Journal of Agromedicine

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/wagr20

# Developing an Intergroup Dialogue Curriculum to Improve Mental Health System Capacity for Farmers and Agricultural Communities

Annie J. Keeney, Morgan Valley, Cheryl Beseler & Lorann Stallones

**To cite this article:** Annie J. Keeney, Morgan Valley, Cheryl Beseler & Lorann Stallones (20 Feb 2025): Developing an Intergroup Dialogue Curriculum to Improve Mental Health System Capacity for Farmers and Agricultural Communities, Journal of Agromedicine, DOI: 10.1080/1059924X.2025.2467960

**To link to this article:** https://doi.org/10.1080/1059924X.2025.2467960

© 2025 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group.

Published online: 20 Feb 2025.

Submit your article to this journal

View related articles

View Crossmark data

Full Terms & Conditions of access and use can be found at https://www.tandfonline.com/action/journalInformation?journalCode=wagr20

JOURNAL OF AGROMEDICINE
https://doi.org/10.1080/1059924X.2025.2467960

Taylor & Francis
Taylor & Francis Group

BRIEF REPORT

OPEN ACCESS Check for updates

# Developing an Intergroup Dialogue Curriculum to Improve Mental Health System Capacity for Farmers and Agricultural Communities

Annie J. Keeney [a,b], Morgan Valley[c], Cheryl Beseler [d], and Lorann Stallones [e]

[a]School of Social Work, San Diego State University, San Diego, CA, USA; [b]High Plains Intermountain Center for Agricultural Health and Safety, Colorado State University, Environmental & Radiological Health Sciences, Fort Collins, CO, USA; [c]Department of Environmental & Radiological Health Sciences, Colorado State University, Fort Collins, CO, USA; [d]Department of Environmental, Agricultural and Occupational Health, University of Nebraska Medical Center, Omaha, NE, USA; [e]Department of Psychology, Colorado State University, Fort Collins, CO, USA

**ABSTRACT**

The purpose of this study is to present the development of an intergroup dialogue curriculum for faith leaders and behavioral health providers to expand rural behavioral health care systems. The Clergy Outreach and Professional Engagement model and intergroup dialogue technique formed the basis of the curriculum. A discussion of the adaptation of an intergroup dialogue intervention developed for use in rural communities is presented. The curriculum was designed to build trust and familiarity among trusted faith leaders, behavioral health providers, and Extension agents to expand the system of care for vulnerable farming populations. Challenges and opportunities regarding the implementation of the intergroup dialogue intervention are explored. Assessing the feasibility of scaling this approach up to other communities has the potential to improve the network providing behavioral health care in rural communities.

**KEYWORDS**

Barriers to mental health care; behavioral health; collaboration; extension agents; faith leaders;; rural

## Introduction

Rural residents and agriculture production workers are disproportionately burdened with higher depression, substance abuse problems, and suicide mortality rates.[1–4] Various barriers limiting access to behavioral health care significantly impact these elevated rates. Approximately 90 million people live in mental health professional shortage areas, most in rural areas.[5,6] In 2020, 61% of calls to Farm Aid came from farmers in a mental health crisis.[7] Many people in the United States see faith leaders as a frontline mental health support system, especially in rural regions.[8,9] Faith leaders are trusted insiders, accessible, and require no additional financial resources. These circumstances allow faith leaders to act as gatekeepers for behavioral health care.[10] Rural faith leaders are well recognized to help navigate mental health challenges. However, studies indicate that faith leaders refer to mental health professionals at low rates[11] and counsel at a low intensity, even for serious problems.[12] This may be further pronounced for farmers in rural areas, where access to behavioral health providers is scarce, and the stigma of help-seeking is high.[10,13,14]

Behavioral health care networks must understand and be familiar with the cultural and social context to foster help-seeking behavior among rural farmers. As such, collaborations between faith leaders and behavioral health providers could expand rural behavioral health care systems. These groups may be reluctant to collaborate, however, most likely because of the perceived contentious relationship between religion and psychology.[15] For example, faith leaders may worry about sending a congregant to behavioral health providers holding conflicting religious beliefs, while psychotherapists are unlikely to refer clients to faith leaders for spiritual help.[16] Unfortunately, there is little guidance on effectively bringing groups holding conflicting or counterproductive beliefs together despite having common goals.

