18 Intergenerational and Familial Influences on Mental Illness in Rural Settings and Their Relevance for School Mental Health

Lisa Curtin, Cameron Massey, and Susan E. Keefe

A literature search of intergenerational patterns of mental illness in rural families within the context of school mental health programs quickly results in an absence of findings. However, familial variables relate to mental illness in multiple, reciprocal, and complex ways. Many models of human development highlight the important role of the family and context in the understanding of behavior (e.g., Bowen, 1978; Bronfenbrenner, 1994). Although significant in any environment, acknowledgement and recognition of familial and contextual variables may be of particular importance in rural communities that have relatively small populations, limited resources, widespread knowledge of personal lives, and are often home to multigenerational families (Curtin & Hargrove, 2010). Further, such models are particularly important to consider when working with children and adolescents in the school system where direct access to family members may be limited.

L. Curtin (✉)
Department of Psychology, Appalachian State University, Boone, NC, USA
e-mail: curtinla@appstate.edu

C. Massey
Department of Psychology, University of South Carolina, Columbia, SC, USA

S.E. Keefe
Department of Anthropology, Appalachian State University, Boone, NC, USA

In this chapter, we first describe Bronfenbrenner's ecological model to frame the importance of the family and other contextual variables in the understanding of child and adolescent mental health problems. We then summarize and evaluate relevant literature. Original findings from a contextual investigation of depression in western North Carolina and from a rural school-based mental health program in this same area are used to illustrate the importance of attention to familial and cultural variables. Finally, we make recommendations based upon current theory and research findings, as well as call for continued research to inform the integration of familial and cultural variables into the development, implementation, and evaluation of rural school-based mental health programs.

Bronfenbrenner's Ecological Model: Implications for School-Based Mental Health

Bronfenbrenner's (1994) ecological model of human development offers a useful conceptualization of the variables that influence individual health and behavior. The ecological model can be used to draw attention to potential strengths and relationships that already exist within a child's environment, which, in turn, can enhance and compliment the use of evidence-based treatments. Bronfenbrenner (1994) proposes that there are

© Springer International Publishing AG 2017
K.D. Michael, J.P. Jameson (eds.), *Handbook of Rural School Mental Health*,
DOI 10.1007/978-3-319-64735-7_18

five systems at play: microsystems, mesosystems, exosystems, macrosystems, and chronosystems. *Microsystems* are most proximal to the individual and oftentimes the most influential. Microsystems include the family, the school, the peer group, and the workplace (for adolescents and adults). The majority of the risk factors for child psychiatric disorder(s) identified by Costello, Keeler, and Angold (2001) in their cross-sectional analysis of over 1000 parent–child pairs in four primarily rural North Carolina counties are consistent with Bronfenbrenner's microsystem variables. They found that a family history of mental illness, poor parenting (e.g., lack of parental warmth, harsh discipline), and residential instability mediated the relationship between poverty and psychopathology in both White and Black children in their sample. School-based intervention programs typically focus on these microsystem variables. For example, therapists address peer conflicts with classmates, behavior in the classroom, and parental stress, if parents are willing and able to participate in treatment.

Mesosystems (Bronfenbrenner, 1994) include the relationships between microsystems (e.g., a child's home and school) and may be particularly important to consider in the context of school-based mental health programs. For example, routine assessment for Attention-Deficit/Hyperactivity Disorder, a service commonly provided in school-based mental health programs, includes reports from both the home environment (e.g., parent reports) and the school environment (e.g., teacher reports). Wang and Sheikh-Khalil's (2013) recent investigation provides another example consistent with Bronfenbrenner's mesosystem. They found that greater parental school involvement predicted decreased risk of depressive symptoms among high school students between their time in the tenth and eleventh grade, suggesting that mesosystems relate to child mental health even during the more developmentally independent high school years. School-based mental health programs often link various mesosystems in a child's life, such as local community mental health agencies, social services, law enforcement, and the school (Michael, Renkert, Wandler, & Stamey, 2009).

Exosystems in Bronfenbrenner's model (Bronfenbrenner, 1994) involve features of the mesosystem or microsystem that influence the child's environment and functioning, but do not directly involve the child. For example, a child's home environment, in which he or she is directly involved, may be affected by a parental job change that requires moving. Regardless of the reason, moving four or more times in the past 5 years has been identified as a risk factor for child psychiatric disorders (Costello et al., 2001), suggesting school-based mental health personnel should routinely assess and understand the exosystems that potentially impact their clients.

Bronfenbrenner's (1994) *macrosystems* incorporate the cultural context (e.g., belief systems, resources, customs) of each of the other more proximal systems. For example, shared cultural beliefs influence individual and familial interpretations of mental illness and affect help-seeking behavior. Our (Keefe & Curtin, 2015) exploration of depression among Appalachian natives revealed culturally informed interpretations of psychological distress as indicative of a spiritual problem rather than a mental health problem, as well as themes of self-reliance and a rejection of external help-seeking.

With better access to the Internet in rural areas and greater influence of social media, it is important to recognize that cultural context and sense of community are no longer strictly place-based. Cross-generational conflicts may be in part due to wider exposure to mainstream (e.g., urban) culture, particularly among children and adolescents. Oftentimes, school-based clinicians, along with parents and students, must balance more traditional cultural norms with broader and increasingly competing norms. For example, youth may be open to seeking mental health services, but family members may be reticent given concerns about confidentiality, family reputation, religious beliefs, and stigma.

Finally, Bronfenbrenner's (1994) *chronosystem* captures the environmental and life transitions that an individual experiences whether directly or indirectly (e.g., historical trauma). For example, considerable scholarship has described the multigenerational impact of massive group trauma experiences such as colonization, slavery, and the Holocaust on ethnic and minority groups

(Abrams, 1999). Importantly, Denham (2008) notes the need to distinguish between historical trauma and the historical trauma response, which may result in empowering multigenerational narratives of resilience and resistance rather than suffering and psychopathology. Many families in rural environments may be affected significantly by events that happened several years in the past. For example, some students report bereavement-related issues in response to emotionally charged dialogue about a death that continues to permeate the family. Although this is not uniquely a rural concern, it is possible that deaths within a smaller community have a larger impact on survivors. Similarly, a historically self-sufficient and kinship-based society, typical of many rural communities, may continue to distrust "outsiders" despite changes in economic and social structure in those same communities.

