

Best Practice Highlights

Appalachian Patients

Authors: Myra Elder, Ph.D., James Griffith, M.D.,
Richard L. Merkel Jr., M.D., Ph.D., & Diana M. Robinson, M.D.

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Appalachian Population

The Appalachian region, as defined by the federal government, is home to 8% of the U.S. population (24.9 million Americans). The region stretches from southern New York to northern Mississippi along the Appalachian Mountains in all or parts of 13 states: New York, Pennsylvania, Ohio, Maryland, West Virginia, Virginia, Kentucky, North Carolina, Tennessee, South Carolina, Georgia, Alabama, and Mississippi. Appalachia is divided into three sections: Northern, Central, and Southern. Heavily impacted by unemployment and underemployment, Appalachia is one of the poorest regions in the country. Approximately 42% of the region's population is rural, compared with 20% of the national population. The poverty rate in Appalachia is 17.1% (the national poverty rate is 14.7%), and 87% of the region's 420 counties have more than 1.5 times the U.S. poverty rate. Poverty is much greater in Central Appalachia than the other regions of Appalachia and about twice that of the U.S. as a whole.¹

Appalachia is less racially and ethnically diverse, compared to the rest of the U.S.²

Based on the 2010 Census	Total Population	% White	% Black	% Hispanic	% Other
US as a whole	308,745,538	63.7	12.2	16.3	7.7
Appalachia as a whole	25,243,456	83.6	9.1	4.2	3.1
Northern Appalachia	8,384,817	89.6	5.1	2.4	2.9
Central Appalachia	9,060,019	89.8	4.8	3	2.5
Southern Appalachia	7,798,620	70	18.4	7.6	4.0

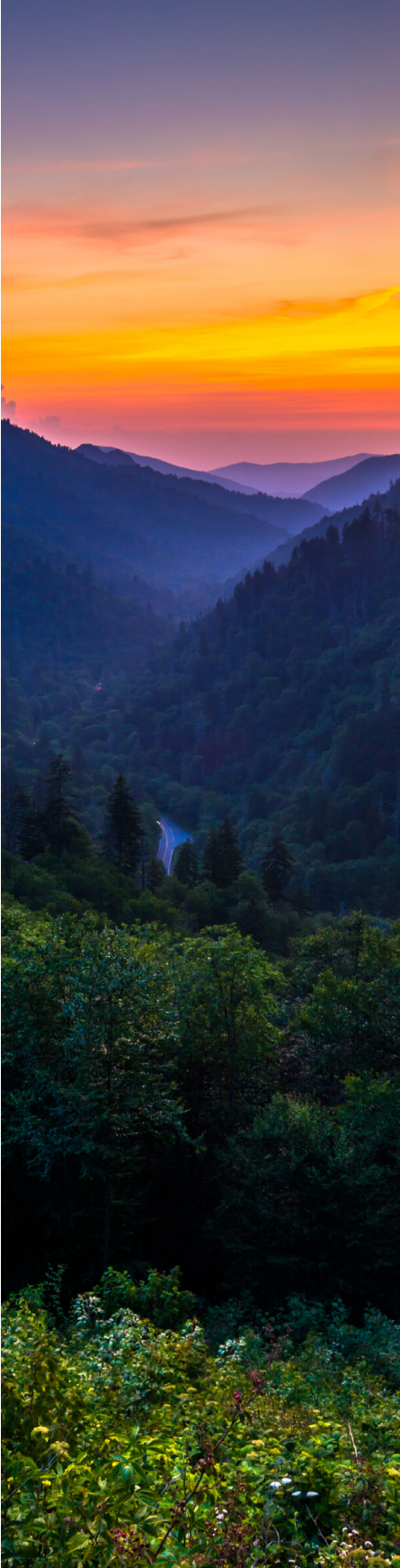
As can be seen in this chart, Central Appalachia is the least diverse, while Southern Appalachia is the most diverse. The Hispanic population is the most rapidly-growing population in Appalachia. The percentage change in the Hispanic population of the US as a whole is 43%, while in Appalachia it is 120%. The white population of Appalachia is only growing slightly faster than the US as a whole, at 1.8 and 1.2% respectively. The growth of the total minority population of Appalachia is almost 50% greater than that of the US as a whole – 42% versus 29% respectively. Most of this growth is in Southern Appalachia, while Northern Appalachia has actually had negative growth.²

