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Depression in a Depressed Area: Deservingness, mental illness, and treatment in the contemporary rural U.S.

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Abstract

People with mental illness face public scrutiny that provokes questions about their ability to cope, membership in society, and entitlement to state support. Less attention has been focused on how such scrutiny occurs at the community level, particularly when shared economic distress has generated a high burden of poor mental health. We employ theorizations of health-related deservingness to examine the local moral economies through which residents of an economically depressed area question who deserves to be depressed, how those with depression should cope, and what forms of treatment are sincere. Drawing on a multi-phase study (2014–2016) in Appalachian Kentucky, we analyze interviews conducted with women with depression and the health practitioners who work with them. In the rural U.S., the dim economy and scarce healthcare resources are attributed to exclusion from broader society. Naturalized as a moral response for enduring dead-end jobs and poverty, participants described how depression coping can positively demonstrate individuals' commitment to providing for their families and mobility. However, when individuals are perceived to use depression diagnoses to access state entitlements or obtain medication as a "quick fix" that facilitates substance use, area residents question the veracity of symptoms and argue that treatment-seeking is insincere. In this way, rural moral concepts about work, entitlement, and self-sufficiency become embedded in contemporary ideas about mental health and its treatment. The tempered normalization of depression may offer possibilities for decreasing stigma and engendering conversations about patterned exclusions of rural Americans from broader U.S. prosperity. However, tense moral meanings about depression coping reveal both deepening and emergent social inequalities within rural communities. Attending to local moral economies that shape mental health deservingness is critical to understanding the complex overlaps and intersections between state, community, and family discourses.

Keywords

depression; rural; treatment-seeking; deservingness; North America; stigma

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Introduction

The economists Case and Deaton drew attention to rising death rates among middle-aged non-Hispanic white people in the U.S. from 1999–2013 due to increased suicide, drug and alcohol use, and their long-term health consequences, deaths they labeled as “deaths of despair” (Case & Deaton 2015, 2017:398). These trends were most present among nonurban and rural populations, attributed by analysts to “underlying social and economic factors in these communities” (Stein et al., 2017:1541), that lead “individuals [to] blame themselves for their changing circumstances and [to] feel desperate and depressed” (Scutchfield & Keck 2017:1565). Less attention has been devoted to understanding public discourses about despair and depression in contemporary rural communities amid such increased mortality. We draw on recent theoretical articulations of health-related deservingness and local moral economies (Willen 2012a, 2012b, 2015) to make sense of local debates about depression in the context of extensive poverty in Appalachian Kentucky. The elasticity of subjective and cultural meanings of depression (Kleinman 2008) sets the stage for multiple and competing interpretations of suffering. Public conversations on depression encompass controversies about the social location of who deserves to be depressed, how those with depression should cope, and what forms of treatment are sincere.

Anthropologist Sarah Willen (2015) has extended scholarship on the ways in which controversial issues are discussed and portrayed by scholars, policymakers, and the media to argue for greater attention to how local debates take shape and are experienced within communities. While acknowledging the critical role that state discourse and policy play in the lived experience of health and illness, Willen (2015) argues for understanding how macrostructural processes state discourses are embedded in local realities that are culturally and historically particular. Following Willen’s (2015:70) observation of the “culturally specific register” of local debates, we focus our attention on how depression and mental health treatment take on various, contrasting meanings in community discourses in Appalachian Kentucky. Here, contested meanings of depression and treatment are refracted through local discourses that valorize self-sufficiency and struggle in daily practices of caregiving and work, recognize the social determinants of depression in a region with long-standing economic distress, and engage with divisive national political debates about entitlements to income support and health insurance. In examining how women with depression and their diverse providers experience and respond to depression, we argue that a moral hierarchy emerges that constitutes certain women as deserving and others as undeserving of care and attention for depression. Through close ethnographic attention to women deemed undeserving, we distinguish between the “deservingness” bestowed through public debate and the “worthiness” generated by the self. “Worthiness” reveals women’s attempts to change a moral economy that does not account for the contemporary structural constraints on getting by. In so doing, we draw attention not only to the local moral economies that mediate broader inequalities generated by the state and biomedicine, but also highlight national moral economies about identity and deservingness among contemporary rural people in the U.S.

Claims to Illness and Deservingness

Scrutinized in intimate and community relationships, claims to illness are weighed to evaluate their reality, and the attention they warrant (Moffatt & Noble 2015). Particularly for those with chronic illnesses that appear invisible, expectations to cope may increase people's suffering, limit their ability to claim a sick role, and receive necessary social support (Garthwaite 2015). In contexts where the personhood of individuals represents that of broader groups, such stigma extends to the group (Kirmayer 1989). In rural communities, stigma can include stereotypes associated with poor, rural Whites and legacies of racism (Burton, et al. 2013).

Such public scrutiny often intertwines with institutional surveillance to significantly shape the stigma of how people cope with illness, disproportionately impacting economically vulnerable people and communities of color (Hansen, et al. 2014). Being disabled, chronically ill, or depressed conflicts with an individualized ideal of personhood because of threats to self-reliance (Galvin 2002). As the welfare state has declined, public health discourses have increasingly stressed individual responsibility to manage and promote one's own health (Galvin 2002) and state discourses and programs have required people to independently manage economic security with fewer state protections (Petryna & Follis 2015). These issues have crystallized in recent policy efforts to link receipt of Medicaid benefits to work requirements in conservative states, including Kentucky, policies that force activity upon people presumed to be less active. In this way, health institutions have become "core institutions' reshaping experiences of poverty and citizenship" (Petryna & Follis 2015:409) as they evaluate claims to sickness that can entitle one to benefits.

