

REGION AS A CULTURAL CONTEXT IN FAMILY THERAPY

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ABSTRACT

Environmentally-constructed, regional culture as defined by geographic place is not generally included in family therapy research and training concerning race, ethnicity, gender, sexual orientation, and other contextual factors. This grounded theory research project explores how practitioners working with families acknowledge, access, and use region as a cultural context in their service delivery, specifically in the New River Valley region of Southwest Virginia. Ecological theory, social construction theory, family systems theory, and cultural competency perspectives were used to frame the research questions, to develop the interview protocol, and to support the analysis of the properties and dimensions of the concepts and categories that emerged from the data analysis. The resulting grounded theory revealed that clinicians working with regionally-distinct clients combine a client-centered approach with multiple-layers of regional knowledge and self-awareness.

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CHAPTER I: INTRODUCTION

Prologue

Just a couple of months ago, I had a family that came in because their son was living with them after being released on parole (a condition of his release), and they were having trouble getting along. The son's parole officer told them that they had to go to family counseling because it looked like the son was getting ready to leave and violate his parole. One of the problems was the local law enforcement – the family couldn't even go out for a hamburger without a patrol car 'stalking' them. The mother's health problems were getting worse due to the stress. As the family described where they lived in the middle of town and what it was like to feel watched and 'tagged,' I was filling in the picture with what I knew of that community from other clients and from my own experiences there – I hike close by and have to drive through there often. I had to work on my own bias about the crime the son had committed. The family didn't fit the stereotypical family from that area, but I feel like I thought they were at first. My opinion changed after hearing about how they held their son responsible for his crime and did not feel that they had to defend him, a trait I had seen in many other families other there. During the months they came to therapy, I learned more and more about their strengths and the hurdles they had to leap over in their community to get to the peace they had experienced before he went to jail. It was a long road, but we made enough progress to make a difference – at least for now.

One of the participants in this research project shared this story with me after I explained the theory that emerged from my data analysis regarding how clinicians use their knowledge of regional culture in practice. She exclaimed, “I do that!” after which, she offered this case example. Her experience with this family illustrates the power of regional cultural context and emphasizes the processes clinicians described to me in the interviews.

Introduction to this Research

Marriage and family therapists have become increasingly aware of culture as a central component of client identity and as a contextual factor. Identity – its composition, development dynamics, and systemic implications – is not always easy to discern, however. Throughout history, people have devised a variety of explanations about who we are and how we develop and/or acquire our beliefs, behaviors, preferences, and norms in socio-cultural and historical contexts. For this study, I have chosen a postmodern perspective to view how geographically-shared, human characteristics develop through language, are socially constructed (Laird, 1998), and function as a culture (Wilson, 1998). This paradigm helps explain how region joins race, ethnicity, gender, and sexual orientation as a cultural context for human identity and behavior. Expanding the conceptualization of culture to include region will help therapists and other practitioners add another facet of awareness to facilitate cultural competence.

Overview

In this chapter, I provide the foundation for this research, including a rationale for the study, definitions of key concepts and terms, and an in-depth exploration of the

theoretical frameworks from which I developed the study. The subsequent chapters follow a traditional American Psychological Association (APA) research format: Chapter II is a review of literature and research central to the research topic; Chapter III includes a discussion of the research methods I used; Chapter IV is a review and discussion of the research findings; and Chapter V concludes the document with a view of research implications.

Purpose and Rationale of the Study

Cultural context is a central theme in many Marriage and Family Therapy (MFT) training programs across the U.S. (Inman, Meza, Brown, & Hargrove, 2004). Yet after reviewing the family therapy literature, I found that *regional identity* --, that is, environmentally-constructed culture as defined by geographic place -- is not generally included in family therapy training regarding race, ethnicity, gender, sexual orientation, and other contextual factors. Although, the majority of MFT cultural competency literature lists region as a context (Hardy & Laszloffy, 1998; McGoldrick, Almeida, Preto, Bibb, Sutton, Hudak & Hines, 1999), it has not been explored in depth as the subject of research or practice. It is clear that family theorists acknowledge the role ecological factors play in family behaviors and beliefs and recognize regional identity as a valid component of cultural identity. For example, regional background has been suggested to be a salient contextual factor in treating families by scholars such as Brueunlin, Schwartz, Kune-Karrer (1992) Robbins, Mayorga, & Szapocznik (2003), and Sugar (2002). Therefore, a gap exists between the acknowledged importance of region as a contextual factor and the state of research and training.

The value of acknowledging cultural identity is accepted by MFT as a field; however, how or whether clinicians exercise cultural awareness, especially concerning regional differences, is relatively unknown. Considering that regional identity is a valid factor identified in the literature but has not been researched, the purpose of this study is to explore the nature of regional identity as a cultural factor and understand how clinicians working with families incorporate it into culturally competent treatment. Knowledge of current practices furthers the state of knowledge and refines ideas about cultural competencies within the field of MFT.

Definitions of Key Concepts

The diversity of disciplines involved in the study of region (e.g., public policy, urban planning, geography, anthropology, social psychology, creative writing, business, and Appalachian and other regional studies), along with the evolving perspectives on cultural context, make defining key concepts in this research imperative. Researchers must refine their definitions so that relationships between the concepts may logically emerge (Shoemaker, Tankard, & Lasorsa, 2004; White & Klein, 2002). The following terms and definitions are specific to and congruent with the purpose of this research; yet, they are not exhaustive and do not represent multidisciplinary perspectives unless appropriate.

- Community: “refers to a geographical area that is recognizable, such as natural boundaries, a recognized history, demographic patterns, or the presence and work within it of particular industries or organizations...to social attributes and interests – such as language, custom, class, or ethnicity – shared by inhabitants and commonly used to designate them as a collective identity” (Chaskin, Brown,

Venkatesh, & Vidal, 2001, p. 8).

- Cognitive pluralism: refers to the idea that cultural groups “may perceive things that others may not perceive, focus on issues that others consider immaterial, attach significance to historical moments that elsewhere are deemed ordinary, and collectively remember events that happened before they were born, or maybe never happened at all” (LaRossa, Simonds, & Reitzes, 2005, p. 423.).
- Culture: “those sets of shared world views and adaptive behaviors derived from simultaneous membership in a variety of contexts; ecological settings (rural, urban, suburban), religious background, etc.” (Falicov, 1988, p.336); a “web of meaning” (Geertz, 1973).
- Cultural/cross-cultural/multicultural competence: the ability “not only to identify cultural factors that may affect client problems (etiology) but also integrate the impact of these factors in conceptualizing relevant strategies (treatment) when working with the client” (Inman, 2006, p. 74). (A more comprehensive discussion, of these competencies appears later in this chapter).
- Family: “a relationship by blood, marriage, or affection, in which members may cooperate economically, may care for any children, and may consider their identity to be intimately connected to the larger group [family system]” (Chibucos, & Leite, 2005, p. 9).
- Local knowledge: “knowledge rooted in local or regional culture and ecology” (Antweiler, 1998, p. 418).
- Practitioners/clinicians: Mental health professionals who administer care within their area of training and expertise, particularly concerning physical,

psychological, and social health and well-being. I use the terms practitioner and clinician interchangeably. The term clinician is used more often in the NRV.

- Place Identity: “a collective construction, produced and modified through human dialogue, that allows people to make sense of their locatedness” (Dixon & Durrheim, 2000, p. 40). This concept is different from regional identity in that it describes the conscious process of meaning making, which is only part of regional identity.
- Psychological essentialism: When human beings represent others in categories based on “deep, hidden, and unchanging properties that make their members what they are” (Prentice & Miller, 2007). Stereotyping is an ordinary form of this natural human process.
- Region: An area defined by division of cultural distinctions and values, such as economics, “language, religion, and politics” (Zelinsky, 1973). Regions share common characteristics depending on the person or group and the agenda for defining the area (Wilson, 1998).
- Regional identity: “feelings of identity expressed through attitudes and notions of belonging...related to the behavior of inhabitants in terms of their membership...” (Millard & Christensen, 2004). “These attitudes appear to be culturally and regionally bound, and become part of the transmitted values that are the legacy and the identity of the region even centuries later” (Sugar, 2002, p. 163).
- Regionalism: “cultural identity, examined within the framework of particular environmental contexts and socially-constructed cultures” (Wilson, 1998, p. xvi).

Theoretical Frameworks

Grounded theory “is meant to build theory rather than test theory” (Strauss & Corbin, 1998). Established theories provided a foundation for explicating concepts and analytical relationships, thus supporting the grounded theory methods I used in this study (Charmaz, 2006). I used ecological theory, social construction theory, and family systems theory in addition to the current perspectives on cultural competency to frame my research questions and to develop the interview protocol. These theories also supported my analysis of the properties and dimensions of the concepts and categories that emerged from the data analysis (Strauss et al, 1998).

There are five assumptions regarding families and family mental health practice underlying this research. The first four assumptions are supported theoretically through ecological theory, social construction theory, and to some degree, family systems theory. These are as follows: (a) Regional boundaries are defined and recognized by the those who share a common experience within a definable area – not only by historically-marked, natural boundaries, such as mountains, rivers, or other homogenous, geographic characteristics (Bradshaw, 1988); (b) Region exists as a cultural context and is a central influence in developing culture (Sugar, 2002); (c) Families participate in the construction of this context and, conversely, regional culture influences families and their collective identities, and (d) Regional culture plays a role in individual identity development. The last assumption regarding practitioner conceptualization of regional culture in treatment is supported in part by more general recommendations for culturally competent practice: (e) Culturally-competent practitioners recognize and use regional distinctions as a cultural context (Piercy,

Hovestadt, Fenell, Franklin, & McKeon, 1982). The specific exploration of the role of region, however, is a new area of investigation in MFT.

Ecological Theory

Human ecological theory serves as the best framework for this exploration and is compatible with diversity and cultural topics. Furthermore, the systemic concepts underpinning ecological theory align with MFT, as well. In the next section, I will describe these theories and explain how they provide a framework for conceptualizing this research (Rafuls & Moon, 1996).

As early as the late 1800s, scholars and social activists such as Thomas Malthus were looking for ways to address and explain emerging social concerns, including poverty, use of resources, population, and economics (White et al., 2002). The call for solutions to these social concerns produced theories focusing on family and the community. Through the ecological perspective, scholars acknowledged the importance of home, community, and larger systems on the individual's health and quality of life (Bubolz & Sontag, 1993). As ecological theory was expanding from home economics to the social sciences, therapists and scholars such as Bateson, Ackerman, and Bowen were developing theories to explain family interactions (Nichols & Schwartz, 2005). Although these theorists did not agree on all aspects of human interaction, they did agree that the focus should be on the family as a system due to the "reciprocal influences of intimate, emotional systems" (Framo, 1996, p. 290).

Components of Ecological Theory

The ideas of ecological theorists and human service practitioner reveal that our identities are bound to the interactions we have with our unique environments and with

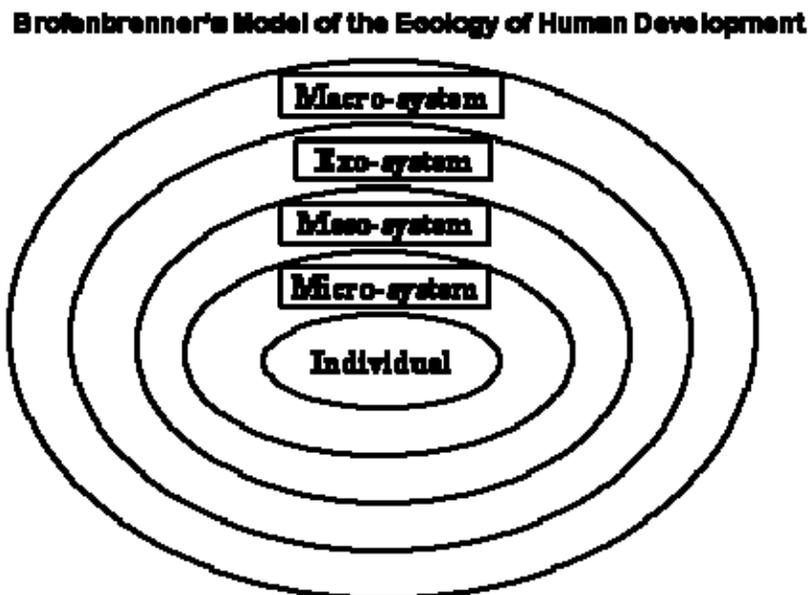
the people who reside in that space with us. Bronfenbrenner (1979), a prominent figure in ecological theory, observed the significance of our shared, proximal settings, stating, “Different settings have different [sic] distinctive patterns of roles, activities [sic] and relationships for persons in those settings” (p. 109). Family coping strategies developed in a regional context can be understood from an ecological perspective. Clinicians may be able to offer more culturally competent treatment by conceptualizing their clients’ behaviors, beliefs, and values within their context (Blakeney, 2006). Furthermore, “specific approaches, opportunities, and limitations in therapy may be derived from the individual’s regional identity” (Sugar, 2002, p. 174). Without this more inclusive perspective, therapists may prematurely assign pathology or dysfunction to behaviors that differ from what the therapist considers the normative. Thus, by adding regional identity to cultural competency training, practitioners may be able to develop more customizable therapeutic models based on clients’ unique ecological contexts.

