducing the stigma around mental health. Furthermore, the results may be helpful in providing health and social care providers with important information to improve the support for rural older adults’ mental health. The results from this study have the potential to inform better care and support for rural older adults with mental health concerns. With more informed resources and care providers, older adults may feel more comfortable accessing community care rather than waiting until they need to be hospitalized. This outcome would decrease the burden on the health care system as this population grows and improve the mental health of rural older adults.
References


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10.1177/109019819702400309


## Appendix A

### Search Strategy

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Appendix B

Rural Mental Health Photovoice Study

Personal Information Questionnaire

Research ID Number: __________________________

1. Age (in years):

_____________________________________________________________________

2. Sex:

☐ Male
☐ Female
☐ Other ______________________
☐ Do not wish to specify

3. Marital status

☐ Single
☐ Married
☐ Common-law
☐ Separated/divorced
☐ Widowed

4. Educational status

☐ Less than high school
☐ High school
☐ Some post-secondary
☐ College/technical diploma
☐ University degree
☐ Postgraduate education
5. Employment status:

- [ ] Employed full-time
- [ ] Employed part-time
- [ ] Unemployed
- [ ] Not employed, not looking for work
- [ ] Homemaker
- [ ] Student
- [ ] On sick/disability leave
- [ ] Receiving provincial disability income benefits
- [ ] Retired

6. Total (or Combined) Household Income per Year (estimate):

- [ ] Less than $25,000
- [ ] $25,000-$39,999
- [ ] $40,000-$59,999
- [ ] $60,000-$79,999
- [ ] $80,000-$99,999
- [ ] More than $99,999

7. Ethnicity: Please indicate all that apply:

- [ ] White (i.e., Caucasian)
- [ ] Aboriginal
- [ ] Chinese
- [ ] South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)
- [ ] Black
- [ ] Filipino
- [ ] Latin American
- [ ] Other, please specify: ____________________________
- [ ] Southeast Asian (e.g., Vietnamese, Cambodian, Malaysian, Laotian, etc.)
- [ ] Arab
- [ ] West Asian (e.g., Iranian, Afghan, etc.)
- [ ] Korean
- [ ] Japanese

8. Have you ever been diagnosed with a mental health disorder?

- [ ] Yes
- [ ] No

If yes, please indicate what type of disorder you were diagnosed with:

- [ ] Anxiety
- [ ] Depression
- [ ] Bipolar Disorder
- [ ] Schizophrenia (or some type of psychotic disorder)
☐ Other, please specify ________________________________

If you haven’t been diagnosed, please describe briefly your mental health concerns:

________________________________________________________

________________________________________________________

________________________________________________________

9. Other health concerns:

☐ Diabetes
☐ Stroke
☐ Heart disease
☐ High blood pressure
☐ High cholesterol
☐ Asthma
☐ COPD
☐

☐ Cancer, please specify: _______________________________________

☐ Other health condition(s), please specify: _________________________

________________________________________________________

________________________________________________________
Appendix C

Rural Mental Health Photovoice Study

Training Workshop Outline

1. Introductions
   o Study Team (including who is facilitating this session)
   o Participants

2. Review selected themes from the focus group

3. Introduce Photovoice
   o Used for people to “identify, represent, and enhance their community” through photographs, interviews, captions and knowledge translation (Wang & Burris, 1997, p.1).

   o 3 main goals: to help people reflect on strengths and concerns of their community, to encourage discussion about the photographs, and to impact policymakers (Wang & Burris, 1997)

   o Photovoice within this project:

4. Using themes from initial group session to guide photo-taking

5. Part of Lauren Airth’s Master of Nursing thesis

6. Study goals: understand the mental health experiences of adults 50 years of age and older in xxxx, to help participants to tell their stories, and to raise awareness and understanding of community members, health care providers, and stakeholders

7. Examples: go through previous Photovoice study photos and have participants describe what they see, how it makes them feel, how it changes their perception (Jongeling, Bakker, van Zorge & van Kakebeeke, 2016)

8. LUNCH

9. Ethics
   a. Safety while taking photos: do not put yourself at risk in order to take a photo (while driving, in an unsafe area, with unsafe people), pay attention to your surroundings, be respectful (Amos, Read, Cobb & Pabani, 2012)
b. Taking photos of others
   1. Do not take photos of anyone who is younger than 19 years of age

   2. Need to consider: privacy (receiving permission from people and/or private property shown in a photograph), false representation (subject not misrepresented by photographer’s narration), benefiting from someone’s likeness for commercial use (photos may be safely used by researchers, not to be sent to other organizations). (Amos et al., 2012)

   3. Review the consent release form to be signed by anyone who appears in their photos. Discuss ways to approach and explain this.

c. Data storage: participants need to keep cameras on their person or stored safely in their home.

10. Photography

   a. Review the instructions for the cameras acquired (on/off, focusing, where to view photos on the camera, where the sd card is stored, changing settings, how to charge)

   b. Photography basics
      1. Use participant feedback on what constitutes a good photo
      2. Refer to photography page in their workshop booklet

11. Have participants take “practice photos” (Jongeling et al., 2016)

12. Review timeline and remaining phases of the study

13. Thank participants for their time, remind them of the voluntary nature of the study, remind them how to contact the researchers if they have any questions or concerns.

References


Appendix D

Rural Mental Health Photovoice Study

Photovoice Information

1. Safety

*Your safety is most important.*

Only take photos where you are comfortable and with people you are comfortable with. You do not need to push yourself to do something that feels uncomfortable or unsafe.

Remember to not put yourself at risk when taking a photo. Please do not take photos while you are driving, if you are in an unsafe area or with unsafe people. Always pay attention to your surroundings and be respectful of others.

Lauren Airth: xxx-xxx-xxxx or lauren.airth@alumni.ubc.ca

Dr. Carolyn Szostak: 250-807-8736 or carolyn.szostak@ubc.ca

Dr. Nelly Oelke: 250-807-9880 or nelly.oelke@ubc.ca
2. The ethics of taking photos: Some do's and don’ts

When taking photos, there are a few things that must be kept in mind.

**Privacy:** It is important that you always receive permission from the person and/or the owner of private property that you would like to take a picture of before you take the photo. Please tell them a bit about the study and have the person read and sign a copy of the Consent to be Photographed form. Also, give them a copy of the form to keep.

Please do **not** take photos of anyone who is younger than 19 years of age.

**False representation:** When someone is presented in a way that is not true or accurate, it is called false representation. For example, a photo could be taken of a child outside a liquor store, making it look as if that is where the child is going, when, in fact, he was actually crossing the street. Please avoid photographing people or situations in an untrue way.

**Benefiting from someone’s likeness for commercial use:** The photos that you take will be your property. With your permission, they may be used safely for the purpose of this project. However, the photos should not be sent or given to other organizations where photos and their subjects may be taken advantage of or used for unrelated purposes. For example, taking a photo of someone else’s property, and then being paid by a real estate agency to use the photo in advertising is not appropriate. Whenever someone else or their private property is in your photo, remember to ask their permission and have them sign a consent form.

**Keeping photos safe:** Please keep your camera on your person or in a safe, secure place in your home at all times. This is to help maintain the confidentiality of you and those in your photos.

3. Using the Camera

We will be using the Canon Powershot Elph 180. We have printed some of the manual for you – the pages that provide basic instructions on using the camera. If you would like to see the manual for the camera online, you can find it at: http://gdlp01.c-wss.com/gds/2/0300022102/01/elph190is-ixus180-cu-en.pdf
Turn the camera on or off.