Willen's (2015) recent theorization of "local moral economies" facilitates the examination of how complex macro-structural processes shape lived realities and how individuals and groups respond locally to collective forces. "Local moral economies" integrate "moral economies" with "local moral worlds." The concept of moral economies is traced to social historian Thompson (1971) and anthropologist Scott (1976), whose scholarship highlighted the moral expectations embedded within economic exchanges, particularly in the context of unequal class relations. The term moral economies has subsequently been applied to a broader set of concerns¹ to frame the ways political-economic and social systems are shaped by moral values (Willen 2015). The concept of local moral worlds developed by Kleinman (Kleinman & Kleinman 1991; Kleinman 2006) provides the grounds for considering how affective and moral orientations take shape within experiential lived realities. Both concepts call attention to the dynamic and contested terrain of human experience as played out across political, economic, social, and cultural processes (Willen 2015). Yet, whereas moral economies focus on the collective level, local moral worlds focus on subjective and intersubjective experience (Willen 2015). "Within any given local moral economy," Willen writes (2015:72), "different stakeholders and groups of stakeholders reckon such matters as inclusion and exclusion, deservingness and undeservingness, in markedly different ways." This lens of health-related deservingness illuminates who deserves to receive attention and

¹This expansion of the application of "moral economies" has led some to raise concerns as to the "banalization" of the term (Fassin 2009).

investment in health (Willen 2012a) through attention to local moral economies that encompass culturally variable and sometimes conflicting moral concepts that shape lived experience (Kleinman & Kleinman 1991; Willen 2015). Taking depression as an area where claims to illness and treatment include fraught questions of personhood, societal inclusion, and state entitlement, we employ the concepts of deservingness and local moral economies to make sense of the diversity of moral responses to depression in rural settings.

The Political, Economic, and Moral Context of Contemporary Appalachia and the Rural U.S.

Appalachian cultural identities include a reckoning with the structural inequality inherent to the region and the general national indifference to the suffering that such inequality has generated (Anglin 2004). While federal initiatives have greatly alleviated poverty in Appalachia, central Appalachia's poverty rate stubbornly remains nearly twice that of the U.S. more broadly, with per capita income 66% of the national average (Mannion & Billings 2006). Yet poverty does not afflict all in Appalachian Kentucky equally, with income inequality steadily rising in the region since the 1980s (Mannion & Billings 2006). Other rural areas echo Appalachia's economic struggles, with 26.2% of nonmetro counties classified as high poverty from 2006–2010, continuing a rate higher than that of U.S. metro areas (Farrigan & Parker 2012). In the last few decades, as the primary well-paying jobs disappeared with the decline of coal (Lobao, et al. 2016), the bulk of employment in the rural U.S. has emerged in the service sector, where livelihoods are unstable (Vias & Nelson 2006).

In this economic context, the high burden of mental health challenges for rural residents is hardly surprising. Epidemiological data on mental health in the rural U.S. shows, in comparison to urban areas, higher rates of suicide (Ivey-Stephenson et al. 2017), depression (Simmons, et al. 2008), and opioid use-related deaths (Paulozzi, et al. 2012). Yet most rural Americans receive less mental health treatment—in terms of amount and effectiveness—than urban Americans (Adams, et al. 2006; Hauenstein, et al. 2007). With mental health providers scarce in the rural U.S., most rural mental healthcare consists of pharmacotherapy delivered by primary care providers (Mohatt, et al. 2005).

In the wake of welfare reform, programs that have served the poorest (like Temporary Assistance to Needy Families, TANF) have declined and new programs that serve families with higher incomes (e.g., Earned Income Tax Credit) or are not tied to income (e.g., Social Security Income, SSI) have expanded (Moffitt 2015). Though overall welfare spending has increased, its restructuring has not improved the economic status of the poorest (Ziliak 2011). For the economically vulnerable, mental health disorders and chronic disorders are now “virtually the only avenues available for access to relatively stable benefits” (Hansen et al., 2014:77). Several rural regions—including Appalachia—receive a disproportionate share of SSI disability benefits, with a mental health related disability as one of the two fastest growing diagnostic categories (Greenley 2016). The Affordable Care Act dramatically expanded access to healthcare for poor rural residents living in states where Medicaid expanded, such as Kentucky (Sommers, et al. 2016). Yet other residents remain stubbornly beyond the eligibility criteria for expanded Medicaid and unable to access employer-

sponsored insurance (Fletcher 2016). Such shifting contexts of welfare produce stigmas borne by those who obtain benefits (Moffat & Noble 2015, Hansen 2014). Even as work-related disability and unstable employment have long normalized the receipt of disability in rural areas like Appalachia and elsewhere, stigma is applied to “those who draw” who are assumed to be uninterested in work (Duncan 2000:7).