Familial Variables and Child/Adolescent Mental Health

Approximately 20% of children and adolescents in the United States are estimated to have a mental illness, the majority of whom do not receive services (Kataoka, Zhang, & Wells, 2002; Merikangas, He, Burstein et al., 2010). Many factors likely contribute to high rates of untreated mental illness among children and adolescents, including barriers to the availability, accessibility, and acceptability of services that are intensified in rural communities (Blank, Fox, Hargrove, & Turner, 1995; Mohatt, Bradley, Adams, & Morris, 2005; Penchansky & Thomas, 1981). Although school-based mental health services help address many of these barriers (e.g., increased availability and access), it can be challenging to engage parents and families (Langley, Nadeem, Kataoka, Stein, & Jaycox, 2010; Weist et al., 2014). However, attention to parental and familial variables, even in their possible physical absence, is vital.

Nearly all etiological models of mental illness acknowledge the impact and importance of the family, ranging from genetic influences to environmental influences. Risk may be complex and multigenerational in nature. For example, in their longitudinal examination of three generations, Weissman et al. (2005) found high rates of psychopathology among offspring who had both parents and grandparents with impairing depression. They also found that problematic anxiety appeared a reliable early indicator of future psychopathology. In addition to familial-related vulnerability, family variables such as multigenerational poverty, which is reliably greater in rural U.S. communities (Rainer, 2012), may increase the risk of mental illness among children and adolescents (Satcher, 2000). Indeed, Sameroff, Seifer, and Zax (1982) found that chronic parental mental illness, particularly when combined with low socioeconomic resources, increased risk for negative outcomes for children in their longitudinal analysis. Further, parental mental illness may directly or indirectly affect parenting behaviors that, in turn, increase susceptibility to mental illness among children. For example, depression among mothers (Turney, 2011) and fathers (Wilson & Durbin, 2010) relates reliably to increased use of negative parenting strategies (e.g., criticism, psychological aggression) and decreased use of positive parenting strategies (e.g., warmth). In turn, negative parenting strategies relate to increased risk of depression and anxiety among offspring (Ho, Bluestein, & Jenkins, 2008).

A large body of literature examines family functioning in relation to risk for mental health problems. The Family Environment Scale (Moos & Moos, 1994) is a 90-item self-report measure of the social-environmental perceptions of the family environment. It assesses family relationships (e.g., family cohesion), personal growth (e.g., independence of individual family members), and systems maintenance (e.g., organization/structure in family activities/responsibilities). High levels of reported conflict, low levels of cohesion, and low levels of expressiveness in the context of the family relate to greater risk of mental illness (Nader et al., 2013). The majority of this research is correlational in nature and based upon retrospective self-reports, calling into question whether family functioning increases mental illness risk or if having a family member with a mental illness alters family functioning (e.g., increases family conflict).

Lucey and Lam (2012) found that perceptions of family conflict, as well as low family cohesion, dependence, and organization predicted suicide risk among a sample of adolescent outpatients (14–18 years of age). In their sample, perception of family organization (clarity and structure in family activities and responsibilities) was the strongest predictor of suicide risk. School-based mental health professionals are frequently called upon to address suicide risk that is reliably greater in rural areas (Curtin, Cohn, & Belhumeur, 2014; Hirsch, 2006). In their review of the literature, Bridge, Goldstein, and Brent (2006) identified parent psychopathology (specifically depression and substance abuse), family history of suicide, non-intact families of origin, loss through death or divorce, quality of parent–child relationships, maltreatment, and disconnection from major support systems as associated with increased levels of suicidal behavior in teens. Given the impact of suicide ideation, attempts, and completions on the family as well as the potential role of the family in addressing risk for suicide, active attempts by school-based mental health professionals to consider family risk factors and to involve parents or other family members may, in some cases, make the difference between life and death. For example, firearms and pesticides are frequently used methods of suicide, particularly in rural areas (Hirsch, 2006). Family members can be enlisted to prevent potential suicides among school-aged children by preventing access to lethal means in the short term, and by increasing environmental structure in the longer term.

Mental Health in the Context of Schools

Individual schools are oftentimes recognized as a microcosm of the larger community (Hemmings, 2004; McQuillan, 1998; Reck, Keefe, & Reck, 1987). It is likely that administrators, teachers, and students have preconceived notions about individual students based upon last name, family reputation and community standing, or other experiences with family members, including pre-existing knowledge of mental health and behavioral problems. Whether positive or negative, expectations and assumptions influence treatment of individual students, and likely academic and behavioral outcomes (Mistry, White, Benner, & Huynh, 2008; Rosenthal & Jacobson, 1968; Sorhagen, 2013). School-based mental health professionals must attend to and challenge their own and others' preconceived impressions, opinions and expectations of students and their families to form a therapeutic alliance and provide equitable and evidence-based services.

Although rural geography may impose some shared elements that relate to child and adolescent mental health (e.g., increased isolation), rural areas vary significantly from one another (Mohatt et al., 2005). Overall, however, in the United States rural and urban areas can be reliably distinguished by the relatively higher rates of poverty and higher rates of uninsured/underinsured residents in rural areas (Rainer, 2012; Zhang et al., 2008). Within the context of rural schools, socioeconomic status is often apparent via free/reduced lunch programs as well as widespread knowledge of families and their resources. High rates of poverty and lack of adequate insurance coverage, combined with decreased availability and access to services, increases the appropriateness of school-based mental health services in rural communities. Although convenient for the student, it can be challenging to integrate parental or other family involvement when children or adolescents are seen by mental health professionals during school hours (Weist et al., 2014). Family involvement in school-based mental health programs is likely further challenged because as poverty increases, the likelihood of parents working multiple jobs, with limited flexibility and resultant difficulties in ability to communicate and participate in school-based mental health efforts, increases (Langley et al., 2010).

