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Local Knowledge and Rural Mental Health Reform

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ABSTRACT: Rural mental health care reform has failed to recognize that service utilization and access is guided by the meanings and explanations that rural dwellers ascribe to symptoms and treatments for mental illness. These meanings and explanations are described here as local knowledge. It is argued that planning for reform in rural mental health service delivery must take into account the local knowledge and explanations for mental illness and its treatment in order to improve rural mental health.

INTRODUCTION

Rural mental health publications over the past five years that address reform policies in rural areas continue to neglect local social and cultural systems of knowledge, behavior, and local non-professional resources. Health policies that treat rural areas as homogeneous by simply comparing the similarities and differences of urban and rural mental health status, service accessibility and availability, and distribution of professional services are neglecting critical information and resources for policy development and planning. Without an understanding of local health beliefs and behavioral responses to health problems, policies may be irrelevant, inappropriate, and ineffective. Reform of mental health policies in rural areas must consider the nature of the

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relationship between diverse populations and mental health policies and providers. Local knowledge, the beliefs and values of people in rural communities, and local practice, the health seeking behavior of people in rural areas, are important factors for developing appropriate and acceptable service delivery programs.

This distinction between knowledge and practice is an essential one. Local knowledge is constituted not only of situationally or culturally specific sets of beliefs and values, but also of the broader cosmopolitan or mainstream approaches to mental health care and therapeutics. Residents of rural communities have such information through their exposure to print and communications media, through public institutions such as schools and workplaces, and in their interactions, even if limited, with health and human service providers. Thus local knowledge incorporates multiple belief systems, and members of rural communities may well be conversant in more than one set of ideas and cognitions about the causes and diagnosis of mental health problems. At the level of practice, however, health-seeking strategies do not necessarily mirror the complexity of the full-range of knowledge held by rural individuals. In part this disjunction is directly connected to rural residents/conceptual distinction between themselves as "knowers" and "doers."

Acting on knowledge entails the operationalization of beliefs and cognitions. It presupposes the individual's (family's community's) judgment about his/her/their expertise or competency in a given system of health-beliefs. Under such circumstances, health-seeking strategies measure perceptions of cultural fit, rather than the content or level of knowledge about available, formal mental health services. The development of cultural competency on the part of mental health providers should include the recognition of this distinction. Models for intervention would be more successful if they worked not only to increase the cultural competency of the providers, but also to support and empower rural patients/families/communities in their sense of expertise about using the formal mental health services that are available to them. As Holzer et al (1988) have suggested, mental health service delivery as it now operates is sadly effective in destabilizing rather than supporting patient expertise and autonomy. Reform works when it gives attention to these qualitative dimensions of care, as well as to the pressing issues of access and availability.

Traditional ethnic diversity and poverty in rural areas coupled with populations increases of "new immigrants" demand a consideration of the heterogeneity of social structures and cultural beliefs, values and attitudes about mental health (Clarke and Miller 1990; Cordes 1989

and Patton 1989). Coward, Miller and Dwyer have stated that "the heterogeneity of rural America makes it entirely reasonable, indeed, expected, that health differences among rural areas may be as pronounced as those between rural and urban areas (1990:359)." Other defining characteristics of rural areas are their high poverty rates, inadequate health and human services, greater levels of disability, impairment, and disorder, and higher rates of non-insured (Jecker and Berg 1992; Rowland and Lyon 1989 and Wagenfeld 1990).

Consequently, mental health problems cannot be separated from the economic and political situation of rural communities anymore than they can from their cultural contexts. Most rural areas have experienced serious economic decline in the past fifteen years resulting in severe increases in unemployment and underemployment, acute levels of poverty, decreases in health services, and a general lowering of the quality of life. Under these conditions, people on the local level often feel that they have lost control of their communities and, in many ways, control of their lives. Such feelings can lead to serious acute and chronic psychological and behavioral consequences. Local behavioral responses to these wider economic and political forces vary according to ethnicity and social class with the poor, who make up the majority of rural residents, often struggling to survive.