The rate of educational attainment in Appalachia is less than that of the US as a whole.²

Based on the 2010 Census	Total Population above 25	Less than High School	High School	Associate Degree	Bachelor or Greater
US as a whole	197,440,772	15.4	49.6	7.4	27.5
Appalachia as a whole	16,656,836	17.7	54.7	7.2	20.4
Northern Appalachia	5,707,850	12.8	57.8	8.1%	21.1
Central Appalachia	6,047,302	21	55	6.4	18
Southern Appalachia	4,901,684	19.5	51.1	6.9	22.5

The rate of educational attainment is lowest in Central Appalachia.

The informal class structure of Appalachia separates those who live in the small and medium size cities and towns from those who live in more rural areas. There is also a significant population of relatively wealthy who live on large properties or may have “get-away” homes in Appalachia and are only temporarily in residence.³ Not only a region, Appalachia has somewhat distinct cultural characteristics. In general, the Appalachian culture is collectivist, compared to the individualist mainstream US culture. Social life revolves around family ties and kinship. Faith is an integral component of the community, and churches have been centers of community services. Appalachian people, especially the rural population, tend to approach their family members and religious leaders first with personal, family, or health problems.⁴ Northern Appalachia has been more influenced by German and Central European cultural traditions, while Southern Appalachia has a greater influence from traditional African American cultural influences. Central Appalachia, and to some degree Southern Appalachia, are closer to the typical impression of Appalachia, with a strong Celtic and Scots-Irish influence. During the late 19th century,



many immigrants from Southern and Eastern Europe, as well as Wales and other Western European countries, along with African Americans, entered the area to work in the coal and timber industries, bringing their cultures with them.⁵

Significant History- Events which influenced the community and contextualize assessment and treatment

Prior to European arrival in the New World, there were many Native American tribal groups in the area now known as Appalachia. The largest were members of the Iroquois Confederacy in the north, which included the Tuscarora. The Shawnee lived in the Ohio Valley area in northwest Appalachia, and the Cherokee lived in Central and Southern Appalachia. These groups gradually lost territory to the Europeans. In 1837 many of the Cherokee were sent west in the infamous Trail of Tears, although some remained hidden in the mountains or had special dispensation to remain. There is a significant Cherokee presence in modern Central Appalachia. Many people who hail from modern Appalachia recognize Native American ancestry.⁶

European immigrants began arriving in Appalachia in large numbers in the early 1700s, although Spanish and French explorers visited the area in the mid-1500s. The largest group of immigrants have been known as the Scots-Irish, although they originated in the lowlands between Highland Scotland and northern England. When England and Scotland began uniting in the mid-1500s, James VI of Scotland became James I of England. Completion of unity occurred under the Act of Union in 1706. At this time, the people living between Scotland and England were seen as renegades and rebels and were transported en masse, first to the Ulster Province of Northern Ireland and then to the New World colonies. They quickly settled in the Appalachian region, where they interacted with and fought against the Native Americans of the region. Many took part in the American Revolution and were prominent in several of the battles. After American independence, immigration slowed.^{7,8}

Many other groups settled in Appalachia, besides the Scots-Irish. Especially in Northern Appalachia, there were large settlements of German, other Central Europeans, and Northern Europeans. There is a population in Appalachia who claim to be descended from very early Portuguese settlers in the region, known as the Melungeons. Africans escaping slavery often hid in the mountains and mixed with Native American populations.⁶

