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The Cultural Context of Depression in Appalachia: Evangelical Christianity and the Experience of Emotional Distress and Healing

Susan E. Keefe and Lisa Curtin

Survey research by Zhang et al. (2008) found that Appalachian residents report experiencing a greater prevalence of serious psychological distress compared to non-Appalachian residents. Specifically, Appalachians report a significantly higher prevalence of major depressive episodes compared to non-Appalachians. Locally conducted studies in Appalachia also find high rates of depression among residents (Hauenstein and Peddada 2007; Huttlinger, Schaller-Ayers, and Lawson 2004; Mutaner and Barnett 2000). Other studies suggest that Appalachian natives are at high risk for suicide, which is often associated with depression (Halverson, Ma, and Harner 2004). We assume that stressors such as high rates of unemployment and poverty, low levels of education and health insurance coverage, long distances to services, fewer institutional resources, and cultural differences between clients and service providers increase the prevalence of mental and emotional problems such as depression in the region. Despite higher rates of depression and suicide, there is little evidence of a higher demand for mental health services in Appalachia. Neither has there been much research on the experience of depression among Appalachian natives.

In 2011, we began a research project investigating illness narratives among Appalachians experiencing depression. We used medical anthropologist Arthur Kleinman's (1980) suggested interview guide

for understanding the patient's experience of illness (as opposed to the biomedical definition of diseases). The questions cover five major topics: etiology, time and mode of onset of symptoms, pathophysiology, course of sickness, and treatment. Our intent was to begin to understand the psychosocial experience and the meaning of depression as perceived by Appalachian natives. We decided to begin with a sample of individuals who had been diagnosed with depression or who were taking antidepressants. Following confidentiality requirements, we solicited volunteers from the offices of physicians, clinics, mental health professionals, and peer support groups in two rural counties in western North Carolina. We offered a stipend of $50 if participants completed all forms and an in-person interview. We distributed 450 flyers over six months. We anticipated receiving a large response. After considerable effort, we received a total of thirty-seven volunteers for the study. After screening for native birthplace and diagnosis, however, we were left with a sample of only twenty-three consultants in the final interviews.

Not only did we have difficulty in gathering a sample, but the final sample appears to be unusual in many ways. Most of our consultants have had severe symptoms. Many have been suffering for decades, requiring repeated hospitalizations, often for suicide attempts. Several have psychological symptoms so severe they have qualified for and are living on disability. Many experience comorbidity with anxiety, alcohol abuse, PTSD or other psychological disorders, or with chronic physical health problems.

Given the high rate of depression in Appalachia, this paper attempts to make sense of the problems we had in attracting a larger sample with a range of symptoms from mild cases to more severe. We begin by briefly introducing the current biopsychosocial model of the symptoms, etiology, and treatment of depression utilized by mental health professionals. Then we move to an examination of

the cultural context of rural Appalachia, particularly the religious nature of evangelical Christianity and culturally embedded conceptions of emotional distress as well as appropriate healing. A case study provides insight into the cultural context for one individual from our sample who suffers from depression.

Symptoms, Etiology, and Treatment of Depression According to Mental Health Professionals

Depression is typically defined using the objective diagnostic criteria specified in the Diagnostic and Statistical Manual of Mental Disorders (e.g., DSM-5; American Psychiatric Association 2013) or the International Statistical Classification of Diseases and Related Health Problems-10 (World Health Organization 1992). Depression, as a syndrome, is defined by depressed mood and/or a lack of pleasure in addition to a host of related symptoms including profound loss of interest in activities, appetite and sleep disturbance, feelings of guilt and worthlessness, changes in behavior, and potentially suicidal ideation and impulses across a minimum of two weeks in the absence of mania. Depression is considered a leading cause of disability worldwide and a treatable illness.

Medicine and psychology offer numerous etiological conceptualizations of depression, but most employ a diathesis-stress model to understand an individual's depression (Beck 1979; Lazarus 1993). A diathesis-stress model accounts for predisposing vulnerabilities, such as a positive family history of depression and dysfunctional attitudes (e.g., negative attitudes toward self, others, and future) as well as negative life events that oftentimes precede and trigger depression (Abela & D'Alessandro 2002). Most modern perspectives on depression, as well as other illnesses, deviate from a pure biomedical model and consider biological, psychological, and social factors as important in the etiology and maintenance of the disorder (Engel 1977). Thus,

vulnerabilities to depression differ from person to person and may be genetic, biological (e.g., serotonin dysfunction), psychological (e.g., personality, learning experiences, internalized messages), or social (e.g., early negative experiences) in nature (Savaneau and Nemeroff 2012). In addition, biological, psychological, and social variables are not considered in isolation but are considered interdependent. In turn, most practitioners employ an idiosyncratic method of case conceptualization and treatment based on a thorough assessment of an individual client's symptomology, vulnerabilities, current stressors, and strengths (e.g., coping skills, social support, economic resources).