Research into local knowledge and practice is important, in this regard, for two reasons. First, the causal relationship between mental stress and socio-economic status is strongly suggested in the research literature (Ulbrich, Warheit and Zimmerman 1989, Kessler 1979; Kessler and Neighbors 1986). But these findings have been subject to critique because they have been used to paint with too broad a stroke especially concerning the maladaptive response to stressors on the part of African Americans, including those residing in rural areas (Taylor, 1992; Dressler 1993). Many rural individuals and communities still successfully cope with economic downturns and/or low or uncertain income. Critiques, therefore, call for investigations of the ways in which rural folk maintain a sense of autonomy and control in the face of rural structural upheaval and social stress. Questions such as this lead us back to local knowledge systems, and then outward to a framework for understanding broader rural patterns of adaptation and dysfunction.

Second, in addition to the close link between socio-economic status and mental health, societal racism and color consciousness are dimensions in the lives of rural minorities that may effect their mental health status in ways that are not immediately discernible in national or urban contexts. One study of social stress and hypertension among a

sample of southern African American populations, for example, reports a higher level of hypertensive disorders among darker-skinned high status individuals than for their lighter-skinned counterparts. The author concludes that given the society's equation of economic success with particular ethnic groupings and skin complexions, individuals who confounded this assumption reported higher levels of stress and frustration in getting others to accord them respect and equal treatment. The daily struggle for recognition correlated with "repeated autonomic arousal and sustained blood pressure elevation" (Dressler 1993:338). Such an association between racism and color-consciousness is hypothesized to also hold for levels of mental health and the nature of the interaction between provider and rural patient (Blank, Tetrick, Brinkley, Smith, & Doheny, 1994).

LaVeist's (1992) recent work also shows a remarkable correlation between African American involvement in electoral politics, the numbers of African American elected officials and community activism with a decline in African American infant mortality rates. Although their findings remain to be tested in the rural context, such studies show that the politics and history of race and racism help to create health inequities. These historical factors must be taken into account in any policy that has as its goal the resolution of these inequities.

Peoples in rural areas construct unique cultural knowledge systems about health and health care which affects the nature of their linkages to the available mental health services. The overlay of the mental health system onto diverse local knowledge systems certainly offers the opportunity to expand local health knowledge but, at the same time, has the potential to create cultural and behavioral conflicts in the "fit" between indigenous persons and mental health services and providers. Often the fit is imperfect. The issues involved in accessibility and acceptability of the receipt of services are complex and multidimensional–they consist of a two way interaction that assumes, on the one hand, that rural peoples accept and have access to mental health services and, equally important, that mental health providers accept and have access to the people (Hill 1988; 1992). In order to understand how people with diverse beliefs and behaviors link to the mental health system and how mental health providers can link to the people, it is essential for policy reformers and providers to gain an understanding of local knowledge and behaviors related to health and mental health and, just as important, of their own cultural beliefs and values and practice.

INTEGRATED HEALTH KNOWLEDGE

While institutionalized health policy and planning separate physical and mental health, our research and experiences with rural peoples indicate that most rural residents conceptually and behaviorally integrated these artificially separated categories. When people integrate these categories and health care providers separate them, even in a structural manner, problems of interaction and expectations often result in underutilization, inappropriate utilizations, and non-compliance to treatment procedures. Reform policies that suggest linking mental and physical health services (Office of Technology Assessment 1990) are, perhaps inadvertently, addressing better use of limited resources as well as addressing best knowledge and local behaviors. Given that most rural residents use resources other than mental health services for their mental health problems (Kamerow, Pincus, and MacDonald 1986; Human and Wasem 1991), it makes sense to delineate policies that use local level knowledge.

Disparities between the concepts of "disease" and "illness" can lead to misunderstandings in the clinical setting at best, and misdiagnosis, at worse, of mental health problems. Health, religion, and morality are closely integrated in the minds of most rural residents and provides them with multicausal explanations for health problems which consider a wider range of variables than the scientific explanatory model. Whenever clients feel "ill" they, more often than not, will have already diagnosed their "illness" within their local explanatory model before seeking professional help. Often the cause is believed to be behavioral rather than biological; illnesses and their causes and cures are viewed holistically, with the mind/body dichotomy often blurred within the context of illness experiences. Consequently, reactions to the stresses of rural life manifest themselves with both mentally and physically symptoms and local explanations do not separate what they are feeling/experiences. These alternative explanations are not necessarily thought of as conflicting as much as alternatives/options for their health seeking behavior.