Slide this tab towards you to zoom in, and push it back to this position to zoom out.

Press this button lightly until it makes a "beep" noise (this helps the camera focus), then push the button down fully to take a photo.

This is the type of photo the camera is taking.

How much charge is in the battery?

View photos you’ve taken.

Record videos (please do not use for this study).

The camera chooses the best settings for your photos.

Turn the flash on/off.

Manually choose the settings for the photo.

See the date, time, and type of photo.

The camera automatically zooms in on people/things.

Delete a photo.

Change different camera settings.

Located on the bottom of the camera, slide this silver compartment to the right to open it.

SD Card, to store photos.

Push this brown tab up to insert the battery.

This battery can be removed by pushing it in slightly first, then it pops out, and can be put in the charger.
4. Taking photos – some photography tips

✓ Steady yourself before taking photos by keeping feet spread shoulder width apart and elbows tucked in

✓ Remember to keep your fingers away from the lens

✓ Try and frame what you want the photo to focus on. Sometimes, photos that are not centered are more interesting

✓ Not everything or everyone needs to be posed, sometimes candid shots capture your experience best

✓ Keep distance in mind

✓ Always use the flash

✓ When possible, keep the sun at your back

5. The next steps …

For the next 2-4 weeks, you will take pictures that are related to the topics that were identified at the first meeting. You may take as many photos as you want. You may find it helpful to keep a journal to reflect on why you took different photos.

You will then meet with Lauren for a 1-2 hour-long interview. Before your interview, choose 5-10 photos that are the most meaningful to you. Once you’ve decided on these, please write a caption for each of the selected photos. The caption should help to explain why you took the photo and how it relates to one of the themes.

During the interview, you will talk with Lauren about what it was like taking the photos and what each of the photos mean to you. If you choose to keep a journal, please bring it to the interview to help you recall your thoughts and feelings.

Before you leave today, please sign up for a time to meet with Lauren. Feel free to record the date and time of your interview here:

________________________________________

Lauren will contact you 1-2 days before your interview to remind you of the date, time, and location.
Thank you for your time and effort in being part of our study! If you have any questions, please contact Lauren, Carolyn, or Nelly at any time (their contact information is on the front of this booklet).

References


Appendix E

Rural Mental Health Photovoice Study

Consent Form

Who is conducting this study?

Principal Investigators:
Dr. Carolyn Szostak is an associate professor in the Department of Psychology at the University of British Columbia – Okanagan (UBCO). She can be reached by telephone at 250-807-8736. Her e-mail address is: Carolyn.Szostak@ubc.ca. Ms. Sharon Evans is the President of the South Okanagan Similkameen Mental Wellness Society/BC Schizophrenia Society-Penticton Branch. She can be reached by telephone at 250-493-7338. Her e-mail address is: bcsspenticton@shaw.ca

Co-Investigators:
Dr. Nelly Oelke is an assistant professor in the School of Nursing at UBCO. She can be reached by telephone at 250-807-9880. Her e-mail address is: Nelly.Oelke@ubc.ca. Lauren Airth is conducting this study as part of her thesis work for the Master of Science in Nursing program at the UBCO. She is also a Registered Nurse. Dr. Oelke and Dr. Szostak are her research supervisors. She can be reached by telephone at xxx-xxxx-xxxx. Her e-mail address is: lauren.airth@alumni.ubc.ca.

Other study team members:
Karen Fulton, an Adult and Seniors Mental Health Nurse, works at the xxxx/xxxxx Mental Health/Substance Use Clinic. Nola Mensch is a community member.

Who is funding this study?

This research is funded a South Okanagan Similkameen Community Health Research Grant. It is also supported in part by funds provided to C. Szostak by the UBCO Provost’s Office.

Why are we doing this study?

Mental health is an important health issue. As we get older, we go through many changes in our living situation, such as retirement, changes in physical health – all of which can impact our mental health. Older adults who live in a rural community often experience even more challenges. For example, services and supports are more limited. As well, lack of transportation and costs can make it harder to access services. Unfortunately, not much is known about adults who are 50 years of age or over and who have mental health concerns. This information will help the community to be more
aware and have a better understanding of mental health. It will also help us to develop better services for older adults who live in a rural community.

Who can take part in this study?

If you

☐ have some type of mental health concern (you do not have to have been diagnosed with a mental health disorder),
☐ live in xxxx or surrounding area, and
☐ are at least 50 years old

you may be eligible to take part in our study. While English doesn’t have to be your first language, you must be able to speak and read English at around a Grade 8-9 level. Unfortunately, if you are not able to provide informed consent you will not be able to take part in our study. For example, you will not be able to participate if you have any kind of health problems that severely affects your cognitive abilities, such as memory, understanding, or language. Also, if you live in a long-term care home you will not be able to take part in this study.

What does participation involve?

There are several parts to this research project. These are described below:

1. You will first attend a meeting with about nine other interested people. At this meeting, we will tell you more about the study and then ask you to sign a Consent Form. Then we would have a discussion of what it is like to live in xxxx as someone who is over 50 and who has mental health concerns. Finally, the group will decide what they would like others (friends, family, health care providers) to know about your experiences. This will help to guide the rest of the project. This initial meeting will be between 2-3 hours long.

   With everyone’s permission, the discussion (after consent forms have been signed) will be audio-recorded. Notes will also be taken during this meeting. A member of the study team will transcribe the recording. No identifying information will be included in the transcripts or notes.

2. A few days later you will attend a workshop (about 5 hours long; lunch and snacks will be provided) with the other participants. Here, you will learn about taking photos, including how to do this in a way that respects you and others. You will also have a chance to practice taking photos. You do not need a camera; you will be given a camera to use throughout the study.

3. You will then spend 2-4 weeks taking as many pictures as you want. All of the photos should be related to the topics that were decided upon at the first meeting. When you have taken all of your photos, you will need to choose 5-10 photos that
are the most important to you. For each photo, you will try to write a small caption that describes what the photo means to you. If you haven’t written your captions before your interview (see #4), you can create them during the interview. During this time, you may want to keep notes about your experiences, what it was like taking the photos, and what your thoughts were about each photo. We will give you a journal for this purpose.

4. You will then take part in an interview with Lauren Airth, the Master of Science in Nursing student. This interview will take 1-2 hours. She will ask you a series of questions about what it was like taking the photos, and what each of the photos mean to you. If you choose to keep a journal, please bring it to the interview to help you recall your thoughts and feelings. If you didn’t write captions for your photos, you will be able to create them during the interview.

You will be asked to bring the camera with your photos to the interview. We will transfer the selected photos to the research laptop. You will also be asked at your interview if we can copy all or some of the other photos that you took. While we will not be using these photos in the present study, we would like to be able to use them later. Also, we will contact you before we do anything with these photos to be sure that you are still willing to let us use them in our research.

With your permission, your interview will be audio-recorded. As well, notes will be taken. Again, no information that could identify you will be included in the transcripts or the notes.

5. Once Lauren has interviewed everyone and we have analyzed everyone’s photos and their answers to the questions, you will be asked to come to another meeting with all of the other participants. At this meeting, we will discuss the findings with you and then you will help decide how to share the findings of the study. Depending upon your interests, you will be able to help plan and organize presentations of the findings. You will also be asked to provide consent for us to use your selected photos in some (or all) of the presentations and publications. This meeting will be about 4 hours long.

With permission of everyone, this session will also be audio-recorded and notes taken. Again, no identifying information will be included in the transcripts or notes.

ALL sessions (group meetings and individual interviews) will be held in a community setting that will provide sufficient privacy.