Family Involvement in School-Based Mental Health

As noted above, family members of children identified in the context of the school system as in need of mental health services may be concerned about the, often unfamiliar, provider

"blaming" them for the child's mental health or behavioral problems. Indeed, family members report caregiver stress (Loukissa, 1995) as well as fears of secondary stigma, blame and contamination (Corrigan & Miller, 2004) when a family member suffers from a mental illness. Perceived personal and social stigma toward mental illness and help-seeking tend to be high among rural residents (Mohatt et al., 2005), and need to be carefully considered and addressed in school-based mental health.

Lightfoot (2003) proposes a sociological examination of often unconsidered and unexplored barriers to effective parent–teacher conferences that may also apply to school-based mental health programs. Although parental engagement with the school system has been found to predict student academic success and emotional functioning (Wang & Sheikh-Khalil, 2013), Lightfoot (2003) notes that "ghosts," in the form of parent childhood school experiences as well as broader social differences between parents and teachers (e.g., educational attainment) can exert an unacknowledged emotional influence in parent–teacher relationships. Thus, teachers may experience parents as "uninvolved" rather than considering the possibility that parents may feel insecure in the school environment. Similarly, Weist and colleagues (Weist et al., 2014) noted that school-based mental health providers often attributed their difficulties involving families to negative and dispositional familial factors (e.g., disinterested) often prematurely abandoning efforts to engage with the family to assist the student. Such assumptions on the part of the clinician or other school staff are unlikely to result in positive outcomes for the student.

Obtaining parental or guardian consent is required for child and adolescent mental health services, even when delivered in the context of the school, but securing parental participation and involvement in the therapeutic process can sometimes be the first barrier to treatment. Zahner and Daskalakis (1997) investigated predictors of service use for child mental health issues (ages 6–11) across a variety of settings including specialized mental health settings, general health settings, and school-based services in two cross-sectional community surveys. They found that although severity of child mental health problem(s) predicted use of services across settings, parental belief that the child needed help was the strongest predictor of service use. Often with children and adolescents, parents are reluctant to consent to mental health treatment until significant events have occurred, such as multiple discipline referrals, academic decline, numerous absences, juvenile justice involvement, or even a suicide attempt. The purpose of embedded mental health services within the context of school settings is to provide the option for therapeutic services prior to these significant events occurring.

When engaging parents and/or guardians in a discussion about whether or not services are right for their child, it is important for clinicians to focus on the positive gains which can be made from participation in therapy and to make themselves available to addressing any and all concerns that parents may have regarding the consent and treatment process. Often this process requires clinicians to be sensitive to the cultural aspects of the community, and alter their presentation of the idea of treatment during the consent-obtaining process to ensure participation from the family during the course of therapy. In the case of rural communities, many parents may appear resistant to the topic of "psychotherapy," particularly in reference to their child. Several families have experience with local mental health agencies, and, if negative, carry the stigma of treatment with them from generation to generation. Occasionally, clinicians may find it helpful to avoid the terms "therapy" or "treatment" in favor of "counseling" or "support" in an effort to reduce stigma. Clinicians may also remind parents that since services are provided in schools, they do not run the risk of being seen in the parking lot of the local mental health agency (reducing stigma) and will not have to miss work to drive their children across the county to the local mental health office (addressing transportation, financial, and occupational barriers). The process of obtaining consent may look different from family to family as well, as concerns regarding treatment will likely vary from case to case. Again,

being sensitive to the parent and/or guardian's perspective and focusing on the benefits of treatment can help to ensure parental participation and support during therapy.

Taking time to address parental concerns and questions about school-based mental health services early on and throughout will likely prove successful in establishing a strong working partnership based on mutual respect, family strengths, and mutual concern for the child's well-being. For example, some rural families feel distrust toward schools and governmental rules and regulations. Clinicians who take the time to set up initial meetings with parents to review the particulars of informed consent, privacy practices, and disclosure of protected health information typically see more engagement from parents. Maintaining candid and open communication is critical to continued involvement throughout the student's treatment. The content of the communication must be presented in such a way as to minimize the distance between therapist and family. For example, terms like "clinical elevations," "self-injurious behavior," or even "therapy" can be substituted with terms such as "high," "cutting," or "skill building," respectively, to facilitate communication with parents. These nuances are typically left to the clinician to incorporate and should be based on an understanding of the unique culture in which they are working.

Rural School-Based Mental Health Exemplar: Assessment, Support and Counseling (ASC) Center

In an effort to address barriers to receiving mental health treatment, programs such as the Assessment, Support, and Counseling (ASC) Center, located in western North Carolina on the borders of Tennessee and Virginia, have been established as a viable means of service delivery to children, adolescents, and families (Michael et al., 2009). This center serves multiple schools in rural communities by providing outpatient therapy, crisis response, and consultation to students, teachers, and families in the rural area at no cost. The ASC Center is grant-funded and acts as a model of integrated care that involves university providers, local mental health agencies, community agencies, and school personnel (i.e., school counselors, administrators, nurses, student resource officers) with a focus on alleviating behavioral health symptoms to allow students to return to the process of learning.

Despite this laudable goal, the ASC Center was not initially welcomed by all members of the community. Whereas many parents and other community members were supportive of the idea of trained mental health clinicians helping students with behavioral and emotional problems, some expressed significant concerns and fears regarding the influence of the university on their children. For example, one individual posted on an online blog, "Beware that the county and board of education want to start a program that will expose your child to a shrink… Do you want this invasion of your privacy? This could open a huge can of worms." Another person wrote, "Again, speak up now or opt out later, IF you are allowed to opt out… Yes, the county has some problems, but most parents are very good parents and good people. They are building this up to make it look like our county has a WORLD of trouble… I think having shrinks evaluate the kids is a waste and will lead to major problems. They will mislead kids from normal homes … those are the ones to be concerned about, not the ones who you feel need help." (goashe.net). On the other hand, many individuals replied in support of mental health services being provided in the school. The expressed fears had to be acknowledged and addressed by ASC Center personnel prior to the onset of service delivery to increase the odds of active participation by students and their family members. Concerns such as those noted above do not disappear as they are often embedded in the culture (e.g., skepticism about "outsiders" coming in to "fix" a small community), and must be continually assessed and addressed.

