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Negotiating the interpretation of depression shared among kin

Claire Snell-Rood, PhD,

Division of Community Health Sciences School of Public Health University of California, Berkeley
207H University Hall Berkeley, CA 94720-7360 859-559-7640

Merkel Richard Jr., MD PhD, and

Department of Psychiatry and Neurobehavioral Sciences, School of Medicine, University of
Virginia, P.O. Box 800623, Charlottesville, VA 22908-0623, 434-243-4646, rlm3u@virginia.edu

Nancy Schoenberg, PhD

Department of Behavioral Science, University of Kentucky College of Medicine, 125 Medical
Behavioral Science Building, Lexington, KY 40536-0086, 859-323-8175, nesch@uky.edu

Abstract

Kinship processes contribute to the experience and interpretation of depression—generating empathy as well as silencing. We explore intersubjective experiences of depression among kin with the aim of understanding how depression can reveal kinship expectations and evolving concepts of distress. In interviews with 28 low-income rural Appalachian women about their depression, participants articulated depression as a social process that neither starts nor ends in themselves. Yet kinship obligations to recognize family members' depression limited women's ability to admit distress, let alone request care. The intersubjective experience of depression among kin can challenge the individual expression of distress.

Keywords

Appalachia; depression; gender; intersubjective; kinship; rural

Responding to a growing body of research on the intersubjective experience of distress among kin (Buchbinder 2010; Das 2006; Garcia 2010, 2014; Horton 2009; Pandolfo 2008), we examine how intersubjective depression can confuse not only the interpretation of distress, but what such intersubjective distress demands from kin—particularly amid conditions of shared social adversity and deep social change. We focus on Appalachian women's narratives of intersubjective depression. In Appalachian Kentucky, a rural region of the US, residents struggle with deep poverty, changing kinship patterns, high rates of depression, and no clear community consensus about the meaning of depression. We found that women related their feelings to those of their family members through “taking over” others' feelings to relieve their burden, knowing kin's feelings as one's own, and containing their own feelings to strengthen their families. Yet amid the low moods that connected

*Corresponding Author: clairesnellrood@berkeley.edu.

Media teaser: What happens when not just one family member is depressed, but most are—because they live in the same challenging conditions? Whose depression is acknowledged and who receives care?

women to their kin through empathy and emotional care-work, women articulated their struggle to name and understand their own distress.

Elevated prevalence of depression is well documented in Appalachia (BRFSS 2013) and high in rural communities across the US—with some researchers estimating 38–51% among rural women (Hauenstein and Peddada 2007; Price and Proctor 2009) in comparison to 10% in the general US population (CDC 2010). Yet Appalachian anthropologists suggest a critical approach toward the study of depression, revealing a legacy of representations naturalizing Appalachian mental illness as a product of supposedly “dysfunctional” kinship (e.g., Loeff 1971; Weller 1965) while drawing attention to “nerves” as an indigenous idiom of distress grounded in social adversity (Keefe and Curtain 2012; Van Schaik 1989).

For scholars hoping to understand the lived experience of distress and depression, the varied use and multiple meanings of the term depression has become problematic (Ehrenberg 2016; O’Neill 2004). We found that even as community members unilaterally described widespread and severe depression, individual narratives held considerable silences in naming depression or other forms of distress. Though medical anthropologists stress the critical role of the local vernacular to mark cultural variations in distress (Nichter 2010), we necessarily acknowledge that “which is *not* said overtly,” though analytically challenging, such an approach can illuminate that which is dangerous to feel or voice (Das, et al. 2000; Good 2012). In what follows, we analyze ethnographic interviews to understand depression as a state acknowledged to be viscerally *there* but difficult to describe. Where possible, we use women’s language, yet most often, we use “distress” and “low mood”—neither emic terms—to convey women’s struggle to interpret their anguish. When referring to the medicalized entity, as when clinically diagnosed or measured in epidemiological research, we use the term Depression.

We examine women’s understandings of how distress is experienced within families, including how family members are expected to buffer one another amid poverty and scarce healthcare resources and how the low mood of family members contributes to the causes, and resolution of their own depression. We argue that cultural expectations for family care and empathy of shared distress normalize low moods as a way of being, while limiting the ability of people, particularly women, to voice distress. Women’s ambivalent articulation of medicalized Depression and embrace of new kinship roles demonstrate the way that social changes can both engender further distress and create new options for recovery.

Kinship and depression: Making sense of or sharing distress?

Psychological anthropologists have long wrestled with the place of emotions and distress within mental health—the “two distinctive states of persons, one normal, the other pathological” at the core of psychiatry’s mission (Kleinman and Good 1985:8). They have emphasized the meanings through which people interpret, articulate, and respond to depression as emotion and illness (Kleinman and Good 1985:31). Central to this endeavor has been the cross-cultural exploration of the role of kin in shaping the identification, vulnerability to, and recovery from mental illness and distress (Jenkins and Karno 1992; Luhrmann and Marrow 2016; Pandolfo 2008; Scheper- Hughes 2001; Yarris 2011, 2014).