It is important to know that participation in this study is completely voluntary. You may change your mind at any time. If you decide that you no longer want to take part in the study, please contact Carolyn Szostak (250-807-8736 or carolyn.szostak@ubc.ca) or Lauren Airth (xxx-xxx-xxxx or lauren.airth@alumni.ubc.ca). If you decide to withdraw before we have started to analyze the data, all information that you have provided to us will be destroyed. However, if you withdraw once analysis has begun, we will make sure
that we do not include any of your photos or quotes from your interview in any presentation or publication.

**What are the risks associated with participating in this study?**

You may experience some feelings of sadness, anxiety, or distress as you take part in this study. For example, as you take your photos, it is possible that you will think about things that have been difficult or upsetting for you. As well, when you take part in the group meetings and/or the one-on-one interview, you will be asked to talk about your mental health concerns and how they have affected you. Please know that you do not have to answer any questions that make you uncomfortable. You are encouraged to talk about things that you are comfortable sharing with us and/or the other participants. Information and resources regarding mental health and mental health support will be provided to you during the initial workshop. During the group meetings and interview (with Lauren), you can ask to take a break or to stop at any time. Remember, you can withdraw from the project at any time.

There are also some legal and ethical issues about taking photos – especially if you want to photograph people or someone’s private property. For example, it is important to respect the privacy of others. You will receive training about these issues (see Point 2 in “What does participation involve?”). We will also talk about staying safe when you are taking photos. You will also be given a short brochure that describes the main points from this workshop.

All photos that you take belong to you. While we cannot control what you do with your photos (beyond the research activities), in order to respect the privacy of others, we would ask that you not post any of your photos of people who are identifiable or private property on the Internet (e.g., social media sites).

There is the possibility that as you take photos or when the results are presented, others will learn that you are taking part in this study, and that you have some kind of mental health concern. We will do our best to protect your privacy (see below for more information).

**What are the benefits of participating in this study?**

There is no guarantee that you will directly benefit from participating in this study. However, you may gain a better understanding of mental health and your mental health concerns. This may include learning what you can do to improve your personal wellbeing. You will be given a copy of the summary report of this study.

You will also have a say in what key issues will be addressed by the research project and how the findings will be presented. That is, you will work collaboratively with the researchers and the other participants. This experience may help you to feel more socially connected, and less isolated. You may also develop new skills or interests.
The community may also benefit from this research. An important part of the study will be to let the community at large know what we learned. The findings may help to promote increased awareness of mental health-related issues, decrease stigma, and improve community resources. This will be achieved through the activities that are conducted at the end of the study.

**Will you be paid for participating?**

You will receive up to $100 for taking part in this study, as follows:

1) initial session: $10.00
2) photovoice training session: $20.00
3) interview: $40.00
4) end-of-study meeting: $30.00

Also, refreshments and/or a lunch will be provided at all of the research sessions. In addition, you may keep the camera as a gift (approximate value: $135.00). You will be given hard copies of the photos that you discussed in the interview.

**How will your privacy be maintained?**

All information that you provide us will be kept confidential. However, because you will be working with other participants, they will know who you are. All participants will be asked to respect the privacy of everyone, and to not tell others who is taking part in the study or what anyone said at the meetings.

As you take your photos, it is possible that others may learn about your involvement in this project – especially if you take pictures of people or private property. As part of the training workshop, we will discuss things that you can do to protect your privacy.

You will be assigned a unique research ID number to protect your confidentiality. This number will be used to identify your information (e.g., interview transcript, photos). This will help us to track your data while keeping your identity private. Only the researchers directly associated with this study will be able to access these files. If you are (or have been) a client of Karen Fulton, who is a member of our study team, please be aware that she will not have access to any files that can be linked to you. Also, your decision to take part in this study (or not) will not have any impact on the services that she provides to you.

Signed consent and release forms will be stored in a locked filing cabinet in Carolyn Szostak’s UBC office. Paper copies of other documents (e.g., prints of your photos, the demographic questionnaire) will be stored in a locked filing cabinet in Carolyn Szostak’s research space at UBCO. Electronic data files (e.g., photos, transcripts) will be stored on Carolyn Szostak’s encrypted and password-protected research laptop that will be used for this study. All electronic files will be backed up on a part of the secure UBC network that only the researchers will have access to. We will keep all research files for at least 5 years after publication of the findings, when they will be deleted or shredded.
Some photos will be included in presentations and publications. These presentations and articles will be used to let community members, community leaders, and health care providers in the South Okanagan and Similkameen know what we learned from this study. We also plan on presenting the findings at professional meetings and in journals. Finally, the results of this study will be published as part of Lauren Airth’s thesis, which will be available online. Because some of the photos may include things (e.g., tattoos, road address) that can be linked back to individual participants, it will be completely up to you to decide which of your photos may be included in presentations and/or publications. You will also be given the choice of being anonymous, or to be credited for your photos and/or quotes from the interview. You will be asked to sign a release form that describes your preferences at the final group session.

**Will the data be used for other purposes?**

This study may be extended to other communities. If this happens, data from this study may be compared with the other sets of data. Also, photos that were not included in the present study may be analyzed later. You will be asked if we can keep a copy of the other photos that you took but were not discussed at your interview. You will be contacted before we analyze these photos to confirm that we have your permission to use your photos in this research.

**Who can you contact if you have any questions about the study?**

If participants have any questions or concerns about this project and you are being asked to, please contact Carolyn Szostak at 250-807-8736 or by e-mail at: carolyn.szostak@ubc.ca.

**Who can you contact if you have complaints or concerns about this study?**

If you have any concerns about your rights as a research participant and/or your experiences while participating in this study, you may contact the Research Participant Complaint Line in the UBC Office of Research Services at 1-877-822-8598 or the UBC Okanagan Research Services Office at 250-807-8832. Participants can also contact the research office by email: RSIL@ors.ubc.ca. Please reference the study number H18-00652 when calling so that the Complaint Line staff can better assist you. You may also contact the Chair of the Interior Health Research Ethics Board by phone at 250-870-4602 or via email to researchethics@interiorhealth.ca.
Rural Mental Health Photovoice Study
Statement of Consent

Would you like to participate in this study?

Your decision to take part in this study is completely up to you. You may refuse to participate without any negative consequences. In addition, you can decide to stop participating at any time during the study.

Your signature below indicates that you have been given a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study and that you agree to the use of the photos that you selected in the data analyses.

Participant Signature ____________________________ Date ____________

Printed Name of Participant ____________________________

I consent to the initial group meeting being audio-recorded: ☐ Yes ☐ No

I consent to my interview being audio-recorded: ☐ Yes ☐ No

I consent to the final group meeting being audio-recorded: ☐ Yes ☐ No

Preferred Contact Information (phone or e-mail)

To be completed by research team:

Research ID: ____________________________
Appendix F

Rural Mental Health Photovoice Study

Consent Form

Who is conducting this study?

Principal Investigators:
Dr. Carolyn Szostak is an associate professor in the Department of Psychology at the University of British Columbia – Okanagan (UBCO). She can be reached by telephone at 250-807-8736. Her e-mail address is: Carolyn.Szostak@ubc.ca.
Ms. Sharon Evans is the President of the South Okanagan Similkameen Mental Wellness Society/BC Schizophrenia Society-Penticton Branch. She can be reached by telephone at 250-493-7338. Her e-mail address is: bcsspenticton@shaw.ca

Co-Investigators:
Dr. Nelly Oelke is an assistant professor in the School of Nursing at UBCO. She can be reached by telephone at 250-807-9880. Her e-mail address is: Nelly.Oelke@ubc.ca.
Lauren Airth is conducting this study as part of her thesis work for the Master of Science in Nursing program at the UBCO. She is also a Registered Nurse. Dr. Oelke and Dr. Szostak are her research supervisors. She can be reached by telephone at xxx-xxx-xxx. Her e-mail address is: lauren.airth@alumni.ubc.ca.
Other study team members:
Karen Fulton, an Adult and Seniors Mental Health Nurse, works at the xxx Mental Health/Substance Use Clinic. Nola Mensch is a community member.