Local Investigation in Rural Appalachia: Family Variables and School-Based Services

Below we present preliminary findings from an investigation of depression among residents in western North Carolina, the same area that houses the ASC Center described above. Certainly, the findings presented here are local and lack generalizability to many other rural communities; however, the methodology utilized to assess and consider the importance of context can apply to any community. The in-depth example highlights how historical and cultural factors influence understanding of a given rural community, and how this knowledge can inform school-based mental health services. Making sense of families and schools requires an understanding of the historical and cultural context, consistent with Bronfenbrenner's (1994) macrosystems and chronosystems. Rural Appalachia has experienced significant changes in recent decades, yet historic cultural patterns continue to influence local families. The mix of old and new in this case study bears some resemblance to many other rural areas where school-based services must be ever adaptable.

Historical and Cultural Context

Appalachia is a geographic region set along the Appalachian Mountain chain, which ranges from northern Alabama to New York (Appalachian Regional Commission, n.d.). Appalachia is a largely rural region of the United States and the population is predominantly white and working class. Often, children and adolescents spend 45–90 min riding buses to and from schools. Local services are also difficult for parents to access given restrictions on time and finances. Seasonal and year-round in-migration has added to the diversity of the population with the development of the recreation and tourism industry in the late twentieth century. In northwestern North Carolina counties, where Christmas tree farming provides much of the counties' annual income, there is an influx of seasonal Hispanic field workers. This pattern of migration has a significant impact on the school systems in these counties, as annual budgets for schools are determined based on the count of kids at the beginning and end of academic years. The influx of children of migrant workers can stretch educational resources, classroom sizes, and overall budgets.

Rural Appalachian natives have a long history of settlement in the region. Most are descendants of northern European immigrants from Germany and the British Isles arriving in the eighteenth and nineteenth centuries. Their pioneer communities were small, egalitarian settlements in which most residents engaged in subsistence agriculture. The subsistence economy was based on family farms, which provided most of their livelihood, and reliance on reciprocal exchange with neighbors, relatives, and friends as well as barter with the local general store for things they could not produce themselves. Extraction of timber, coal, and other minerals, made possible by the railroads built in the late nineteenth and early twentieth centuries, brought about considerable economic integration with the larger nation, especially in the coal mining areas of Central Appalachia. However, in the more agrarian southern section of Appalachia where our case study is located, engagement with the cash economy was minimal until after World War II when electrification and better roads made it possible for manufacturing to enter the region. Many who are alive today remember a time when life was less influenced by the modern world, and these chronosystem influences are palpable in Southern Appalachian communities today.

The rural people of Appalachia retain much of the influence of this premodern culture (Beaver, 1986; Halperin, 1990; Keefe, 1998), and it impacts all other systems via the cultural context as captured in Bronfenbrenner's (1994) macrosystem. In general, Appalachians value family and egalitarianism. They have a communal orientation marked by neighborliness and caring for others. At the same time, they are remarkably self-reliant, demonstrating "cooperative independence" whereby people cooperate in order to preserve their autonomy. People tend to resist charity and desire to be left alone to manage personal

affairs. This can manifest in reluctance to seek mental health treatment. Stigma and its impact on personal reputation, in rural Appalachian communities pose a significant barrier to people who require mental health services. By honoring the autonomy of others, one is likely to avoid social conflict, a trait also valued in Appalachian mountain communities. Thus, people are unlikely to advise others to seek mental health services. Finally, the area is predominantly evangelical Christian and many people embrace a sacred worldview. Because evangelical Christians understand their emotions as God-driven, they may resist psychological interpretations of the meaning of mental illnesses, such as depression, and their treatment (Keefe & Curtin, 2015).

Appalachian Illness Narratives: Informing School Mental Health Services

Much of the following is based on a qualitative study completed by Susan Keefe and Lisa Curtin in 2011[1] as well as examples from the ASC Center that provides school-based mental health services in the same communities. The 2011 study elicited illness narratives by adult Appalachian natives about their experience with depression. An illness narrative is the participant's self-reported culturally informed version of the illness etiology, symptoms, course, and treatment. This approach to the study of illness was developed by Kleinman (1980, 1988) in his research on depression in China and influenced the Cultural Formulation Interview featured in the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5; American Psychiatric Association, 2013).

The value of self-sufficiency with regard to mental health was reflected in the comments by many in our sample, often in the context of the family. As one of our consultants said highlighting macrosystem influences, "In Appalachia, there is self-reliance. You have to be strong. So depression, thoughts of suicide, and abandonment are the easy way out. There's no cultural acceptance of that. You just have to keep fighting on, no matter how much you hate things." Others specifically mentioned that Appalachian natives avoid seeking help from others, again often referring to familial influences as well as the chronosystem and macrosystem. One woman said," I think mountain people didn't have help for so long, so when it finally did come, they ignored it. They were brought up to care for themselves. They don't reach out for help."

Of course, this tradition of self-care is also a reflection of the high number of uninsured in the region. Many parents are uninsured or underinsured and rely on state-funded Medicaid programs for child and adolescent health care that have age restrictions and limitations on coverage that interfere with individuals obtaining help. Furthermore, rural areas in Appalachia are underserved by health care providers and accessibility may be limited due to lack of transportation options, poor roads, and weather conditions. School-based mental health programs help address many of these barriers by attempting to reduce or eliminate the obstacles that are in place. The ASC Center, as described above, eliminates the barrier of insurance coverage. Providing services within the school and during the school day also reduces transportation barriers that may be present in rural communities.