Bronfenbrenner’s Ecological Model

Bronfenbrenner’s concept of human development explains why people learn and grow in relation to their contexts. According to Bronfenbrenner (1979), “the family is one among many ‘nested’ ecosystems in which the individual develops and interacts (p. 3).” Considering the fact that there are distinct political, social, and historical differences in regions (Bradshaw, 1988), ecological theory, “provides a framework for looking at ways in which intrafamilial processes are influenced by extrafamilial conditions and environments” (Bubolz & Sontag, 1993, p. 423). In other words, ecological theory encompasses all cultural factors in this model, including those considered regional or community-based.

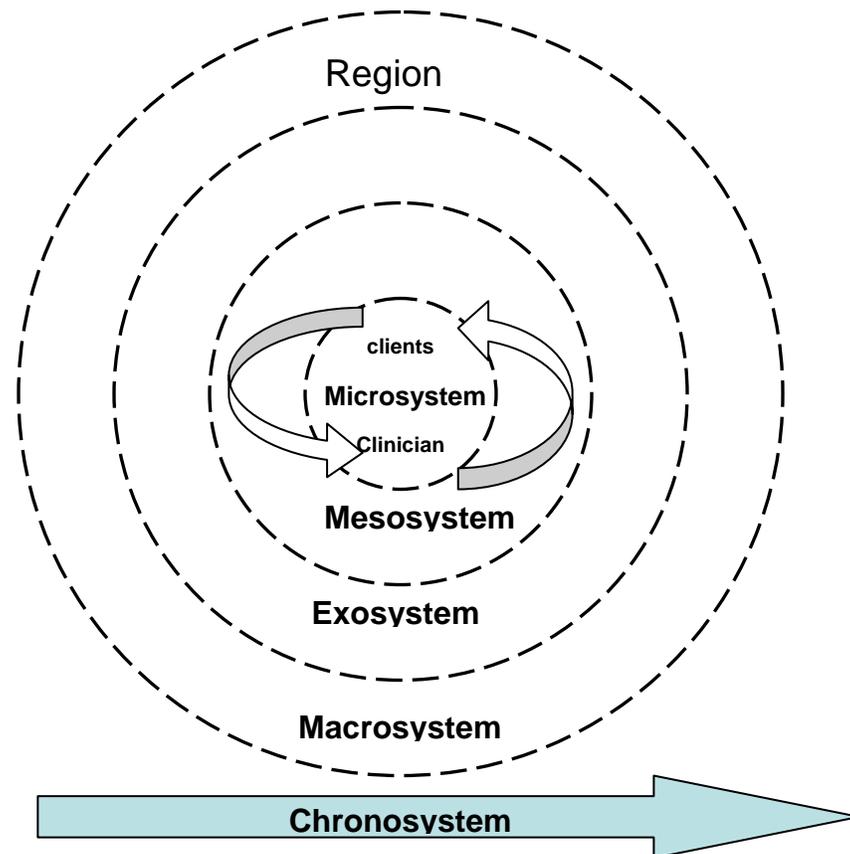
People bring influences from their communities, transgenerational histories, and family dynamics with them to therapy. Bronfenbrenner's (1975, 1979, 1986) model (see Figure 1) includes a layer for every one of these factors, exposing the power of cultural circumstances on human identity and interaction.

Figure 1: Representation of Bronfenbrenner's Ecological Model



Even though the solid lines surrounding the nested systems could imply closed, contained systems, the components of the theory suggest more permeable, open systems that interact with and affect each other. My adapted model (see Figure 2) not only includes broken lines to indicate this mutual influence but also places region in the macrosystem as a defining context.

Figure 2: Regional Ecological Model



The broken lines around the regional boundary show how other contexts, including global and technological influences, infiltrate systems levels and affect people residing in a defined geographical space (in this case, a defined region). These boundaries function like permeable membranes. The differences between the adapted model and Bronfenbrenner's original model may initially appear subtle, but the findings of this research indicate that the influence of region is important to an understanding of ecological contexts. This adjusted model also includes the clinician in the clients' microsystem. During the therapeutic interaction, the clinician enters the clients' immediate system interacts with the clients' ecological contexts. This assertion is based on ecological theory's basic concepts and assumptions.

The following is a short review of the systems Bronfenbrenner conceived in his original model. I will note adaptations I have made to the model in an effort to identify region as an ecological context for identity development.

Microsystem. The *microsystem*, the first and most immediate level, includes the individual's immediate systems and settings -- such as the family, classroom, church, work, or neighborhood. These systems directly influence the individual's choices and identity development (Bronfenbrenner, 1986; White et al., 2002). Within these intimate places, people develop moral values and struggle to find the love, acceptance, and structure human beings need. Each person interprets the interactions that occur on this level differently, depending on his/her personality traits, personal goals, cultural values, and other factors in this system. Nevertheless, those individuals who share experiences on this level influence each other and share meanings that become part of who they are. For example, a family may have a history of substance abuse and share this problem through their collective family narrative – the story of who they are as a family (Freedman & Combs, 1996). Or school community members may suffer in result of the death of a teacher or student, affecting all of the people who have had a relationship with that person or who identify with that institution or community.

The concept of *interconnectedness* from family systems theory describes how the microsystem works as a cohesive whole to generate unified meanings and interact with the other systems (White et al., 2002). Interconnectedness describes each member's influence on and connection to the system (White et al.); applying this concept helps theorists and researchers view the way families act as a unified whole

while interacting with other systems within the microsystem. Okun (1996) regarding family systems theory's relationship to ecological systems theory, noted,

Family systems theories have taught me to appreciate the importance of organizational structures and interactional patterns. I have learned to nest these models within the following larger ecological framework: (1) psychosociobehavioral consideration of the individual with the contexts of family of origin and current family systems, (2) consideration of families within larger sociocultural, political, and economic contexts, and (3) consideration of (1) and (2) as shaping and being shaped by gender, ethnicity, class, sexual orientation, and race. I try to differentiate among individual, group, and universal issues in order to have a better understanding of each client. (p.17)

Okun articulates the link between the family and other systems, thus reinforcing the assumption that systems do not exist in isolation.

Mesosystem. According to Bronfenbrenner (1986), systems interact continually. He called the connection between two or more systems the *mesosystem*. Microsystems, such as families, are inevitably influenced by the other systems. Knowing this allows practitioners to expand their view of ecological factors influencing families. It would be simple to apply a systemic lens exclusively to the family's patterns and behaviors. However, by ignoring what informs some of these behaviors, such as church, parents' work, children's school, or even intergenerational influences, the therapist may miss important pieces of the puzzle. By considering community-level connections, one can see how families differ in their processes by geographic area or even by neighborhood.

Exosystem. The next ecological layer of influence in Bronfenbrenner's model is the *exosystem*. Exosystems do not contain or affect the individual directly; however, these systems do shape the individual's experience. This level may include social, professional, or community systems directly related to another person in the individual's microsystem (Bronfenbrenner, 1986). In therapy, knowing how these exosystems make an impact on the individual or family's functioning would be beneficial. The fact that exosystemic levels vary per the individual's context lays the foundation for acknowledging those types of systems geographically. For example, changes in a workplace, such as a layoff, will inevitably become part of the collective experience in an area, not only for those employed by the manufacturer. Local business owners may be one group affected by layoffs through decreased earnings, thus lowering the quality of life for many residents in the region.

Macrosystem. The *macrosystem* encompasses the remainder of the contextual systems. The cultural values, political philosophies, economic patterns, and social conditions influencing all of the other systems reside in this layer. As shown on my adjusted ecological model (see Figure 2), region is one of the determinate factors in the macrosystem. For the purpose of this research, participants were asked to identify how region interacts with and/or determines the attitudes and ideologies represented in this layer and influences the other systems.

Chronosystem. The final component of the model Bronfenbrenner (1986) conceptualized was the *chronosystem*. This temporal element was included to account for transitions over the life course, but it also includes historical and generational experiences (Bronfenbrenner, 1986). The time element in this system is significant to

this research because many people struggle to break problematic patterns that are embedded in intergenerational maladaptions to life changes or life-changing interactions with larger systems, such as the community. Furthermore, many communities transfer and may even amplify regional characteristics and cultural “memories” across generations (Sugar, 2002). The chronosystem is not represented as a layer in my diagram or in Bronfenbrenner’s original model due to its linear nature.

Applying Ecological Theory

A basic tenet of ecological theory highlights community and regional proximal interactions. White and Klein (2002) note, “Human interactions are spatially organized. Populations of humans organize their interactions within their environments” (p. 208). People are connected by their shared physical environments, and in fact, organize these environments so that individuals will interact and make meaning of that communal space, which is a related ecological assumption.

Marriage and family therapists have acknowledged the ecological perspective in theory and practice. The early theorists and practitioners working from an ecosystemic approach provide diverse views of the family within larger systems (Seaburn, Landau-Stanton, & Horwitz, 1995). They used Bronfenbrenner’s ecological model as a way to understand and structure family interventions for problems that occur as a result of the clients’ interaction with others in their social context (Robbins et al., 2003). For example, a family may resist seeking help with a child’s behavioral problems at school for fear of alerting an overly aggressive social services system to their dysfunction. This reticence may originate from stories they have heard from other family members and neighbors or from families who have drawn attention to their child’s behavior and were consequently

investigated themselves for child neglect and poor parenting. In addition, the family could be reacting to a shared belief in the community that parents should not be involved in their child's discipline at school because the school is the ultimate authority. In the ecosystemic model of therapy, the therapist can work with the family and the system to negotiate a safe forum for getting help, but the origin of the family's behaviors and beliefs may never be revealed and addressed. This example shows how ecosystemic interventions may require inclusion of and reports from other members and entities in the clients' context. This type of case management intervention has traditionally been more focused on the community involvement in the problem and less on the way in which the ecology influences the meanings and interactions shared by the members of the family.

Because there are no current theories or models that focus on the shared meaning constructed by individuals and families within a region, I used ecological theory as a framework for conceptualizing the pluralistic distinctions shared by members of a defined area. The systems surrounding the individual and the family may or may not be included in interventions. A family's problems are not necessarily related to their distinct regional characteristics. That is, applying the ecological framework "is not purely for causal relationships between factors but for how those factors are systematically organized to facilitate particular behavior patterns" (Coleman & Wampold, 2003). Furthermore, ecosystemic approaches could counter the desired goals of culturally-competent therapy. Due to the focus on differences, the practitioner may potentially pathologize cultural distinctions as he or she conceptualizes the origin of the presenting problems. The value of understanding and anticipating cultural difference in cultural

competency hinges on the practitioner's ability to distinguish between what constitutes a problem and what is a functional cultural behavior or belief.

Bronfenbrenner's description of contextual interactions provides a sound foundation for exploring both individual and collective regional identity. Ecological theory offers a way to

examine how factors such as race, or gender, which may have vastly different meanings within each ecological level as well as within various cultures (i.e., within various ecologies), can serve to organize an individual's sense of self. This perspective is not possible when one is attempting to examine how factors such as race and gender cause an individual's sense of self as a member of a group. (Coleman, Norton, Miranda, & McCubbin, 2003, p.40)

Social Constructionism

Social constructionism may be integrated with ecological theory to describe the relationship between individual and community identity development. Social constructionism's concepts and assumptions can be used to describe the processes by which the individual members of systems interact to construct meaning and social realities. Understanding these shared, or co-constructed meanings in addition to those constructed meanings that are dissonant among members "opens the door for cultural bridges of connectedness between family and therapist" (Falicov, 1995, p. 380). Social realities are constructed at each level of the ecological model (Freedman et al., 1996) through daily interactions and across generations. Beliefs, values, behaviors, roles, and customs – those constructs by which members of a society understand their world – are just a few of these social realities. Therapists and others working with families from

cultures different from their own may use a social constructionist perspective for navigating “the realities [they] inhabit” (Freedman et al., 1996, p. 20).