Much of this work has questioned the individual as the unit of analysis, highlighting depression - and mental health more broadly - as an intersubjective process, in which kin absorb and share distress (Buchbinder 2010; Das 2006; Garcia 2010, 2014; Horton 2009; Pandolfo 2008)

In making sense of family members' behavior, kin draw on shared cultural understandings of emotion that "provide models that may shape how individual might or should feel in a given situation" (Jenkins and Karno 1992:17), including differentiating between depressed emotion—which may be culturally valued—and disorder (Good, et al. 1985; Scheper-Hughes 2001). At times, interpretation has been intertwined with force, as kin have marginalized their family members, using a mental illness label to Other or forcibly institutionalize them (Das and Addlakha 2001; Scheper-Hughes 2001). Families and communities battle over the moral interpretations of emotional life because of their potential to sanction behavior change and interpersonal obligations (Jenkins and Karno 1992; Throop 2010). Narratives of mental distress reveal "disruptions in social systems and kinship systems" (Yarris 2011:227), in which social-economic conditions challenge family members' ability to fulfill kinship expectations, and dramatically reshape normative kinship forms (Scheper-Hughes 2001; Yarris 2011). Cross-culturally, women living in poverty have borne a disproportionate burden of such distress due to their immense social responsibilities and high exposure to adversity (Finkleler 2010; Yarris 2011, 2014).

Emotion and mental health are intersubjective processes (Buchbinder 2010; Das 2006; Garcia 2010, 2014; Horton 2009; Pandolfo 2008). In understanding this, researchers have questioned how mental distress is embedded within larger social histories of family, place, and state, with histories of dispossession embodied as melancholy "to keep it alive" (Das 2006; Garcia 2010:75; see also Stevenson 2014:157). They resist the medicalization of distress by refusing to label it as an entity that can be compared cross-culturally and rejecting the therapeutic resolution of such pain. Instead, they portray distress as intergenerational, unknowable and moral (Das 2006; Garcia 2010, 2014; Horton 2009; Stevenson 2014; Yarris 2014).

While in the earlier literature, kin play a key role in *interpreting* the meaning of depression either as emotion or as disorder by drawing on broader cultural understandings, in recent research kin *share* and *absorb* distress, connecting it to deeper histories and resisting interpretation. We draw on a disconnect between these literatures to ask when and how the experience of intersubjective distress can be confusing to individuals, such as when they evaluate and seek to differentiate their personal distress from intergenerational histories; ruminate on the tension involved in accepting others' distress; and desire resolution even if others do not. We ask whether the intersubjective nature of distress among kin can complicate its experience and interpretation. What are the consequences of this challenge to make sense of low mood for those experiencing it and their involvement in family life? We explore how individuals *interpret* their distress and seek interpretation of it by others through the experience of rural Appalachian women whose complex relationships with kin may shape their ambiguous interpretation of depression.

Anthropological and epidemiological perspectives of depression and kinship in Appalachia

Historically, Appalachian families have been characterized by the nuclear family unit, which was fundamentally interconnected with the broader extended family through exchange, visiting, and shared land (Keefe 1988). At once an economic unit, source of emotional support, and basis of group identity (Scott 1995), the deep reciprocity within the household unit contributes to wellbeing while adding stressful social burdens (Keefe 1986). Critical examination of the gendered inequities that sustain the Appalachian family unit illustrate how women are held to be “responsible for family cohesion and continuity...the mortar of their marriage” (Horton 1984:649), enduring without complaint their own challenges in the interest of the family (Browning, et al. 2000; Horton 1984; Keefe and Curtain 2012).

Other academic and journalistic representations have indicted Appalachian families for increasing mental health problems and poverty (Looft 1971; Weller 1965), obscuring the patterns of structural inequality that generated and sustained Appalachian poverty. Even into the 1990s, representations of Appalachian mental health echo culture of poverty themes, describing Appalachians as afflicted with a “culturally transmitted traumatic stress syndrome,” an “enduring sense of resignation, depression, and disrupted relationships,” and a “poverty of the spirit; a poverty of the soul” (quoted in Anglin 2002:565, 566). Contesting these representations, anthropologists have emphasized emic interpretations and highlighted the unequal social conditions that generate distress. These scholars documented how “nerves” has constituted the predominant mental-somatic idiom of distress in Appalachia, particularly among women, characterized by symptoms of depression, anger, fear, nervousness, physical distress, and challenges sleeping (Keefe and Curtain 2012; Van Schaik 1989). Sufferers of nerves attributed their state to their harsh social conditions and the weight of their care-giving responsibilities (Van Schaik 1989). Those who suffered from nerves reported seeking “nerve pills” from biomedical practitioners, although this did not address the social causes of their distress (Van Schaik 1989).