Another roadblock to seeking mental health care in the Appalachian Mountains, and many rural areas worldwide, is the lack of awareness about the nature of mental illness and its treatment (Keefe, 2005). Rural communities are often marked by lower education levels and few venues for public service media announcements. Several cases in our sample said neither they nor their family had a name for their illness at its onset. One man said: "My family is clueless about it. I haven't talked about it at all with them." A number mentioned learning about depression through psychology classes that they or their friends attended. Many individuals in our treated sample

[1]The methods of this study are described in more detail in Keefe and Curtin (2015). The sample consists of 23 participants from two counties in western North Carolina who were diagnosed with depression by a health care provider and/or who were taking antidepressants, and who volunteered for the study.

learned about their illness as a result of mental health or medical intervention; for example, one-third of our sample was hospitalized at some point for their mental health condition, and 64% participated in psychotherapy (Keefe & Curtin, 2015). The etiological conceptualization of depression according to individuals in our sample was very similar to that supported by current theories. Eighty-two percent mentioned the impact of biological factors, most commonly a history of family illness that many saw as hereditary or genetic. The vast majority also believed that psychological and social factors as well as negative life experiences and other stressors, such as health problems, contributed to their depression. However, comments made by our participants and our interviews with providers and other experts suggest that this kind of complex understanding of depression is not shared by all residents in rural Appalachian communities, and is likely different across generational cohorts.

In line with the mission of the ASC Center, clinicians provide psychoeducational training to educators and school personnel on adolescent mood disorders as well as suicide. Presentations at teacher conferences, school board meetings, and monthly faculty meetings serve to both demystify mental illness and to better prepare individuals working within school settings to address behavioral health issues. Other topics, such as substance abuse and bullying, have been areas of concern among community members and the ASC Center has provided relevant education with an open invitation for continued education throughout the school year. Much of the information about mental health though is done on a case-by-case, family-by-family basis, as a significant portion of treatment is focused on educating individuals and families about the specifics of mental health problems and how they manifest in everyday life.

Many of the participants in our cultural exploration of depression (Keefe & Curtin, 2015) said their family rejected the idea that their problem(s) might be a mental illness, often spontaneously referencing the simultaneous influence of Bronfenbrenner's microsystem, macrosystem, and chronosystem. Culturally and familial-informed conceptualizations of mental illness have the potential to influence the use of services, including school-based mental health services. For example, family members may hesitate to acknowledge that someone within their family is experiencing a mental illness. One man said that when he told his grandparents that he suffered from depression, they replied: "Don't worry. We won't tell nobody." Another woman noted, "My illness has affected my relationship with my sister. My sister really won't talk to me at all. She sees mental illness as something to be ashamed of."

As noted earlier, concerns about public and self-stigma can negatively impact acceptability and use of available and accessible school-based mental health services (Mohatt et al., 2005). Family members directly and indirectly influence conceptualization of mental illness, and, in turn, propensity for help-seeking. According to one man we interviewed, "Pride is the biggest problem. Our county is small and everyone knows everyone else. People are concerned about how other people perceive them. So they [my family] won't tell no one "I've been suffering from depression"." School-based mental health professionals should be aware of the multigenerational transmission of messages concerning the stigmatized nature of mental illness as well as the potentially unspoken concerns students may have about the impact of help-seeking on their family members.

Despite the supportive religious macrosystem of rural Appalachia, clergy and the church were not frequently cited as sources of help among our participants (Keefe & Curtin, 2015). Instead, the symptoms of depression were, for many, regarded as spiritually problematic and shameful. "People who go to church see it as a bad thing," said one man. Many cases cited the special stigma that accompanies mental illness in evangelical Christian churches. Feelings of worthlessness, hopelessness, and helplessness may be interpreted by evangelical Christians as due to a lack of spiritual strength and the need for religious healing through prayer. Turning to a mental health professional might be perceived as not only inadequate but inappropriate, since most mental health profes-

sionals use secular therapeutic models. One young man from a Pentecostal family said "You don't talk about it. In my family, we don't talk about the sins that we're committing. Not premarital sex, not alcohol, not thoughts of suicide. It's not something you talk about. There was just a blanket response to problems: 'Remember to pray.' That was the all-encompassing solution." Another said, "People don't talk about it because they're embarrassed. It's not like a disease like cancer or something. They don't see it as a mental health problem… There is a stigma that goes with depression. If you're depressed, there's something wrong with you. Religious people like to keep that in the closet."

Concerns about the lack of attention to religious or spiritual variables may be even more acute in the context of secular public schools. In school-based mental health settings, the interpretation of mental illness as a religious concern occasionally arises. However, clinicians typically focus on a psychological perspective to understand and treat behavioral health problems. Nevertheless, religious views of mental illness must be taken into account when working with many clients in rural settings, as it is likely important in the lives of the individuals and families served (Aten, Hall, Weaver, Mangis, & Campbell, 2012). In an effort to provide culturally responsive services, clinicians should seek to incorporate client's individual views into treatment while maintaining the integrity of interventions for the presenting problem.

Summary and Practice Recommendations

When working with youth in school settings, cultural and familial variables must be taken into account. This is particularly true for rural environments where barriers to treatment often present clinicians with early challenges that can quickly derail successful intervention. Before embarking on clinical practice with rural families in school settings, mental health professionals must first consider behavioral and emotional disorders from an expanded framework rather than from just a set of standardized diagnostic criteria. Bronfenbrenner's (1994) ecological model provides a pragmatic way to conceptualize treatment context for clinicians working in rural communities. This model can help to identify potential barriers to behavioral health services as well as family and contextual variables that may help guide selection of appropriate evidence-based interventions.

Often, school-based clinicians are asked to intervene with adolescents on various microsystem issues, such as improving peer relationships, classroom management of behavior, or family conflict. These issues gain the most attention from school personnel, as they are likely to lead to discipline referrals, absenteeism, or declining grades. However, although the school and the clinician may value academic success, clinicians must assess and understand the family's values, particularly attitudes regarding the importance of education. These attitudes may be intergenerational in origin and therefore clinicians must strike a balance between the desires of the school and beliefs of the family they serve. The initial meetings with the child and family are critical to understanding these familial opinions and influences. At the time of intake, in addition to standard questions related to mental health symptoms and protective factors, mental health professionals would also benefit from incorporating each of the tiers in Bronfenbrenner's model. Assessment tools to identify school connectedness or family environment and attitudes may be helpful in recognizing mesosystem variables that clinicians can address during treatment (e.g., gap between family and school value of education). A historical and cultural analysis of an individual rural community integrated with an idiographic assessment, such as the illness narrative (Kleinman, 1980) as illustrated in this chapter, provides example of how to approach individualized and culturally responsive assessment and intervention.