In other words, social constructionism offers a way to understand the challenges and strengths both clients and therapists experience, with the caveat that reality will always reside within the interaction between the client and therapist (McNamee & Gergen, 1992). This theory is important when working with people whose worldview and realities are different from the therapist’s – beliefs, behaviors, language, and values that may appear dysfunctional or strange to the therapist may in fact be a legitimate part of the clients’ socially-constructed reality. Marsella and Yamada (2000) point out,

Knowledge in psychiatry and in the social sciences is culturally relative, and as such, it is ethnocentric and biased. What passes for truth is, in fact, a function of who holds the power. Those who are in power...have the ‘privilege’ of determining what is acceptable. (p. 7)

Ideally, instead of pathologizing or judging, the therapist would ask clients to attempt to articulate their reality by talking about how their behavior fits within their family and cultural contexts. In this process of understanding meaning, therapists who do not focus on cause, the past, or contextual issues may need to adjust their model to gain more information regarding client behavior, and consider their own cultural backgrounds as possible bias (Hardy et al., 1995).

Clinical Cultural Competency

Cultural competencies transcend theoretical musing when they are operationalized and therapists are asked to adjust their current models to accommodate clients from diverse cultures. Hansen and Falicov (1983) note that “cultural lenses are constructs

that serve to organize complex realities” (p.xiii). Cultural competency standards and theoretical perspectives further define the way therapists apply those lenses in their practice. For the following discussion, the term “culture” will continue to include region because the skills and competencies required for culturally-competent therapy are applicable to treating all culturally-distinct groups. Although there are many published recommendations for culturally competent therapy, there is little research examining how (or whether) family therapists actually address cultural/regional factors in practice; this research is intended to fill this gap in the MFT literature.

Cultural Competency Domains

The three basic cultural competency domains identified (Arrendondo, Toporek, Brown, Jones, Locke, Sanchez, & Stadler, 1996; Sue, Arredondo, & McDavis, 1992) and endorsed by the APA (2003) include attitude, knowledge, and skills. As cultural competencies are beginning to emerge and converge within the human services, health, and mental health fields, several key factors appear across disciplines. Each discipline institutes cultural competency standards according to their clients’ needs and the mode of service delivery; therefore, there are varying degrees of social action and services offered by the practitioner (McGoldrick et al., 1999; Robbins et al., 2003; Okun, 1996). Marriage and family therapy has not adopted a definitive set of cultural competence standards, yet most of the MFT literature and research on the subject recognize the following:

- Cultural self-awareness (Hardy et al., 1995; Sue, 2006; Sue et al., 1992), which includes an inventory of one’s own cultural identity, background, and heritage.

- Cultural sensitivity, which requires the therapist to respond to the client with “delicacy and respectfulness” (Hardy et al., 1995, p.227), and which requires that therapists be aware of their power and biases in order to accept their clients.
- An appreciation for shared human factors (McGoldrick, Giordano, & Pearce, 1996), by acknowledging what is similar as well as being aware of what is different.
- An attempt to learn about and accept others’ experience (Hardy et al., 1995; Sue et al., 1992)
- Knowledge of common beliefs, practices, and values held by a specific group (McGoldrick et al., 1996).

Since this research focuses on practitioners who work with families, I have selected and expanded these specific topics in the following subsections.

Cultural self-awareness. Chi-Ying Chung and Bemak (2002) warn, “One major problem in working across cultures is the tendency for counselors to impose their cultural values on clients, which may occur in a conscious or unconscious level” (p.159). This imposition can be transmitted through both verbal and non-verbal communication between the family and the therapist. Culturally-sensitive therapists are aware of gestures and other types of body language because nonverbal can transmit covert messages of power (Atkinson and Hackett, 1998). Such therapists also constantly deconstruct their own cultural identity in order to avoid imposing their own values and beliefs onto their clients. Practicing culturally-competent therapy “has also been defined, not in terms of what we know about others, but by what we know and keep trying to know about ourselves” (Lee and Everett, 2004).

Looking deeply into one's own cultural identity, including the morals, values, and beliefs built into it, helps therapists perceive their social impact on their clients and the therapeutic process (Sue et al., 1992). Therapists who incorporate culturally sensitive perspectives in their treatment recognize their own biases and tendencies to stereotype, judge, or pathologize (Sue et al., 1992).

Cultural sensitivity. Hardy et al. (1995) make the distinction between awareness (cognition) and sensitivity (affect). For some therapists, moving beyond awareness to achieve genuine cultural sensitivity requires that they adjust interventions and techniques. Therefore, it is not uncommon for therapists to adapt models and the techniques they use when responding to clients of a differing culture (Moorhouse, 2000). Validation of clients' unique experiences and circumstances is a key to empathic, culturally-sensitive therapy (Okun, 1996). This sometimes means helping clients become aware of their reaction to and interaction with the dominant forces in the society and culture they are a part of and helping them become aware of how that ecology frames their lives (Okun, 1996).

Being culturally sensitive requires that the therapist recognize how culture often influences family structures, roles, and rules. According to Grushue, Greenan, and Brazaitis (2005), in order to adjust to culturally-influenced family structures, the therapist may consider:

- With whom to speak initially if there is an overt hierarchy;
- how to address family processes without provoking resistance or confrontation (the inquiry could be construed as threatening and therefore defensible);

- the major communication patterns and rules governing the family's interactions and behaviors;
- how to adjust to the family's view of the authority and function of the therapist as influenced by the family's culturally constructed experiences or expectations; and/or
- what strengths, including commonalities, the therapist and the clients recognize when building the therapeutic relationship.

Even though sensitivity requires that therapists not impose their cultural values on their clients, therapists have to be aware of and address unethical and illegal cultural practices, such as child abuse and domestic violence. Therapists should address issues involving power and abuse that they are trained to recognize and report (McGoldrick and Giordano, 1996; Negy, 2000).

Learning about the clients' experience. Culturally-competent therapists attempt to understand their clients' experiences, focusing on the clients' strengths and coping strategies (Hansen et al., 1983; Sue et al., 1992) but without sacrificing ethical and/or legal responsibilities and standards. Falicov (2003) notes how integrating a "not-knowing" stance with some general knowledge of the specific culture "allows for more complexity and effectiveness" (p. 51). This approach encourages clients to articulate and explore their cultural experience and helps the therapist avoid stereotyping or making assumptions about a member of a cultural group. From a postmodern perspective, therapists and clients alike come to therapy with values by which they compare others to themselves, which Freedman et al. (1996) refer to as "typification" (p.24). Although this type of comparison is unavoidable, it is a process culturally-

competent practitioners attempt to address as part of their self-awareness (Falicov, 1995).

Learning about clients' experiences and cultures requires the therapist to use an ecological lens to understand the culture's influence and how the individual makes sense and use of it. As Coleman et al. (2003) explain, "The ecological perspective assumes that a person's behavior is organized within and by his or her context...that core human processes involving issues related to such factors as affect, cognitive development, or perceptions are shared by people across contexts" (p.234). This aspect of competency happens within the therapeutic relationship and requires that the therapist acknowledge his or her own cultural identity in the process; there is an interplay of self-awareness and awareness of other's experience. Awareness is more complete if the therapist and the client recognize that cultural experiences can occur on a micro/individual level or on a larger level that affects the entire community.

While learning about clients' experiences, therapists need to consider how those experiences are unique to the way the family has accepted or rejected aspects of their culture (Freedman et al., 1996). Clients from rural areas are especially vulnerable to stereotyping due to some of the common characteristics rural people share in relation to geographic isolation, economic, and political factors (Bagarozzi, 1982; Blakeney, 2006). However, not all rural areas, especially in Appalachia, share the same ecological infrastructures, geographical boundary systems, and environmental limitations (Fisher, Church, Daughtery, Judkins, & Scott, 2006). Distinct regional characteristics define groups within Appalachia, characteristics therapists can acknowledge and use in

culturally competent practice. This observation is salient to this study because the participants practice and live in a small rural area in Appalachia.

Cultural competence has come under fire (Patterson, 2004) because one may argue that if therapists have to explore each person's experience, then they can never be fully competent – they will always “not know” or fully understand another person's cultural perspective (Dean, 2001). Yet, it is this “not knowing” stance that offers the client the chance to reveal, explore, and unpack his or her cultural beliefs. Otherwise, the therapist would assume that the clients' experiences are the same as other people who belong to the same distinct cultural group and fail to learn fully about them in relation to their context. Another argument is that all therapy requires cultural competence, regardless of apparent differences or similarities between client and therapist. This perspective reflects an expanded definition of and focus on culture in the therapeutic relationship (Patterson, 2004). However, Ridley and Kliener (2003) argue that cultural competence is different from general therapeutic competence because working with people from distinctly different cultures requires increased knowledge and skills, adapting therapeutic models, and re-conceptualizing therapeutic goals and change.

Cultural knowledge. Prior knowledge or additional knowledge of a culture requires that therapists gain information outside of the therapeutic relationship. Seeking knowledge about the culture from the community is valuable in understanding the context and mores generally shared by the group (Piercy et al., 1982). In addition, through this knowledge, therapists are able to understand their clients' cultural contexts and to anticipate the strength of the ecology in which the family resides. Understanding

the systemic pulls and reactions asserted by the clients' ecological context helps the clinician work with families to devise solutions that are helpful but which allow them to live within the boundaries of their greater systems. Change is often restricted by the cultural context (Ariel, 1999). For regionally-distinct clients who may not be outwardly different ethnically or racially, practitioners may fail to apply their cultural sensitivity or self-awareness. Thus, it is important for therapists to regard all types of cultural contexts as valid identity constructs worth exploring.

Awareness of difference can be helpful, but using that knowledge to make assumptions about clients' experiences may prevent or impede effective treatment (Dean, 2001). Furthermore, the normative values and behaviors ascribed to specific groups in the cultural competency literature have the potential to perpetuate stereotypes (McGoldrick et al., 1996). Practitioners must be careful to use these cultural descriptions as mere points of reference. For example, a therapist who is not tuned into clients' distinct forms of communication may miss some of the more subtle ways in which they present their difficulties and feelings (Comas-Diaz, 2006). Regarding the risk of stereotyping, Bronfenbrenner and Crouter (1983) observe that "[n]o explicit consideration is given ... to intervening structures or processes through which the environment might affect the course of development. One looks only at the social address" (pp. 361–362). Yet, classifying, or psychological essentialism, is an ordinary human process that is not understood fully and has far-reaching social implications (Prentice et al., 2007).

Corey (2004) finds it important for therapists to recognize within-group difference and warns counselors against "cultural encapsulation," noting that "culture-specific

knowledge about a client's background should not lead counselors to stereotype him or her" (p. 19). Over-generalizing and stereotyping are liabilities of identifying commonalities in culture. Nevertheless, if regionally-based differences are included as a cultural context in competency training, practitioners' awareness of how these shared experiences and histories influence the family system may add another layer of understanding. Acknowledging one's own socially-constructed biases will also further the practitioner's ability to provide more culturally-sensitive, client-centered care (Like, Steiner, & Rubel, 1996; Sue, 2006). Constantine and Sue (2005) believe that "[a]n appreciation of how cultural identities interface, in addition to recognition of within group differences along varied dimensions of identity...may lead to richer understandings of individuals' experiences..." (p.7).

CHAPTER II: LITERATURE REVIEW

Region as a cultural context for identity and family functioning is not widely addressed in the current body of marriage and family therapy literature. Therefore, the following review of literature relevant to this research primarily originates from mental and public health, sociology, Appalachian and rural studies, human development, and psychology research. Literature related to regional context and clinical application provides a foundation for developing a theory from the data collected in this study.

Region as Cultural Context

Typically, when theorists and activists address multicultural and cross-cultural context in their work, they are referring to race/ethnicity, gender, or sexual orientation. Mental health researchers who investigate regional contexts explore the diverse needs and cultural traits for differing racial, gender, and age groups. In doing so, they develop specialized treatment applications. For example, studies of African Americans are typically conducted in the rural South (Porter, Ganong, & Armer, 2000). The greatest body of regionally-based research involves rural women and older adults because of their traditionally vulnerable status and the lack of health services for women and the elderly in remote regions. Although these populations have been shown to have a greater occurrence of mental illness, depressive symptoms, and stress-related diseases (Boyd, 1995; Chalifoux, 2001; Lyon & Parker, 2003; Miller, 2002), studies have not focused on regionally-constructed identities and how cultural context influences health or systemic issues such as family and interpersonal relationships. In addition, researchers have not examined the experiences of practitioners who serve these

regional groups, especially how they view their clients and how their own identities influence service delivery.