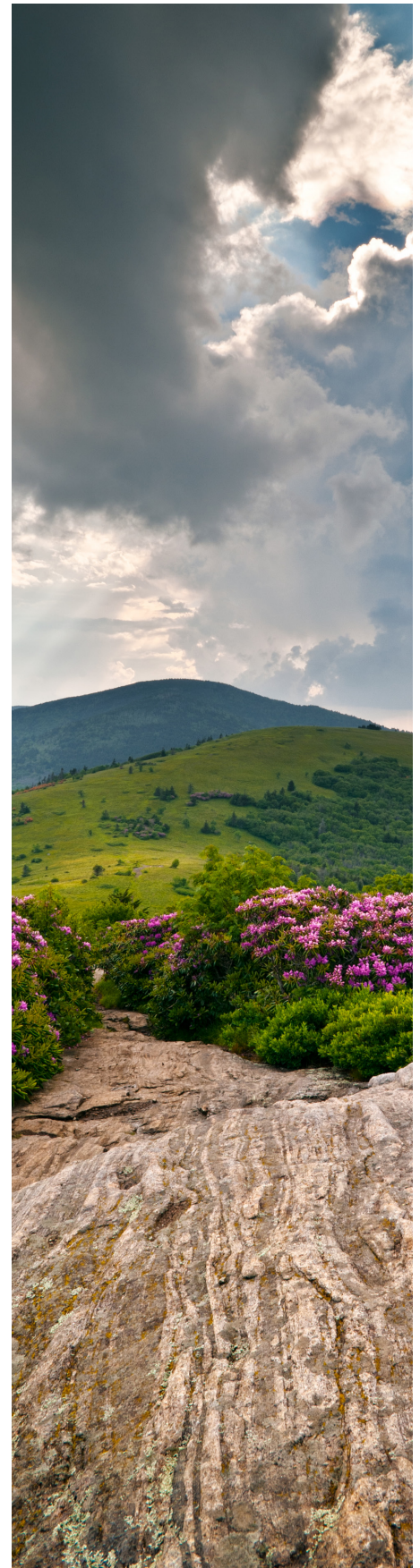
After the American Revolution until the Civil War, Appalachians were mostly involved in agriculture, raising cattle and pigs, supplying most of the pork for the young country. They lived quietly with little outside interference. However, the Civil War was very disruptive and caused

strongly-divided loyalties. There were very few slave owners, and those who owned slaves owned few. Regional loyalties and ties to the regional cities, due to kinship and commerce, played a strong role, drawing many into the seceding south. During this time, because of opposing secession, West Virginia separated from Virginia. Many regional families were divided by the conflict. Parts of Appalachia were seen as vital to both sides, and much fighting occurred in the Tennessee and Shenandoah Valleys.^{6,7}

After the Civil War, the area began to undergo a tremendous change. As it became more industrialized, the growing nation needed raw materials found in Appalachia – timber, iron, and especially coal. The economy shifted from one based on agriculture to one based on the extraction of natural resources. Few in Appalachia benefitted from this economic shift, which disrupted the local culture and kinship structure. Many people were forced off their land and moved into mining and other camps. During this period the stereotype of those from Appalachia was created, seeing them as ignorant, backwards, and violent, allowing and justifying exploitation. This is a tragic period in the history of Appalachia, which in many ways has continued into the present. The present poverty, environmental degradation, and poor health of the region is a direct result of this period and the collapse of the extractive industries in the mid-20th century.

Best Practices

- Awareness of and sensitivity to the cultural context of Appalachian individuals and families should take priority over assessments and interventions guided by professional practices that are customary for mental health professionals from the mainstream culture. How problems are assessed and formulated should be based upon the “insider’s view,” using language, values, and assumptions that belong to the local culture to the extent possible.⁹
- Appalachian culture is more relational than contractual. That is, whether one feels treated with courtesy and respect moment to moment is more highly valued than the expertise, status, or authority of the outside professional or promised benefits of the program that the outsider proposes. Honor and shame are dominant values, which translate into the importance of courtesy, etiquette, good manners, and expressions of respect. Being “down to earth” and authentic is more greatly valued than being an expert with credentials.¹⁰
- While symptom surveys will show elevated scores for depression and anxiety, mental health problems are more greatly driven by “normal syndromes of distress,” such as demoralization, grief, alienation (thwarted belongingness), loss of dignity, spiritual crises, rather than mental illnesses. There are effective methods to provide care for normal syndromes of distress, but they require different skill sets from those for treatment of mood and anxiety disorders. Caution





should be exercised to avoid over-medicalizing social suffering. The question, "What happened to you?," is often more the issue than, "What is wrong with you?"