When rural residents, particularly the poor, feel as though they have lost control of their lives or their communities, local explanations of stress responses such as depression, alcoholism, drug abuse, or child abuse are framed within the parameters of one's integrated knowledge system rather than two separate health models. While middle and upper class rural residents are more likely, however, to separate these

categories (physical/mental: scientific/traditional). They tend to utilize mental health resources more often than the poor non-white or white populations. Not surprising, their knowledge about mental health converges more closely with mental health providers. In Hill's (1988) study of health systems in a rural community in Georgia, over 80% of the poor were unaware of public resources for mental health care and Flaskerud and Kuiz (1983) report they found fewer than one-half of the residents of rural counties in six Midwestern States were aware of available treatment centers and services for mental health and substance abuse problems.

LOCAL BELIEFS, VALUES, AND BEHAVIOR

Local beliefs and behavior about health and mental health vary according to ethnicity and class in rural areas. However, since most rural residents are poor and African-American or White, generalizations can be made regarding their beliefs and illness responses. The conceptualization of individual personality seems an appropriate starting point. Many rural residents believe that the idea of personality is fixed by God in an individual and can only be changed by Him. A mental health worker is often viewed as an intermediary between individual with personality disorders and God. In her study of a southern rural county, Greenhouse reports that ". . . individual roles are seen as fixed in their personality which are unalterable except by God" (1986:53). Problems and conflicts are negotiated between individuals and God, not by changing their roles within family and community. As a result, conflict becomes inner conflict first and foremost with the only appropriate remedy coming from within individuals. They deal with conflict by internalizing it, not confronting it. These beliefs are supported by the basic core values found in rural areas. They are individualism, independence, indirectiveness, personalism, and in some areas such as Appalachian, egalitarianism.

Basic core values such as egalitarianism, just to take one example, can often run directly counter to the key paradigms of the formal health care sector. Such conflicts occur in ways that are not immediately predictable but that give insight into the interaction of multiple features of the same belief system. Egalitarianism, at one level, seems to fit perfectly within broader American norms about individual rights and access to the resources offered through consensual contributions to the nation through taxes, and through citizenship. At another level, it

speaks to the notion that hierarchies are inherently problematic and that rural communities operate in a more orderly fashion when no one thinks themselves better than any other. This "leveling" process has been identified in the anthropological literature as a key characteristic of peasant and agricultural communities (Wolf 1982; Nelkin 1984). With this form of egalitarianism individual members are encouraged to conform to the established customary rules and traditions. Mental health therapeutics in this context can be negatively perceived as an attempt to take action that will improve on, tinker with or "better" the individual self–a step that is directly counter to egalitarian principles of homogeneity and shared conditions of life. Efforts to improve on a fixed characteristic such as personality separates the individual out from the group, challenges the established social and moral order, and indirectly questions the actions and behaviors of those who hew to the traditional view. Such culturally framed concerns can act to inhibit individuals from seeking external professional help for mental health problems.

But in spite of the importance of the above identified core features of rural health values and beliefs, these are idealized formulations. We thus return to the heterogeneity of rural communities. Individuals and communities at local levels are likely to have variants of these features. In some instances, there will be generational disjunctions in the degree to which people hold to and live by these ideals. Such intergenerational differences was a source of concern expressed by older members of the rural Virginia county studied by Fraser (1994). Parental and grandparental members of households, while not subscribing to what they termed "modern" ideas of personal transformation and health care intervention, were willing to, indeed were convinced that such cognitions and treatments were the appropriate, and perhaps only course of action for younger members of the household. They argued in a sense that their methods would not be effective for those who were not raised, and did not believe in the efficacy of treatments available in the informal or folk sector of health practice.

Not all rural residents are wary of professional providers. In an early study, Krug (1974) found that rural African Americans in North Carolina ranked the medical doctor as the "legitimate and most trustworthy" provider. Fraser found warm and pleasant memories expressed by rural African Americans for the "country doctors" that formerly served their communities through the 1950s. Further the core values and beliefs that we have enumerated are also subject to change. Moerman (1981) traces the transformation of a strong self-help folk medical

tradition among the Gullah of the South Carolina Sea Islands to one that increasingly depended on the formal health sector for mental and physical health-care. While Moerman, an anthropologist, lamented the passage of this community's autonomy, we might understand these changes as an inherent part of rural health systems. Systems of local knowledge are flexible, open to the influences, beliefs and practices from the outside, yet are resilient and relevant to the needs and expectations of their participants.