Ideally, psychotherapy is evidence-based and individualized with attention to cultural context rather than a one-size-fits-all approach (American Psychological Association 2012). Indeed, psychotherapy, particularly cognitive-behavioral therapy that focuses on increasing engagement in reinforcing behaviors and challenging irrational and self-defeating thoughts, has been found to be as effective as medication in the treatment of depression (Antonuccio, Danton, and DeNelsky 1995). However, between 1998 and 2007, the use of psychotropic medications for the outpatient treatment of mental illness increased, and the average number of outpatient psychotherapy sessions decreased (Olfson and Marcus 2010). In addition, there is concern about the potential for increased use of antidepressant medications for the treatment of depression in the future. For example, the DSM-5 allows for the diagnosis of Major Depression in the context of bereavement whereas the DSM-IV did not unless symptoms persisted longer than two months or resulted in significant impairment. Many practitioners and researchers (e.g., Friedman 2012) are concerned that this diagnostic change may pathologize the normal process of grief and that unnecessary intervention, particularly the use of antidepressants, could interfere with adaptation to loss and grief.

"It's a weakness, not an illness": A Case Study

The following case study collected during our research presents an Appalachian response to depression. Sammy's experience illustrates that evangelical Christians have a different way of interpreting the symptoms and etiology of emotional suffering ascribed to depression in the biopsychosocial model just described.

Sammy[1] is a forty-eight-year-old woman who grew up in a rural part of a nearby county. Sammy's father was a Baptist preacher. He never had his own church, in part because he got divorced, which is considered a sin among conservative evangelical Christians. He has had a brain aneurism in recent years and was diagnosed with depression and schizophrenia as a result of that, according to Sammy. Her mother suffered from depression, was suicidal, and had nervous breakdowns many times; she often left young Sammy to fend for herself beginning when Sammy was a preschooler. When her parents were separating and her mother was drinking, Sammy became the object of their anger and violence. Sammy tried to commit suicide and was hospitalized at the age of eighteen. Her father refused to take her to counseling afterwards, according to Sammy, because he was ashamed.

Sammy proceeded to give a detailed portrait of how religion in the mountains affects attitudes toward depression. "Suicide is a very shameful thing in the mountains," said Sammy. "It's considered a sin. You'll go to hell; that's what my family believes." It means you have failed in your faith. It's not your right to "play God" and choose when to die, Sammy said; according to evangelical Christians, it's God's choice. To commit suicide means you renounce God. According to Sammy, people will tell you "to snap out of it. Buck up. Stop crying. Put your feet on the floor and keep going. Toughen up." You need to have stronger faith, and at church, she said, "you would be expected to go to the altar and ask forgiveness for wallowing in your misery,

because that's sinful. God is good to you, and you have to count your blessings. Don't worry about things you can't have any control over."

Nobody from her family's Baptist church or the Methodist church she now attends has ever called to offer support in her suffering. "You're an embarrassment," Sammy said. "I wasn't allowed to tell anyone at school after I came back from trying to commit suicide. I wasn't allowed to go to the counselor at school or to tell the principal. I had embarrassed my father because he was a Baptist preacher. He was an evangelist. He did tent meetings, tent revivals, and went to preach at revivals at different churches. I would have ruined any chance of him ever getting a church if it had gotten out that I had done that. He would never have been able to preach again." Without any social support, Sammy suffered a heavy burden after her suicide attempt. "It was just pure isolation," she said, "and shame and guilt."

After her marriage to a local man, Sammy had a baby, and when she suffered from "the baby blues" afterward, her general practitioner put her on an antidepressant, and she began to feel better. However, her husband, Kyle, would not let her get a refill. She remembered that her husband said, "You shouldn't depend on pills." He felt it was a waste of money and that if she simply tried harder, she could pull herself out of it on her own. Kyle has had a long history of alcohol and drug abuse, and Sammy suffered from domestic violence over the course of their marriage. After their divorce, Kyle was arrested for statutory rape of a minor and was put in a psychiatric hospital for two years awaiting trial due to mental incompetence with bipolar disorder. He was in jail at the time of the interview. Kyle's brother committed suicide many years ago, and according to Sammy, Kyle's mother (Sammy's former mother-in-law) "is still struggling over that because she thinks he will be in hell. She thinks you have no chance of going to heaven if you commit suicide." Sammy's daughter

is currently being treated for Major Depressive Disorder. Mental illness clearly runs on both sides of the family.