These rural economic and demographic shifts “have had consequences for identities and the structure of social relations around gender, race, and class that inform these” (Burton et al., 2011:102), making it difficult to fulfill ideals of the moral economy. Many in rural communities celebrate their constructions of a shared solidarity that may be expressed through egalitarian or kinship models (Burton et al., 2011; Scott 1995) that promote the ethic of mutual, persistent care for kin that is deeply embedded with attachment to place (Scott 1995; Buer et al., 2016). Still, research on Appalachian life shows tension between discourse about community “as a place where egalitarian relationships of reciprocity and mutual affection prevailed” (Scott 1995:115) and shared awareness of local inequality (Scott 1995) that has also manifested in discrimination against particular family backgrounds and the social exclusion of those perceived to rely on the government (Duncan 2000). Despite a strong history of labor organizing in central Appalachia, recent decades have seen little social mobilization, as coal companies have built a regional identity around sustaining an industry perceived as under attack and have successfully broken up unions that had been critical to community identity and economic security (Bell 2009). In terms of health, self-sufficiency is valued, but anthropologists have shown that enduring--rather than actively seeking care for--physical and mental suffering is common in Appalachia because, for many health services seeking out quality, accessible care can take more resources than they are worth (Drew & Schoenberg, 2011; Snell-Rood et al, 2016). As the nature of rural communities change, we examine how distress and efforts to cope with distress invite new debates about the ability to be part of society.

Materials and Methods

The data presented in this paper were collected during multi-phase research to identify the social-cultural factors shaping treatment-seeking among rural Appalachian women with depression, with the goal of informing culturally appropriate, feasible treatment options (described in Snell-Rood et al., In Press). All phases have been approved by the University of Kentucky Institutional Review Board and have been conducted in collaboration with the community-based research and healthcare organization Center of Excellence in Rural Health and community health workers (CHWs) at Kentucky Homeplace, both located in Appalachian Kentucky. This paper focuses on emergent themes about the deservingness to be depressed and receive treatment that were not directly related to our applied research goals, but critical to understanding the emic experience of depression in central Appalachia.

From 2014–2016, researchers at the Center of Excellence in Rural Health recruited consumers and health professionals through purposive sampling, employing community-engaged relationships to identify vulnerable rural women who may not identify as depressed and working with CHWs with long-standing relationships to underserved rural women. We describe the research questions, eligibility criteria, and data collection for each phase in

Table 1. All consumers were screened for depression with the CES-D but were not required to be in treatment or be formally diagnosed as depressed. In the second phase of research, we used the CES-D 10 short-form. While the CES-D is typically considered to be an appropriate screener for depressive symptoms but an insufficient stand-alone diagnostic for depression (Vilagut et al., 2016), our primary concern was to identify individuals with significant distress while acknowledging the varied cross-cultural presentation of depression (Kleinman 2008), particularly in a region where admitting distress can be censored as complaint. In Table 2, we list the CES-D scores and current treatment status of all consumer participants. We intentionally sampled women of a variety of ages, treatment experiences, religious affiliations, employment experiences, and family sizes. We purposively sampled healthcare professionals from a variety of backgrounds (social work, physicians, CHWs) who worked in varied settings (primary care, community mental health clinic, community outreach) in order to capture perspectives on caring for women with depression in and out of treatment. Our theoretical approach to sampling--focusing predominantly on the lived experience of consumers with supplementary perspectives from key informant healthcare professionals who work with a range of consumers--enabled us to explore varied dimensions of depression in the region (e.g., its presentation, significance in daily life, subjective meaning) and identify variations between and within the groups (e.g., Palinkas et al., 2015). Participant racial backgrounds reflect the demographics of Appalachian Kentucky, where 95.4% people identify as White, 1.7% identify as Black, and 1.3% identify as Hispanic (Pollard & Jacobsen, 2011), despite our efforts to recruit a more racially diverse sample.

Research coordinators based in the region described study procedures and obtained informed consent. We conducted semi-structured interviews and focus groups with Appalachian women with depression (N=37) and healthcare professionals (N=12). (Of the healthcare professionals, 9 were interviewed in both phases and 3 in only one phase.) Interview guides varied by study phase, beginning with a formative phase to understand the lived experience of depression and treatment-seeking among rural women; followed by interviews with providers that focused on access and barriers to treatment, strategies to improve care, and available resources to improve treatment. The final two phases included interviews and focus groups with providers and consumers concerning how to adapt a specific intervention (see Snell-Rood et al., In Press) to make it feasible and culturally acceptable. Interviews were used to inquire into personal experiences of depression, as well as to accommodate the busy clinical routines of healthcare providers. Focus groups (N=4) were conducted with community health workers, mental health and general practitioners, and consumers to generate ideas about adapting the intervention. Demographic information about participants was collected in questionnaires to enable private reporting of income and health information. Interviews and focus groups were recorded and transcribed.

Our analysis was guided by thematic analysis, a systematic approach to understanding themes (Braun & Clarke 2006). In preliminary open coding during the first study phase, we identified core theme areas (treatment-seeking behavior, family experiences of depression, intervention strategies) that have been presented elsewhere, as well as emergent, intertwined themes about work, class, living in an economically depressed region, entitlements, and the moral interpretation of coping behaviors. As other phases of the study proceeded, we noted that this theme cluster continued to appear across different participant types and settings—

even with different interview guides. The lead author composed an initial codebook of these preliminary codes that was reviewed with the co-author (conducting research in another rural setting) to check and refine the codes. The lead author applied the codes line by line to the entire data set using the qualitative data analysis program MAXQDA. In memo writing during the coding process, the appearance of codes across participant types (e.g., consumer versus provider; in or out of treatment) was compared to identify core areas of agreement and define distinctions. Charting the relationships between the codes enabled us to understand how they were interrelated in a local moral economy concerning depression coping and deservingness. Data were further triangulated through theoretical comparison with a) other rural samples, and b) identification of changing social trends in contemporary rural U.S. The lead author conducted member checking in several presentations to community members, who confirmed the material presented here.