Depression has potential salience as an emic category in Appalachia and other rural areas. Recent anthropological studies of distress in the region show fewer reports of nerves (Keefe and Curtin 2015), but increased use of the label and symptoms of depression consistent with biomedical standards (Simmons, et al. 2007). While outside of nerves, Appalachians have been hesitant to seek mental health care beyond the family or religious institutions (Hill and Fraser 1995; Keefe 1986), now Appalachian residents receive pharmacotherapy at rates comparable to non-Appalachians (Zhang, et al. 2008), predominantly through primary care settings due to continued shortages of mental health professionals. Still, Appalachians acknowledge that depression remains stigmatized and silenced (Browning, et al. 2000; Snell-Rood, et al. 2017), resulting in an ambiguity over such symptoms for many.

In spite of the conceptual challenges in identifying the higher prevalence of Depression in Appalachia, important links can be made between social shifts and mental distress. Though many Appalachians have long endured poverty, political-economic changes have re-shaped family configuration, economic structures, and community life. Among families in Appalachian Kentucky, the poverty rate in 2010-2014 was more than 1.5 times (25.4%) that

of families in the broader US (15.6%) (Commission, 2016). For many communities in southeastern Kentucky, coal and manufacturing jobs offered the most stability, with many women providing vital homework to care for family members and small jobs to transition through periodic layoffs (Newsome et al. 2008; Scott 1995). As coal has declined, more women generate income for their families through part-time, low-wage work in the service economy (Oberhauser 1995). For men, dismal economic opportunities have provoked a feeling of disconnection (Brown 2010). Appalachian communities have also negotiated changing diversity as urban migrants, wealthy retirees, and immigrants have moved to the region, providing valuable resources, while provoking debates about community identity (McCall 2012).

Even as divorce and single-parenthood increased from the 1980s onward to mirror broader American kinship patterns, and economic stress has altered gendered patterns of livelihood, “the conjugal family—parents and their unmarried children—remained the ideal unit of kinship and society” in Appalachia as a “fundamental and unbreakable family tie” (Scott 1995:110). Yet the social work to maintain this ideal is evident in allusions to the challenges of separations, supporting the broader extended family, and, at times, family disintegration (Buer 2016; Scott 1995). These changing family patterns have increased the vulnerability of many rural women (Snyder and McLaughlin 2004) who depend on informal support from multiple sources (Nelson 2006), and must negotiate new care-giving arrangements for children in the wake of widespread drug use and rising incarceration (Buer 2016). Low wages and poor housing have forced many families to double up with extended family or friends, resulting in stress and vulnerability to violence (Edin and Shaefer 2015).

Declines in health among rural Americans may represent the embodiment of these dramatic social-economic shifts. Rural Americans endure high rates of substance abuse (Keyes, et al. 2013). Middle-aged rural white women face rising mortality, dying 47% faster than they were 25 years ago (Achenbach and Keating 2016). In the region where this research was conducted, years lost to premature death are more than twice that of people across the US (Marshall and Alcalde 2017). While popular representations of Appalachia stress the government resources flowing to the region through social security income and healthcare reform’s Medicaid expansion, there have been precipitous drop-offs in benefits to families with income close to the poverty line (Moffitt 2015); challenges in accessing welfare benefits in rural areas with limited employment and education (Buer 2016); insurance coverage that fails to cover much healthcare (Fletcher 2016); and few options in substance abuse treatment (Buer 2016), adequate, quality mental health care (Buer 2016; Snell-Rood et al. 2017) and preventative health services (Schoenberg et al. 2013).

STUDY BACKGROUND

In 2014, seeking to learn about mental health among rural Appalachian women, the first author collaborated with researchers at the Center of Excellence in Rural Health (CERH), a group of researchers in Appalachian Kentucky with extensive knowledge of the community and a history of providing health services to this underserved region. We concentrated on women because they faced higher prevalence of Depression (CDC 2010) and their greater exposure to Depression risk factors, including social stress and poverty (Chen, et al. 2005).

Our goals in the broader study were to understand the social and cultural factors that shaped depressed women's treatment seeking in a context where services were limited.

As shown in Table 1, we recruited a demographically representative group of women with a range of treatment histories and religious affiliations. A research coordinator and community health workers at the CERH led recruitment of women who "feel down" to talk about their experiences, drawing on their own networks, publicizing the study among area health practitioners who referred eligible women, and posting fliers about the study. Interested women called the research coordinator and were screened for Depression with the Center for Epidemiological Studies Depression Scale (CES-D; Radloff 1977), by income level (200% of US federal defined poverty level), and Appalachian residence. Interviews were scheduled at a location of their preference. Of the 58 women who passed screening, 28 showed up for their scheduled interviews. Travel in this rural region, severe depression, care-giving responsibilities, and the influence of controlling men were all barriers to participation (see Snell-Rood et al. 2017:6), and our sample is biased toward women with moderate—rather than severe—Depression. To compensate participants for their time, we mailed participants \$30 checks and, at the conclusion of the study, a summary of the findings.