Sammy continues to suffer from bouts of depression. She responds, as she says, by "caving," just going into the bedroom and hiding: "If you're not out working and looking good and contributing to society, then you're shameful, you're an embarrassment." She is a substitute school teacher in an adjacent county, and depression keeps her from working sometimes. She has been to mental health professionals over the years, including a Christian counselor who she thinks was "wonderful." She is on antidepressants and believes the medication is helpful. She also finds writing cathartic, and she loves gardening, hiking, Tai Chi, and dancing in her living room. But she is afraid that the school system will find out that she suffers from depression. Sammy knows a peer support counselor who had a nervous breakdown when she was a teacher, and they fired her. "You just don't do that around here," said Sammy. "I mean if someone has cancer, they do everything in the world to try to help them. But if somebody's got depression, they do not consider it an illness. It's a weakness, not an illness." Sammy has reason to be anxious; she says she was fired by the school system after she married a Mexican man a few years ago and has only been able to get substitute teaching jobs in the county since then.

Scholars in Appalachian Studies would find several manifestations of mountain values in Sammy's words (see Jones 1994). The idea of independence and self-reliance is clearly present in the description of her family's encouragement to stop crying, snap out of it, pick yourself up, and keep going. Also present is the value of hard work and effort and the desire not to look lazy by staying in bed all day. Characterizing depression as a weakness might be interpreted as a general moral weakness in character in someone who refuses to get up and get to work. In other cases in our study, consultants

mentioned that it is inappropriate to seek out social attention when sick due to the value of humility and keeping a low profile in the mountains. However, the overriding reference to religious concerns in Sammy's case leads us to consider a different framework for interpreting this weakness that leads to the shameful condemnation of the entire community: it is a spiritual weakness.

Evangelical Christianity and the Cultural Context

A number of questions arise from Sammy's case. What are the cultural beliefs in Appalachian communities that create a context of intense shame involving the experience of depression-like symptoms? Why would a family's shame prevent them from making use of mental health professionals and medications when a family member like Sammy has severe depression, especially when suicide is believed to have such devastating eternal consequences? Why would families, especially those like Sammy's in which severe depression and serious mental disturbances affect many family members, not jump at the chance to control symptoms with medication and other forms of orthodox treatment? What is different about emotional suffering (because there is no similar reticence among native Appalachians to make use of medical services for physical illness)? Why is it difficult for people to even talk about depression in Appalachia—including within families touched by severe forms of the illness? Why should evangelical churches, preachers, and congregation members in rural Appalachia (normally characterized as forming supportive communities) respond to members suffering from depression-like symptoms with avoidance and, sometimes, ostracism?

Most native Appalachians are evangelical Christians; they believe in God and try to develop a personal relationship with God through prayer. The most common evangelical religious affiliations in the mountains are Baptist, Methodist, and Pentecostal-Holiness, and

churches in rural areas are typically small and independent of hierarchical associations (such as the Southern Baptist Association). As fundamentalists, evangelical Christians in the mountains agree on the five fundamentals of faith: (1) the infallibility of the Holy Bible, (2) the Virgin Birth, (3) the resurrection of Jesus Christ, (4) Christ's atonement on the cross for the sins of humanity, and (5) the Second Coming when Jesus will return for believers (Riesebrodt 1993, 10). From the evangelical Christian viewpoint, God is in control of all things in heaven and on earth. This includes the emotional life of believers.

Evangelical Christians agree that humans have fallen away from God due to original sin, but this separation from God can be overcome through an emotional heartfelt encounter with the divine. First, sinners must repent and affirm their belief and faith in the Savior, Jesus Christ. Believers are then urged to seek a personal relationship with God once they are "born again."