Who is funding this study?

This research is funded a South Okanagan Similkameen Community Health Research Grant. It is also supported in part by funds provided to C. Szostak by the UBCO Provost’s Office.

Why are we doing this study?

Mental health is an important health issue. As we get older, we go through many changes in our living situation, such as retirement, changes in physical health – all of which can impact our mental health. Older adults who live in a rural community often experience even more challenges. For example, services and supports are more limited. As well, lack of transportation and costs can make it harder to access services.
Unfortunately, not much is known about adults who are 50 years of age or over and who have mental health concerns. This information will help the community to be more aware and have a better understanding of mental health. It will also help us to develop better services for older adults who live in a rural community.

Who can take part in this study?

If you

☐ have some type of mental health concern (you do not have to have been diagnosed with a mental health disorder),
☐ live in xxxx or surrounding area, and
☐ are at least 50 years old

you may be eligible to take part in our study. While English doesn’t have to be your first language, you must be able to speak and read English at around a Grade 8-9 level. Unfortunately, if you are not able to provide informed consent you will not be able to take part in our study. For example, you will not be able to participate if you have any kind of health problems that severely affects your cognitive abilities, such as memory, understanding, or language. Also, if you live in a long-term care home you will not be able to take part in this study.

What does participation involve?

There are several parts to this research project. These are described below:

1. You will first attend a meeting with about six other interested people. This meeting will be between 4-5 hours long; lunch and snacks will be provided. At this meeting, we will tell you more about the study and then ask you to sign a Consent Form and complete a short questionnaire that will provide us with a bit of background information about you. After a short break, you will learn about taking photos, including how to do this in a way that respects you and others. You will also have a chance to practice taking photos. You do not need a camera; you will be given a camera to use throughout the study.

2. You will then spend 2-4 weeks taking as many pictures as you want. All of the photos should be related to the topics that were decided upon at the first meeting. When you have taken all of your photos, you will need to choose 5-10 photos that are the most important to you. For each photo, you will try to write a small caption that describes what the photo means to you. If you haven’t written your captions before your interview (see #3), you can create them during the interview. During this time, you may want to keep notes about your experiences, what it was like taking the photos, and what your thoughts were about each photo. We will give you a journal for this purpose.
3. You will then take part in an interview with Lauren Airth, the Master of Science in Nursing student. This interview will take 1-2 hours. She will ask you a series of questions about what it was like taking the photos, and what each of the photos mean to you. If you choose to keep a journal, please bring it to the interview to help you recall your thoughts and feelings. If you didn’t write captions for your photos, you will be able to create them during the interview.

You will be asked to bring the camera with your photos to the interview. We will transfer the selected photos to the research laptop. You will also be asked at your interview if we can copy all or some of the other photos that you took. While we will not be using these photos in the present study, we would like to be able to use them later. Also, we will contact you before we do anything with these photos to be sure that you are still willing to let us use them in our research.

With your permission, your interview will be audio-recorded. As well, notes will be taken. Again, no information that could identify you will be included in the transcripts or the notes.

4. Once Lauren has interviewed everyone and we have analyzed everyone’s photos and their answers to the questions, you will be asked to come to another meeting with all of the other participants. At this meeting, we will discuss the findings with you and then you will help decide how to share the findings of the study. Depending upon your interests, you will be able to help plan and organize presentations of the findings. You will also be asked to provide consent for us to use your selected photos in some (or all) of the presentations and publications. This meeting will be about 4 hours long.

With permission of everyone, this session will be audio-recorded and notes taken. Again, no identifying information will be included in the transcripts or notes. ALL sessions (group meetings and individual interviews) will be held in a community setting that will provide sufficient privacy.

It is important to know that participation in this study is completely voluntary. You may change your mind at any time. If you decide that you no longer want to take part in the study, please contact Carolyn Szostak (250-807-8736 or carolyn.szostak@ubc.ca) or Lauren Airth (xxx-xxx-xxxx or lauren.airth@alumni.ubc.ca). If you decide to withdraw before we have started to analyze the data, all information that you have provided to us will be destroyed. However, if you withdraw once analysis has begun, we will make sure that we do not include any of your photos or quotes from your interview in any presentation or publication.

**What are the risks associated with participating in this study?**

You may experience some feelings of sadness, anxiety, or distress as you take part in this study. For example, as you take your photos, it is possible that you will think about things that have been difficult or upsetting for you. As well, when you take part in the
group meetings and/or the one-on-one interview, you will be asked to talk about your mental health concerns and how they have affected you. Please know that you do not have to answer any questions that make you uncomfortable. You are encouraged to talk about things that you are comfortable sharing with us and/or the other participants. Information and resources regarding mental health and mental health support will be provided to you during the initial workshop. During the group meetings and interview (with Lauren), you can ask to take a break or to stop at any time. Remember, you can withdraw from the project at any time.

There are also some legal and ethical issues about taking photos – especially if you want to photograph people or someone’s private property. For example, it is important to respect the privacy of others. You will receive training about these issues (see Point 2 in “What does participation involve?”). We will also talk about staying safe when you are taking photos. You will also be given a short brochure that describes the main points from this workshop.

All photos that you take belong to you. While we cannot control what you do with your photos (beyond the research activities), in order to respect the privacy of others, we would ask that you not post any of your photos of people who are identifiable or private property on the Internet (e.g., social media sites).

There is the possibility that as you take photos or when the results are presented, others will learn that you are taking part in this study, and that you have some kind of mental health concern. We will do our best to protect your privacy (see below for more information).

**What are the benefits of participating in this study?**

There is no guarantee that you will directly benefit from participating in this study. However, you may gain a better understanding of mental health and your mental health concerns. This may include learning what you can do to improve your personal wellbeing. You will be given a copy of the summary report of this study.

You will also have a say in what key issues will be addressed by the research project and how the findings will be presented. That is, you will work collaboratively with the researchers and the other participants. This experience may help you to feel more socially connected, and less isolated. You may also develop new skills or interests.

The community may also benefit from this research. An important part of the study will be to let the community at large know what we learned. The findings may help to promote increased awareness of mental health-related issues, decrease stigma, and improve community resources. This will be achieved through the activities that are conducted at the end of the study.

**Will you be paid for participating?**

You will receive up to $90 for taking part in this study, as follows:
1) Introduction to the study and photovoice training session: $20.00
2) Interview: $40.00
3) End-of-study meeting: $30.00

Also, refreshments and/or a lunch will be provided at all of the research sessions. In addition, you may keep the camera as a gift (approximate value: $135.00). You will be given hard copies of the photos that you discussed in the interview.

**How will your privacy be maintained?**

All information that you provide us will be kept confidential. However, because you will be working with other participants, they will know who you are. All participants will be asked to respect the privacy of everyone, and to not tell others who is taking part in the study or what anyone said at the meetings.

As you take your photos, it is possible that others may learn about your involvement in this project – especially if you take pictures of people or private property. As part of the training workshop, we will discuss things that you can do to protect your privacy.