The first author conducted interviews using a guide exploring women's experiences of depression and seeking treatment; CERH-based colleagues informed the wording and content of the guide. Questions explored women's experience of symptoms; the trajectory of their illness; the impact of symptoms on their daily life and relationships; experience of stigma; and strategies to manage or treat their depression. Interviews averaged 40–60 minutes in length and were tape recorded and transcribed. During a first cycle of analysis, all transcripts were reviewed to identify preliminary themes. Our interview data and the treatment histories of women indicate that, although women held deep ambivalence about identifying as "depressed" as a diagnosis or to their social networks, the term possessed relevance for them in describing their condition. Twenty-three of the 28 women we interviewed applied "depressed" to their feelings or themselves during the interviews. Half of the women reported current engagement in treatment and two-thirds reported previous treatment. Several codebooks were developed around specific content areas, with the analysis for this article emerging from codes concerning family experiences of distress, kinship expectations, and communicating distress with kin. After codes were defined and applied line by line to the data by the first author, all coded segments were compared for each code and regrouped into a second cycle of codes that drew new relationships within the data to better reflect emic categories.

FINDINGS

Shared distress, shared strength

"When it comes to, right down to it, your family's all you got," commented one young woman she explained why she invited her niece into their home when she completed her jail sentence, though it was already crowded with nine others. In a place with few jobs, challenges accessing health insurance outside of extreme poverty, and housing costs that sent her struggling family members to her overflowing home, her family kept expanding even as her financial resources stayed the same. She reasoned, "I'm not going to let her go to a

homeless shelter because if you have family that really love you, you know they're going to do what they can for you." Without providing this support, she implied, they were neither doing what they could for her niece, nor were they "really loving" her. But her decisions to support family regardless the cost would have consequences for the pace of their daily life. She explained, "We all have to pitch in and help one another."

Women counted on their families to "find a way out" or to "lean on." Women described an idealized family in which family members worked hard to support one another through continued struggle. Remembering her stern yet warm grandmother who raised her, one young woman indicated, "it wasn't a question of why did you do it; you did it because that's what you had to do to get by to survive to provide for your family." Taking care of family was challenging, admitted one older woman, "but that's all a part of life is what I was taught. You gotta live and breathe, die and pay taxes." Against this naturalization of family care, she differentiated the family members who made no effort as "worthless," voicing vehemently that "anybody that won't take care of their own young 'uns, their own family, I ain't got much for them."

Many women's memories of their family members intertwined their appreciation of their parents' efforts to care for them and the challenges of doing so in poverty, while acknowledging the emotional distance of family. One woman differentiated between family care and distance, explaining: "I just never had no encouragement as a kid, I guess. My mom had a lot of problems. She done good with us. She was a good mom. She kept us fed and clean and all of that but like talking to me or giving me advice, I never had anything like that."

Families were expected to face challenges together—whether unemployment, bills, loss, or difficult pasts—even as repeated losses threatened families' ability to do so. Many women referenced having "gone under" as their families buckled under the pressure of sustaining themselves in the absence of state resources and adequate jobs. Women's narratives emphasized the emotional support that ebbed and flowed among family members as they sought to "be there" through poverty and loss. The material and emotional components of "being there" constituted efforts that were neither effusive nor direct expressions of care: standing by someone or tolerating anger or violence without withdrawing access to family resources.

Sources of family distress

Women's narratives of depression connected their own feelings to those experienced by their family members, as one woman charted: "I've lived with it, I lived around it, I've been with it, I've been through it, still going through it." Women were challenged to describe their own distress without mentioning the distress they saw in family members. Though none of our questions asked women to report on their family members' mental health, half of the women we talked to described at least one family member—and sometimes up to four—as seemingly depressed: parents, husbands or partners, siblings, and children. Many linked particular behaviors to depression: sleeplessness, the need to chop wood to release constant anger, and being set off by any little thing. Additionally women used vague terms that conveyed emotional valence: a mother abused by past partners now "has problems," a

husband “struggles.” Women accounted for their own distress and that of family members in similar ways, and posed the same sources of distress: the stress of supporting family in poverty, repeated deaths of family members in an area with early mortality, and harsh childhoods.

Though women acknowledged how important it was to be there for family, they also described reciprocity-induced stress—both their own experiences and that of stressed family members. Insecurity arose from situations in which women felt they would not be able to provide for their children in particular: when it was harder to put food on the table at the end of the month; the fear, months before Christmas, that they might not be able to afford gifts. How to make ends meet, one woman sighed, “it’s all the time on my mind.” As women looked back on their family histories, they recalled shared economic and mental struggles between themselves and their mothers, while still referencing the resourcefulness of parents who sustained their families regardless.