The model of rural communities as static and change resistant is not borne out in the literature. It is therefore important that we look to the ways that rural informal health systems and local institutions such as the church can incorporate effective treatment modalities into their customary framework. The task is to work at the local level to identify 1) the kinds of changes that would be most acceptable and effective; 2) the resources needed to make such changes tenable; 3) the locally identified change agents (whether individuals or institutions). If not, the risk is that in modifying existing institutions, the institutions will be so radically altered as to lose their original function (Jordan 1992). Mutual accommodation or participatory models as approaches to reciprocal exchange of knowledge and practices are primary means through which providers acknowledge their own willingness to adapt their techniques and core value systems to the local community and its residents.

Rural residents, then, believe that problems should be faced privately, through using the inner resources of religion and family. Resorting to public facilities runs counter to their world view and if they decide to seek help outside the family and religion, they more often will choose a physician (Van Schaik 1988; Keefe 1988). The old saying, "we will take care of our own" explains local responses to mental health problems, especially for rural residents who are poor. Ideally, crises are taken care of by family, friends, and/or community.

Local beliefs serve as a template for local behavior and the use of local resources. In the rural south, they combine elements of African culture, European culture, Greek classical medicine, Native-American medicine, scientific medicine, and voodoo religion. In rural areas located in other parts of the U.S., they will reflect the historical context of the diverse groups in the region. Ideas about health are inextricably bound to religious beliefs and practices and are perceived to ultimately result in achieving a balance between universal good and evil forces that are always present in their lives (Snow 1993; Keefe 1988; Humphrey 1988; Hill and Mathews 1981). Individuals attempt to maintain a harmony between these forces through their behavior–their decisions. Illnesses

are often classified according to their believed-in causes which are classified as natural or unnatural. The "cause" may be more important to the people than symptoms in diagnosis and treatment. For example, Quinn and Mathews (n.d.) found that root doctors in North Carolina determine whether an illness is the result of unnatural causes, such as a "spell," in which case the treatment will consists of "counter rootwork." Diseases with natural causes generally are treated by herbal or medicinal remedies. Root doctors also decide if the illness is predominately of the body, or the mind, or both. Most conditions are believed to affect both the mind and body, as in "nerves" or "hysteria." Thus, mental and emotional disorders or full-blown mental illness may have unnatural causes such as sorcery (Hillard 1982; Pellegrini and Putman 1984; Snow 1993).

Among many African-Americans in the South, illnesses from natural causes are explained by the balance of the blood in the body (Snow 1993; Hill and Mathews 1981). Blood can become unbalanced by being either too sweet ("high blood") or too bitter ("low blood"). Imbalance can be caused by an improper diet (too many sweet or bitter foods), lack of proper rest, or too much worry. Traditional treatment for these conditions include dietary modification, counseling by family and friends for the purpose of reducing stress, and herbal remedies. If the blood remains out of balance, individuals are susceptible to other illness, both physical and mental.

Illnesses, especially chronic ones or those that do not seriously incapacitate individuals or create chaos in the family/household/community, are often treated within informal networks and social supports, including the use of non-professional caregivers living within a community. Keefe (1988) reports that Appalachians are more likely to consult religious faith healers or chiropractors for mental disorders. Every community has individual(s) who are regarded as "local healers." They are believed to have special powers and knowledge about health and illnesses and are frequently the initial contact in the health seeking process for health problems outside the family. These "healers" are referred to by a variety of names, depending on location and ethnicity, such as herb doctor, conjurer, shaman, root doctors, priests, etc. They are utilized to heal a variety of health problems (Snow 1993; Hill and Mathews 1981; Ruiz 1976a, 1976b). They are sought out for problems such as headaches, backaches, occasional loss of memory, tiredness, thinking about a particular subject or person too much, stress, and sexual dysfunction. These cases are often diagnosed as symptoms of "overwork," "nerves," "worry," or "stress." Snow found that among African-Americans "it is not surprising to find that the

problems of daily life, particularly relationships with other people, are the source of "nervous troubles," and "nerves," and "worriation." These commonly heard terms refer to a broad range of symptoms ranging from inability to eat or sleep or falling-out spells to full-blown mental illness" (1993:82).