Intergroup dialogue is an evidence-based technique for increasing communication processes and bridging differences.[17] The core tenets of

**CONTACT** Annie J. Keeney akeeney@sdsu.edu School of Social Work, San Diego State University, 5500 Campanile Drive, San Diego, CA 92182, USA

© 2025 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group.
This is an Open Access article distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/4.0/), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited. The terms on which this article has been published allow the posting of the Accepted Manuscript in a repository by the author(s) or with their consent.

intergroup dialogue focus on active listening, structured interactions, and facilitative guidance. Previous successes implementing intergroup dialogue with various social identity groups have found ally development, positive attitude changes, increased critical consciousness, and action preparedness.[17,18] Therefore, we developed an intergroup dialogue curriculum to build and increase collaborations and partnerships between rural behavioral health care providers and faith leaders, with Extension agents serving as the facilitators of these collaborations. The Clergy Outreach and Professional Engagement (COPE) framework guided our intergroup dialogue curriculum development. COPE aims to establish mutual burden reduction (i.e., reduce the need for one group of service providers to deliver direct care by sharing with other providers) by defining the roles of those involved in behavioral health care and sharing expertise across professions.[19–22]

## Curriculum development

Between September 2022 and December 2022, we interviewed content experts, including a faith leader, behavioral health provider, Extension agent, an individual familiar with the COPE framework, and an intergroup dialogue facilitator ($N = 5$). We used semi-structured interview guides tailored to each interviewee's expertise to conduct 60-min individual interviews via Zoom. For example, the interview guide developed for the behavioral health provider content expert aimed to understand how the profession broadly supports spiritual health and perceptions related to faith leaders' role in providing direct behavioral health services. The interview guide with the COPE expert focused on how questions related to adapting the framework to rural communities, specifically in the study sites of Colorado, Wyoming, and Nebraska. Each interview was recorded and transcribed. All five content experts agreed to review the draft curriculum developed based on the interview findings and serve as project informants throughout the project. The San Diego State University Institutional Review Board approved the study (Protocol #: HS-2021–0270-SMT).

Grounded theory analysis was used to identify common themes and content across the interviews.[23] The established codes and themes found within the interviews were used to draft an intergroup dialogue curriculum that included adapting and tailoring the core intergroup dialogue curriculum components, icebreakers, reflection activities, areas for mutual knowledge, and approaches to critical asset mapping. We found the overarching themes of (1) cultivating trust and humanizing experiences, (2) honor diversity and finding common ground, (3) identifying common goals, and (4) collaborative action planning. These themes became the basis of the curriculum modules, which are further described below. In June 2023, we convened a meeting with the five content experts and presented the draft curriculum. The purpose of this meeting was to strengthen the curriculum by allowing the content expert members to check, confirm, and identify gaps or unclear content areas. Additionally, we asked the content experts to provide recommendations on the curriculum delivery (e.g., hybrid vs. in-person, all-day session vs. multiple sessions, etc.). We then revised the curriculum based on the feedback received from the content experts.

## Intergroup dialogue curriculum

A four-session, 8-h intergroup dialogue curriculum was developed to create new levels of understanding, relating, and action between faith leaders and behavioral health providers. Adhering to the core components of intergroup dialogue, our curriculum aims to (1) discuss the community challenges and needs, (2) explore the intersection between faith and mental health, (3) foster collaboration, communication, and coordination to create a continuum of care, and (4) promote mental health awareness, reduce stigma, and create a supportive community environment.

Using the COPE framework to guide how best to expand the continuum of mental health care in rural settings between clinicians and community clergy, which allows for the sharing of expertise across professions, the curriculum's modules focus on (1) cultivating trust and sharing experiences, (2) honoring differences and finding common ground, (3) building bridges and fostering connections, and (4) mapping resources and taking action together. These four curriculum

modules are intended to be delivered across four sessions that aim to build, expand, and improve the internal and group processes between faith leaders and behavioral health providers (see Figure 1). For example, focusing on building and developing the communication processes between these two professions can result in alliance building, which provides the foundation for resource sharing and establishing formal referral pathways, thus strengthening the continuity of mental health care in rural, agricultural-dominant communities.

Each session lasts approximately 2 h, with the first 90 min being structured, direct curriculum/content, and the last 30 min designed as a semi-structured "coffee and conversation" that allows participants to engage more organically in conversations with other participants. We intentionally designed this curriculum to be delivered in-person and with a desirable group size of six to eight people, while ensuring that the same number of each population is represented – for example, two behavioral health providers and two faith leaders. Having one group represented "less" is not desirable and goes against intergroup dialogue best practices. However, modifications could be made to adapt it to an online format. All sessions are guided by a facilitator PowerPoint that structures the beginning of each session with an overview of the session goals, expectations, community agreement (developed collectively in the first session and reviewed thereafter), a review of prior session content (if applicable), and an icebreaker.