You will be assigned a unique research ID number to protect your confidentiality. This number will be used to identify your information (e.g., interview transcript, photos). This will help us to track your data while keeping your identity private. Only the researchers directly associated with this study will be able to access these files. If you are (or have been) a client of Karen Fulton, who is a member of our study team, please be aware that she will not have access to any files that can be linked to you. Also, your decision to take part in this study (or not) will not have any impact on the services that she provides to you.

Signed consent and release forms will be stored in a locked filing cabinet in Carolyn Szostak’s UBC office. Paper copies of other documents (e.g., prints of your photos, the demographic questionnaire) will be stored in a locked filing cabinet in Carolyn Szostak’s research space at UBCO. Electronic data files (e.g., photos, transcripts) will be stored on Carolyn Szostak’s encrypted and password-protected research laptop that will be used for this study. All electronic files will be backed up on a part of the secure UBC network that only the researchers will have access to. We will keep all research files for at least 5 years after publication of the findings, when they will be deleted or shredded.

Some photos will be included in presentations and publications. These presentations and articles will be used to let community members, community leaders, and health care providers in the South Okanagan and Similkameen know what we learned from this study. We also plan on presenting the findings at professional meetings and in journals. Finally, the results of this study will be published as part of Lauren Airth’s thesis, which will be available online. Because some of the photos may include things (e.g., tattoos, road address) that can be linked back to individual participants, it will be completely up to you to decide which of your photos may be included in presentations and/or publications. You will also be given the choice of being anonymous, or to be
credited for your photos and/or quotes from the interview. You will be asked to sign a release form that describes your preferences at the final group session.

**Will the data be used for other purposes?**

This study may be extended to other communities. If this happens, data from this study may be compared with the other sets of data.

Also, photos that were not included in the present study may be analyzed later. You will be asked if we can keep a copy of the other photos that you took but were not discussed at your interview. You will be contacted before we analyze these photos to confirm that we have your permission to use your photos in this research.

**Who can you contact if you have any questions about the study?**

If participants have any questions or concerns about this project and you are being asked to, please contact Carolyn Szostak at 250-807-8736 or by e-mail at: carolyn.szostak@ubc.ca.

**Who can you contact if you have complaints or concerns about this study?**

If you have any concerns about your rights as a research participant and/or your experiences while participating in this study, you may contact the Research Participant Complaint Line in the UBC Office of Research Services at 1-877-822-8598 or the UBC Okanagan Research Services Office at 250-807-8832. Participants can also contact the research office by email: RSIL@ors.ubc.ca. Please reference the study number H18-00652 when calling so that the Complaint Line staff can better assist you. You may also contact the Chair of the Interior Health Research Ethics Board by phone at 250-870-4602 or via email to researchethics@interiorhealth.ca.
Would you like to participate in this study?

Your decision to take part in this study is completely up to you. You may refuse to participate without any negative consequences. In addition, you can decide to stop participating at any time during the study.

Your signature below indicates that you have been given a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study and that you agree to the use of the photos that you selected in the data analyses.

Participant Signature                                      Date

Printed Name of Participant

I consent to my interview being audio-recorded:  □ Yes    □ No

I consent to the final group meeting being audio-recorded: □ Yes    □ No

Preferred Contact Information (phone or e-mail)

To be completed by research team:

Research ID: __________________
Appendix G

Copies of photographic images not selected for this study

Principal Investigators:

Dr. Carolyn Szostak is an associate professor in the Department of Psychology at the University of British Columbia – Okanagan (UBCO). She can be reached by telephone at 250-807-8736. Her e-mail address is: Carolyn.Szostak@ubc.ca.

Ms. Sharon Evans is the President of the South Okanagan Similkameen Mental Wellness Society/BC Schizophrenia Society-Penticton Branch. She can be reached by telephone at 250-493-7338. Her e-mail address is: bcsspenticton@shaw.ca

Co-Investigators:

Dr. Nelly Oelke is an assistant professor in the School of Nursing at UBCO. She can be reached by telephone at 250-807-9880. Her e-mail address is: Nelly.Oelke@ubc.ca.

Lauren Airth is conducting this study as part of her thesis work for the Master of Science in Nursing program at the UBCO. She is also a Registered Nurse. Dr. Oelke and Dr. Szostak are her research supervisors. She can be reached by telephone at xxx-xxx-xxxx. Her e-mail address is: lauren.airth@alumni.ubc.ca.

What we are asking you to do:

As you know, this research project is about the mental health experiences of adults who are at least 50 years of age and who live in xxxx, BC (or surrounding area). As a participant in this study, you took a number of photos related to the focus (defined by you and the other participants) of this project. You then selected 5-10 of your photos that were discussed in your interview today.

You may also have taken a number of other photographs related to this project. At this time, we are asking if you would let us keep digital copies of some or all of the other photographs that you took for this study. While we will not be using these photos in the present study, we would like to be able to use them later – for related research. We will store these photos on Carolyn Szostak’s encrypted and password-protected research laptop. The photos will also be backed up on a part of the secure UBC network that only the researchers will have access to. We will contact you before we do anything with these photos to be sure that you are still willing to let us use them in our research. At that time, we will explain to you exactly how we would like to use these photos. It will be completely up to you if we can use them or not. You may also decide at that time that you would like us to delete these extra photos.
Who can you contact if you have any questions about the study?

If participants have any questions or concerns about this project and what you are being asked to do, please contact Carolyn Szostak at 250-807-8736 or by e-mail at: carolyn.szostak@ubc.ca.

Who can you contact if you have complaints or concerns about this study?

If you have any concerns about your rights as a research participant and/or your experiences while participating in this study, you may contact the Research Participant Complaint Line in the UBC Office of Research Services at 1-877-822-8598 or the UBC Okanagan Research Services Office at 250-807-8832. Participants can also contact them by email: RSIL@ors.ubc.ca. Please reference the study number H18-00652 when calling so that the Complaint Line staff can better assist participants. You may also contact the Chair of the Interior Health Research Ethics Board by phone at 250-870-4602 or via email to researchethics@interiorhealth.ca.

Consent:

I agree that the research team can keep a digital copy of the other photos that I took as part of this study and that I have given to them. I understand that they will contact me before they use any of my photos for other research purposes. At that time, I can decide which, if any, of my photos that they can use. I can also tell them at that time that I would like them to delete the photos.

My signature also indicates that I have received a copy of this consent form for my own records.

__________________________________________
Participant Signature                              Date

__________________________________________
Printed Name of Participant

I prefer to be contacted by:

Telephone: ________________________________

Email: ________________________________
Appendix H

Rural Mental Health Photovoice Study

Release Form – Use of photographic images

Principal Investigators:

Dr. Carolyn Szostak is an associate professor in the Department of Psychology at the University of British Columbia – Okanagan (UBCO). She can be reached by telephone at 250-807-8736. Her e-mail address is: Carolyn.Szostak@ubc.ca.

Ms. Sharon Evans is the President of the South Okanagan Similkameen Mental Wellness Society/BC Schizophrenia Society-Penticton Branch. She can be reached by telephone at 250-493-7338. Her e-mail address is: bcsspenticton@shaw.ca.

Co-Investigators:

Dr. Nelly Oelke is an assistant professor in the School of Nursing at UBCO. She can be reached by telephone at 250-807-9880. Her e-mail address is: Nelly.Oelke@ubc.ca.