Weidman et. al. (1978) found that southern blacks showed a reluctance to acknowledge mental illness but freely admitted to nervous trouble. These mental/nervous/emotional conditions are often thought to be the manifested in both physical and mental problems, depending on the circumstances of the individual who exhibits the symptoms (Camino 1989). As Snow states "nerves produce physical, mental, and emotional changes" in the individual and are also found in white rural residents" (1993:85). "Nerves" has also been reported as a local illness among women in Appalachia (Van Schaik 1988). Physicians in eastern Kentucky find that many of their female clients seek treatment for their nerves and expect to receive "nerve pills" for their symptoms. She states that ". . . nerves are experienced as feelings of nerviness and aggravation, anger, impatience, fearfulness, and depression. . . . Becoming angry, cursing, and calling names are among the symptoms of nerves . . . (1988:86). This illness seems to occur at all stages of the life cycle and is frequently associated with family crises. All her respondents rely on medication or "nerve pills" to relieve their symptoms. If the woman has seen a physician for "nerves," it appears that these pills are either Valium or phenobarbital.

The treatments recommended by local "healers" range from changing work habits and social behavior and relations to taking special herbs and teas or over-the-counter medicines. They attempt to restore a balance to the social, psychological, and physiological life of their client. As one healer told me, "they just need to believe that they can survive and they need to know that somebody cares about them." Other community persons who are often sought out for help are more publicly acknowledged such as clergy, midwives, teachers, school counselors, and public health nurses.

LOCAL MENTAL HEALTH MANAGEMENT

For the most part, the mental health problems of rural residents are initially handled through informal networks and social support that exist within a community. This network functions as social support and varies according to a number of factors–class, ethnicity, length of time

in a community, and type of illness. Hill's (1992) recent research on social support and illness responses of HIV/AIDS clients in rural Georgia indicates that informal networks and "peer counseling" are the main sources of psychological support for the increasing numbers of rural HIV/AIDS infected individuals. The key variable that emerges from this example is the stigma associated with the type of disease. On the whole, however, in rural areas, there tends to be a greater acceptance of behavior labeled "abnormal" by mental health providers. Their acceptance levels are broader than those who live in urban areas. When an individual's behavior is deemed by family/community members as not being harmful to themselves or to others, they are often given roles in the community allowing them to continue to live in their community.

Behavioral responses and/or interventions into mental health problems begin with the family and support networks. If disruptions in their social life persists, an individual is taken to a doctor or a hospital for help. Mermelstein and Sundet (1986) found that the traditional sources of referral to mental health services, such as public health nurses, clergy, agricultural extension specialists, were ranked low by community residents as sources of help for personal problems. Regier, et. al. (1978) found, over fifteen years ago, that a majority of mental disorder cases were cared for in the primary health sector indicating an "underutilization" of available mental health services in rural areas. This situation has not changed since that time (Office of Technological Assessment 1990).

In her study in Appalachia, Keefe found that "mental health clients are referred to the clinic through formal agencies or services, are likely to receive a more severe diagnosis at the clinic, and are somewhat less likely to continue treatment after the initial contact" while "non-Appalachians" come to the clinic through informal referral and are likely to receive a less severe diagnosis (1988:156). She attributes such differential diagnosis and treatment to cultural differences and to the negative perceptions and attitudes of mental health providers toward poor Appalachians which results in perpetuating their fear, suspicion, and often hostility toward mental health providers. Likewise, Taylor (1992) has recently pointed out that the problem or institutional racism, unemployment, and poverty among African-Americans places the African-American community at tremendous risk for diminished mental health. Frequently however, they avoid or delay seeking professional help partially due to fear and suspicion of mental health providers. As a consequence, they frequently by-pass the mental health system and use emergency room as the gateway to mental health care.

Explanations of "underutilization" or "non-utilization" can be found in the local level management of health and mental health.

In the rural south, mental health management is considered the domain of local institutions such as family or religion; people often refrain from linking to public institutions. They are reluctant to be seen at the local mental health center. When the local center is used, some people will drive to another town or park their car "on the other side of town." Thirty years ago, Weller (1965) found that Appalachians will only accept psychiatrists' care if they are called "nerve doctors," a local concept that is acceptable within a community. Stigma associated with mental disorders (categorized by us, not them) directly relates to rural residents' belief about the nature of personality, the role of family, and the local patterns of seeking help from "outsiders." A majority of respondents in one study felt that people cannot really recover from mental disorders (Hill 1988).