In the family studies field, a growing number of theorists explore the way families are influenced and are influenced by the communities in which they live. According to Mancini, Bowen, and Martin (2005), families are “surrounded by [community contextual] forces...that influence both their everyday life experiences and their individual and collective life trajectories” (p. 570). Concepts emerging from community context research, such as community capacity and social capital can reveal how family systems cope and thrive in their ecological contexts. Coping strategies are key considerations when looking at culturally-distinct behaviors and adaptive functioning because they typically emerge from cultural contexts and beliefs (Coleman, 1995).

Results from community context research not only reveal community strengths but also point to centralized deficits. For example, regions where residents are not able to contribute to the economy have lower social capital (less community investment in citizen well-being) and struggle to provide services and care for the entire community (Cuoto, 1994). This dynamic occurs often in many rural Appalachian communities (Blakeney, 2006).

In addition to influencing well-being, social systems can shape collective experience and may define a community's boundaries. For example, a community may be socially distinct based on the quality of education, the commitment of its local government to economic growth, the level and availability of health services, or the integrity of the justice system (Bradshaw, 1988; Mancini et al., 2005). Within this contextual framework, the ecological systems work together to create the shared goals,

values, and energy that initiate growth and influence quality of life. Place also shapes interpersonal experiences, such as “regional orientations to time” or preferred degrees of space and boundaries in relationships (Brueunlin et al., 1992, p. 226). Contextual factors, such as an aggressive social services system, may interrupt poor parenting or violent relational behaviors that may otherwise go unchecked in a more unregulated system. Similarly, patterns of intimacy, sexuality, and gender identity are connected to cultural contexts that shift across time within a region (Emilio & Freedman, 1997).

Cultural Competency

Identified Cultural Competencies in the Mental Health Fields

In the majority of the cultural competence and cross-cultural counseling literature and theories, competence is measured by learning more about the common characteristics ethnic, racial, and sexual groups share. For example, many texts address cultural differences within African American, Asian, Native American, and other specified groups. This practice of generalizing group characteristics is meant to increase the practitioner’s knowledge of commonly shared cultural distinctions (McGoldrick et al., 1996). While having foreknowledge provides a point of reference (Sue, 2006), there are many variations within groups as between groups classified as cultures (Lee et al., 2004).

Psychology’s leaders have not had an easy journey toward making cultural issues part of the core competencies; the Multicultural Competencies (MCCs) are recognized and applied in the psychological community but are at the center of controversy (Patterson, 2004). Currently, several versions of the MCCs exist, many of which inform research and practice across the behavioral health fields (Stanhope,

Solomon, Pernell-Arnold, Sands, & Bourjolly, 2005). The MFT field has been relatively slow to identify a standardized set of competencies (Miller, 2005) and has not endorsed a definitive set of cultural competencies (Inman et al., 2004). Furthermore, it lags behind the other behavioral health fields in measuring and operationalizing culturally competency, which is a prevailing facet of best practice. The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) (2002) requires integration of diversity issues into training, however.

In 2004 the American Association for Marriage and Family Therapists (AAMFT) released the Core Competencies (CCs), which defined the standards for training, practice, research for marriage and family therapists. The six Core Values from the Institute of Medicine (e.g. safe, person-centered, efficient, effective, timely, and equitable) were used as the foundation for this list of proficiencies (Core Competencies, 2004). The AAMFT Core Competences include six primary domains:

- 1) Admission to Treatment,
- 2) Clinical Assessment and Diagnosis,
- 3) Treatment Planning and Case Management,
- 4) Therapeutic Interventions,
- 5) Legal Issues, Ethics, and Standards, and
- 6) Research and Program Evaluation.

and five subdomains:

- 1) Conceptual Skills,
- 2) Perceptual Skills,
- 3) Executive Skills,

- 4) Evaluative Skills, and
- 5) Professional Skills.

After several iterations, 128 core competencies were identified by the MFT Core Competency Taskforce (Northey, 2005). Cultural and contextual factors are listed as considerations in three of the six main domains. Yet, specific skills related to cultural competency were not described in the document.

Region in Cultural Competencies

Client-centered, culturally-sensitive perspectives have emerged from growing awareness and criticism. Lago and Smith (2003) reflect on a source of these evolving perspectives: “Counseling and psychotherapy have often been criticized for focusing on the psychology of the individual and on the internal life of the client while ignoring the impact on the social, economic and cultural environment in which people live” (p. 1). While most cultural competency training offers information regarding common group characteristics, these programs often fail to raise practitioners’ awareness of their cross-cultural experiences and the impact of their own cultural identity (Hardy et al., 1995; Sue, 2006). The inclusion of all types and origins of cultural identity is therefore critical in raising practitioners’ awareness of self and others (Hardy et al., 1995).

Even though articles and books regarding multiculturalism and cultural sensitivity in therapy list region as a relevant cultural factor, regional culture is almost never pursued in research or theorizing. Max Sugar (2002), a psychiatrist who became interested in the differences in the rates in pathologies according to geographical region, wrote one of the only books I found on correlation between behavior and region. In his work *Regional Identity and Behavior*, Sugar divides the United States into the four

earliest British North American colonies and tracks the historical evolution of identity and behavior components. His work follows an ecological framework, yet he does not focus on more granular distinctions such as counties or specific communities. In addition, he looks mainly at the individual and less at the family. Like others in cross-cultural literature, he identifies common features among the specific regions.

Throughout the remainder of the literature where region is addressed, the authors tend to describe common population characteristics without exploring the clinical processes and perspectives of practitioners who work with these populations. The training manual, *Addressing Cultural Complexities in Practice: A Framework for Clinicians and Counselors* (Hays, 2001), includes rural region in a list of possible class factors, but the majority of the cultural discussion is devoted to ethnic/racial concerns. McGoldrick et al., (1999) incorporate class and status in their call for “students to use a very widely angled [sic] sociocultural lens that places families in cultural, class, and gender contexts of the communities and society in which they live” (p. 191). Applying this more ecological perspective could expand the definition of cultural diversity and challenge currently accepted criteria for clinical competence. However, the authors do not explore regional culture directly in this article. Houser, Ham, and Wilczenski’s (2006) work *Culturally Relevant Ethical Decision-making* is one of the only sources to date that incorporates geographic region as a component of their contextual model for culturally-competent counseling. In the hermeneutic ethical decision-making model presented in the book, the authors identify specific regional issues for each cultural group discussed. In this work, region is defined in broad, general terms, such as urban and rural and large geographic quadrants (Northern and Southern United States).

Cultural Competency Research

There is a substantial body of research literature addressing cultural competency in psychology, social work, and community and educational counseling. The majority of this research literature concerns the development and testing measures of cultural competence, training practices, and clinical practices from both clinicians' and clients' perspectives. In addition to the findings from this multidisciplinary research, my study is informed by findings from rural mental health research.

Researchers and practitioners in a variety of human services fields have established the rationale and support for the American Psychological Association's (2003) *Guidelines for Multicultural Education and Training, Research, and Practice for Psychologists* and similar lists of knowledge and skill sets produced by the American Counseling Association in 1995 and the American Mental Health Counselors Association in 2000 (Goh, 2005). In addition, a group of cultural counseling scholars and practitioners (Arredondo et al., 1996) established a set of standards called the Multicultural Counseling Competencies (MCCs) for the Association for Multicultural Counseling and Development. The MCCs were initially a source of controversy due to the lack of empirical research behind their development (Patterson, 2004). Consequently, the MCCs have been heavily researched and validated across disciplines and are currently used as standards in training, practice, and research (Arredondo et al., 1996).

In addition to the MCC standards, research has produced a variety of cultural competency measures. Few incorporate self-awareness as a reliable subscale, however (Stanhope et al., 2005). Therefore, measures have to be adjusted and

reevaluated for validity and reliability if the researcher adds that construct as a subscale or variable (Sansone, Morf, & Panter, 2004).

Since 1988, the Commission of Accreditation for Marriage and Family Therapy Education (COAMFTE) has endorsed the need to train marriage and family therapists to provide culturally-competent therapy. The field of Marriage and Family Therapy has not adopted the MCCs or other standardized sets of cultural competencies; however, MFT training programs are increasingly recognizing the importance of multicultural competence (Constantine, Juby, & Liang, 2001). Many MFT programs incorporate the three areas of competence – attitudes/beliefs (awareness), knowledge, and skills (Arredondo et al., 1996; Sue et al., 1992) – which have been espoused by other counseling fields (Goh, 2005). As a field, MFT has increased its attention to diversity and the needs of culturally-distinct clients (Hardy et al., 1998; McGoldrick et al., 1999), but MFTs are lagging behind the other fields in regard to operationalizing their cultural competence experiences and developing empirically-based best practices (Constantine et al., 2001). As mentioned earlier, the MFT Core Competencies (2004) prescribe training, practice, and research proficiencies in general but do not address culture competencies specifically.

A review of the psychotherapy research on cultural competencies reveals disparate approaches and inconsistent findings. For example, Nelson, Brendel, Mize, Lad, Hancock, and Pinjala (2001) used qualitative methods to study ethnicity issues that guide MFTs in their training and service delivery. The results reflect a lack of consistent perspectives among therapists on providing culturally-sensitive family therapy. In another study of MFT practices, Constantine et al., (2001) measured multicultural

counseling competence of white MFT therapists and found that racism and racial identity were salient predictors of self-perceived cultural competence after controlling for social desirability and number of diversity courses taken.

Similar to Constantine et al.'s findings, in a quantitative study conducted by Teasely (2006) also revealed that the number of diversity training workshops, accounted for the majority of the variance in social workers' self-perceived cultural competence. Yet cultural beliefs emerged as the best predictor of cultural competence in Glockshuber's (2005) mixed methods study of practitioners' self-perceived competencies. From the inconsistencies in the cultural competency literature in general, it is clear that further research is required and better measures and designs are needed (Stanhope et al., 2005).

From the clients' perspective. The majority of studies regarding multicultural counseling competency reports the therapists' perspective and experience. I found one relevant exception: Pope-Davis, Toporek, Ortega-Villalobos, Ligiero, Brittan-Powell, Liu, Bashshur, Codrington, and Lang (2002) conducted a grounded theory study focusing on the clients' view of their multicultural counseling experiences. This team of researchers revealed that the quality of the clients' experience depended on their therapist's ability to meet their self-identified needs. Of the factors identified, the clients' interpretation of the therapists' cultural identity was important, especially if the client felt a gap in their connection due to cultural differences. The study's findings also revealed the importance of the clients' perception of the therapists' biases and awareness. This study did not identify region as a cultural factor in either the client or the therapist.

Cultural Competency Training

Several models of cultural competency training for both students and supervisors exist. McGoldrick et al. (1999) explore the viability and need for including social justice into MFT training programs. The authors recognize the dominant cultural themes and practices in many training programs and provide some strategies, such as modifying teaching, supervision, and assignments and readings, to create a more culturally-sensitive training perspective. Awareness of power and privilege are key issues in the adjustments required for this type of learning experience.

In a reaction to the needs of increasingly diverse student trainees and supervisors, both in the therapeutic and supervisory relationships, Divac and Heaphy (2005) developed the all-inclusive “Space for GRRACCES” (an acronym for gender, race, religion, age, abilities, culture, class, ethnicity, and sexual orientation) program. This experiential approach focuses on the relationship processes and experiences that facilitate greater knowledge and awareness of power in contextual and relational positions. Nevertheless, the authors do not explore or mention region in this article, as is the case with much of the MFT literature.

Cultural competency in rural areas is critical, yet there are few programs that specifically train rural mental health providers (New Freedom Commission, 2004). For practitioners in general, Ridley et al. (1994) offer two options for developing multicultural training programs: one that relies on the prevailing factors found in current research, and one that requires field-specific educators to collaborate in order to develop training that relates directly to the professionals and the uniqueness of their service and clients. Blakeney (2006) also offers suggestions for training practitioners in rural areas of

Appalachia; her proposed program combines emersion experiences as well as experiential exercises involving fiction and creative non-fiction written by local writers. In Blakeney's program, students are asked to compare the families in works of fiction to their previously held conceptions.