Lauren Airth is conducting this study as part of her thesis work for the Master of Science in Nursing program at the UBCO. She is also a Registered Nurse. Dr. Oelke and Dr. Szostak are her research supervisors. She can be reached by telephone at xxx-xxxx-xxxx. Her e-mail address is: lauren.airth@alumni.ubc.ca.

About the study

This research project is about the mental health experiences of adults who are at least 50 years of age and who live in xxx, BC (or surrounding area). As a participant in this study, you took a number of photos related to the focus (defined by you and the other participants) of this project. You then selected 5-10 of your photos that were discussed in your interview and were included in the data analyses.

In order to let other people know about the findings of this study, we would like to publish the results and to make presentations to various community and professional groups. You and the other participants worked with us to decide upon the nature of these activities.

You are now being asked to tell us how we can use your photos. We would also like to know if you want us to keep your name private. If you give us permission to use some (or all) of your photos, please be aware that this may allow others to know that you participated in the study and that you have experienced mental health concerns. This
may occur even if you are not identified, in any way, as the photographer. Also, if you agree to your photos being included in publications that are web-based (see below), other people may be able to download and use the photo for other purposes. To minimize the likelihood of this happening, all web-based photos will clearly indicate that the photo is copyright-protected.

Who can you contact if you have any questions about the study?

If participants have any questions or concerns about this project and you are being asked to, please contact Carolyn Szostak at 250-807-8736 or by e-mail at: carolyn.szostak@ubc.ca.

Who can you contact if you have complaints or concerns about this study?

If you have any concerns about your rights as a research participant and/or your experiences while participating in this study, you may contact the Research Participant Complaint Line in the UBC Office of Research Services at 1-877-822-8598 or the UBC Okanagan Research Services Office at 250-807-8832. Participants can also contact them by email: RSIL@ors.ubc.ca. Please reference the study number H18-00652 when calling so that the Complaint Line staff can better assist participants. You may also contact the Chair of the Interior Health Research Ethics Board by phone at 250-870-4602 or via email to researchethics@interiorhealth.ca.

Consent for release of the photographic images:

I am aware that my permission to release my photographic images beyond the study, as indicated below, is voluntary. My signature indicates that I consent to the release of my photographs for the uses described below (see page 3) and how I want my photographs to be credited.

My signature also indicates that I have received a copy of this release form for my own records.

<table>
<thead>
<tr>
<th>Participant Signature</th>
<th>Date</th>
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Printed Name of Participant
Rural Mental Health Photovoice Study: Photo Release Consent Form (Research Participant)

A. I, ____________________________, have been taking pictures related to my mental health experiences. This form describes the kinds of presentations and/or publications that the researchers can include my photos in.

Please initial the box(es), for each of your photos, to indicate how we can use your photos.

<table>
<thead>
<tr>
<th>Photo ID</th>
<th>Description of Photo</th>
<th>Local presentations (South Okanagan, Similkameen, and Okanagan regions)</th>
<th>Other presentations (provincial, national, or international)</th>
<th>Local publications (South Okanagan, Similkameen, and Okanagan regions)</th>
<th>Other publications (e.g., professional reports and journal articles)</th>
<th>Lauren Airth’s Master Thesis (note: her thesis is considered a public document and will be available online)</th>
<th>Web-sites created by the researchers</th>
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B. In giving permission to Section A above, I also give permission to be identified as the photographer as indicated below:

Please initial the appropriate box(es) to indicate how you want to be listed (or not).

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<thead>
<tr>
<th>Local presentations (South Okanagan, Similkameen, and Okanagan regions)</th>
<th>Other presentations (provincial, national, or international)</th>
<th>Local publications (South Okanagan, Similkameen, and Okanagan regions)</th>
<th>Other publications (e.g., professional reports and journal articles)</th>
<th>Lauren Airth’s Master Thesis (note: her thesis is considered a public document and will be available online)</th>
<th>Web-sites created by the researchers</th>
</tr>
</thead>
<tbody>
<tr>
<td>I want my FULL NAME to be listed as the photographer</td>
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<td>I want only my FIRST NAME to be listed</td>
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<td>I want a code name chosen by me to be listed</td>
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<td>I do NOT give permission for my name to be used</td>
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Appendix I

Rural Mental Health Photovoice Study

Photo Release Form by Person who was Photographed

Principal Investigators:
Dr. Carolyn Szostak is an associate professor in the Department of Psychology at the University of British Columbia – Okanagan (UBCO). She can be reached by telephone at 250-807-8736. Her e-mail address is: Carolyn.Szostak@ubc.ca. Ms. Sharon Evans is the President of the South Okanagan Similkameen Mental Wellness Society/BC Schizophrenia Society-Penticton Branch. She can be reached by telephone at 250-493-7338. Her e-mail address is: bcsspenticton@shaw.ca.

Co-Investigators:
Dr. Nelly Oelke is an assistant professor in the School of Nursing at UBCO. She can be reached by telephone at 250-807-9880. Her e-mail address is: Nelly.Oelke@ubc.ca. Lauren Airth is conducting this study as part of her thesis work for the Master of Science in Nursing program at the UBCO. She is also a Registered Nurse. She can be reached by telephone at xxx-xxx-xxxx. Her e-mail address is: lauren.airth@alumni.ubc.ca.

About the study
This research project is about the mental health experiences of adults who are at least 50 years old and who live in Xxxx, BC (or surrounding area). Participants have been asked to take photos of things or people in order to help them describe their mental health-related experiences to the researchers. The results of this project will help to increase awareness and understanding of mental health. It will also help us to develop better services for older adults who live in a rural community.

The person who asked if they could take your picture is a participant in our study. Your permission is required in order for them to share your picture with the research team. If you agree, it is possible that the picture of you (along with other pictures taken for this project) will be included in presentations or published in a community or professional report. The photo may also be included in Lauren Airth’s (co-investigator) Masters Thesis. Her thesis is considered a public document and will be available on the Internet. If your photo is included in a presentation or publication, it is possible that people who see your picture may recognize you – even though your name will not be used. All photographs will be stored on Carolyn Szostak’s encrypted and password-protected research laptop. All electronic files will also be backed up on a part of the secure UBC network that only the researchers will have access to. In keeping with UBC policy, all photos will be kept for at least five years after publication of the research findings.

Please be aware that the photos are the property of the person who took them. We, the researchers, have asked everyone who is participating in our study to not post any of their photos that include people who are identifiable or private property on the Internet (e.g., social media sites).
The decision to be photographed is completely up to you. You must be at least 19 years old. If you are not comfortable being photographed or having your photo be shared with the researchers, you are free to say no. You also are able to choose how the photo of you can be used. You can change your mind up until the time that the data are being analyzed. Please contact Carolyn Szostak (see contact information below).

Who can you contact if you have any questions about the study?
Please contact Carolyn Szostak at 250-807-8736 or by e-mail at: carolyn.szostak@ubc.ca if you have any questions about how your photo will be used, if you change your mind about having your photo used, or if you have any other questions about this project.

Who can you contact if you have complaints or concerns about this study?
If you have any concerns about your rights and/or your experiences of being photographed for this study, you may contact the Research Participant Complaint Line in the UBC Office of Research Services at 1-877-822-8598 or the UBC Okanagan Research Services Office at 250-807-8832. You can also contact them by email: RSIL@ors.ubc.ca. Please reference the study number H18-00652 when calling so that the Complaint Line staff can better assist you. You may also contact the Chair of the Interior Health Research Ethics Board by phone at 250-870-4602 or via email to researchethics@interiorhealth.ca.

Consent for release of your photograph:
I am aware that my decision to be photographed and to have the photo used, as indicated below, is voluntary. My signature indicates that I am at least 19 years old and that I consent to the release of my photographs for the uses described below.