For Evangelicals, when one is born again, God enters your heart. You surrender your will, give up everything, and welcome God into your heart to work through you. The Holy Spirit "warms" your heart, comes to dwell within you, and you feel joy/bliss/peace/love. This is love in the sense of the Christian religious concept of agape, or charitable, selfless, altruistic, and unconditional love—as God is believed to love humanity. Early evangelical Christian leaders wrote about this feeling. In 1738, John Wesley described in his journal when responding to a speaker who was describing "the change which God works in the heart through faith in Christ, I felt my heart strangely warmed. I felt I did trust in Christ, Christ alone for my salvation" (in Noll 2001, 11). In another example, early-eighteenth-century evangelist Charles Finney, talked about feeling "waves and waves of liquid love" during a religious service (in Luhrmann 2012, 147). Evangelical Christians today speak of being "filled with the Spirit" when the Holy Spirit is

working through them, and they often sense the spirit of God flowing through their bodies (something like electricity) as well as filling their hearts. In this new life as an evangelical Christian, God takes control of your life, and your actions as well as your emotions become "God-driven." Your suffering is lifted by Jesus through his suffering on your behalf on the cross. God is said to love and accept you just as you are. Moreover, evangelical Christians believe that humans were created in the image of God for the purpose of enjoying His fellowship, that God wants to be your confidant and wants you to come to Him in prayer (Noll 2001).

The heart is the locus of this change in the new believer. God, in the form of the Holy Spirit, works on the heart. In the Bible, Luke 6:45 (King James Version), Jesus says, "A good man out of the good treasure of his heart bringeth forth that which is good; and an evil man out of the evil treasure of his heart bringeth forth that which is evil: for of the abundance of the heart his mouth speaketh." In other passages, Jesus (Mark 8:17) and the Holy Spirit (Hebrews 3:8) warn against the hardening of hearts to the word of God. Evangelical Christians understand God to be breaking through the "wall of reason" to touch the heart (Mathews 1977, 12). As the heart is moved and transformed by these religious affections, these feelings begin to operate on a higher plane of existence, ultimately making an impression on the soul and infusing the believer with grace (McLoughlin 1978). New believers are encouraged to nurture the God within by developing the heart—stretching it to accept more of God's love.

Evangelical Christians do this through many practices including lifelong individual prayer, keeping prayer journals, individual and group Bible study, hymn singing, and worship in church in communal prayer and communal rituals. Mountain people talk about creating "fellowship" with God, just as they work to create fellowship with the members of their church. Often this occurs through firsthand

conversations with Jesus, who becomes like a personal friend. In a fascinating ethnography entitled *When God Talks Back*, anthropologist T. M. Luhrmann describes the way in which new evangelical Christian believers learn to recognize the thoughts in their mind that are not their own but, rather, represent God talking to them. Luhrmann says they learn a "new theory of the mind" that is different from common sense, on the one hand, or psychologists' understanding of the mind, on the other (Luhrmann 2012, 41). In this new theory of the mind, believers learn how to recognize thoughts that are from beyond the natural world, from God. In addition to recognizing God's voice, they also learn to recognize the feelings and sensations in their body that emanate from God.

Emotional calm and stability is the norm in the mountains where people are expected to demonstrate self-control and independence of others in their actions. Strong emotions, on the other hand, are enthusiastically unleashed in church, where spontaneous and heartfelt expression of emotion is considered a sign of connection with God (Dorgan 2006). In church, people are allowed to cry without shame. They might physically feel a sense of bliss in God's presence. Commonly in the past, though perhaps less common today, people in church who were moved by the Holy Spirit would shout, or run, or fall to the ground writhing in ecstasy. This is also described in early writings about the revivals that swept through the mountains during the Great Awakening at the turn of the nineteenth century and in the religious awakenings that followed (Mathews 1977). This primacy of the emotions provokes one scholar to call evangelicalism "the democracy of emotion rather than the hierarchy of the intellect" (Mathews 1977, xvi). God is also believed to work directly through individuals, emotionally inspiring them to preach, among other things; in mountain churches, the preachers are often "called" to preach rather than being trained in seminary for religious leadership. Moreover,

their preaching in church typically depends on spontaneous and direct inspiration from God rather than being carefully worked out in written sermons (Jones 1999).