Regional Identity

A vast constellation of cultural factors shape people's behavior and relationships. Regional identities are distinguishable by shared histories, ethnic and racial heritages, economics, idioms and vernaculars, and perspectives on government. Rural regional identities in particular can be distinguished partly as a result of isolation and homogeneous, shared experiences (Bagarozzi, 1982). From an ecological theory perspective, the social and political infrastructures combine with geographical resources and challenges to influence directly the identity of regional culture. As this study concerns a predominantly rural region of Southwest Virginia, additional discussion of region will be particular to rural characteristics.

People in all helping professions find a variety of unique challenges to service delivery in rural areas (Weigel & Baker, 2002). The greatest body of rural mental health literature and research is concerned with the barriers to service and clients' attitudes toward mental health intervention. Nevertheless, how rural cultural values, morals, and beliefs influence family interactions and social dynamics is relatively underrepresented in the literature.

Scholars and researchers outside the U. S. have explored regional proximity, what many call "place," as a factor in public health for over two decades. Theories regarding social and place identity and sense of place have been developed in an

endeavor to understand human behavior and well-being in proximity to others. In a study conducted in England, researchers found that place identity explains the collective, discursive process by which people view social disparities between themselves and people from other regions (Bolam, Murphy, & Gleeson, 2006). Results of this study showed that the overall well-being and health of a community is affected by the collective, socially-constructed experience, and is tied directly to the physical place in which the participants live. Conversely, in quantitative study conducted in the United Kingdom (Weich, Holt, Twigg, Jones, & Lewis, 2003) found that neither the locale nor the collective experience of the residents correlated with the prevalence of common mental disorders. The researchers in this study recommend that households and individuals be targeted for public health reform instead of communities.

Schachter (2004) reviews the debate regarding the modern versus postmodern views of identity construction presented by Erikson's theory of identity formation. Through his qualitative study in Israel, he found that there are multiple ways in which individuals actively construct their identities in response to personal objectives and cultural contexts. These configurations are not static; therefore, this theory allows for changes that occur as a result of accumulated, transitory experiences. These findings are significant for this research because the characteristics, beliefs, and other elements of culture acquired from one's environment may change when the individual moves to another environment. According to Schachter, the individual may decide to retain or discard parts of his or her identity through time and context.

Even though the majority of studies regarding place and regional identity and mental health originate outside of this country, regional community context is a salient

issue in the U.S. Blakeney (2006) noted that region is salient to service delivery, in light of healthcare disparities caused by uneven federal and state-wide funding and the resulting local fight for funds, services, and rights.

Rural Mental Health

Rural Populations and Experience

Scholars and practitioners from the fields of human development, community health, social work, psychology, and sociology provide valuable vantage points regarding regional mental health issues, particularly in regard to rural populations. The body of literature is broad, yet there are some common issues addressing primarily rural residents' experience and perception of healthcare and mental health intervention. In her review of the rural health literature concerning Appalachia, Blakeney (2006) found that three predominate concerns emerged: "(1) the accessibility of health-care services to all citizens in the region, (2) the education of health professionals, (3) the importance of providing culturally-sensitive health-care services" (p. 101). Her findings are consistent with my review of the rural mental health literature. In addition, it is important for the purpose of this research (therapist recognition and use of regional identity in practice) to review rural demographics, rural residents experience with and perception of mental healthcare, and the obstacles rural therapists and service providers face.

Demographics. A good deal of quantitative, demographic data exists that addresses specific regional factors across the country. Census data show that some factors are more prevalent than others by region, such as obesity, substance abuse, and unemployment, and that regions differ in levels of income and education (U.S. Census Bureau, n.d.). Findings from a study by Huttlinger, Schaller-Ayers, and Lawson

(2004) showed that “there was enough of [sic] dissimilarity [related to culture and attitudes toward health and healthcare] with the population [of Southwest Virginia] to set them apart from other areas in Appalachia” (p. 109). Other sources for regional demographic data include quantitative research findings and government or private healthcare company reports (US Census Bureau, n.d.; Appalachian Regional Commission, n.d.). From these sources, it is obvious that there are regional differences in quality of life and health, both of which influence behavior (Huttlinger et al., 2004).

Rural residents' experience with mental healthcare. Scholars and health professionals observe communal experiences and factors that influence the way people in rural areas perceive mental health intervention, a topic especially relevant to this research. In a qualitative study exploring the relationship between family proximity, social support, and mental health, McCullough (1995) found a strong connection between social support and mental health. Similarly, stigma and distrust resulting from close proximity of the residents and the methods by which information is transmitted within the community (often rumors and storytelling) present challenges that rural therapists must address (Roberts, Battaglia, & Epstein, 1999; Weigel et al., 2002). The therapists' ability to adjust to clients' attitudes and help-seeking behaviors have a direct impact on the therapeutic relationship and the therapists' ability to treat (Hovestadt, Fenell, Canfield, 2002). Many seasoned, successful rural family therapists join quickly and effectively by finding points of entry into the family and community context (Piercy et al., 1982). Such practice recognizes that the behaviors, morals, values, and beliefs that constitute regional culture are embedded in the many layers of collectively-constructed and shared experiences (Bronfenbrenner, 1986; Freedman et al., 1996);

therefore, interventions must extend beyond family to the wider community (Bagarozzi, 1982).

In the community health field, Helton (1995) offers case studies in an effort to encourage practitioners to integrate regional cultural factors into their practices by acknowledging the significance of migration patterns and values influencing their patients' regionally-distinct behaviors and attitudes. Similarly, Meyer, Hamel-Lambert, Tice, Safran, Bolon, and Rose-Grippa (2005) incorporate culture into their training course for mental health professionals practicing in Appalachia. Likewise, Bagarozzi (1982) recommends that practitioners working in rural areas consider the uniqueness of populations, keeping in mind that they "differ according to their socioeconomic status, ethnic composition, racial makeup, geographical location, regional identification, and subculture dynamics" (p. 52). Rural health researchers have found these "subpopulations....distinct yet overlapping within a defined population" (Huttlinger et al., 2004, p.103), thus asserting the need to recognize and study collective experiences and perspectives.

Barriers to services, including transportation, geographic factors, funding, and quality of health care professionals, prevent members of rural populations from attending to both basic health and mental health concerns (Bagarozzi, 1982; Baldwin, 1999a, 1999b; Lyckholm, Hackney, & Smith 2001). Social science studies also show that many people in rural areas rely on some type of public assistance or sliding scale to pay for medical and mental health care because many do not have insurance or sufficient means (Baldwin, 1999a; Banziger & Foos, 1983). Meyers (1999)

acknowledges the lack of “timely mental services” as one of the most specific problems in health care disparity (cited in Baldwin, 1999b, p.2).

Traditional regional practices and the support of close-knit communities have been found to be preferred avenues of treatment in many rural populations. Cavender (2003) asserts that folk medicine and mountain remedies will prevail as the preferred means of treatment, especially when services are not available or culturally incompatible. In addition, McCullough (1995) found a strong correlation between social support and mental health in a qualitative study exploring the relationship between family proximity, social support, and the mental health of older adults.

Rural practitioners' experiences. Factors pertaining to practitioners also affect treatment and service delivery in rural regions. Recruitment and retention of qualified, competent practitioners to work in rural areas is difficult, as is providing adequate training. Researchers have found that these professionals are difficult to recruit and retain due to lower incomes and higher case loads (American Psychological Association Office of Rural Health, 1995; Bergman, 2004; Casto, 2001; Miller, 2002). This research highlights the unique challenges rural mental health care providers face. Baldwin (1999a) addresses the problems originating from the inability to attract mental health and other health care professionals to rural Appalachia. In his review of the current problem, Baldwin explores three state-level programs that have been initiated to address the shortage of qualified healthcare providers: Traveling pediatric diabetes clinics, telemedicine services, and a new medical school dedicated to training rural physicians. The author makes it clear that these efforts are just a start and additional

programs across the country need to be instituted in order to resolve the healthcare disparities.

In addition to these obstacles, provider ethical behaviors and values account for a substantial portion of the populations' negative perspectives toward mental health care. Practicing in rural communities naturally comes with ethical challenges regarding dual relationships and other boundary issues involving cultural mores. Although ethics in rural mental health care is an under-researched topic, scholars and practitioners have tried to identify behaviors and strategies that will maintain professional integrity (Lyckholm et al., 2001; McGann, 2000; Piercy et al., 1982). Piercy et al. review how therapists in a marriage and family training setting learn more about the rural communities they serve, including going to local restaurants and retailers, attending town meetings, and getting involved in civic functions. A deeper understanding of the community's culture helps clinicians meet their clients' needs, which is the cornerstone of ethical practice.

Despite the difficulties, there are benefits to practicing in rural areas. Therapists and counselors may find that the community values their work and the help they give, that the setting offers them more autonomy in their work, and shared experiences foster close relationships with the other professionals in their communities (Bushy & Carty, 1994; Pearson & Sutton, 1999).

Rural Family Therapy

The anecdotal history and the scant literature on rural family therapy may reflect the lack of understanding of and the negative experiences rural people have had with mental health intervention. Given that much of the therapy in rural regions is mandated

by either court or social services, and that trained family therapists in rural areas are scarce, it is no wonder that therapists have found resistance and/or complete rejection from rural inhabitants (APA, 1995; Keefe, 1998). Poverty in itself has been misunderstood, with the rural impoverished often being “politicized” and sometimes “demonized” (Badagliacco, 2005; p. 457). It makes sense, therefore, for healthcare professionals to be trained to recognize the ecological and social effects of poverty on behavior in rural areas in order to deliver better care (Blakeney, 2006).

Although relatively scarce in rural areas, marriage and family therapists, unlike other mental health professionals, “have a significantly greater representation in rural counties than psychiatrists” (Bergman, 2004, p. 32). In fact, according to Randolph and Davis (1996), directors of rural mental health centers find marriage and family therapy skills important for their masters’ level clinicians. This underscores the value of rural clinicians and scholars adopting a more inclusive, contextually-based perspective. Bagarozzi (1982) recognizes the application of general systems theory in effectively treating rural clients. Anderson (1976) specifically suggests a crisis intervention “operational framework” that incorporates adaptive short-term treatment involving families in rural settings. Anderson (1976) makes therapeutic recommendations based on her rural clients’ shared, lived experiences that bring ecological aspects of the community into the therapy room. Therapists using this approach include members from the community and the extended family to provide information about the presenting problem and to help with healing and change. Other models have been created by incorporating multiple contextual factors, including “metaframeworks” by Brueunlin et al.

(1992). Multisystemic Therapy (MST) is also based on ecological principals (Brunk, Henggeler, & Whelan, 1987).

Defining the Region of Study

The New River Valley (NRV) in Southwest Virginia is a locally- and state-recognized region comprised of the independent City of Radford and four counties: Giles, Montgomery, Pulaski, and Floyd (see Figure 3). This rural region is in the northern corner of the Southern Appalachian states, as labeled by The Appalachian Regional Commission (Appalachian Regional Commission, n.d.). The NRV fits the definition of a rural area, which is typically defined by having a population of 50,000 or less (Houser et al., 2006).

Figure 3: The New River Valley



Despite similar geographic characteristics, including mountains, proximity to the New River, farmland, forests, and access to a major highway, the area's population demographics are diverse on the county level. The presence of Virginia Tech, a major research university in Montgomery

County, and Radford University in the City of Radford, account for distinct differences in the level of income and education among residents in the NRV (see Table 1).