In Hill's study of Coberly, a rural community in the south, mental health problems such as alcoholism and drug abuse were considered the most serious mental health problems that affected their lives. They believed that these problems were caused by social and economic disorder, not individual disorders attributed to other mental health problems. African-Americans reported that drinking and taking drugs were a way of dealing with the problems and pressures of not having enough money or not having a job which, in turn, caused problems with family and friends. Getting high allowed people to relax and to forget their problems for awhile. While African-Americans talked about "pressures," Whites referred to "stresses" caused by economic problems, loneliness, family problems and depression. One middle class White resident stated that "much of drinking is caused by southern culture, with its strict moral code and intense family relationships." Family violence and child abuse was also found to be a serious problem in Coberly. African-Americans talked about these problems in terms of "the pressures of living" and believed that those people who abuse or use violence grew up with parents who abused them. They felt that legal intervention was a viable solution while Whites felt that, in most cases, the family should solve these problems, not the law (Hill 1988).

In summary, mental health management on the local level is not conceptually separate from physical health management. Both are thought to reside within the domain of the contexts of individual, family, and community. While individuals are not necessarily responsible for the causes of their disorder, they are responsible for overcoming them mostly with the help of their informal network and support

system. They can be helped by God, family, clergy, or, in some cases, through the intervention of public systems and resources. From the consumer's perspective, help-seeking includes any available and accessible health care service, not necessarily a specialty mental health facility. Health is managed within the local social and cultural systems and linkages to the institutionalized health system, to a large extent, depend on people's stage in the life cycle, their gender, their ethnic background, and their social class.

LINKING REFORM TO LOCAL KNOWLEDGE

Contextualizing mental health within local social and cultural systems, in addition to economic systems, means that policy makers must extend their data bank beyond numbers and conventional mental health categories. Instead of viewing cultural beliefs, values and behavior of people as barriers to the delivery of services (Wagenfeld and Wagenfeld 1981), local level resources that can be tapped for developing a more integrated and holistic mental health policy. Through understanding that each level of health care systems (national, regional, state, and local) have cultural and social components that guide behavior (including policy makers), programs can be developed and implemented that follow a participatory model of consensus building rather than a top-down model that often diverges with local level knowledge. By mapping cultural and structural convergence and diverges, health care reformers can solve some of the problems of accessibility, acceptability, and availability.

Consequently, accessibility, availability, and acceptability as outcome measures must be redefined as interactive concepts indicated access and acceptance between health care providers and clients. Expanding the definition of these terms has far-reaching implications for mental health policies and service delivery system. An empirical database that includes the peoples' local knowledge is essential to reforming rural health policy. Recently, Human and Wasem (1991) have suggested that "data and research" is the first step in policy formulation and policy decision making. We are calling for expanding the policy database to include information about the diverse local beliefs and behavior of rural peoples.

Can policies be made for diverse rural areas? The answer is definitely "yes." But, they must begin with the people for whom policies are designed to serve. Local communities must participate in designing policies and programs which utilize existing informal mental health

support networks through: (1) developing sustainable linkages to the institutions of family and community; (2) providing linkages for lay health providers; (3) overcoming the separation of mental and physical health care delivery systems; and (4) linking mental health service delivery to the wider social and political context of communities, including local schools, industries, and voluntary organizations. As Salber (1979) states, "health care professionals must be plugged into the natural system of the people." The lay referral network strengthens the ties of professionals to communities and channels knowledge to and from the community to the appropriate resources in the medical system. This knowledge is essential to plan preventive programs and to harness appropriate resources to make a preventive program effective.

Finally, rural mental health care reform must include cultural competency training (Yawn, et. al. 1993) for providers to increase their awareness of the differences that exist between the culture of their professional and personal context and that of the peoples they wish to serve. These differences include: (1) definition of health problems; (2) description and importance of symptoms; (3) diagnosis of health problems; (4) causes of health problems; (5) treatment procedures or strategies for change, and (6) meaning and impact of behavioral changes. Lack of knowledge about these fundamental differences on the part of providers can result in barriers to successful mental health programs (Wagenfeld and Wagenfeld 1981). This corresponds to the second element Human and Wasem (1991) suggest for mental health policy formulation–mental health professional needs.

Intervention into social networks involves linking diverse individuals/groups to other individuals/groups that interface the community with the wider health care system. Once all the social and cultural contexts of the local people and the health care providers have been delineated, specific interventions into relevant networks can be planned and implemented with people for specific health problems (Pattison and Polister 1980; Hill 1986). Current health care reform that includes local knowledge and practices into formalized rural health policy will better serve rural peoples by integrating physical and mental health services in rural areas and by linking the existing informal health care system in rural areas to the formal health care system.