Ecologically based interventions appear promising in the context of school mental health services (Dishion, Kavanagh, Schneiger, Nelson, & Kaufman, 2002). Specifically, the Family Check-up (Dishion, Stormshak, & Siler, 2010) utilizes individualized assessment and feedback using a Motivational Interviewing (MI) style

(Miller & Rollnick, 2013) to purposely target parental motivation and engagement. It is likely that the term "check-up" may be appealing to rural residents given the familiarity of the term from medical services and potential for decreased stigma. In addition, the MI style focuses on building intrinsic motivation to change, autonomous decision-making, and values-consistent goals that may be appealing to rural families.

Measuring treatment outcomes with rural populations in school settings also requires an understanding of familial and environmental variables. For example, the ASC Center program described in this chapter, charts outcome based on scores on the Behavioral Assessment System for Children (BASC-2; Reynolds & Kamphaus, 2004) and the Youth Outcome Questionnaire (YOQ-30; Burlingame et al., 2004) pre-intervention, throughout intervention, and post-intervention (Albright et al., 2013). These measures are not standardized on rural populations so it is often beneficial for clinicians working in rural communities to review individual items with clients to increase understanding of interpretation of questions. For example, in our case study, a student may report having no issues with "anxiety" but may struggle occasionally with "nerves," the latter being a term their family acknowledges and the former being one their family does not use. By taking the extra step to understand findings within a cultural context, outcomes become more meaningful and more indicative of successful intervention.

Mental health professionals, and more importantly consumers, in rural communities often face significant gaps in service. These gaps can be in types of services available, quality of services, or lack of procedures for handling mental health issues. Clinicians must be diligent about evaluating these gaps and take steps necessary to best bridge these gaps so clients do not go underserved. This process of developing appropriate procedures requires clinicians to utilize information about the culture and the systems that influence and are influenced by adolescents (e.g., Bronfenbrenner's model) and then tailor interventions. One example of this was the development of the Prevention of Escalating Adolescent Crisis Events (PEACE) Protocol by members of the ASC Center (Sale, Michael, Egan, Stevens, & Massey, 2014). Mental health workers, through partnering with and integrating into the school culture, developed a protocol for handling suicidal and homicidal crisis events that may occur during the school day. This protocol used language common to all personnel involved with youth (administrators, student resource officers, nurses, teachers, school counselors, etc.) to establish an effective and rapid way for students in crisis to be served. Protocols such as PEACE benefit from being developed organically from onsite workers faced with situations where students were not being served adequately. Since each culture has different needs, different protocols must be developed or adapted to fit the requirements of a specific school environment.

Consistent with the development of the PEACE protocol, Community-Based Participatory Research (CBPR; Israel, Schulz, Parker, & Becker, 1998) that actively involves an identified community (e.g., school system and personnel, parents, students, university partners) equally in all aspects of research, ranging from hypothesis development to dissemination, offers a promising methodology for rural school-based mental health services. In particular, it is recommended that CBPR, as well as traditional controlled clinical trials, be utilized to investigate ways to increase school connectedness for students and family members, and to investigate the effectiveness and efficacy of ecologically sensitive interventions (e.g., Family Check-up) within school-based mental health services. Investigations of student and family understanding of mental illness and attitudes toward mental health services, including the influence of religious beliefs, in rural communities will likely prove informative in further contextualizing school-based interventions.

School-based mental health services address many of the barriers to care in rural areas. However, family involvement is a critical element of successful intervention with children and adolescents. The therapeutic alliance with child/adolescent clients and their family members (e.g., parent[s]) is predictive of treatment

outcome, and attention to a working alliance with parents/guardians may be particularly important relative to treatment continuation (Shirk & Karver, 2011). It can be challenging to engage family in the context of the school system, and these challenges may be enhanced in rural environments which are often characterized by poverty, lower educational attainment, concerns about stigma relative to mental health problems, and relatively little anonymity and privacy. Careful consideration of familial and local understanding of mental health problems, social and political history as well as current forces, long-standing intergenerational relationships between families and school systems, and policies and procedures that respect the powerful and proximal influence of both the family and schools on youth development may prove to reciprocally and positively impact rural communities.

References

Abrams, M. S. (1999). Intergenerational transmission of trauma: Recent contributions from the literature of family systems approaches to treatment. *American Journal of Psychotherapy*, *53*, 225–231.

Albright, A., Michael, K., Massey, C., Sale, R., Kirk, A., & Egan, T. (2013). An evaluation of an interdisciplinary rural school mental health programme in Appalachia. *Advances in School Mental Health Promotion*. doi:10.1080/1754730X.2013.808890

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Appalachian Regional Commission. (n.d.). *The Appalachian region*. Retrieved from http://www.arc.gov/appalachian_region/TheAppalachianRegion.asp.

Aten, J., Hall, P., Weaver, I., Mangis, M., & Campbell, C. (2012). Religion and rural mental health. In K. B. Smalley, J. C. Warren, & J. P. Rainer (Eds.), *Rural mental health: Issues, policies, and best practices* (pp. 79–96). New York: Springer.

Beaver, P. D. (1986). *Rural community in the Appalachian south*. Lexington: The University Press of Kentucky.

Blank, M. B., Fox, J. C., Hargrove, D. S., & Turner, J. T. (1995). Critical issues in reforming rural mental health service delivery. *Community Mental Health Journal*, *31*, 511–524.

Bowen, M. (1978). *Family therapy in clinical practice*. New York: Aronson.

Bridge, J. A., Goldstein, T. R., & Brent, D. A. (2006). Adolescent suicide and suicidal behavior. *Journal of Child Psychology and Psychiatry*, *47*, 372–394. doi:10.1111/j.1469-7610.2006.01615.x

Bronfenbrenner, U. (1994). Ecological models of human development. In *International encyclopedia of education* (vol. 3, 2nd ed.pp. 1643–1647). Oxford: Elsevier.