Results

“We are a depressed area, so we are a depressed people”

Even as stigma against depression and its treatment in rural areas persists (Hauenstein 2008; Snell-Rood et al., 2016), conversations among rural residents naturalized depression as a response to the bleak economy and social conditions. As one primary care provider stated plainly, “we still don’t have jobs, we still don’t have the things that we need so we are a depressed area so therefore I think we’re a depressed people.” “This area is just depressing,” stated one woman frankly. For young people, “there’s just nothing really for them to look forward to...it’s either get pregnant, draw a check or they’re on drugs or both.” Without a vision of the future, jobs, or activities in the area, this young woman commented, “It’s just like a hit of sadness, I mean it really is.” By emphasizing how depression emerged from a depressed area, women naturalized its presence. These narratives described how the economic depression of the region became embodied as sad affect, uninspired futures, and depressed personhood.

Still, many women described initial aspirations for mobility. Then, “reality bit hard,” one young woman narrated as she delineated the history of her depression, when she began working and realized, “oh no I’m stuck, I have my own place, I have to pay these bills, I can’t afford to go back to school.” Numerous women commented on the barriers to accessing the educational opportunities required for social mobility. “If you don’t have somebody behind you to help support you” through high school and college, explained one provider, “and people just don’t...many people just cannot get out of that cycle of poverty and they have a lot of depression from that.” The reality of dead-end jobs was that women barely earned enough to support their families, and many people patched together multiple livelihood strategies (cf. Mannion & Billings 2006), while worrying that earning “too much” could exclude them from state entitlements like Medicaid or social security income upon which they relied. Whatever was exerted to get ahead did not amount to much. “I think that’s got a lot to do with why people my age feel like this,” one younger woman explained. They felt depressed because, “[you] feel like I’m working so hard for nothing.”

Women described the constant nag of knowing that financial dread was around the corner. One woman reflected, “I’ve actually had good days and went to bed and said, ‘Lord I’ve had

a wonderful day but just take me before the next bad one comes.' I mean it's just, even though [you've had] a good day, you're asking that because you know the next bad day is coming." Such dread came to envelop all aspects of women's lives, explained one CHW, who explained how depression emerged among Appalachian women because, "you can't pay your bills, you know the kids are sick, the kids need this, you know the car is tore up, the husband's gone, the husband's back, you know he can't get to work, there's not a lot of jobs here; you know there's a lot of things just piles up."

In their descriptions of "people my age," a "depressed people," and the "hit of sadness" stemming from lack of opportunity, rural community members made connections between shared experiences of economic hardship and mental depression. This conceptual coupling within local discourses naturalized the existence of depression in the context of economic precarity. Yet naturalizing depression as an expected response to living in economically depressed circumstances did not upend local moral expectations regarding self-sufficiency. Paired with naturalized depression were efforts to still try to make it work despite the seeming impossibility of mobility: embracing the good days with dark anticipation, seeking to manage the bills and family, and trying to get more education despite such efforts often being in vain. In this pairing, economic and mental depression remain attached to the valorization of work, caregiving, and individual responsibility.

Disabling effects of depression: deservingness through coping

Depression, with its dulling, dragging symptoms, contradicted the values of work and self-sufficiency central to narratives about rural Appalachian ideal (cf. Scott 1995). Women struggled with depressive feelings and the moral, social, and cultural compulsion to cope through action, the fact that "you don't want to do nothing but you just, you just gotta keep going." While these women admitted the vulnerability imposed by depression, they countered it with caring for family, and with working. "You can't just quit," explained one single mother. "I make sure my clothes is washed, my house is clean." Another woman contrasted how she felt with her social reality: "I'd want to lay and do nothing. But when you've got 3 to 5 kids hanging around you all the time, you can't do that now see because well then your mom and dad hollering at you so I just kept doing. It helped me not to think about it." In these descriptions, women narrated their experiences of depression as evidence that they persisted for their families and that they refused to let depression limit their self-sufficiency.

Yet as much as conversations about depression offered commentary on shared economic hardship, they also revealed commentary about social difference through moral constructions of coping. In reflecting on the region's economic and social depression, many participants commented on those who did not push themselves through depression, charting a hazy nexus between "the people that make the welfare system their lifestyle...then the drug problem is so bad...this is a, it's a sad area." Numerous participants cast doubt on claims to depression among those perceived to depend on government assistance in the absence of work or to use drugs, as such individuals were imagined to willingly turn away from work and self-sufficiency and release themselves to the pull of doing nothing.

“We have people who cope normally and healthily. And who seek treatment,” outlined one provider, yet the people most in need of mental health treatment are those who do cope unhealthily: “the people who have little to no education, little to no experience in the work world...[the] more poverty stricken groups of people.” While her statement echoed public health literature on the disproportionate prevalence of depression among low socio-economic groups, she drew attention to differential coping practices. At times, comparisons between the depression of those working and those not illuminated claims to deservingness—that work provoked distress and that unemployment with support from government benefits enabled comfort. “It’s the working people that have to stress and struggle and get through--struggle to get through everyday life; pay their bills,” explained one woman. Yet their depression was under-recognized because such people rarely named their suffering, she and an interlocutor agreed. Depression happens to such educated working people, she continued, “more than it happens to these out here you know on disability. Because they’ve got it made.” People on disability were imagined to be able-bodied and continue multi-generational traditions of not working, while rural hard-working citizens “keep those people up.”