Women reacted strongly to loss when it dramatically reshaped their family forms and when it occurred repeatedly, as it often did in a region with early mortality. One woman tallied her losses of the last few years: “Within four years of my dad passing away, my brother died from an overdose. And then about six years after that, my sister died. And then two years after she died, my mom died; she had cancer.” The ensuing pain rippled through the family as it was “going to pieces,” be it from the drug use of a sister no longer able to handle her family responsibilities, a mother now completely absent, or the exhaustion of keeping family together amid increased distress. In some cases, women commented on how loss of one family member marked a new point in time, the last their family was together: “When mom passed away...that was what you know held all of us together and now we’re all separated.” In each case, women said they did what they needed to do: working to support their family and distract themselves, filling in to care for family members, or finding release in “crazy” acts—like tongue piercing—to step away from tragedy.

Finally, several women traced their low moods, and those of other family members, to the “hard time” they had when they were young—managing too much responsibility, experiencing violence, and getting little support from parents caught up in their struggle to get by. One woman reasoned that her father’s mother “said her nerves couldn’t handle” taking care of him and his brothers, with the result that he cared for his younger brothers in foster care from a young age. As a result, her father was a man who was “always tired” and “never knew how to show [love] to us.” Outlining intertwined depression, women pointed out how their family members turned away from them as they propped up other weak family members. One woman described: “I loved my parents dearly but my dad was an alcoholic. And my mother was so distant with me that I think that it was because she dealing with my dad.” Women hoped that their reassurance in the present could help repair the long-term damage from such injuries. As one woman commented about her husband, “I know he has to be suffering himself to be so mean and cruel and I try to build his self-esteem up and tell him he’s a good man.”

In the same way that their parents had accommodated and absorbed the emotional distress of their spouses and caregivers, women commented on their own synchronized moves a

generation later. As she thought about the origins of her own depression, one woman hypothesized, “I probably was sensing my mom’s worries and then I took over you know. I just...I wanted to make things better.” “Sensing” her mother’s worries, her own depression began with her “taking over” her mother’s place. As she reflected on her recent abusive relationship, one young woman explained, “I mean [such abusive men] just made you feel worthless and that’s what my mom feels. I’ve been with her 21 years; I can tell every emotion that she has even if she doesn’t say anything.”

Women’s accounts of their own depression diverged from their parents’ in the context of familial and economic shifts. Describing how challenged she had been with finding a reliable partner, one single mother quipped, “it’s hard to find a good guy anymore that ain’t on drugs or out of work.” Women who had left emotionally or physically abusive husbands questioned themselves—would they be alone, or did their failure to find another partner just indicate their own flaws? One woman remarked on how she increasingly worried that companionate partnership was no longer available to her: “It kind of worries me that I’m going to be alone for the rest of my life.” Many women traced their distress to the fact that they could not count on their partners to provide in the way that their fathers had. Other women were weighed by the responsibility to financially support their family when their husbands did not or could not: “I want the stress free; I want to be financially stable; I want my husband to actually find a job instead of [state disability stipends].”

Containing and protecting

With regional poverty causing endless shocks, family members lost in their own struggles, and few medical or community resources where they could share their own depression, women contained their feelings. When everyone struggled, women reasoned that their own depression was no more worthy of attention. As one 24-year-old reflected, “I don’t like putting my worries on top of their worries for them to worry about.” But feelings also had to be contained when they threatened those of different family members, in order to insulate already fragile family members who might feel responsible for “fixing” them. Women resisted revealing past family violence or silenced doubts that, they sensed, would make their children feel unstable.

Unable to share how they felt, women retreated to the porch swing or the bedroom for moments of silence, violent “pillow screaming,” or uncontrolled tears. A few women reported relief from these efforts to escape, but then, “you gotta go right back in and do it again.” Many women hoped that solitude would help them maintain self-control: “When I get mad I like to be to myself; that way I know I ain’t going to flip out or anything.” Yet finding retreat could be challenging when family members and partners, threatened by alone time’s implication that women held dangerous feelings, trailed them or closely monitored their outside relationships.

Women feared that if they revealed their feelings, they could not be strong for others in the way they needed to. So they concentrated on what they felt family members needed from them. “Mama’s the backbone of the family,” said one mother of two, “or tries to be.” Negative feelings did not disappear, but in the face of their responsibilities to others, women contained them: “It wasn’t that you didn’t cry because you felt numb; it was you didn’t cry

because you felt like you needed to be strong for everybody.” Though women were frank about the limits to their strategies of containing their feelings, they maintained that their sacrifices contributed to the stability of their families: “Sometimes you can let it go; sometimes you can’t; sometimes it just stays with you. But as long as they’re alright I’m okay with that; as long as my babies are fine.” When they doubted their own ability to care for their family, women would restate this obligation to themselves, in moral terms—whether religious or secular. Describing how her doubts about her worthiness as a caregiver had brought her suicidal thoughts, one woman reassured herself by framing her caregiving as a moral obligation: “I have to tell myself, God gave him to you; he’s your gift. He gave him to me to nurture and to take care of and to make sure that he comes up as an adult; make sure that he gets everything he needs.”