While these positive emotions of joy and bliss and love are signs of spiritual inspiration, negative and inappropriate emotional responses such as anger, hatred, pride, lust, envy, greed, worry, self-absorption, and self-doubt are sins and things of the flesh. For Evangelicals, the Holy life is "a constant and ruthless struggle" against worldly temptations, but one that is worth waging (Mathews 1977, 62). Loyal Jones (1999) makes clear that mountain people typically believe in the Devil as well as in God, and these negative emotions are typically understood by evangelical Christians to be the result of the work of the Devil, who is always trying to draw humanity away from God. To submit to Satan's temptations is to sin; hence, the conclusion that suicide is a sin. To question God's Will and unconditional love is a sin; thus, the warning that worry and self-doubt are sins. In the mind of the evangelical Christian, God does not withdraw, rather you pull away. Instead of withdrawing, believers are admonished to remain strong in their faith, to return to prayer, and to resist the temptation to fall away from God. Jesus is typically the intermediary for the emotional concerns of evangelical Christians; one's sins and concerns are confessed directly to Jesus and, thus, to God. Religious leaders are rarely sought out for confessions, although the intercessory prayers of others are welcomed. If another believer is aware of the suffering of others, he or she typically does not probe further but simply responds by saying, "I'll pray for you." The assumption is that resolution requires the work of the sinner himself or herself, who must go to God in prayer.

Feelings of worthlessness, helplessness, and hopelessness, in other words, may be interpreted by evangelical Christians as due to a lack of spiritual strength. These commonly cited symptoms of depression

may *not* be understood by evangelical Christians as a mental health problem requiring the care of a therapist. Instead, appropriate healing would require the individual to pray and to seek God's help. Turning to a mental health professional might not only be seen as inappropriate but misleading, since most mental health professionals use secular therapeutic models that do not specifically incorporate religious healing. Christian counselors, on the other hand, are known to incorporate spirituality and prayer in their understanding and treatment of emotional problems. Several of our cases, including Sammy, spoke highly of the Christian counselors they consulted.

Evangelical Christians do not conceptualize themselves as atomistic individuals with self-contained feelings and emotions triggered by social or environmental factors. Instead, their emotions are interpreted as an outcome of their relationship with God, or the lack thereof. Through faith, God works through them as they endeavor to become "good Christians" and to transcend their sinful nature. Self-scrutiny is the means by which they assess their success in following the path of Jesus Christ. Sinful behavior, often interpreted to include drinking, taking drugs, swearing, fornicating, smoking, or dancing, is to be avoided. Other behavior often believed to be immoral and sinful by evangelical Christians includes homosexuality, premarital sex, abortion, divorce and remarriage, many symptoms of depression (including feeling worthless and hopeless), and forms of outrageous behavior deemed bizarre or "crazy." Individuals are assumed to be responsible for these sinful behaviors and are expected to reform. In addition, church discipline may be used to sanction these kinds of behavior in individual members, who may be called out by name during a sermon in church or made to suffer shunning or ostracism by the congregation (Mathews 1977). However, congregants generally remind themselves to "hate the sin; love the sinner." Thus, religious healing is always possible since God's love is considered to be

unconditional. By "making it right with God" through confession, repentance, and the receipt of God's forgiveness in prayer, evangelical Christians believe they can overcome their sins, reform, and find peace.

Evangelical Christians in rural Appalachia often have little understanding of mental illness in the modern psychological sense. In fact, their religious stance rejects a secular, scientific, and naturalistic view of the world. Instead, they see their health and well-being as coming from God. This includes their emotional as well as their physical health. They have come to accept the healing powers of physicians because they see God working through doctors and medications to heal the physical body. In this sense, they have a holistic view of healing. On the other hand, they do not subscribe to Cartesian dualism, which perceives mind and body as separate from one another. Instead, they make a distinction between physical versus spiritual problems, and mental and emotional disturbances are for the most part connected with the spiritual dimension. This distinction becomes clear when considering the folk illness "nerves." Only one of our consultants identified as having nerves, which typically was equated with anxiety and nervousness and not the symptoms of major depression experienced by most of our cases. Our consultants perceived nerves as having somatic symptoms which are appropriately treated by a physician with "nerve pills" such as Xanax or Valium.

Emotional problems are more likely to be understood as in need of spiritual healing. A number of our consultants, like Sammy, describe learning about psychology in high school or college courses, perhaps first identifying depression as a medical diagnosis there. Many have learned extensive psychological language and causal models, likely as a result of years, sometimes decades, of treatment and, often, hospitalization. Most have accepted that they have a chronic illness that

requires medication. Many have families that have learned, through the experience of one of their own, about the biopsychosocial model of depression and have become more supportive of mental health treatment. Most have learned various ways of coping with the shame they feel in their community, often resorting to relocation to find anonymity.