REFERENCES

Blank, M.B., Tetrick, F., Brinkley, D.F., Smith, H.O., & Doheny, V. (1994). Racial matching and service utilization among seriously mentally ill persons in the rural South. *Community Mental Health Journal, 30*(3), 271–281.

Camino, L. (1989). Nerves, Worriation, and Black Women: A Community Study in the American South. In D.L. Davis and S.M. Low, (Eds.), *Gender, Health, and Illness*, 203–222. New York: Hemisphere Publishing Corporation.

Clarke, L.I. & Miller, M.K. (1990). The Character and Prospects of Rural Community Health and Medical Care. In A.E. Luloff and L.E. Swanson, (Eds.), *African Rural Communities*, 74–105. Boulder: Westview Press.

Cordes, S.M. (1989). The changing rural environment and the relationship between services and rural development. *Health Services Research, 23(6):* 757–784.

Coward, R.T., M.K. Miller and J.W. Dwyer (1990). Rural America in the 1990's: A context for rural health research. *Journal of Rural Health, 6,* 357–366.

Dressler, W.E. (1993). Health in the African American community: Accounting for health inequalities. *Medical Anthropology Quarterly, 7*(4), 325–345.

Flaskerud, J.H. and F.J. Kuiz (1983). Rural attitudes toward knowledge of mental illness and treatment resources. *Hospital and Community Psychiatry, 34*(3), 229–233.

Fraser, G.J. (in press). Modern minds, modern bodies: Reproductive change in an African-American community. In F. Ginsburg and R. Rapp (Eds.), *Conceiving the New World Orders.* Berkeley: University of California Press.

Greenhouse, C. (1986). *Praying for Justice: Faith, Order and Community in an American Town.* Ithaca: Cornell University Press.

Hill, C.E. (1986). Folk beliefs and practices. In L.R. Jones and R.R. Parlour, (Eds). *Psychiatric Services for Underserved Rural Populations,* 27–36. New York: Brunner/Mazel Publishers.

Hill, C.E. (1988). *Community Health Systems in the Rural American South: Linking People and Policy.* Boulder: Westview Press.

Hill, C.E. (1992). Reproduction and transformation of health praxis and knowledge among southern Blacks. In H.A. Baer and Y. Jones, (Eds). *African-Americans in the South: Issues of Race, Class and Gender,* 34–59. Athens: University of Georgia Press.

Hill, C.E. & Mathews, H. (1981). Traditional health beliefs and practices among southern rural blacks: A compliment to biomedicine. In M. Black and J. Shelton, (Eds). *Social Science Perspectives in the South,* p. 307–322. New York: Gordon and Breach, Science Publishers.

Hillard, J.R. (1982). Diagnosis and treatment of the rootwork victim. *Psychiatric Annals, 12*(7), 709–711.

Holzer, C.E., Goldsmith H.F., Jackson D.J., & Swanson, J.W. Indirect Indicators of Need for Mental Health Services: Comments and an Independent Formulation. In Goldsmith H.F., Lin E., Bell R.A. and Jackson D.J., (Eds.). *Needs Assessment: Its Future* NIMH Series BN No. 8, 33–46, 1988. U.S. Department of Health and Human Services, Rockville, Maryland. Paper presented at the Conference on Needs Assessment held in Rockville, Maryland, 1985.

Human, J. & Wasem, C. (1991). Rural mental health in America. *American Psychologist, 46*(3), 232–243.

Humphrey, R.A. (1988). Religion in Southern Appalachia. In S.E. Keefe (Ed.), *Appalachian Mental Health,* 36–47. Lexington: University of Kentucky Press.

Jecker, N. & Berg, A.O. (1992). Allocating medical resources in rural America: Alternative Perceptions of Justice. *Social Science and Medicine, 34,* 467–474.

Kamerow, D., et. al. (1986). Alcohol abuse, other drug abuse, and mental disorders in medical practice: Prevalence, costs, recognition and treatment. *Journal of the American Medical Association, 255,* 2054–2067.

Keefe, S.E. (1988). Appalachian Family Ties. In S.E. Keefe (Ed.), *Appalachian Mental Health,* 24–35. Lexington: University of Kentucky Press.

Keefe, S.E. (1988). An exploratory study of mental health service utilization by appalachians and non-appalachians. In S.E. Keefe (Ed.), *Appalachian Mental Health,* 145–160. Lexington: University of Kentucky Press.