People who were perceived to use drugs to cope with depression were characterized in a similarly passive way. “I know there’s a lot of people that go through this stuff and the only way they can cope with it would be through medication and that’s how people get addicted to drugs,” explained one middle-aged woman. Empathetically, she commented, “I’m no different. I think I could,” reasoning that she too could become addicted. Yet still, she and many others distinguished themselves from those who responded to shared economic hardship with drugs. She explained she took an alternate path of coping with depression, “because I had a son to raise. I had to work and in order to work, I had to pass a drug test every so often. It just wasn’t something that was just you know handed to you.” In this way, refusing the temptation to soothe depression with drug use was asserted as a moral choice to work. In contrast, coping through medication and then drug use was imagined to lead to the passive decision to be “handed to” through government benefits.

Yet the women who actually received government benefits or were in the process applying for them—whether TANF, Medicaid, or disability SSI—carefully refused this negative characterization through similar language about work and independence. One woman likened the Medicaid card she received from the government to the help she had pursued for depression: “I don’t want a handout, I don’t want to not work, I don’t want to just live off the government. I don’t want to do that...but there’s some times when you struggle so much to make ends meet that you have to have help and that’s the same with depression.” Another woman proclaimed with frustration that “I hear [people] bitching all the time” that “the people [like me] who’s disabled and can’t get out and make money and we have to pay taxes for you people to just lay around.” She answered their critiques by claiming her disability was not a “choice”: “We don’t want to, we don’t choose to just lay around; we just ain’t like everybody else. Everybody’s different.”

Others stressed their longing for work and the mental health effects of not being able to work. “I loved work,” explained one woman, “It killed me since I haven’t had a job in over a year.” Among women with limited work histories, there was a feeling that work would make

a difference for their depression, if it were possible: “I want to be able to go out and be able to have somewhere to go during the day to talk to people and to do things and getting a job would help my depression, not only to be able to get out and have someone to associate with but when the paycheck came, you know it would be very good to have too.” Here women stressed that their unemployment was beyond their agency and emphasized the work involved in their struggles to cope and make ends meet.

In other cases, people took efforts to carefully frame their disabilities as emerging from physical, work-related injuries. They tied present depression to their frustration at having their legitimized, work-related disability prevent them from working. Describing her husband whose depression kept him from sleeping at night and whose disability resulted in considerable financial stress for them all, one woman commented, “he’s worked hard all of his life and he’s got a lot of health problems now because he has worked so hard.” Nonetheless, his deservingness to claim disability--and the physical and mental conditions it included--was drawn into question. As he applied for disability, “they just keep giving him a hard time you know because of his age; they try to say he’s too young to have problems like he does but if you work hard labor all your life, you know your body’s only going to be able to do that for so long.” Depression was described as a normal response to economic woes brought on my labor-related physical injury: “He’ll sit up during the night and not be able to sleep and I know it’s depression.” In a region where occupational injury prevalence is high and tied to the high rate of opiate abuse, women were careful to distinguish coping practices as grounded in the desire to want to continue to work.

These discourses weaving through individual narratives of depression and perceptions of depression in the community make depression coping a fulcrum of moral personhood—enacting one’s duty to work and care for one’s family, or being considered less morally worthy for not working, whether due to depression perceived as real or performed. The latter raises suspicion that people who do not work are “using” depression to make undeserved claims to entitlements. In contrast, “real” depression emerges from being forcibly shut out of work, due to injury or other circumstances beyond one’s control.

Deservingness through Treatment

“Working” through depression also made its way into understandings of treatment. When some women explained decisions to forgo pharmacological treatment for depression, many expressed that taking medication meant relying on medical intervention rather than harnessing personal strength to overcome depressed feelings: “I don’t want to be somebody who depends on medicine to feel good. I’ve never been like that.” Women not only made this choice for themselves, but also contrasted their choice to those of others in the region: “I think too many people in this area just, they want a quick fix and they want a pill. And I don’t want a pill.” Women felt that more broadly, many people resisted the desire to “work” to deal with their depression in favor of “quick fixes” through pharmacological treatment:

It seems like in this area, [people] want to just go, ‘just give me the medication’, you know, ‘how long is this gonna take’, you know, ‘is it gonna be awhile, I need help now’, and I think they want, preferred the medication versus actually kinda maybe dealing with their issues, saying, ‘yeah, I’m depressed.’

“Work” in this sense encompasses the time, effort, and commitment required for meaningful engagement in therapy in contrast to the perceived “quick fix” of medication. This sentiment belied the fact that counseling was difficult to access in this area with mental health specialist shortages and significant barriers to accessing treatment (Snell-Rood, et al. 2016). Amid the opioid crisis impacting many rural communities, some women hesitated to even ask providers for antidepressants, fearful they would be perceived as drug users trying to game the system. “They look at you in front of a waiting room full of people and say, ‘I think you’re just here drug seeking,’” explained one woman, who described her experiences in a local doctor’s office when she was in need of medication. So scarred by this public accusation and fearful of its implications for her identity as an educator, she stopped going to the doctor at all.