Table 1. Selected Demographics for the New River Valley

	Floyd County	Giles County	Montgomery County	Pulaski County	Radford City	State
Population, 2005 estimate	14,649	17,098	84,303	35,081	15,859	7,567,465
Land area, 2000 (square miles)	381	357	388	320		39,594
Persons per square mile, 2000	36.4	47	215.5	109.4		178.8
White persons, percent, 2005 (a)	97.50%	97.90%	89.90%	92.60%	88.20%	73.60%
Black persons, percent, 2005 (a)	1.95	1.50%	4.00%	6.10%	8.10%	19.90%
Persons of Hispanic or Latino origin, percent, 2005 (b)	2.10%	0.80%	1.90%	1.20%	1.20%	6.00%
High school graduates, percent of persons age 25+, 2000	70.10%	75.90%	82.80%	74.20%	83.4	81.50%
Bachelor's degree or higher, pct of persons age 25+, 2000	12.50%	12.40%	35.90%	12.50%	34.10%	29.50%
Persons with a disability, age 5+, 2000	2,869	3,889	11,462	7,564	1,732	1,155,083
Median household income, 2003	\$34,968	\$35,732	\$34,446	\$35,604	\$34,869	\$50,028
Persons below poverty, percent, 2003	11.40%	10.80%	15.10%	13.00%	31.40%	9.90%
Rate of unemployment	3.50%	4.90%	3.10%	4.40%	3.60%	3.50%

Residents are not only identified by their location in the state of Virginia, but they also have an Appalachian regional identity. Appalachia spans thirteen states and is composed of a diverse mix of racial and ethnic cultures (Edwards, Asbury, & Cox, 2006). Media and literature have created stereotypes of Appalachian people that do not represent all residents. These characteristics include “fundamentalism, isolationism, familism, and homogeneity” (Coyne, Demian-Popescu, & Friend, 2006). In reality, there are commonly-shared beliefs in specific parts of the Appalachia, but these pluralistic cultures are as diverse as the geography shared among them (Jackson, 2006). For instance, beliefs, behaviors, and attitudes evolve in part from regional economic experiences. Parts of the NRV touch the coal fields, an industry associated with the stereotypical Appalachian identity (Shannon, 2006), as well as limestone mines, yet there are other parts of the area with rich agricultural, railroad, and industrial histories. This diversity within the same region underscores the need to explore the distinct regional identities and their origins (Sugar, 2002).

Research Questions

From the literature, I have reviewed and through the research methods discussed in Chapter III, I endeavored to answer the following questions through this research project:

- What are the practitioners' recognition and awareness of regional distinctions as a context when working with families in their practice?
- How do practitioners learn about regional identities and form their own view of their clients' ecosystem?
- What are practitioners' clinical processes when working with clients from distinct regional backgrounds?

CHAPTER III: METHODS

This research project explores how practitioners working with families acknowledge, access, and use region as a cultural context in their service delivery, specifically in the New River Valley region of Southwest Virginia. The value of this research lies in its exploration of marriage and family therapists' cross-cultural practices in general, which Constantine et al. (2001) found lacking in MFT literature and research. In addition, formative research of this kind has the potential to improve existing practice (Maxwell, 1998) by expanding competencies through raising awareness of self and client identities (Sue, 2006). This research also expands the definition of culture by adding region as a context influencing identity and behavior. Furthermore, Sells, Smith, & Sprenkle (1995) point out that within marriage and family therapy, studies should produce theoretical concepts directly tied to clinical practice. I believe this study addresses that need.

Participants

Sampling

I have elected to use theoretical sampling because its focus on the interaction between behavior and conditions makes it compatible with emergent and generative data analyses (Sells et al., 1995). Sample size was determined by saturation of themes in the data analysis (Strauss et al., 1998). Saturation is one of the key mechanisms for generating the initial theoretical assumptions. I neared saturation after analyzing the 12th interview, so I conducted two more interviews and no longer found new codes. To confirm the saturation, I interviewed one more participant and confirmed saturation at 15.

Selection process and sample characteristics. I identified participants through the purposeful sampling of mental health clinicians, including family therapists, who hold an LMFT, LPC, LSCW, or who were licensure eligible. The clinicians in the sample work with families as well as individuals and offer services and/or treat clients across the NRV. Participants also reside in the NRV; thus they were able to offer their personal perspectives as residents of the area. One clinician no longer lives in the NRV but lives outside in an adjoining county. Her perspective was valuable due to her ability to compare the NRV with her county of residence. I recruited participants from a variety of service settings, including the local community services board, private practices, a private mental hospital, and the university-based MFT training program. Upon contacting prospective participants face-to-face and via e-mail and telephone, I invited them to participate in the study.

Sample demographics. The sample composition data excludes one person who declined to report age and one person who chose not to complete the demographics form. The sample included four men and 11 women, with an average age of 44, ranging from 27 – 60 years old. Nine participants reside in Montgomery County, 3 in Radford City, and 2 in Pulaski County. The average number of years residing in the NRV was 17.5, ranging from 3 – 37 years.

Table 2 presents the remainder of the basic demographics of the sample. For the purpose of insuring anonymity, this table does not include all of the information participants reported on the demographics form. The region from which this sample comes is small and the services are limited; therefore, the threat of exposing a clinician's identity, especially upon reading the experiences I report in the findings, was

significant. Due to the small number of male participants, I changed the gender of a participant in the findings if that factor identified the participant in his or her current job position. I changed the pseudonyms the participants selected if the name was too close to their real first or last name or revealed gender.

Pseudonym	Licensure	Area of training	Yrs in Practice
Andy	No	MFT	3
C. J.	LPC, LMFT	Counseling, Education, Supervision	28
Jesse	LPC	Counseling	20+
Shaun	None	Social Work	9
Sumner	LPC	Counseling	6
Rae	LPC	Mental Health	22
Sal	No	Forensic Counseling	3
Toni	LMFT	MFT, Supervision	5
Reni	LCSW	Clinical Social Work	10
Chris	LCSW	Clinical Social Work	7
Micky	No	MFT	3
Elle	LPC	MFT, Psychology	6
Dee	LPC	Counseling, Law	25+
Gram	LPC	Family therapy	14
Lou	LCSW	Clinical Social Work	27

Compensation. There were no funding sources for this project; therefore, participants were not compensated for their time. I alerted the participants of this detail during the recruiting process and reinforced it in the informed consent form each person signed prior to data collection.

Procedures

Research Design

Researchers from anthropology, sociology, and human development often use qualitative methods to explore multicultural relationships, interactions, and events

(Choudhuri, 2003). In the same vein, qualitative methods are congruent with my research goals, the subject matter, and my own postmodern philosophy.

The goal of this research was to make greater connections between theory, practice, and research; to provide useful recommendations to clinicians and implications for research; and to further the field of MFT research and practice (Sprenkle & Piercy, 2005). This project incorporates grounded theory methods as a means to plan, collect, analyze, and interpret data. Considering the lack of current theories addressing regional culture in therapy and of research in MFT cultural competencies, I decided to follow a generative qualitative approach.

Qualitative inquiry, in general, is congruent with the ecological and social constructionist theories from which I view regionally-distinct context and regional identity. Most qualitative methods assume that “reality is constructed by individuals interacting with their social worlds. Qualitative researchers are interested in understanding the meaning people have constructed...” (Merriam, 1998, p. 6).

Qualitative research requires some of the same skills previously recommended for culturally-competent therapists, including an awareness of self as well as of the client. In addition, it requires a “tolerance with the messiness and complexity of human variability” (Choudhuri, 2003, p. 271) along with an attention to the contexts within which clients (or research participants) reside. Therefore, qualitative methodology is consistent with my research goals, subject matter, and theories.

Because there are no theories to illuminate the way practitioners experience and use regional culture in their clinical practice, grounded theory as a method allowed me to explore the experiences reflected in the data in order to develop a theoretical

framework (Strauss & Corbin, 1990). It also helped me “discover, expand, revise, and operationalize theoretical relationships” (Sells et al., 1995, p. 203) necessary in the exploration of a phenomenon. Even though the literature and previously-established grand theories (i.e., ecological, social constructionism, and family systems) provide a foundation for the study, there is little known about how or *whether* practitioners consciously acknowledge and address region as a cultural context. Uncertainty and openness to discovery are congruent with the emergent methods and assumptions underlying grounded theory (Strauss et al., 1990). Therefore, this method fit the ambiguity of this research topic.

The ultimate purpose of this research is to broaden the definition and understanding of cultural context in regard to practitioner competence. To this end, MFT practitioners and others working with families may add regional awareness to their practice and training. According to Rafuls et al. (1996), grounded theory is more accessible to clinicians because data are represented in a narrative format. In addition, including practitioners as participants and co-researchers in this inquiry may “bridge their [clinicians] practice with research by enabling them to participate in research that is conducted in groups composed of both clinicians and researchers” (Rafuls et al., p. 79). Therefore, clinicians may be more inclined to use this research in their cultural competency training or in their practice.

Finally, the methods and steps taken in grounded theory mirror some of the same processes family therapists experience in their practice, such as the deductive and inductive processes many therapists undergo when forming hypotheses about their clients' problems (Eschevarria-Doan & Tubbs, 2005). These parallels make this

methodology theoretically compatible with the topic under study.

Data Collection

Data collection and analysis followed a recursive process; therefore, the information I gleaned from the initial data informed the development of my interview protocol and guided my subsequent analysis of the transcripts (Sells et al. 1995; Strauss et al., 1990, 1998). Therefore, I engaged in a recursive process of transcribing and analyzing throughout the data collection process in order to identify theme saturation.

Instrument

I developed the interview questions from the literature in combination with the purpose of the study and existing theories (see Appendix A). My postmodern perspective also guided my development of the inquiry's direction and structure. The initial questions followed a semi-structured protocol and included but were not limited to the following topics:

- 1) Therapists' experiences with regional cultural beliefs, values, and practices that appear to influence clients' behaviors and the therapeutic relationship – examples and common influences.
- 2) Therapists' self-awareness of cultural identity when interacting with culturally-distinct clients – how and when does that work for them? Biases? Past experiences that emerge?
- 3) Ways in which the therapist interacts with the community and other service providers to access information about the communities' cultures – How do they access the knowledge? What types of knowledge do they seek? How do

- they use this knowledge in therapy?
- 4) The skills they use to work with culturally-distinct clients – what do they do differently? How do they adjust? What adjustments do they make for their regionally-distinct clients?

The wording and delivery of these questions followed the participant's cues, both verbal and non-verbal. Such modifications are consistent with published guidelines for qualitative interviewing considering the sensitive subject matter concerning the practitioners' awareness, practices, and personal identity (Patton, 2002). For example, I initially asked participants for their definition of culture and found that the concept was difficult for them to articulate. Several participants provided what they later admitted was a "politically correct" regurgitation from prior diversity training or literature. I deleted the direct question and looked for opportunities throughout the interview to ask about culture when the participant used the word "culture" or made a reference to a component of it.

I also adjusted the questions as the categories emerged to fill gaps in data from the pilot phase of the interviews and throughout my coding processes. For example, as the category "sense of place" started to emerge, I began to ask participants to tell me how they felt when driving through each county or community in the region. Information from this line of inquiry often illuminated the connection participants made to their clients and their own personal experiences in the area, which is discussed further in Chapter IV of this study.

Researcher as Instrument

It is necessary to discuss the evolution of the protocol, considering the fact that I

was an integral part of the data collection instrument. During the initial phases of data collection, the interviews yielded less than I had hoped, and I had difficulty identifying the barriers. After several conversations with other researchers, therapists, and several of the pilot participants, I realized that the clinical work I was doing was impeding my ability to give the participants room to explore the topic. I was working as an emergency services clinician at the time, which meant that I was following a more directive, immediate crisis intervention model with clients. As a result, the interviews paralleled a typical crisis situation; I felt pressed for time, was too focused on what I wanted to know, and was rigid regarding my need to have the questions answered in a consistent order. Consequently, I had to raise my self-awareness or end up with a vacuous data set.

Data Collection Procedures

Upon receipt of IRB approval, I sent informed consent forms (see Appendix B) to participants in advance of their interviews, if possible. As the interviews progressed, I found it more fruitful to bring the form with me so that I could explain the study and the procedures in person. Participants who received the form prior to the interview typically waited to read it at the interview. Several had not printed it, so I presented them with another copy at the beginning of the interview. The form provided a brief overview of the study as well as pertinent ethical information, including an in-depth discussion of their rights (e. g. they have the right to discontinue participation at any time, their identity will be confidential through the use of pseudonyms, and they may revoke permission to use any or part of their information from the findings and any written representation of the study at any time). I included a clause noting the potential effects this type of research may have on the participant (Glaser, 1998). The consent form also included a request to

audiotape the interviews. The interviews were transcribed from these audio tapes. The transcriptionist signed a confidentiality agreement and kept the digital recorders in a locked desk. Once transcribed, I stored the electronic copies of the transcripts on a portable disk that I kept in a locked cabinet with the hard copies, the signed consents, the demographics forms, and my field notebook.

Initially, I also sent a demographic form (see Appendix C) to participants in advance of their interviews but found it to be better to bring the form with me so that I may explain the data fields prior to the interview. I began doing this initially because several of the initial participants did not fully understand some of the questions on the form. Consequently, I changed the wording of these questions. This form included age, gender, race or ethnicity, number of years in practice, number of years in current location, type and level of education, and number and types of diversity training courses taken. Table 2 shows a compilation of the demographics for the sample.