Burlingame, G. M., Dunn, T., Hill, M., Cox, J., Wells, M. G., Lambert, M. J., & Brown, G. S. (2004). *Administration and scoring manual for the Y-OQ-30.2*. Youth Wilmington, DE: American Professional Credentialing Services.

Corrigan, P. W., & Miller, F. E. (2004). Shame, blame, and contamination: A review of the impact of mental illness stigma on family members. *Journal of Mental Health*, *13*, 537–548. doi:10.1080/09638230400017004

Costello, E. J., Keeler, G. P., & Angold, A. (2001). Poverty, race/ethnicity, and psychiatric disorder: A study of rural children. *American Journal of Public Health*, *91*, 1494–1498.

Curtin, L., Cohn, T., & Belhumeur, J. (2014). Suicidal behavior in the rural population. In D. A. Lamis & N. J. Kaslow (Eds.), *Advancing the science of suicidal behavior: Understanding and intervention*. Hauppauge, NY: Nova Science Publishers.

Curtin, L., & Hargrove, D. S. (2010). Opportunities and challenges of rural practice: Managing self amid ambiguity. *Journal of Clinical Psychology*, *56*, 549–561. doi:10.1002/jclp.20687

Denham, A. R. (2008). Rethinking historical trauma: Narratives of resilience. *Transcultural Psychiatry*, *45*, 391–414. doi:10.1177/1363461508094673

Dishion, T. J., Kavanagh, K., Schneiger, A., Nelson, S., & Kaufman, N. K. (2002). Preventing early adolescent substance use: A family-centered strategy for the public middle school. *Prevention Science*, *3*, 191–201.

Dishion, T. J., Stormshak, E., & Siler, C. (2010). An ecological approach to intervention with high-risk students in schools: Using the family check-up to motivate parents' positive behavior support. In M. R. Shinn & H. M. Walker (Eds.), *Interventions for achievement and behavior problem in a three-tier model including RTI* (pp. 101–124). Bethesda, MC: National Association of School Psychologists.

goashe.com (2011, December 7–8). *Heads up for ACHS parents* [Web chat room comments]. Retrieved from http://www.goashe.com/voice/view/?startview=20&msg=2613&h=101230.

Halperin, R. H. (1990). *The livelihood of kin: Making ends meet "the Kentucky way"*. Austin: University of Texas Press.

Hemmings, A. B. (2004). *Coming of age in U.S. high schools: Economic, kinship, religious, and political crosscurrents*. Mahwah, NJ: Erlbaum Associates.

Hirsch, J. K. (2006). A review of the literature on rural suicide. *Crisis*, *27*, 189–199. doi:10.1027/0227-5910.27.4.189

Ho, C. J., Bluestein, D. N., & Jenkins, J. M. (2008). Cultural differences in the relationship between parenting and children's behavior. *Developmental Psychology*, *44*, 507–522. doi:10.1037/0012-1649.44.2.507

Israel, B. A., Schulz, A., Parker, E., & Becker, A. B. (1998). Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health*, *19*, 173–202.

Kataoka, S. H., Zhang, L., & Wells, K. B. (2002). Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. *American Journal of Psychiatry*, *159*, 1548–1555. doi:10.1176/appi.ajp.159.9.1548

Keefe, S. E. (1998). Appalachian Americans: The formation of reluctant ethics. In G. R. Campbell (Ed.), *Many Americans: Critical perspectives on race, racism and ethnicity* (pp. 129–153). Dubuque, IO: Kendall/Hunt.

Keefe, S. E. (2005). *Appalachian cultural competency: A guide for medical, mental health, and social service professionals*. Knoxville: University of Tennessee Press.

Keefe, S. E., & Curtin, L. (2015). The cultural context of depression in Appalachia: Evangelical Christianity and the experience of emotional suffering and healing. In C. L. King (Ed.), *Recovery, renewal, reclaiming: Anthropological research toward healing*. Knoxville: University of Tennessee Press.

Kleinman, A. (1980). *Patients and healers in the context of culture*. Berkeley: University of California Press.

Kleinman, A. (1988). *The illness narratives: Suffering, healing, and the human condition*. New York: Basic Books.

Langley, A. K., Nadeem, E., Kataoka, S. H., Stein, B. D., & Jaycox, L. H. (2010). Evidence-based mental health programs in schools: Barriers and facilitators of successful implementation. *School mental health: A multidisciplinary research and practice journal*, *2*, 105–113. doi:10.1007/s12310-010-9038-1

Lightfoot, S. L. (2003). *The essential conversation: What parents and teachers can learn from each other*. New York: Random House.

Loukissa, D. A. (1995). Family burden in chronic mental illness: A review of research studies. *Journal of Advanced Nursing*, *21*, 248–255.

Lucey, C. F., & Lam, S. K. Y. (2012). Predicting suicide risks among outpatient adolescents using the family environment scale: Implications for practice and research. *International Journal of Advanced Counseling*, *34*, 107–117. doi:10.1007/s10447-011-9140-6

McQuillan, P. J. (1998). *Educational opportunity in an urban American high school: A cultural analysis*. Albany: State University of New York Press.

Merikangas, K. R., He, J., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., … Swendsen, J. (2010). Lifetime prevalence of mental disorder in US adolescents: Results from the National Comorbidity Survey Replication-Adolescent Supplement (NCS-A). *Journal of the Academy of Child & Adolescent Psychiatry*, *49*, 980–989. doi:10.1016/j.jaac.2010.05.017

Michael, K. D., Renkert, L. E., Wandler, J., & Stamey, T. (2009). Cultivating a new harvest: Rationale and preliminary results from a growing interdisciplinary rural school mental health program. *Advances in School Mental Health Promotion*, *2*, 40–50. doi:10.1080/1754730X.2009.9715703

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd ed.). New York: Guilford Press.