Depending on the session, the structured content varies between small and large group activities, reflections, and discussions. For example, in session one, *Cultivating Trust and Sharing Experiences*, participants are given a handout and asked to categorize a series of statements. Some are specifically about faith leaders, some about behavioral health providers, and some could apply to both roles. After participants complete the handout individually, they are brought together for a large group discussion on the roles in mental health wellness. Adhering to intergroup dialogue core components (engage in critical self-reflection, see Figure 1), participants are encouraged to use examples and stories from their personal or professional experience when reflecting on why they answered the way they did. (See Figure 2 for an example of the handout).

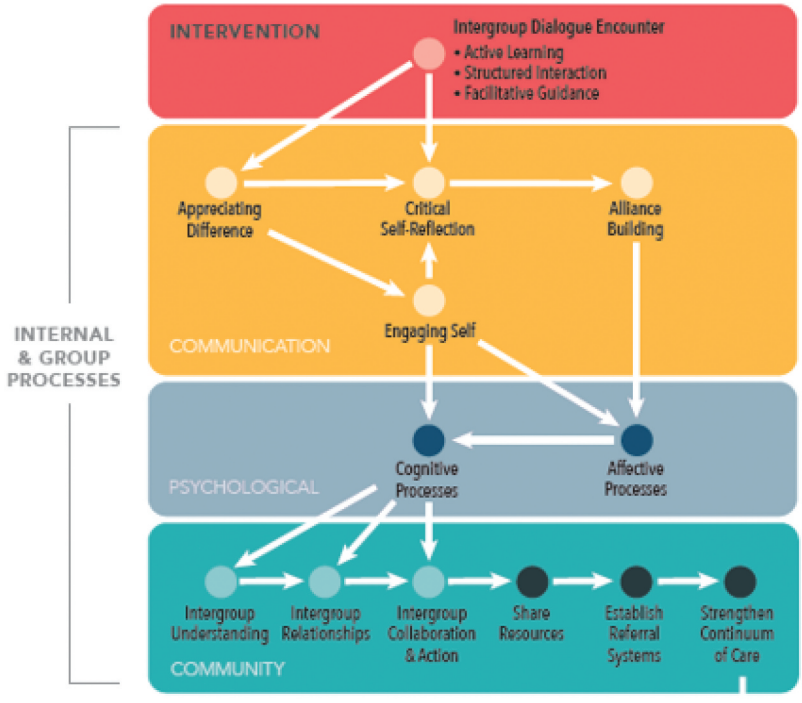
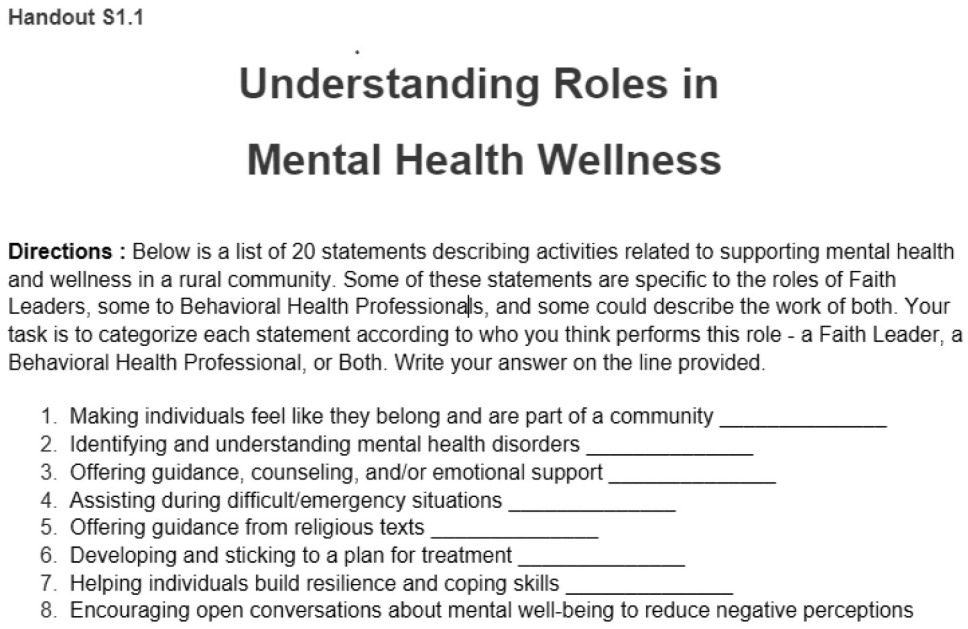



**Figure 1.** Intergroup dialogue communication, psychological, and community processes expected to strengthen COPE model continuum of care.