I conducted three pilot interviews – two with MFT practitioners from the community services board where I was previously employed and one with a local, MFT private practitioner. After completing the pilot interviews, I adjusted the initial set of questions to reflect their feedback and finalized the interview protocol (see Appendix A). This process of reassessing the questions from one interview to the next continued throughout the project. I used open-ended questions to explore the various facets of the therapist experience (Patton, 2002). Each pilot interview lasted approximately 30 minutes. As I honed the protocol and the interview process became less rigid, the interviews ranged from approximately 40 minutes to one hour.

I conducted the face-to-face interviews at a time and place convenient to each participant. In addition to recording the interviews on a digital tape recorder, I took field notes to assist in recalling key points and to create memos that I used throughout the sampling and coding process. I asked participants for permission to call them no more than twice or to email them to confirm emerging categories and themes as a way to verify the analysis (Sells, Smith, Coe, Yoshioka, & Robbins, 1994). Follow-up email messages, phone calls, and face-to-face conversations required no more than 20-30 minutes of additional time from selected participants. These contacts typically included clarification of the participant's response, my interpretation of an emerging theme or category, or a request for additional information. For example, several participants later emailed me to say that they found that their awareness of regional identity in their practice had increased after the interview. Consequently, I contacted several other participants to inquire about their post-interview experiences. I also discussed the emergent theory with five participants after data collection and analysis was complete.

Analysis

In accordance with grounded theory methods, I used constant comparative analysis techniques (Strauss et al., 1990, 1998) to analyze the data. These recursive techniques involved continually comparing emerging categories, themes, and codes. The results of this process influenced subsequent data collection concerning participant selection and in my analysis of the interview transcripts. I used this type of theoretical sampling and recursive data analysis throughout the data collection in order to refine and test parts of the emerging theory (Schwandt, 2001) and to establish propositions (Creswell, 2003). In the early stages of this continual analysis, I began to see where

additional information or clarification in the interviewing process could fill gaps and increase understanding. Once new codes failed to emerge, I recognized saturation (Strauss et al., 1998) in my data analysis. I conducted three final interviews to confirm the level of saturation and subsequently discontinued interviewing additional participants.

Memos

In addition to analyzing the transcripts, I recorded analytical memos throughout the data collection and coding processes. Grounded theorists use memos to confirm the hypotheses and propositions that emerge from the connections they make from the categories and themes (Glaser, 1998). I used these memos to confirm my categories, to check my biases, and to guide me from one iteration to the next. Several memos informed the concepts and assumptions I developed as the building blocks of the emergent theory.

Coding

Grounded theorists typically use three types of coding processes to organize the categories and themes that emerge (Strauss et al., 1998). I followed this process, which include:

- Open coding – The process used to identify concepts through analyzing the data. Properties and dimensions of each concept emerge at this stage;
- Axial coding – The stage of analysis in which subcategories are identified and “linked” to specific categories according to their properties and dimensions (p. 123);

- Selective coding – The final process of “refining” and articulating the theory (p.143).

Open coding. The generative coding processes are emergent and typically begin with the researcher “opening up” (Strauss et al., 1998, p. 101) the data through reading the transcripts. As I read the pilot interviews and made adjustments to the interview protocol, I identified preliminary codes and categories. As I conducted the open coding, I wrote memos in my notebook and at the top and bottom of each transcript. The codes and what they meant were placed on the right and left margins of the interviews. In an effort to be concise, I chose to single space the interviews because the space limit forced me to use a minimum number of words to represent each code. I used NVivo software to manage the data and track the initial codes. However, it is important to note that I abandoned this method before I developed the final categories because I felt more comfortable interacting with the data through handling the paper transcripts. I also believed that I would become more familiar with the data and would be able to confirm the emerging categories by having to search the transcripts manually.

As the categories started to surface, I began writing possible themes at the top of note cards, using the words that participants used as often as possible. I wrote codes on the cards as they continued to emerge in those categories. Concepts, which are the building blocks of the theory (Shoemaker et al., 2004) began to appear as categories, and subsequently, relational statements (Strauss et al., 1998) emerged during my interaction with the open and axial codes.

Axial coding. Once new categories ceased to develop, I refined the categories through consistent language used by the participants and from corresponding concepts

from the literature and theoretical frameworks. I subsequently placed the cards in groups of like themes. By this point, the data had reached saturation because I no longer found new codes to place on the cards. By using the cards as a visual representation of the categories, I was able to move the categories around in different groupings as I tested the relationships between them. By following the constant comparative method of data analysis, this process was not linear and the shuffling of these categories and codes was not a linear process. I read through the transcripts each time a new category or relational statement emerged in order to confirm the saliency of the category to the sample and to ground the proposition in the data. In addition, my research questions, the memos I recorded during the interviewing and analysis process, and the literature guided the first set of categories; however, as propositions and relationships between the categories became clearer, I reshuffled the cards, collapsed several of the categories, and filled in levels one and two of the coding matrix (see Appendix D). In addition, I found that incorporating a separate creative process was helpful in seeing the theoretical “story” in another form of concrete representation (Shoemaker et al., 2004). I used poster-size post-it sheets to draw storyboards, diagrams, and maps of the relationships that emerged in the open and axial coding process.

During the final selective coding phase, I was able to develop hypotheses and theoretical propositions (Creswell, 2003) after reiterating the categories and making connections between them. It was at this point that I collapsed one of the research questions into the others (see Chapter IV for further discussion of the questions and findings).

Defining the Theoretical Assertions

As noted above, I used an coding matrix I adapted from Anfara, Brown, and Mangione's (2002) coding map (see Appendix D). I used this matrix to refine the coding scheme and present an organized, visual representation of the emergent themes and theoretical propositions I present in the Findings chapter of this dissertation. This coding matrix illustrates how I condensed codes to more thematic and categorical groupings and documents how I moved from codes to final overriding analytical insights (Anfara et al., 2002). I have chosen to deviate from the standard grounded theory process by using this table because I found this coding map helpful in confirming themes, thus providing an additional mechanism for establishing credibility and trustworthiness.

Trustworthiness

Trustworthiness is the set of criteria by which qualitative research is judged (Lincoln & Guba, 1985; Schwandt, 2001). The criteria include credibility, dependability, transferability, and confirmability (Anfara et al., 2002; Lincoln et al., 1985). Throughout this research, I was diligent in my pursuit of these validating processes to aid in building the theory so that others may use this information to further the field (see Table 3).

Credibility concerns the similarities between the participant's experience and the way the researcher interprets it (Schwandt, 2001). This standard is comparable to internal validity in quantitative research. I achieved credibility through peer debriefing, thick description, confirming my analysis and interpretation with several participants, and through the reiterative coding processes (Anfara et al., 2002). I had many opportunities to debrief with peers and participated in a triangulation process with a colleague from a related field. I also discussed the emerging themes with participants in

order to check my interpretation of the data. I was comfortable with exposing my biases and explaining my thoughts and feelings during the coding phases, and I feel that those I included in that reflective process provided me with valuable, insightful feedback. As a result, I was not isolated in my interaction with the data. Regardless of the attempts at credibility, I believe the final interpretation of the data relies on the admittedly biased perspective of the researcher.

For the peer debriefing and data triangulation, I asked a colleague from a related field and who has researched and written on like topics of interest to review several transcripts and confirm or disconfirm the emerging themes developed from the analysis. I selected one particularly troubling transcript for which I had difficulty objectively coding the data. She processed my view of the participant's perspective and attitude with me, which allowed me to move beyond my personal feelings about the interview and look more objectively at the data.

I attempted to achieve dependability by noting the categorized steps for coding and recoding (Echevarria-Doan et al., 2005) peer examination of the findings and debriefing, thick description, and by creating an audit trail through memos and creative representations (Anfara et al., 2002).

Similar to the steps taken for credibility, I worked toward transferability through my theoretical sampling procedures and by providing thick description in my findings (Anfara et al., 2002, Echevarria-Doan et al., 2005). This concept is the qualitative equivalent of external validity. Grounded theorists are not concerned with generalizing their research to a population; they are more concerned with case-to-case transferability (Echevarria-Doan et al., 2005). However, I feel that this research could be transferred to

other contexts and inform cultural competency training programs.

Confirmability, the final criterion, concerns the researcher's ability to report the data with some degree of objectivity, which I achieved through reflexivity, memoing, auditing (Anfara et al., 2002; Schwandt, 2001), the constant comparative data analysis methods, confirming interpretations with participants, and triangulation (Strauss et al., 1998). This criterion is difficult to obtain for grounded theorists because of the researcher's subjective role in interacting with the data. In grounded theory, "objectivity does not mean controlling the variables, it means openness, a willingness to listen and to 'give voice' to respondents..." (Strauss et al., 1998, p. 43).

Action	Credibility	Dependability	Transferability	Confirmability
Theoretical sampling			X	
Memoing and reflection	X	X		X
Audit trail		X		X
Peer debriefing	X	X		
Thick description			X	
Data Triangulation	X	X		X
Participant follow-up	X			X
Constant comparative data analysis	X	X		X

Negative Cases

Negative cases are those that do not fit the emerging patterns or provide additional support and trustworthiness to the study and findings. The overall themes are strengthened through identification and explanation of these differences by adding

variability to the participants' perspectives (Patton, 2002). I identified exceptions through negative case analysis and explored these cases for further analytical insights. Of the 15 participant interviews, two represented negative cases examples. One clinician explicitly expressed her belief that differences do not exist among people and asserted that her clinical model is built on universalism. The other clinician stated that she does not usually recognize cultural differences and rarely uses that knowledge in her clinical work. Both clinicians recognized distinctions in the region, however, and expressed their own sense of place on community, town, and county levels.

Self of the Researcher

Throughout the data collection phase, I attempted to assess my own biases, experiences, and positions on the subject by memoing, triangulating the data, and peer debriefing (Creswell, 2003). I accepted and anticipated the influence my subjective perspective had on the research process and findings considering the fact that I am the primary instrument in grounded theory methodology (Strauss et al., 1998). Therefore, I approached the data from a subjective perspective, acknowledging my biases, thus drawing on personal experience and understanding to formulate the theory from the vast amount of data (Echevarria-Doan et al., 2005).

In my attempt to address researcher bias throughout this grounded theory project, I had to identify several key aspects of my own identity in addition to my motivations for pursuing this topic. I am an invested resident of the region under study. I grew up in an adjoining county, and purposefully moved back to this area to live and raise my children. I have had direct experience with a variety of systems in my community and across the region, both personally and professionally. I have been a

student, faculty member, and staff member at one of the primary universities in the area, and have been consistently active in cultural climate issues on campus throughout my tenure. I received my marriage and family therapy training as a doctoral student in the Department of Human Development at Virginia Tech. Having worked as an emergency services clinician for the local community services board for a year and currently as a clinician for Carilion Behavioral Health, my experience is similar if not identical to most of the clinicians in the sample. My interest in this topic comes from my own sensitivity to regional context. I grew up hearing about the distinctions of neighboring communities and feeling the systemic influences of my own small town. After moving away and returning, these distinctions were even clearer to me as I compared my new identity features to my previous ones. Further, I became a resource to several clinicians from other places at the university-based clinic where I trained. These clinicians from other places recognized the value of my local knowledge and accessed me as a “cultural broker” when they found it difficult to understand an aspect of the local culture.

All of these details point to many biases. I had to be very careful not to project my own experience onto the interviews during analysis, considering the similarities between me and my sample. I also had to make sure that my investment in this topic – my hope for other clinicians to recognize regional context and identity in their work and lives – would not keep me from seeing the negative cases and the disconfirming data as well as the data that validated my point of view. These tasks of self-reflection and often self-admonishment were not easy, but I believe that the steps I took were sufficient to assure the trustworthiness of the data. The process of self-reflection continued from the

development of the protocol throughout the final drafting of this document. I am sure it will continue as I pursue additional research on this topic.

This research is intended to provide a better understanding of MFT's experience with diverse clients in the NRV. The findings should be read as a subjective understanding between the researcher and the data (Echevarria-Doan et al., 2005). As a native of the area, a current resident, and a marriage and family therapist, I naturally bring my own experience and regional identity to this research. I believe that my analysis of the data and view of the emergent theory are enriched by my connection to the subject and the participants' experiences. The ultimate goal is to generate a theory that others in the field can use.