- Traditional Appalachian families have strong boundaries around them, which can be deceptive for outsiders (including healthcare workers) who mistake hospitality for friendship. A period of getting to know each other person to person, outside of professional roles and settings, is typically needed before openness may be extended to an outside professional to learn about problems or failures within the family. Because of the years of external exploitation and stereotyping, Appalachians are slow to tell outsiders about family business. Non-intrusiveness is an expression of respect.¹¹
- Utilize existing community leaders (i.e., local teachers, pastors who believe in MH treatment) and lay health providers who receive front-line training and offer initial treatment, then refer to more specialized intervention providers.²⁷ Community support groups (i.e., NAMI) provide consumers the opportunity to share recovery stories. Knowing someone who was helped by treatment increases the likelihood of others utilizing healthcare services in this relational culture.^{12,13}
- Mental health services, such as assessment, counseling, and psychopharmacology, need to be expanded in Appalachia through recruitment of more providers, as well as expanding telepsychiatry and counseling services integrated in existing primary care clinics. Successful recruitment methods include targeted marketing of these positions to highlight the region's natural beauty, outdoor activities, lower cost of living compared to urban areas, and lifestyle that may suit providers seeking to raise their families or those in the second phase of their careers.¹⁴
- Screening for mood disorders and suicidality should be done regularly with validated rating scales such as the Patient Health Questionnaire-9 (PHQ-9) and Generalized Anxiety Disorder-7 (GAD-7). Of note, it's important to assess a patient's literacy level when choosing the appropriate format of material.
- Screening for alcohol and illicit substance use should be done regularly with validated rating scales such as the Alcohol Use Disorders Identification Test (AUDIT). Appalachians do not focus on amounts of alcohol use; behavior problems with use are more salient, showing that someone cannot "hold their liquor."
- Due to the high rates of trauma and exposure to adverse events through the life cycle, many people consider these events part of life, but still exhibit symptoms of trauma-related disorders. Corporal punishment of children and even domestic violence may be considered normative or, sometimes, justifiable according to Biblical scriptures.¹⁵ Therefore, in screening for adverse and trauma-related experiences, it is important to ask about specific experiences and

not just use a general question such as “Have you ever experienced a traumatic event?” Some useful questions may be:

1. “Have you ever been hurt physically by someone else, or seen someone else get physically hurt?”
 2. “Are there times when you don’t feel safe at home?”
 3. “Do bad memories from the past ever keep haunting you, forcing themselves into your present thoughts, when you don’t want to think about those things?”
- Medication assisted treatment with buprenorphine, methadone, and naltrexone should be considered for patients with opioid use disorder. Extra time and education may be needed to shift patients/families from the perspective that medications may simply aid addiction substitute one addiction for another.
 - School nurses are an important resource for children and adolescents, as advocates and referrals for access to mental health care. With proper training, they can identify the early warning signs of mental illness and help reduce stigma, as well as provide care coordination.¹⁶
 - Expand transportation services to medical appointments through such demand response programs as Mountain Empire Transit, which serves three counties and the city of Norton, Virginia, for as little as 75 cents per ride.¹⁷

Future Needs

What is needed most is economic development, jobs, and the hope of a better life. Without this, attempts to improve mental health are of limited benefit.¹⁸ Mental health workers can help with this by hiring locally, supporting development efforts, being active in their community, and providing local material support.

- Integrated mental health care through the increased use of behavioral health specialists, community workers, and nurse practitioners in primary care facilities.
- The establishment of Community Networks involving mental health providers, other health care providers, community leaders, and community members, especially peers and consumers.
- Local rural providers need connections with specialty services. Hub and spoke systems with university providers and other tertiary-care facilities have proved to be very helpful. The use of ECHO-type (Extension for Community Healthcare Outcomes) support and training are important.
- Local hospitals are often in desperate need of support and are vital to the local community. Means to support and preserve these through referral and consultation with larger regional facilities is very important.

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