Women described being surrounded by family—especially other women—who had endured similar trials and eschewed their emotional responses. Regardless of their age, participants described a cultural difference between how their parents handled emotions and their own desire, no matter how ambivalent, to at least acknowledge their feelings. Women commented on mothers who were “strong willed and tougher than wet leathers,” and perceived feeling down as “complaint,” something to “snap out of,” or be “stronger than.” The pressure to avoid worry, many women felt, was because worry represented doubt in God’s ability to resolve the situation. “I try not to worry,” explained one woman, “I know the Lord tells you not to worry but sometimes it’s hard not to worry.” One woman expressed ambivalence as she recalled her mother’s prohibition on worry. After her brother was killed in Vietnam, one woman remembered how, “My mom says, ‘now you gotta quit this worrying.’ I said, ‘Mom if you’ll tell me how I will.’ She never said a word. She knew she couldn’t tell me how.”

Women understood their work to contain and manage distress as strengthening relatedness, but also morally strengthening themselves. Though women’s depression might emerge from the exhaustion of this caring, such depression—unlike that of other family members—was expected (e.g., O’Neill 1998). Maintaining the backbone, making sure the babies were fine, protecting vulnerable family members from further burdens, all demonstrated that women were caring in the right way. They had seen the exhaustion of others from such care-work, and they were not surprised to feel the same themselves—they celebrated their own strength when they persisted. In a setting where evangelical Christianity is common, such sentiments resonated with the notion that “God’s Will and unconditional love” should not be questioned, interpreting worry and self-doubt as sin (Keefe and Curtain 2016: 128), with women on individual paths to “work out their own salvation” rather than seek spiritual guidance through religious community (Humphrey 1988). Still, at the edges of women’s moral commitments lay their doubts about the challenges of sustaining their containment strategy.

Needing their own depression

As elaborated elsewhere (Snell-Rood et al. 2017), while some women identified as “depressed,” feeling that such a formal label socially legitimated their feelings or helped them to access healthcare resources, others were ambivalent about this diagnosis because it was felt to convey weakness or “craziness.” Women described their feelings as problematic

at the point when they could no longer contain them—the point of breakdown, realizing that they needed to seek help, or were no longer able to empathize with others. “I put on a front for everybody else to be able to help everybody else and everybody else’s problems is causing me more depression,” one 36 year old woman explained. She contrasted her gratitude for family with what could no longer be contained: “I’ve got the family, but inside me [the depression is] just screaming out, let me out, let me out.” Having reached the limits of her endurance, and after losing her mother, one woman reflected on how she would deal with death in her husband’s family: “I was saying a prayer for myself because I thought, I don’t know if I can hold it together for somebody else.” This, she commented, was the point when she sought counseling for the first time.

Family members felt threatened when women expressed their distress, casting doubt on women’s personal strength and dedication to family, and sometimes aggressively retaliating. Having admitted their distress when they asked for help from their parents—whether for small favors or through dramatic events like divorce—some women now felt unworthy or “failures,” refusing to reveal their distress again. Some women explained that they contained their feelings to avoid violent negative reactions from family members, impacting not just themselves, but others too. One young woman had become miserable after her emotionally abusive stepfather had moved into the home she shared with her mother, but she avoided arguments with him because he was physically daunting: “You know, with my mom there, I mean I don’t want to jeopardize anything with her ... Where else do I go?” Other women admitted their frustration when family members tried to shut off their access entirely to family. For instance, one woman, during an abusive relationship, had offered custody of her children to her own mother (the children’s grandmother). She described that her mother would react negatively to any expression of feelings, sometimes restricting her access to her personal belongings or preventing her from visiting her children.

Only when women admitted the strain of containing their feelings did they stop prioritizing the comparative distress of their family members over their own. Women felt frustrated when they were not able to demonstrate the same distress that they accepted in other family members, when their family’s gestures to “be there” were used to undermine their own efforts. Though perhaps their mothers, grandmothers, and husbands might continue to endure their distress, women were not sure this was adequate.

Changing families and changing feelings

As much as women took pride in providing the family backbone, they admitted the desire for others to scaffold *them* through distress. Many imagined this release principally through a partner—an ideal (and not yet present) one, or a more empathetic version of their current partner: “You just want somebody that’s going to love you and take care of you and be there for you.” Many acknowledged frankly that they would always shoulder the responsibilities of caring for their parents and children, but they could imagine relying on a partner. Women longed to be able to voice their feelings without worrying about how they affected others, wallowing—at times—in frustration or disappointment: “That would be nice to say, I’m feeling this way. Just somebody to talk to sometimes that makes me not feel like I just need to snap out of it and get on with it.”