Handout S1.1

# Understanding Roles in Mental Health Wellness

**Directions :** Below is a list of 20 statements describing activities related to supporting mental health and wellness in a rural community. Some of these statements are specific to the roles of Faith Leaders, some to Behavioral Health Professionals, and some could describe the work of both. Your task is to categorize each statement according to who you think performs this role - a Faith Leader, a Behavioral Health Professional, or Both. Write your answer on the line provided.

1. Making individuals feel like they belong and are part of a community _____
2. Identifying and understanding mental health disorders _____
3. Offering guidance, counseling, and/or emotional support _____
4. Assisting during difficult/emergency situations _____
5. Offering guidance from religious texts _____
6. Developing and sticking to a plan for treatment _____
7. Helping individuals build resilience and coping skills _____
8. Encouraging open conversations about mental well-being to reduce negative perceptions

**Figure 2.** Session one participant handout.

### *Next steps*

Next, our team will pilot-test the curriculum using the Implementation Outcomes Framework (IOF)[24] within the Reach, Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM) framework[25] in a hybrid model of implementation science to evaluate the feasibility and effectiveness of the intergroup dialogue intervention to increase collaboration between the groups and ultimately increase the accessibility and continuum of behavioral health care in rural communities. We will assess changes in communication, psychological, and community processes stemming from intergroup dialogue (depicted in Figure 1) and determinants of adoption leading to implementation. We expect that the RE-AIM evaluation model will inform us of the feasibility, accessibility, and sustainability of the curriculum, particularly around whether and how the intergroup dialogue sessions helped participants become comfortable in pursuing partnerships and whether these would be a good fit for their congregation or clinical practice. Thus far, we have presented our curriculum at the USDA Center for Faith-Based and Neighborhood Partnerships, the Health Resources Services Administration – Rural Mental Health, and the International Society for Agriculture Health and Safety for discussion. Our team is currently recruiting participants among faith leaders and behavioral health providers in rural and agricultural counties in Colorado, Nebraska, and Wyoming. If our IGD curriculum can be successfully implemented, we will consider utilizing a Community Capitals Framework to inform "spiraling up" efforts across rural, agriculture-dominant communities,[26] and we will seek to add the curriculum to the Farm and Ranch Stress Assistance Network (FRSAN) resources available to communities.

## Conclusion

Given that COVID-19 has further exacerbated access and service delivery of behavioral health services and resulted in increasing chronic health care provider shortages in rural areas, this project is critical because it aims to build behavioral health system capacity for farmers, who have an elevated risk of suicide, and their broader agricultural communities. The long-term goal is to build referral pathways between faith leaders and behavioral health providers.

## Disclosure statement

No potential conflict of interest was reported by the author(s).

## Funding

Supported by the High Plains Intermountain Center for Agricultural Health and Safety CDC/NIOSH [Grant No. U54OH008085]. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC/NIOSH. .

## ORCID

Annie J. Keeney http://orcid.org/0000-0002-0318-9772
Cheryl Beseler http://orcid.org/0000-0002-2135-3839
Lorann Stallones http://orcid.org/0000-0001-7616-582X