Others’ descriptions of the perceived effects of antidepressant medication indicated that medication interfered with caregiving and work responsibilities. One woman described how, when she had taken antidepressant medicine in the past, “I’m like a zombie so I would rather deal with it on my own and be able to see my children grow up than to take the medication and not know nothing about them.” Her description alluded to gendered stereotypes of neglectful, absent drug-using mothers encountered in healthcare settings, social services offices, and sometimes, within women’s families. In a region where pharmacotherapy is sometimes abused (Zhang et al., 2008), some women envisioned depression treatment as a path to addiction: “A lot of them that end up on pills for depression end up on worse pills and the next thing you know they’re robbing stores and it just escalates...I’ve seen too many people you know that go down that road.” In contrast, those who abstained from medication or counseling did so to “take control” of the depression on their own.

Several women voiced frustration with obtaining treatment because of the perceived insincerity of other patients. In some cases, women pursuing mental health treatment resented the presence of substance abuse patients at the same facility because their treatment pursuit was labeled “a joke; it’s a waste of taxpayers’ money” because “the court ordered drug court people, they don’t want to be there.” Others felt that psychiatric care was sought in order to build claims for mental health-based entitlements, not because it was sincerely needed. One older woman commented that some people sought care at psychiatric hospitals “because they know the criteria for [social security income] disability is in hospitalizations and therapy for mental health problems and then they go to Social Security and say, ‘I’m depressed and I’m this and that.’” Recipients of SSI benefits, another woman explained, were willing to claim the label of depression but unwilling to pursue therapy, a treatment option perceived to require more effort than pharmacotherapy. Across all these women’s perspectives--all of whom had pursued depression treatment--lay doubt in the deservingness of the patients they described, evidenced by a perceived lack of interest in sincerely pursuing treatment, and interrogated whether such patients’ perceived abuse of treatment corrupted the treatment institutions themselves. Due to their skepticism about the sincerity of these treatment pursuits, women cast doubt on financial support for depression’s disabling effects. Such support was felt to be for those who wanted a way out: medication to “quickly fix” their problems or money to live off of.

In contrast, numerous women pursued treatment, reasoning that their decisions enabled them to better work and fulfill their roles as caregivers. As one single mother put it, “As long as I can work and take care of my son and function, I’ll be okay. When I get to the point that I can’t, that’s when I go to the doctor and say, ‘hey I think you need a new medication adjustment.’” Other women who took medication stressed that it was not the quick fix that others perceived it to be. Taking medication required thoughtful work: “It’s still something you have to work on, even if you are on medication for it. If you want it to be 100%, you really have to do it yourself; you really have to wake up and say you can and get up and start your day and try to forget about it.” Women even defended the sincerity of their treatment decisions within their families. One woman described her sister’s disapproval of her decision to maintain pharmaceutical treatment. Her sister was similarly depressed but, “needs help, and she doesn’t [think so].” She recalled her sister’s accusation that, “‘You’re overmedicated, you don’t have any feelings anymore’, and I’m like ‘well, I do, you know, they’re just not as up and down as yours are, mine’s kinda, you know, following a steady line now.’” In so doing, she asserted the “steady line” of emotion resulting from treatment to deflect her sister’s critique of “overmedicated” thoughtless treatment. She continued, “I think it’d be good if people would consider it, and would want to say, well, yeah ‘I need to do this, I need to deal with this’...versus just ‘nah, just give me some meds.’” Treatment consisted of “doing” mental work and “dealing” with challenging situations rather than being “given” to.

Narratives about treatment can reveal the moral agency of personal treatment decisions--either to “work through” depression independent of a “quick” medical fix or through the effort of confronting depression through medication and therapy. In these narratives, treatment was not the lazy choice of the disengaged, but a regime requiring the initiative to persist, revealing the complex interface between pharmaceuticals, self, agency, and recovery (Jenkins 2010). At the same time, depression treatment can show a *lack* of moral agency when not worked for--treatment that is judicially mandated, that is consumed without thought, or that enables financial reward without engagement in healing. The intention of seeking treatment, rather than engagement with it alone, reflects back on one’s deservingness to be depressed and to receive care.

Discussion

Using the case example of women’s depression in Appalachian Kentucky, we have elaborated how depression provokes debates about health-related deservingness that are informed by local moral economies. Though depression is naturalized as a moral response for enduring a difficult economy, persisting through depression with work and caregiving is seen to demonstrate individuals’ continued engagement in, and commitment to, the local moral economy even as structural limitations make it increasingly difficult to realize “the good life.” When individuals are perceived to cope insincerely—through drug use, using depression diagnoses to access state entitlements, or obtaining medication as a “quick fix”—area residents question the veracity of depression, the sincerity of treatment, and even the institutions providing treatment. The goals of our larger study to focus on women’s depression limits our ability to comment comparatively by gender on the themes we have presented here. Nonetheless, we demonstrate how both depression and coping reveal the

fraught terrain of social responses to vulnerability, and the complex terms through which social inequality is shifting in rural areas like Appalachia.

Popular media focusing on rural unrest in the U.S. throughout the 2016 election cycle and afterwards drew attention to the disjuncture between the federal policies that delivered Medicaid and disproportionate amounts of supplemental Social Security income to economically distressed rural regions and the rural citizens that expressed distrust—and distaste—at state services and support (e.g., Kliff 2016; Sheryl 2017). But such popular analyses of ill-informed rural residents downplay the inequalities within rural communities (Farrigan & Parker 2012), and underestimate the severity of the rural health disparities that these new resources are only beginning to address. While healthcare reform has dramatically expanded rural access to healthcare, some of its provisions—like the insurance marketplaces—may have played a role in accelerating differential access in rural populations that were already underinsured (Fletcher 2016; Zimmerman et al., 2016), likely reinforcing and deepening the moral questions about deservingness that we describe here. With income and health status as scrutinized characteristics to access the state safety net, the ability to work and the state of behavioral health hold high stakes for security. Policymakers intent on preserving the Affordable Care Act must acknowledge the localized rural realities of entitlement and address their inequalities.