Mistry, R. S., White, E. S., Benner, A. D., & Huynh, V. W. (2008). A longitudinal study of the simultaneous influence of motehrs' and teachers' educational expectation of low income youth's academic achievement. *Journal of Youth and Adolescence*, *38*, 826–838.

Mohatt, D. F., Bradley, M. M., Adams, S. J., & Morris, C. D. (2005). *Mental health and rural America: 1994–2005*. Washington, DC: U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy.

Moos, R., & Moos, B. (1994). *The family environment scale manual* (3rd ed.). Palo Alto: Consulting Psychologist Press.

Nader, E. G., Kleinman, A., Caramão Gomes, B., Bruscagin, C., dos Santos, B., Nicoletti, M., … Caetano, S. C. (2013). Negative expressed emotion best discriminates families with bipolar children. *Journal of Affective Disorders*, *148*, 418–423. doi:10.1016/j.jad.2012.11.017

Penchansky, R., & Thomas, W. (1981). The concept of access: Definition and relationship to consumer satisfaction. *Medical Care*, *19*, 127–140.

Rainer, J. (2012, Fall). The state of rural mental health: Caring and the community. *The National Register of Health Service Providers in Psychology*, 8–13.

Reck, G. G., Keefe, S. E., & Reck, M. (1987). Ethnicity and education in southern Appalachia: Implications for educational equity. *Proceedings of the UK Conference on Appalachia*, 14–24.

Reynolds, C. R., & Kamphaus, R. W. (2004). *BASC-2: Behavioral assessment system for children manual* (2nd ed.). Circle Pines, MN: AGS.

Rosenthal, R., & Jacobson, F. (1968). Teacher expectations for the disadvantaged. *Scientific American*, *218*, 19–23.

Sale, R., Michael, K., Egan, T., Stevens, A., & Massey, C. (2014, Winter). Low base rate, high impact: Responding to teen suicidal threat in rural Appalachia. *Emotional & Behavioral Disorders in Youth*, *14*, 4–8.

Sameroff, A. J., Seifer, R., & Zax, M. (1982). Early development of children at risk for emotional disorder. *Monographs of the Society for Research in Child Development, 47*, (serial no. 199).

Satcher, D. (2000). Mental health: A report of the Surgeon General-Executive summary. *Professional Psychology: Research and Practice*, *31*, 5–13.

Shirk, S. R., & Karver, M. (2011). Alliance in child and adolescent therapy. In J. C. Norcross (Ed.),

Psychotherapy relationships that work: Evidence-based responsiveness (2nd ed.). New York: Oxford University Press.

Sorhagen, N. S. (2013). Early teacher expectations disproportionately affect poor children's high school performance. *Journal of Educational Psychology*, *105*, 465–477.

Turney, K. (2011). Labored love: Examining the link between maternal depression and parenting behaviors. *Social Science Research*, *40*, 399–415. doi:10.1016/j.ssresearch.2010.09.009

Wang, M., & Sheikh-Khalil, S. (2013). Does parental involvement matter for student achievement and mental health in high school? *Child Development*. doi:10.1111/cdevl.12153

Weissman, M. M., Wickramaratne, P., Nomura, Y., Warner, V., Verdeli, H., Pilowsky, D. J., … Bruder, G. (2005). Families at high and low risk for depression: A 3-generation study. *Archives of General Psychiatry*, *62*, 29–36.

Weist, M. D., Youngstrom, E. A., Stephan, S., Lever, N., Fowler, J., Taylor, L., … Hoagwood, K. (2014). Challenges and ideas from a research program on high-quality, evidence-based practice in school mental health. *Journal of Clinical Child and Adolescent Psychology*, *43*(2), 244–255. doi:10.1080/15374416.2013.833097

Wilson, S., & Durbin, C. E. (2010). Effects of paternal depression on fathers' parenting behaviors: A meta-analytic review. *Clinical Psychology Review*, *30*, 167–180. doi:10.1016/j.cpr.2009.10.007

Zahner, G. E. P., & Daskalakis, C. (1997). Factors associated with mental health, general health, and school-based service use for child psychopathology. *American Journal of Public Health*, *87*, 1440–1448.

Zhang, Z., Infante, A., Meit, M., English, N., Dunn, M., & Harper Bowers, K. (2008). *An analysis of mental health and substance abuse disparities and access to treatment services in the Appalachian Region*. Washington, DC: Appalachian Regional Commission.

Lisa Curtin earned her Ph.D. in Psychology at Virginia Tech and completed a clinical internship at Brown University School of Medicine. She has been a faculty member in the Department of Psychology at Appalachian State University since 1996. She served as chairperson of the American Psychological Association's Committee on Rural Health, and is an active member of the North Carolina Psychology Association. Her main areas of research involve the understanding and treatment of addictive behaviors, and rural mental health services, including community needs assessments and evaluations.

Cameron Massey completed his B.A. in Psychology from the University of North Carolina—Chapel Hill in 2004 and his M.A. in Clinical Health Psychology from Appalachian State University in 2010. He worked as a licensed masters-level staff psychologist for a community mental health center in rural Western North Carolina before accepting the position of Clinical Research Coordinator at Appalachian State as part of a Title V federal grant project. In this role worked on a community needs assessment and provided direct clinical service to adolescents through a school-based mental health program. He is currently a doctoral student at the University of South Carolina, working with Dr. Mark Weist and the School Mental Health Team. His areas of interest include diagnosis and treatment of adolescent disorders, school-based mental health, and issues surrounding rural mental health.

Susan E. Keefe, Ph.D., is a Professor Emeritus of Anthropology at Appalachian State University. She has authored and edited six books and monographs, including *Appalachian Mental Health, Appalachian Cultural Competency: A Guide for Medical, Mental Health, and Social Service Professionals, and Participatory Development in Appalachia: Cultural Identity, Community, and Sustainability*. Her current interests are in the fields of health and mental health in the Appalachian region, especially as they intersect with religious world view. Her most recent research on depression with Lisa Curtin is discussed in the Southern Anthropological Society Proceedings, *Recovery, Renewal, Reclaiming: Anthropological Research toward Healing.*