## References

1. Ezekiel N, Malik C, Neylon K, Gordon S, Lutterman T, Sims B. Executive summary. In: *Improving Behavioral Health Services for Individuals with SMI in Rural & Remote Communities*. Washington, D.C.: American Psychiatric Association for the Substance Abuse and Mental Health Services Administration; 2021:vi–x.
2. Substance Abuse and Mental Health Services Administration (SAMHSA). The 2018 national survey of drug use and health (NSDUH) releases. *SAMHSA.gov*. https://www.samhsa.gov/data/release/2018-national-survey-drug-use-and-health-nsduh-releases.
3. Substance Abuse and Mental Health Services Administration (SAMSHA). RuRal behavioral health: telehealth challenges and opportunities. *SAMASHA In Brief*. 2016;9(2). https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4989.pdf.
4. Gale J, Janis J, Coburn A, Rochford H. Behavioral health in rural America: challenges and opportunities. *Rural Policy Res Inst*. 2019. https://rupri.org/wp-content/uploads/Behavioral-Health-in-Rural-America-Challenges-and-Opportunities.pdf.
5. Farm Aid. Farmer stress. farmaid.Org. https://www.farmaid.org/wp-content/uploads/2018/08/farm_aid_2018-farmer_stress-08.22.2018.pdf. 2018.
6. KFF. Mental health care health professional shortage areas (HPSAs). *State Health Facts*. https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed November 11, 2002.
7. The Economist. America's farmers face multiplying pressures. https://www.economist.com/united-states/2020/09/20/americas-farmers-face-multiplying-pressures. Accessed September 20, 2020.
8. Ellison CG, Vaaler ML, Flannelly KJ, Weaver AJ. The clergy as a source of mental health assistance: what Americans believe. *Rev Relig Res*. 2006;48(2):90–211.
9. Weaver AJ. Has there been a failure to prepare and support parish-based clergy in their roles as front-line community mental health workers? A review. *J Pastoral Care*. 1995;49(2):129–149. doi: 10.1177/002234099504900203.
10. Pescosolido BA. The public stigma of mental illness: what do we think; what do we know; what can we prove? *J Health Soc Behav*. 2013;54(1):1–21. doi: 10.1177/0022146512471197.
11. McMinn MR, Runner SJ, Fairchild JA, Lefler JD, Suntay RP. Factors affecting clergy-psychologist referral patterns. *J Phychol Theology*. 2005;33(4):299–309. doi: 10.1177/009164710503300406.
12. Wang P, Berglund P, Kessler R. Patterns and correlates of contacting clergy for mental disorders in the United States. *Health Serv Res*. 2003;38(2):647–673. doi: 10.1111/1475-6773.00138.
13. Baldwin I, Poje AB. Rural faith community leaders and mental health center staff: identifying opportunities for communication and cooperation. *J Rural Health*. 2020;44(1):16–25. doi: 10.1037/rmh0000126.
14. Jones DL, Cassidy L, Heflinger CA. "You can talk to them. You can pray": Rural clergy responses to adolescents with mental health concerns. *Rural Ment Health*. 2012;36(1):24–33. doi: 10.1037/h0094777.
15. Breuninger M, Dolan SL, Padilla JI, Stanford MS. Psychologists and clergy working together: a collaborative treatment approach for religious clients. *J Spiritual Ment Health*. 2014;16(3):149–170. doi: 10.1080/19349637.2014.925359.
16. Oppenheimer JE, Flannelly KJ, Weaver AJ. A comparative analysis of the psychological literature on collaboration between clergy and mental-health professionals—perspectives from secular and religious journals: 1970–1999. *Pastoral Phychol*. 2004;53(2):153–162. doi: 10.1023/B:PASP.0000046826.29719.8d.
17. Frantell KA, Miles JR, Ruwe AM. Intergroup dialogue: a review of recent empirical research and its implications for research and practice. *Small Group Res*. 2019;50(5):654–695. doi: 10.1177/1046496419835923.
18. Nagda BA. Breaking barriers, crossing borders, building bridges: communication processes in intergroup dialogues. *J Soc Issues*. 2006;62(3):553–576. doi: 10.1111/j.1540-4560.2006.00473.x.
19. Milstein G, Manierre A, Susman VL, Bruce ML. Implementation of a program to improve the continuity of mental health care through clergy outreach and professional engagement (C.O.P.E.). *Prof Psychol Res Pr*. 2008;39(2):218–228. doi: 10.1037/0735-7028.39.2.218.
20. Smith, Smith AE, Riding-Malon R, Aspelmeier JE, Leake V. A qualitative investigation into bridging the gap between religion and the helping professions to improve rural mental health. *J Rural Ment Health*. 2018;42(1):32–45. doi: 10.1037/rmh0000093.
21. Milstein, Ferrari. Supporting the wellness of laity: clinicians and catholic deacons as mental health collaborators. *J Spiritual Ment Health*. 2020;24(2):172–190. doi: 10.1080/19349637.2020.1850391.

22. Rudolfsoon L, Milstein G. Clergy and mental health clinician collaboration in Sweden: pilot survey of COPE. *Ment Health, Religion & Culture*. 2019.
23. Strauss A, Corbin J. ed *Basics of Qualitative Research: Procedures and Techniques for Developing Grounded Theory*. Thousand Oaks, CA: Sage; 1998.
24. Proctor E, Silmere H, Raghavan R, et al. Outcomes for implementation research: conceptual distinctions, measurement challenges, and research agenda. *Adm Policy Ment Health*. 2011;38(2):65–76. doi:10.1007/s10488-010-0319-7.
25. Reilly KL, Kennedy S, Porter G, Estabrooks P. Comparing, contrasting, and integrating dissemination and implementation outcomes included in the re-aim and implementation outcomes Frameworks. *Front Public Health*. 2020;8:430. doi:10.3389/fpubh.2020.00430.
26. Emery M, Flora C. Spiraling-up: mapping community transformation with community capitals framework. *Community Devel*. 2006;37(1):19–35. doi:10.1080/15575330609490152.