The local discussions about mental health we have described engage with both established class-based inequalities—of Appalachia as an economically distressed place (Anglin 2004)—and new inequalities that have emerged as socio-economic mobility becomes increasingly difficult (Mannion & Billings 2006), investments in community social institutions decline (Sherman 2009), and increases in drug-related incarceration disrupt rural communities (Kang-Brown & Subramanian 2017). Such discussions reveal coping and treatment-seeking to be turgid with meaning about social position and moral worth. Often, such moral meanings reproduce historic inequalities—valorizing the coping of the educated and those who can access work (Duncan 2000), while shaming the coping of those without access to complete treatment or work (cf., Hansen et al., 2014). But in regions like Appalachia, the struggle of depression centrally involves how people deal with the contradiction of trying to engage in a regional moral economy of self-sufficiency, work, and mutual family care where widespread structural constraints make it extremely difficult to do so. The Appalachian moral economy likely holds relevance for other rural communities in the U.S. that share stigma about receiving state entitlement (Sherman 2009, 2013), face barriers in maintaining economic self-sufficiency (Carpenter-Song et al., 2016), and possess limited options for behavioral healthcare (Mohatt et al., 2005). Beyond the rural U.S., this moral economy echoes scholarly discussions on the erosion of citizenship entitlements (Petryna & Follis 2015) and the anger provoked by austerity policies amid economic distress (Hansen et al., 2014; Moffatt & Noble 2015; Sherman 2009).

The ample debate to interpret depression and its coping demonstrate that the boundaries between deserving and undeserving are never as clear as they are represented. In Appalachia's local moral economy, a Medicaid card combined with intent to work is differentiated from a Medicaid card of a depressed drug-user with no intent to work or recover. Women who “don't want to work” and “want a hand out” are distinguished from

those who are viewed as legitimately disabled or engaged in earnest efforts to cope with depression through work, caregiving, or mental health treatment. Women seeking counseling that enables work or family caregiving are distinguished from those looking for a “quick fix” through medication. Notably, all participants ascribe moral value to work—whether or not they perceive themselves to have the capacity. In this moral hierarchy, the legitimacy of some women’s depression is questioned or denied and their motives for seeking mental health services are deemed suspect. Yet, these “undeserving” women draw on the same local moral economy (cf. Willen 2015) to resist this characterization through their expressed desires to work and care for their families. Women carefully negotiate the meanings of their individual struggles, morally differentiating treatment as work-enabling and unlike drug use, and arguing moral claims to seek state support.

In this form of resistance, a companion concept to deservingness is revealed: worthiness. Whereas deservingness is a state *granted by others*, worthiness is a state *asserted by the self*. Women deemed “undeserving” assert that they are, in fact, worthy of care and attention. This distinction underscores the importance of attending to how individuals respond to collective discourses. In worthiness we may find a fracture in the political homogeneity attributed to rural regions: while the stigma described here shows how deep tension remains, arguments demanding care for mental suffering compel questions about the need for change. Privately, such responses may amount to individual resistance. Yet, drawn together in social movements such as those seen before in Appalachia (Anglin 2002), such responses could reshape the moral economy. While both deservingness and worthiness draw from the same political, economic, social, and cultural terrain, *worthiness* makes a claim to what is dismissed by *deservingness*—how hard it is to feel good in this context when so many hurt and there are so few resources to feel better, economically or through health. Women’s discursive and practical efforts to establish and maintain worthiness underscore the profound struggle of enduring with mental illness in the context of precarity (Jenkins 2015).

Conclusion

Both the ability to work and one’s mental health are profoundly moral questions, engaging notions of health-related deservingness because they involve defining just vulnerability and protection. The challenges we describe here affirm the dire economic and social conditions described in scholarly discussions of contemporary rural behavioral health—including those that attempt to make sense of the opioid epidemic (Keyes et al., 2014) and rural despair (Case & Deaton 2015; Scutchfeld & Keck 2017; Stein et al., 2017). However, while “rural despair” encompasses the social and mental vulnerability of many rural residents, it fails to capture the intense moral “work” of understanding one’s depression and its resolution in a place where depression feels so common. Even where there is no work, participants described how they could “work through” depression in a depressed area—working to care for family, laboring to get state support, and working to recover from depression with or without treatment. These discussions both contest and engage with dominant health discourse by advocating for individual responsibility, acknowledging social causes, and sometimes refusing treatment.

Such interpretations have profound implications for the ways that mental health is experienced, from the way it is defined, to whether it is seen as treatable, to how treatment is pursued and sustained, to whether mental health recovery is viewed as possible. In the past decades, “recovery” and “trauma” have powerfully morally redefined how mental wellbeing can be understood, drawing attention to the limitations of biomedical systems (Hopper 2007), the importance of consumers’ agency and self-care (Hopper 2007; Fullagar & O’Brian 2014), the social isolation of mental illness and the healing capacity of inclusive communities, and the social conditions that unequally distribute mental distress (Quiros & Berger 2014). In communities burdened with distress, efforts to reduce mental health disparities must address the social meanings of work and social position that shape the experience of depression—efforts that extend from treatment settings, to community spaces, to entitlement policy. Our finding that women drew on a common cultural discourse promoting the value of work, effort, and responsibility points to the potential for building on shared orientations to minimize othering and social exclusion of individuals and groups deemed less deserving. As much as the local moral economy of depression can constrict deservingness, so too can its varying ingredients across diverse rural communities offer tools to reimagine the self, healing, and deservingness to do so.