My signature also indicates that I have received a copy of this release form for my own records.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

Printed Name

I agree that the photograph of me can be included in (please check all that apply):

- [ ] local presentations (South Okanagan, Similkameen, and other parts of the Okanagan)
- [ ] other presentations (provincial, national, or international)
- [ ] local publications (South Okanagan, Similkameen, and other parts of the Okanagan)
- [ ] other publications (provincial, national, or international)
- [ ] Lauren Airth’s Masters Thesis (note: her thesis considered to be a public document and will be available on the Internet)
- [ ] Web-sites created by the research team
- [ ] I would like to be contacted by the research team before they use any photos that include me in them. Please contact me at:

  Telephone: ____________________________

  Email: ____________________________
Appendix J

Rural Mental Health Photovoice Study

List of Resources

1) Xxxx Mental Health Centre (public services—a referral from your physician is required)
   700 – 3rd Street
   xxxx, BC V0X 1N3
   Phone: xxx-xxx-xxxx
   Toll Free: 1-800-xxx-xxxx
   Hours: Monday – Friday: 8:00 am to 3:30 pm
   Wheelchair accessible

2) South Okanagan Similkameen Mental Wellness Society
   118 – 246 Martin Street
   Penticton, BC V2A 5K3
   Phone: 250-493-7338
   Email: bcsspenticton@shaw.ca
   https://www.facebook.com/SOSMentalWellnessCentre/?ref=hl

3) Canadian Mental Health Association, South Okanagan Similkameen Branch (public services)
   2852 Skaha Lake Road
   Penticton, BC V2A 6G1
   Phone: 250-493-8999
   Email: cmha_sos@shaw.ca
   Website: http://sos.cmha.bc.ca

4) HealthLink BC (public services)
   Call: 811
   Website: www.healthlinkbc.ca

5) Local Crisis Line (public services)
   Phone: 310-6789 (do not add 604, 778, or 250 before the number)

6) BC Partners for Mental Health and Addictions Information – HeretoHelp (public services)
   Website: www.heretohelp.bc.ca
Appendix K

Rural Mental Health Photovoice Study

Recruitment Script

I want to tell you about a research project that might be of interest to you. The people who are running the study are interested in learning about the mental health experiences of adults who are at least 50 years old, and who live in xxxx and nearby communities. This study will involve you taking photos of things that reflect your mental health experiences. You would then meet one-on-one with someone from the research team to talk about some of your photos – the ones that you feel are most important or meaningful. It is hoped that the findings from this project will help to improve mental health resources and support in xxxx. Additionally, the research will help others to have a better understanding of mental health related experiences.

If you would like to know more about this project and what you would be asked to do, here is a pamphlet about the study. You can see that, at this point, the researchers only want to know if you would be interested in having someone call and talk with you and give you more details about the study. If you are interested in talking with someone from the research group about the study, you will need to check the box and sign in the space at the bottom of the Permission to Contact form.

It’s important that you know that your decision will not influence our relationship. In fact, I won’t know if you decide to participate. [In the event that Karen Fulton (RMHPS Co-investigator) approaches someone who is a current client (or has been previously), she will explain that while she may learn about their decision that she will not have access to any of their photos or other files].]
Appendix L

Rural Mental Health Photovoice Study

Permission to Contact

You are invited to take part in a research study that is about the mental health experiences of people who are at least 50 years old and who live in Xxxx, BC (or surrounding area). Mental health is an important health issue. As one gets older, mental health concerns become more complex. For example, changes in our living situation – due to retirement, increasing physical health problems, etc. – can also influence our mental health. Older adults who live in a rural community often experience even more challenges. For example, services and supports are more limited. As well, lack of transportation and costs can make it harder to access services.

Unfortunately, not much is known about older adults with mental health concerns. The information will help the community to be more aware and have a better understanding of mental health. It will also help us to develop better services for older adults who live in a rural community.

To take part in the study, you must:

☐ have experienced some type of mental health concern (you do not have to have been diagnosed with a mental health disorder)
☐ be a resident of Xxxx or surrounding area
☐ be at least 50 years old
☐ be able to speak and read English at around a Grade 9 level

Unfortunately, you will not be able to participate if you cannot provide consent. For example, if you have some kind of health problem that seriously affects your cognitive abilities, such as memory or language, or if you live in a long-term care home.

To help you decide if you are interested in this study, it is important that you know what you will be asked to do. There are several parts to this research project. First, you would come to a meeting with other interested people. At this meeting, we will tell you more about the study and then ask you to sign a Consent Form. Then we would have a discussion of what it is like to live in Xxxx as someone who is over 50 and who has mental health concerns. Finally, the group will decide what they would like others (friends, family, health care providers) to know about their experiences. This will help to guide the rest of the project.

A few days later, you will attend a workshop (about 5 hours long; lunch and snacks will be provided). You will learn about taking photographs, including how to do this in a way
that respects you and others. You will also have a chance to practice taking photographs. You will be given a camera to use throughout the study.

You will then be given two to four weeks to take pictures that are related to the topics that were identified at the first meeting. Then, you will take part in an interview with Lauren Airth, a member of the study team. She will ask you a series of questions about 5-10 of your photos – ones that you think are most important.

Once Lauren has interviewed everyone and had time to analyze everyone's photos and their answers to the questions, we will have another group meeting. At this meeting, we will decide how to share the findings of the study.

ALL sessions (group meetings and individual interviews) will be held in a community setting that will provide sufficient privacy.

If you would like more information on the study or to volunteer, please complete the information on the next page and give the form back to whoever told you about our study. Lauren Airth will contact you within a few days.

If you prefer, you can contact Lauren or Carolyn Szostak for more information.

Thank you!!

Dr. Carolyn Szostak  
Principal Investigator  
Department of Psychology  
University of British Columbia Okanagan  
Ph: 250-807-8736  
Email: Carolyn.szostak@ubc.ca

Lauren Airth  
Co-Investigator  
Master of Science in Nursing Student  
School of Nursing, UBC-O  
Ph: XXX-XXX-XXXX
Please return this form to the person who provided you with it, and they will give it to the research team.

I would like to learn more about the “Rural Mental Health Photovoice Study”. Please have one of the study team members contact me.

Name: __________________________

Phone number: __________________

Email: _________________________

I prefer to be contacted by:

☐ phone

☐ email

☐ either
Appendix M

Rural Mental Health Photovoice Study

You are invited to take part in a research study that is about the mental health experiences of people who are at least 50 years old and who live in Princeton, BC (or surrounding area). This study consists of several parts, including 2 group sessions and an individual interview. As well, over a 2-4 week period, you will take photos about your mental health experiences in Xxxxxxx. In total, you will spend about 12-17 hours over the next 4-6 months. Participants will receive up to $90 to help cover your time and travel costs. We will also provide you with a digital camera to use.

To participate in the study, you must:

- have experienced a mental health concern (it does not need to have been diagnosed)
- live in Xxxxxxx or surrounding area
- be at least 50 years old
- while English doesn’t have to be your first language, you must be able to read and speak English at about a Grade 8 level

You will not be able to participate in this study if you are unable to provide consent (e.g., you have a health problem that seriously affects your cognitive abilities, such as memory or language). Also, if you live in a long-term care facility you cannot participate.