While many women were skeptical of treatment, they described an openness to admitting depression that was foreign to their parents. Some women commented on generational differences that guided how they sought help. “I can’t talk to my mom about it because she’s more, I guess, old fashioned. She doesn’t really see depression the way I do,” explained one younger woman. In contrast, her boyfriend encouraged her to pursue treatment, assuring her, “Just take it, see how you feel and you know if it makes you feel weird, don’t take it.” Some younger women commented that their partners refused their habits of containment. After enduring an earlier episode of depression, one young woman’s boyfriend commented when he noticed her retreating again: “He’s like, ‘you have to let somebody in; if it’s not me, you have to find somebody and let them in because you’re going to slip away’.” Yet many women acknowledged that they wanted to express their depression beyond the family. Unsatisfied with containment, women remarked: “Family, you can talk to them but it’s nothing like, you cannot get out what you need to get out with family.”

Despite generational differences, a number of women recounted that they had witnessed a new softening in family members. One woman whose father had been physically abusive when she was a child described the relationship she developed with him once she became an adult. Though she generally felt isolated, “he was somebody that I could talk to. I got close to him.” Though her mother still relied on her physical labor around the home, she recalled how her father would warn her to “quit working like a dog.” Women acknowledged a new capacity in family members for reflection. Another woman, whose father had been physically and emotionally abusive as he dealt with his trauma as a veteran, reflected that, “It’s almost as if he tries to make up for what he lost with us with the grandkids...He’s a wonderful grandpa and he’s a good dad to us now.” As women recognized positive characteristics of their previously unsupportive family members, they imagined feeling stronger through sharing—not just containing—their distress.

DISCUSSION AND CONCLUSIONS

Kin help endure and absorb distress, in ways that fundamentally tie the experience of distress to larger histories of struggle and broader conditions of adversity (Garcia 2010, 2014; Das 2006; Stevenson 2014; Yarris 2013, 2014; Horton 2009). Our findings reinforce this account of intersubjective distress. Women articulated the same causes for their distress and that of family members: shared conditions of hardship, like previous accounts of “nerves” in Appalachia (Van Schaik 1989; Keefe and Curtain 2011). Embedded within women’s accounts of shared distress were kinship expectations that family “be there” as a social safety net, and cushion against the emotional effects from chronic stress. Strategies to contain depression were efforts to reduce shared hardship and evidence of love in the face of adversity, supporting previous research on intersubjective distress held inter-generationally (Garcia 2010, 2014; Yarris 2011, 2014; Horton 2009).

Accounts of intersubjective depression focus on what is shared between those who suffer—history, structural vulnerability, and reciprocity—while critically resisting medicalization through refusing to label such distress (Garcia 2010, 2014; Stevenson 2014; Das 2006; Horton 2009). Yet the blurred lines between subjects and between states can confuse the morally appropriate response that distress demands, with consequences for theoretically and

actually understanding not only what *counts* as distress, but also for what kin *owe one another* amid distress. Scaffolding women's narratives of intersubjective distress were the "morally compelling demands to share, give up, or exchange" at the heart of kinship that produce deep ambivalence (Peletz 2001:434) and bind people together over time (Han 2011). In this account, attention to, empathy of, and care for distress were exchanged reciprocally, with the understanding that some was pathological (e.g. alcoholism) and some temporary (e.g. financial worry). Women focused less on the concepts guiding the interpretation of distress, and more on the moral obligation to recognize distress and respond with care. While researchers continue to focus on the tangled cultural concepts undergirding the interpretation of distress, our work indicates the importance of focusing more closely on the kinship ethics at the core of the mental health experience.

The reciprocity that undergirded kinship ethics was often unequal in terms of what distress was recognized and what such distress demanded from kin. While women steadfastly monitored and interpreted distress at the family level, they were hesitant to interpret, much less share, their own distress. Such hesitation accounted for many of their silences, illustrating how deliberately hidden pain reveals critical aspects of power in daily life (Good 2012; Das 2000). At times, women critiqued the ways in which moral ideas about shared distress were used to control them (O'Neill 1999:188), such as when family demanded that they contain emotions that protected others at their own expense (often connected to violence) or labeled their feelings as evidence of "breakdown" when they failed to contain feelings of distress. The unilateral nature of intersubjective distress silenced rather than recognized women's suffering, leaving them doubly exhausted and burnt out—unable to access adequate livelihood or healthcare amid neoliberal shifts, and unable to access emotional support from kin.