Kessler, R.C. (1979). Stress, social status, and psychological adjustment. *Journal of Health and Social Behavior, 20,* 259–273.

Kessler, R.C. & Neighbors, H. (1986). A new perspective on the relationship among race, social class, and psychological distress. *Journal of Health and Social Behavior, 27,* 107–115.

Krug, E. (1974). Folk medicine beliefs. *Annals of Internal Medicine, 81*(5), 705–706.

LaVeist, T. (1992). The political empowerment and health status of African Americans: Mapping a new territory. *American Journal of Sociology, 97,* 1080–1095.

Moerman, D. (1981). Masterful Marginals: Black life on a Carolina island. In M. Black & J. Reed (Eds.), *Social Perspectives on the American South.* London: Gordon and Breach.

Nelkin, D. (1984). A response to marginality: The case of Black migrant farm workers. In N. Whitten & J. Szwed (Eds.), *Afro-American Anthropology.* New York: The Free Press.

Office of Technology Assessment (1990). *Health Care in Rural America.* U.S. Congress, OTA-H-434. Washington, DC: U.S. Government Printing Office.

Mermelstein, J. Sundet, P. (1986). Rural community mental health centers response to the farm crises. *Human Services in the Rural Environment, 10*(1), 21–26.

Pattison, E.M. & Polister, P.E. (1980). Community groups: An empirical taxonomy for evaluation and intervention. In R.H. Price and P.E. Polister (Eds.), *Evaluation and Action in the Social Environment,* 51–68. New York: Academic Press.

Patton, L. (1989). Setting the rural health services research agenda: The congressional perspective. *Health Services Research, 23*(6), 1005–1051.

Pellegrini, A.J. & Putnam, P. (1984). The amytal interview in the diagnosis of late onset psychosis with cultural features presenting as catatonic stupor. *Journal of Nervous and Mental Disease, 172*(8), 502–504.

Quinn, N. & Mathews, H. (Note 1). Processes of disease diagnosis among southern Black root doctors. Unpublished manuscript. Durham: Department of Anthropology, Duke University.

Regier, D.A., et. al. (1978). The de facto U.S. mental health system. *Archives of General Psychiatry, 35,* 685–693.

Rowland, D. & Lyons, B. (1989). Triple jeopardy: Rural, poor, and uninsured. *Health Services Research, 23,* 975–1004.

Ruiz, P. & Langrod, J. (1976a). Psychiatry and folk health: A dichotomy? *American Journal of Psychiatry, 133*(1), 95–97.

Ruiz, P. & Langrod, J. (1976b). The role of folk healers. *Community Mental Health Journal, 12,* 392–398.

Salber, E.J. (1979). The lay advisor as a community health resource. *Journal of Health Politics, Policy and Law, 3,* 469–477.

Snow, L.F. (1993). *Walkin' Over Medicine.* Boulder, Westview Press.

Taylor, S.E. (1992). The mental health status of Black Americans: An overview. In. R.L. Braithwaite and S.E. Taylor (Eds.), *Health Issues in the Black Community,* 20–34. San Francisco: Jossey-Bass Publishers.

Ulbrich, P.M., Warheit, G.J. & Zimmerman, R.J. (1989). Race, socio-economic status, and psychological distress: An examination of differential vulnerability. *Journal of Health and Social Behavior, 30,* 131–146.

Van Schaik, E. (1988). The social context of "nerves" in eastern Kentucky. In S.E. Keefe (Ed.), *Appalachian Mental Health,* 81–100. Lexington: University of Kentucky Press.

Wagenfeld, M.O. (1990). Mental health in rural America: A decade review. *Journal of Rural Health, 6,* 507–522.

Wagenfeld, M.O. & Wagenfeld, J.K. (1981). Values, culture, and delivery of mental health services. Special issue on perspectives on rural mental health. *New Directions for Mental Health Services, 9,* 1–12.

Weidman, H., et al. (1978). *Miami Health Ecology Report.* Miami: University of Florida Offprint.

Weller, J. (1965). *Yesterday's people.* Lexington, University Press of Kentucky.

Wolf, E. (1982). *Europe and the People Without History.* Berkeley: University of California Press.

Yawn, B., et. al. (1993). Making your practice palatable for your patients: Cultural competency. In B.P. Yawn, A. Bushy and R. Yawn (Eds.), *Exploring Rural Medicine: Current Issues and Concepts,* 253–270. Thousand Oaks: Sage Publications.