If you are interested in participating or would like more information, please contact: Lauren Airth (Co-investigator, Masters of Nursing student, UBCO) at lauren.airth@alumni.ubc.ca OR xxx-xxx-xxxx.
Appendix N

Rural Mental Health Photovoice Study

Permission to Contact

You are invited to take part in a research study that is about the mental health experiences of people who are at least 50 years old and who live in xxxx, BC (or surrounding area). Mental health is an important health issue. As one gets older, mental health concerns become more complex. For example, changes in our living situation – due to retirement, increasing physical health problems, etc. – can also influence our mental health. Older adults who live in a rural community often experience even more challenges. For example, services and supports are more limited. As well, lack of transportation and costs can make it harder to access services.

Unfortunately, not much is known about older adults with mental health concerns. The information will help the community to be more aware and have a better understanding of mental health. It will also help us to develop better services for older adults who live in a rural community.

To take part in the study, you must:

☐ have experienced some type of mental health concern (you do not have to have been diagnosed with a mental health disorder)
☐ be a resident of xxxx or surrounding area
☐ be at least 50 years old
☐ be able to speak and read English at around a Grade 9 level

Unfortunately, you will not be able to participate if you cannot provide consent. For example, if you have some kind of health problem that seriously affects your cognitive abilities, such as memory or language, or if you live in a long-term care home.

To help you decide if you are interested in this study, it is important that you know what you will be asked to do. There are several parts to this research project. First, you would come to a meeting (about 5 hours long; lunch and snack will be provided) with other interested people. At this meeting, we will tell you more about the study and then ask you to sign a Consent Form. After a short break, you will learn about taking photographs, including how to do this in a way that respects you and others. You will also have a chance to practice taking photographs. You will be given a camera to use throughout the study.

You will then be given two to four weeks to take pictures that are related to the topics that were identified at the first meeting. Then, you will take part in an interview with
Lauren Airth, a member of the study team. She will ask you a series of questions about 5-10 of your photos – ones that you think are most important. Once Lauren has interviewed everyone and had time to analyze everyone’s photos and their answers to the questions, we will have another group meeting. At this meeting, we will decide how to share the findings of the study.

ALL sessions (group meetings and individual interviews) will be held in a community setting that will provide sufficient privacy.

If you would like more information on the study or to volunteer, please complete the information on the next page and give the form back to whoever told you about our study. Lauren Airth will contact you within a few days.

If you prefer, you can contact Lauren or Carolyn Szostak for more information.

Thank you!!

Dr. Carolyn Szostak
Principal Investigator
Department of Psychology
University of British Columbia Okanagan
Ph: 250-807-8736
Email: Carolyn.szostak@ubc.ca

Lauren Airth
Co-Investigator
Master of Science in Nursing Student
School of Nursing, UBC-O
Ph: xxx-xxx-xxxx
Please return this form to the person who provided you with it, and they will give it to the research team.

I would like to learn more about the “Rural Mental Health Photovoice Study”. Please have one of the study team members contact me.

Name: ____________________________
Phone number: ____________________
Email: ____________________________

I prefer to be contacted by:

☐ phone
☐ email
☐ either
Rural Mental Health Photovoice Study

Training Workshop Outline

1) Introductions I: Who is conducting this research? Who is facilitating this session?

2) Review consent form. Answer any questions. Complete Personal Information Questionnaire (if they decide to participate).

BREAK

3) Introductions II: Who is participating in today’s session?

4) Review selected themes from the original focus group

5) Introduce Photovoice

   1. Used for people to “identify, represent, and enhance their community” through photographs, interviews, captions and knowledge translation (Wang & Burris, 1997, p.1).

   2. 3 main goals: to help people reflect on strengths and concerns of their community, to encourage discussion about the photographs, and to impact policymakers (Wang & Burris, 1997)

   3. Photovoice within this project:
      - Using themes from initial group session to guide photo-taking
      - Part of Lauren Airth’s Master of Nursing thesis. Study goals: understand the mental health experiences of adults 50 years of age and older in xxxx, to help participants to tell their stories, and to raise awareness and understanding of community members, health care providers, and stakeholders

6) Examples: go through previous Photovoice study photos and have participants describe what they see, how it makes them feel, how it changes their perception (Jongeling, Bakker, van Zorge & van Kakebeeke, 2016)

7) LUNCH
8) Ethics

1. Safety while taking photos: do not put yourself at risk in order to take a photo (while driving, in an unsafe area, with unsafe people), pay attention to your surroundings, be respectful (Amos, Read, Cobb & Pabani, 2012)

2. Taking photos of others
   Do not take photos of anyone who is younger than 19 years of age
   Need to consider: privacy (receiving permission from people and/or private property shown in a photograph), false representation (subject not misrepresented by photographer’s narration), benefiting from someone’s likeness for commercial use (photos may be safely used by researchers, not to be sent to other organizations). (Amos et al., 2012)
   Review the consent release form to be signed by anyone who appears in their photos. Discuss ways to approach and explain this. All signed consent forms have to be kept in large envelop (we give to them) … bring to interview

3. Data storage: participants need to keep cameras on their person or stored safely in their home.

9) Photography

1. Review the instructions for the cameras acquired (on/off, focusing, where to view photos on the camera, where the sd card is stored, changing settings, how to charge)

2. Photography basics
   a. Use participant feedback on what constitutes a good photo
   b. Refer to photography page in their workshop booklet
   c. Have participants take “practice photos” (Jongeling et al., 2016)

10) Review timeline and remaining phases of the study

Thank participants for their time, remind them of the voluntary nature of the study, remind them how to contact the researchers if they have any questions or concerns.

References


Appendix P

Rural Mental Health Photovoice Study

Interview Guide

This interview guide is based on the “SHOWeD” method discussed by Wang and Redwood-Jones (2001): “What do you See here? What is really Happening? How does this relate to Our lives? Why does this problem or strength exist? What can we Do about it?” (p. 562).

Introduction Script:

1. Thank the participant for their participation in the process
2. Validate that this experience may cause the participant to feel emotional at times and reassure the participant they can take a break if they need to. Encourage the participant to plan a positive activity after the interview.
3. Reassure the participant there is no right or wrong descriptions or answers, and that we are seeking to understand their experiences as they see and experience them.

<table>
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<tr>
<th>Questions</th>
<th>Possible probes</th>
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<tbody>
<tr>
<td><strong>To start the interview:</strong></td>
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</tr>
</tbody>
</table>
| What was it like for you taking these photos? | What sorts of things did you encounter that surprised you?  
What occurred as you expected it to?  
How did this impact you? |

For each photo selected by the participant:
| **What do you See here?** | **What made you decide to take this photo?**  
Describe what you were feeling when you decided to take this picture.  
What strengths are represented in this photo?  
What weaknesses are represented in this photo? |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| **What is Happening in this picture?** | **What was happening before and after you took the photo?**  
Describe events related to this photo which have occurred in the past.  
Which parts of this picture represent your values, beliefs, or experiences?  
What parts of this picture represent helpful or challenging activities for you? |
| **Why does this problem or strength exist?** | **How does what you’re capturing here impact your life as a person with mental health concerns?**  
Describe how this impacts your day-to-day life and/or decisions related to your mental health.  
How does this phenomenon exist in other ways? |
| **How does this relate to Our lives?** | **How does this photo relate to the lives of people in Xxxx?**  
What parts of this photo resonate with you as being true to/unique to Xxxx?  
How would this photo tie into the lives of your community members? |
| **What can we Do about it?** | **How can these thoughts be applied to create a mentally healthy space for older adults in your community?** |

**To end each interview:**
| How can we address the strengths and weaknesses of mental health for people 50 and over in Xxxx? | What would be most important for community members and health care providers to take away from your photos? |