For women living in poverty and experiencing chronic trauma, Knight suggests that identifying with the label of a particular mental disorder can bring them "into moral worlds that felt explanatory of their familial history...and even comforting" (2015:149), even as such terms may distort their experiences through medicalization. The accounts presented here reveal a gradual, alternative medicalization of depression. In naming their distress as depression, women were able to capture their low moods as their own — separating it from shared distress and the unequal kinship obligations that encouraged them to fold their own distress back into themselves. In this alternative medicalization, women acknowledged the social conditions causing their distress but affirmed the need for naming and attempting to resolve their low moods, whether as an illness (Depression), as moral recognition of their social labors to be there for family, or something in between. While some desired more treatment options, many sought more amorphous resources: better economic conditions and improved social support.

At the edges of many of women's narratives about family and shared distress are their struggles to build and preserve families as the shape of rural American families change in response to economic shifts, reconfigured gender expectations, and high rates of substance use. While anthropologists underscore how social-economic transformations generate distress through disrupting kinship patterns and expectations (Finkler 2010; Horton 2009; Yarris 2011; Yarris 2014), how do these transformations impact intersubjective distress?

Although women made sense of their distress through cross-generational histories, their inability to “be there” in the same way as they had expected provoked self-questioning. It may be that in this context the urge to “be there” for family increases as the family itself, not just individual family members, is a resource that needs to be sustained. Yet even as women expressed anxiety about keeping their families together, they also celebrated some aspects that were different than “how it used to be”—parents whose “old-fashioned” silence had transformed into nurturing warmth, male partners that shared their vulnerability rather than hiding it, support for pursuing treatment. These commentaries form a powerful counter-narrative to a new generation of social constructions of poverty and family in Appalachia that depict rural families “in crisis” (Vance 2016). While women acknowledged the social burdens that contributed to their depression, their identification of depression as a social process that neither starts nor ends in themselves forms a powerful critique of intervention strategies that concentrate primarily on women without targeting families as a whole. Strategies to help women must centrally include efforts to ease the social burdens at the root of their own distress—the mental health challenges of their family members—as well as the social, economic, and political factors against which their families struggle.

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Biography

Dr. Claire Snell-Rood is a medical anthropologist interested in exploring the critical intersection between social relationships and mental health among women living in poverty. An Assistant Professor at the University of California, Berkeley’s School of Public Health, she has conducted formative research on the social and cultural factors that contribute to Appalachian women’s mental health and mental health disparities. The goal of her long-term research is to understand the complex social and cultural factors that contribute to mental health disparities cross culturally and to translate this awareness into culturally tailored interventions to improve mental health.

Dr. Richard (Larry) Merkel is a Board Certified Psychiatrist with a PhD in Anthropology. As an Associate Professor in the University of Virginia's Department of Psychiatry and Neurobehavioral Sciences, he has over 10 years of experience conducting clinical and ethnographic work in Appalachia. He also has clinical fieldwork experience with Southeast Asian Refugees and Maori populations in New Zealand.

Dr. Nancy Schoenberg is the Marion Pearsall Professor in the Department of Behavioral Science in the College of Medicine and the Associate Dean for Research in the College of Public Health at the University of Kentucky. A medical anthropologist and gerontologist, she focuses her research, service, and instruction on addressing health inequities, specifically working on the prevention and management of chronic diseases, including nutritional disorders, cancer, cardiovascular disease, and diabetes. Throughout her work, Dr. Schoenberg has emphasized the cultural context of health decisions and community-based participatory approaches - approaches that she has used to develop and implement numerous community-engaged interventions in rural Appalachia.

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Table 1:

Demographic Characteristics of Study Sample

Characteristics		Percentage	
Race	White	96	
	Black	4	
Marital Status	Married/Partnered	54	
	Separated/Divorced	18	
	Widowed	3	
	Never Married	25	
Household Income ¹	Below \$10,000	25	
	\$10,000-\$20,000	31	
	\$20,000-\$30,000	22	
	\$30,000-\$40,000	11	
	\$40,000 and above	11	
Employment ²	None (retired, unemployed)	43	
	Employed	57	
Treatment Status	Currently receiving treatment	50	
	No current treatment	50	
Religiosity (Consider self to be...)	Very religious	28	
	Moderately religious	36	
	Slightly religious	25	
	Not religious at all	11	
		Mean	Std. Deviation
Length of time living in region (years)		33	15
Age		40.5	13.3
# of children		1.4	1
# people living in household		2.7	1
# of years of education completed		13.8	2.5

¹ In Appalachian Kentucky from 2011–2015, 95% of the population was white; 1.8% was African American.

² Median household income in Appalachian Kentucky is \$33,492 from 2011–2015.

³ 59.8% of people ages 25–64 in Appalachian Kentucky were in the civilian labor force from 2011–2015.

All comparative demographic information from Pollard et al 2017, “The Appalachian Region: A Data Overview from The 2011–2015 American Community Survey.”