Conclusion

In conclusion, the beliefs of evangelical Christianity are at odds with modern medicine and psychology on the derivation of emotions and their consequences. Whereas modern psychology understands emotions as fairly universal and resulting from a mixture of biological, evolutionary, cognitive, and social factors (Kim, Thibodeau, and Jorgensen 2011), evangelical Christians see negative emotional states, such as depression, as evidence of spiritual problems in need of God's guidance. Since the majority of the rural population in Appalachia is evangelical Christian, we suspect that these beliefs dominate the cultural context in most rural communities in Appalachia. They also inform the beliefs of many urban Appalachians, and, considering the fact that more than one-third of the American population is evangelical Christian, they undoubtedly inform the beliefs of many communities throughout the South and in other parts of the United States as well. Since evangelical Christianity dominates the religious landscape in Appalachia, mountain communities with religious diversity may find that even the attitudes and feelings of people of other faiths are affected by these beliefs.

Although, in general, research has found an inverse relationship between religion/spirituality and depression, for a subset of people who may experience themselves as falling short of the expectations of their religion, religion and spirituality appear to be related to greater depression (Bonelli et al. 2012). Specifically, Bonelli and

colleagues, in their review of over four hundred studies across the last fifty years that examined the relationship between religious/spiritual involvement and depression or depressive symptoms, found relatively high levels of depression among those who identified as Pentecostal, although the relationship between the two is unclear and correlational. In addition, they found that involvement in religion/spirituality predicted greater symptoms of depression for those who reported family problems as opposed to other problems such as financial or health problems. The authors hypothesize that those religious beliefs that place great value on family may result in greater guilt, and, in turn, depression. Indeed, Kim and colleagues in their meta-analytic review found that guilt related to an exaggerated sense of responsibility for uncontrollable events, as well as "free-floating" guilt, was associated with depression (Kim, Thibodeau, and Jorgenson 2011).

For evangelical Christians, emotions typically attributed to those suffering from depression, such as feelings of worthlessness, hopelessness, and helplessness, are not immediately recognized as symptoms of mental illness but rather as spiritual problems emanating from humanity's sinful nature. As such, they are stigmatized emotions that people hide from others, including close friends and family (as well as social scientists). To speak of them is to admit sin, and so no language exists to speak about them without condemnation. Evangelicals respond by redoubling their religious practices and socially isolating themselves to avoid public humiliation. For those whose efforts are unsuccessful and whose problems become known due to hospitalization or a suicide attempt, the victim not only experiences individual guilt but also shame and communal sanctions including avoidance and, in some cases, ostracism. For those who commit suicide, they leave behind family members who suffer embarrassment for their inability to lead the victim back to God's

fold, grief at the loss of their loved one, and pain in the knowledge that they will never again see their family member who is damned to hell for eternity.

These beliefs have contributed to the growth of Christian counselors in recent decades as evangelical Christians search for culturally appropriate forms of treatment. The American Association of Christian Counselors, for example, has over fifty thousand members and claims as its mission "to equip clinical, pastoral, and lay care-givers with biblical truth and psychosocial insights that minister to hurting persons and helps them move to personal wholeness, interpersonal competence, mental stability, and spiritual maturity" (American Association of Christian Counselors 2014). Three private colleges in North Carolina offer degrees in Christian counseling. For many Evangelicals, Christian counseling is a clear alternative to secular mental health services because it incorporates Christian spiritual practices (including prayer) with psychological counseling, blending the benefits of both. Few Christian counselors practice openly in secular settings such as community mental health centers or state-supported mental hospitals. Perhaps hiring Christian counselors is perceived as a conflict of church versus state or religion versus science. However, given the need for well-trained therapists who can provide culturally competent mental health care in the Appalachian region, mental health agencies would do well to consider better integrating religion and spirituality into public services. Preliminary investigations of actively addressing and utilizing faith in the context of mental health interventions suggest this may be fruitful (Smith, Bartz, and Richards 2007). Furthermore, college-based training programs should actively train practitioners to consider religion and spirituality in the assessment and treatment of depression as well as other forms of emotional suffering. Professional journals such as *Psychology of Religion and Spirituality*, published by

the American Psychological Association, are evidence of promise in addressing this gap.

Given the difference between the evangelical Christian-shaped worldview of Appalachian natives and that of modern psychology, we were lucky to get any volunteers in our study at all. Because we solicited volunteers who had experienced depression or took antidepressants, we largely collected a sample of consultants who had adopted the biopsychosocial model of mental health professionals. Yet, their illness narratives reveal a rich cultural context, complicating our original thinking. Future research on mental health and illness in Appalachia will do well to take religion in general and evangelical Christianity, specifically, into consideration.

[1] All names used in the case study are pseudonyms.

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