Local moral economies manifest in community-level scrutiny of mental health across an expansive terrain of relationships and settings in which women must not only deal with depression, but its meaning for their moral identity within their rural communities. Yet as much as the tensions inherent within rural debates about mental health demonstrate *local* moral economies, they also result from broader community economic decisions and partial public investments in health infrastructure. In this way, local moral economies encompass a constellation of family, community, and national understandings of social inequality and belonging.

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- Highlights community dynamics shaping experience of rural mental health
- Analysis of community discourse on who deserves to be depressed and get treatment
- Shows how many face scrutiny of their work, caregiving, state benefits
- Insists on moral factors shaping experience of depression
- Argues for role of deepening rural inequalities in rural behavioral health stigma

Table 1:

Overview of Study Phases, Goals, and Participants

Phase and Goal	Participants	Eligibility Criteria	Data Collected
<u>Formative</u> : understand how Appalachian women with depression understand their experience and make treatment-seeking decisions	Low income women with depression ¹ (N=28)	Female gender, depression as measured by the CES-D (diagnosis of depression not necessary), up to 200% of poverty line, resident of Appalachian Kentucky	Semi-structured interviews (45 min-1.5 hours)
<u>Exploration</u> : identify care provider perspectives on needs of Appalachian women, barriers to care, opportunities for task-shifting, provider needs	Providers (N=11) who work with Appalachian women with depression (PCPs, mental health specialists, CHWs)	Experience working in a healthcare role in eastern Kentucky for at least 2 years, experience working with Appalachian women with depression	Semi-structured interviews (45 min-1 hour)
<u>Adaptation</u> : identify provider and consumer perspectives on how to adapt intervention for Appalachian women and providers	Providers (N=10) who work with Appalachian women with depression (PCPs, mental health specialists, CHWs) and Appalachian women with depression (N=9)	<u>Providers</u> : experience in a healthcare role in Appalachian Kentucky for at least 2 years, experience working with Appalachian women with depression <u>Consumers</u> : female gender, depression as measured by the CES-D 10, resident of Appalachian Kentucky	Focus groups (N=4) (PCP and mental health specialists, CHWs, women with depression); semi-structured interviews
<u>Review</u> : present adapted intervention to provider and consumer stakeholders for final review	CHWs (N=3), PCPs (N=3), CHW administrator (N=1), women with depression (N=3)	Same as previous. Administrators also had experience in overseeing rural CHW program	Structured interviews

¹We define depression here as measured by the CES-D, knowing that this category was not meaningful to all participants.

Abbreviations: PCP=primary care provider; CHW=community health worker

Table 2:**Participant Demographics**

<i>Consumers (N=37)</i>	N	SD
Age	41.38	12.42
Years lived in Appalachia	32.90	15.66
Number of people in household	2.87	1.37
Years of education completed	13.70	2.38
	N	%
Currently in treatment for depression	17	46
<u>Gender</u>		
Female	37	100
<u>Race</u>		
White (not Hispanic)	36	97
Black	1	3
<u>Marital status</u>		
Married/partnered	22	59
Divorced	7	19
Widowed	1	3
Never married	7	19
Currently employed	24	65
<u>Household income</u>		
<\$10,000	7	19
\$10,000–20,000	11	30
\$20,000–30,000	8	22
\$30,000–40,000	4	10
\$40,000 and above	7	19
<u>Insurance coverage</u>		
Private insurance		22
Company insurance	11	30
Medicaid	6	16
Medicare	10	27
Veterans' insurance	1	3
No insurance	2	5
<i>Providers (N=21)</i>	N	SD
Age	43.85	9.18
Years lived in Appalachia	34.71	16.56
Years worked with consumer population	12.97	9.33
	N	%
<u>Gender</u>		
Female	17	81

<i>Consumers (N=37)</i>	N	SD
Male	4	19
<u>Race</u>		
White (not Hispanic)	20	95
Black	1	5
<u>Job title</u>		
Community health worker	11	52
Social worker	2	9
Mental health specialist	6	29
Nurse	3	14
Nurse practitioner	1	5
<u>Location of practice</u>		
Community outreach center	9	43
Public clinic	8	38
Private practice	1	5
Research, community outreach	2	9
Hospital	1	5

Note: "insurance coverage" allowed more than one count

Table 3:

Depression & Treatment Status of Consumer Participants

	Mean CES-D Score **	Receiving Treatment	No Current Treatment
Participants (n=28) in Phase I *	32	14	14

	Mean CES-D 10 Score ***	Receiving Treatment	No Current Treatment
Participants (n=9) in Phase II	14	3	6

* During the first phase, a total of 61 women were screened, of whom 53 were eligible to participate. Of these 53 women, 25 did not show to their interviews—attrition that we describe in full detail elsewhere (Blinded et al, 2016). However, it is significant that among these no-shows, the mean CES-D score was 46, some 14 points higher than the women who participated in interviews.

** For the CES-D, a score >15 is considered depressed; the maximum score is 60.

*** For the CES-D 10 short-form, a score 10 is considered depressed.