CHAPTER IV: RESULTS

The grounded theory process allowed me to develop a theory by analyzing an identified phenomenon: Family clinicians' experiences with region as a cultural context. The resulting theory is grounded in the data (Strauss et al., 1998); consequently, the following chapter offers an in-depth account of the findings, including thick description to support the categories, concepts, and propositions that emerged from the analysis. Due to the overwhelming volume of supportive data, the quotes I selected reflect but do not exhaust the participants' individual points of view.

I identify exact numbers of participants relating to specific findings only when the number has meaning (e.g. negative cases or exceptions to a consensus). In grounded theory the reporting methods are tied to sampling procedures in that they "are designed to look at how concepts vary along dimensional ranges (how properties vary), not to measure the distribution of persons along some dimension of a concept" (Strauss et al., 1998, p. 280).

Emergent Themes

The purpose of this research was to explore region as a cultural context in family therapy. The grounded theory resulting from this endeavor ultimately addressed three questions: What regional distinctions do the clinicians recognize, how do they access this knowledge, and how do they use it? At the end of the selective coding process, two broad categories remained: 1) Recognition and awareness of regional distinctions, and 2) Client-centered processes. The coding matrix reflects the building blocks of these final categories found through data analysis (see Appendix D) and shows how the

resulting categories emerged from the questions. The following is a discussion of these codes and categories in their respective phases.

Recognition of Regional Distinctions

The initial codes that emerged were organized in part by the three overarching research questions. The first question addresses the nature of the practitioner's recognition of regional distinctions as a context for family therapy and for the clinicians' lives. Participant interviews revealed two themes: 1) Recognition of multiple levels of regional distinctions, and 2) Recognition of systemic influences. The codes from the first iteration fit into these two themes; however, several of the codes informed both categories.

Multiple Levels of Regional Distinctions

The clinicians in the study recognized regional distinctions on a variety of geographic, economic, and cultural levels. The participants' recognition of distinctions defined the following levels (listed smallest to largest geographically): 1) neighborhood level— collective housing or groups of families residing in a common area; 2) community level – a recognized section of an area where residents share a common identity; 3) county level -- the entire area defined by the county boundaries, which may or may not include bordering communities, 4) town or city level – defined by an organized governing body and commercial boundaries; and 5) catchment level— the entire NRV, including Floyd, Montgomery, Giles, and Pulaski and Radford. They were able to identify common perceptions of these areas as well the features distinguishing the distinct communities. There was a consensus on many of “the flavors” that typify the

NRV; even though, some participants showed deeper perceptions and stronger opinions than others.

Country-level Comparison

Clinicians also compared the NRV to other distinctive parts of the state of Virginia and other states across the country. One participant stated,

You know, my own, uh, understanding of cultures has been greatly expanded by, by moving from the much more intensely urban to the rural and small town area that I live in. And certainly it's helped me see how, how um, how rigid, how regionally rigid folks from the Northeast, particularly in New York are.

Geographically, the NRV is in Southwest Virginia. Even though the counties in this distinct part of the state share many common geographic features, the participants recognized the social and economic demarcations. C. J. commented on an adjacent county's view of the NRV:

...then you go up towards Salem there is another type of people that see themselves more elitist, um Roanoke maybe looks down on all the people in the New River Valley more or less, maybe less educated or sophisticated as someone from Roanoke.

These findings confirm divergent attitudes among the regional populations when comparing the counties of the region (Huttlinger et. al, 2004).

In addition, many people consider Virginia to be a southern state and a section of Appalachia. The participants in the study recognized cultural factors commonly associated with the American South and Appalachia, including fundamentalism, purposeful social isolation, lack of trust, and strong family ties (Coyne et al., 2006).

Clinicians consider the NRV more of a traditionally rural Southern American region when talking about Pulaski and Montgomery Counties, and consider Giles and Floyd more of an Appalachian region. Clinicians spoke of the remote nature of Giles and Floyd counties, which appeared to follow their notion of Appalachian culture more than the former, more populated, commercialized counties. Shaun observed religion as one of these mutually shared cultural factors:

I think religion, especially in Southwest Virginia, religion is very important to people....someone will call [the clinic] and say, “well, if you believe in God, pray for me,” things like that – things I don’t think people say everywhere. It’s very Southern.

Appalachian culture. Appalachian culture was not as widely recognized by participants as I had anticipated. Several participants mentioned Appalachia when talking about the region’s position in the country or in comparison to other distinct regions, such as the Pacific Northwest, but only a few associated common behaviors, beliefs, and other sources of identity with Appalachian culture specifically. C. J., who had trained in another rural Appalachian area, reflected on how clinicians have to adjust MFT theories to this distinct culture:

I remember working in another rural area and um, having studied, um, structural family therapy and being sensitive to issues around enmeshment and having a probably pretty informed psychiatrist that was supervising me, give mean article on Appalachian culture which basically said that it’s not a problem unless it’s a problem. So these families live so close together, but it

doesn't mean that it's a problem. You have to let the clients tell you it's a problem here.

Jessie was one of the only clinicians who identified the regional culture with Appalachia specifically. When discussing her role as a supervisor, she stated,

I think it [culture] is what supervision is all about; it's really to deal with those cultural differences and shift. The bulk of what we have to deal with is the Appalachian culture and making sure we have a better understanding of what that means to each community individually.

Chris talked about helping her supervisees understand the Appalachian influences in the region:

In Floyd I do talk about people being more guarded, that they're this kind of family or that kind...I think I frame it a lot as Appalachian culture. It just feels very traditionally Appalachian.

Rural features. Recognition of geographic features of these more rural areas also surfaced as a theme. Several participants used words like "isolation" and "distant" to describe the culture resulting from mountainous barriers between communities and residents. While these distinctions may seem subtle, they underscore the preconceptions that clinicians use to "fill in the identity map" of their clients.

County-Level Distinctions

The most frequent comparisons the clinicians made were on a county and community level. Primarily, the participants perceive geographic, cultural, behavioral, economic, and systemic differences on these levels. The participants were able to see regional identity factors when comparing the counties to one another and to global,

national, state, and local areas. The table in Appendix E reflects the distinctions they recognize between counties and the perceptions of which the clinicians' are aware. It is important to note that this table includes stereotypes and perceptions that the participants do not necessarily espouse. The data was taken from questions about both the local perception and their own opinions. Specific examples of the participants' recognition of county-level distinctions are represented throughout this chapter and are therefore not elucidated in this section.

Community- and Neighborhood-Level Distinctions

The demarcation between socioeconomics is blurred in rural regions such as the NRV due to the prevalence of the variance in housing types and costs. Specific types of communities and neighborhoods clearly define a family's financial and social status, such as trailer parks, apartment complexes, and subdivisions, and other small, geographically-organized groups of homes and businesses. Elle's description of an apartment complex in Pulaski illustrates this point:

There are certain areas in town that you don't go in...like [name omitted] apartment complex in Pulaski. There's a lot of low-income housing around there...those are definitely areas I wouldn't go into.

Sumner, a clinician who practices in a local community mental health organization, expounded on the predominance of clients from trailer parks:

Another phenomenon I've noticed is that there is a real system of trailer parks in the region, and probably half of my clients live in a trailer park. And within that system, it's like Peyton Place of some sort. Every known stressor seems to

be times two, whether it's incest, drug abuse, domestic violence, mental illness, it seems to be times two in that system.

However, lower-income housing can have a proximal distance of less than a mile from a more affluent subdivision or upscale home. Sumner's perspective on community-level identity seemed to be influenced by mixture of property types:

I live off a road that goes by two or three trailer parks, and we call it a microcosm. It's a little micro, you know a climate that is a micro-economic climate. At the bottom are trailers with the gutters falling off and at the top are houses that are worth 400,000 dollars. In the space of miles and the feeling at the bottom of this hill is despair, the feeling of hopelessness and despair. So, you know the feeling is really sadness and the clients come in with that. They feel trapped.

For someone outside of the area with little local knowledge, these types of neighborhoods may not hold the same social meanings as they do for residents. This point is important to the findings of this study because the residents of the trailer park may feel that they are misunderstood due to the experiences they have had with people from higher social classes or from their neighbors in the subdivision. Sumner presented an awareness of his own community's status and resulting influence on the residents of his neighboring trailer park; his life experiences and community identity influence his perspective on his clients who come from neighborhoods like this.

Dee presented another view of the way local residents assign meaning to their neighborhood-level experience:

Up in Pembroke the small area uh of Little Stoney Creek, it is a community people refer to basically and they know what they're talking about and they look at it, they look down their nose at it, and they look at it as being a bunch of losers who live there.

Micky, a family therapist who has lived in the area for less than two years, finds that her clients assign meaning to their community-level experience. However, as she reflected,

I think there's a lot of people who assume I should get it, and when I do try and probe for more information about what that means to them, it hard for them to explain because they assume I should know what it's like for them.

Accumulated knowledge appears to help the clinician as clients struggle to explain their lives. From the data, the participants work hard to understand what it means to live in the New River Valley from a broad perspective to a more intimate-level vantage point.

Definition of Culture

Throughout the interviews, participants used the word "culture" to describe collective behaviors and beliefs. Phrases such as "culture of helplessness," "mountain disability culture," "redneck culture," and "trailer park culture" emerged as the participants observed regional cultural groups. During the pilot interviews, I asked participants for their definition of culture, but I abandoned this question in result of the lack of rich data it yielded. Clinicians seemed to be able to define culture through their observations much better than trying to dredge up a formal, operationalized definition. Rich descriptions emerged during our discussions of county- and community-level

distinctions. Participants observed political and social groupings, using labels such as “hippie culture” or “redneck culture.” Leisure and hobbies also defined culture. Reni articulated these cultural trends as she asserted,

I’ve seen a definite regional phenomenon -- an adoration for professional wrestling and car racing. I never knew anything about car racing until I moved to the New River Valley. It’s all about car racing on television and everywhere else.

Geo-demographics

Urban vs. rural. The majority of the clinicians identified the region according to geo-demographics, such as urban vs. rural or in relation to poverty and socioeconomic status. These factors are typically included in population studies and are particularly salient to the NRV. The participants drew comparisons between their prior urban experiences and their current rural practice and lives. Andy observed,

In urban areas grandparents live in other cities. When I was in [name omitted] grandparents did not live next door to, you know, help raise the kids or influence your behavior. Right. So, it was a lot different [from in NRV].

Andy notices not only the tendency for extended families to live near each other, but also the transgenerational influences that result from rural family systems. Other cultural factors, such as observance of death emerged as the participants discussed urban versus rural areas. Reni reflected on this concept:

...there’s a big reverence and there’s big respect for funerals when relatives die. That maybe the same in urban areas, depending on the people, but it isn’t as profound as it is here.

Poverty. Many observe the “intense level of poverty” evident throughout the region. Sal provided her perception of the prevalence of lower-income families in the region and considers how poverty affects their behaviors:

There are some areas here, particularly Giles County, Floyd County, and Pulaski County, where there’s a higher population of individuals who lack resources. I mean, overall, this area is somewhat depressed anyway, but those areas have, it seems, a larger population at or below the poverty line, and so there are some things that they would view as acceptable that I would think that’s not what most people would view as acceptable. For instance, I saw a woman who, uh, her bathroom fixtures were broken and she been bathing out of a sink for months, and I thought that most people with resources in other areas would not tolerate that...In Radford, she would have been called a “type,” but where she was living, she was completely fine.

Class. Class discrimination, which is closely related to poverty, is more prominent than race and ethnicity in the region. This may be a result of demographics, but the participants found it embedded in regional identity. Elle, one of the two clinicians in the sample who was born in the area, reflected on class specific to Pulaski:

You’re either high class and you don’t use or you use drugs recreationally, or you’re low class and you use lots of drugs and you’re on Medicaid and you have Welfare and WIC and all that, and that’s pretty true. It’s pretty divided.

She furthered her thoughts about the differences in the area and class by saying, “It’s so tight between kind of SES and locality – a lot of it has to do with class.” Elle’s words

show the difficulty many clinicians in the study had with separating the typical demographic features (e.g. SES), and the umbrella under which these distinctions are nurtured (region); even though, many participants were able to identify regional influences on identity.

Racism. The participants emphasized racism as a cultural trait in the region, but observed the relative absence of problems associated with it in comparison to other parts of the country. More than half of the clinicians identify Parrot, a small community in Pulaski County, as one of the most openly racist places in the region. Several clinicians who had come from more northern or far western states tell of being “shocked” at the level of blatant racism they have observed. Micky is unable to reconcile the friendliness of the residents and the prevalence of confederate flags. She also anticipated what she would do if the issue came up in therapy, feeling unsure of the way she may challenge the clients’ beliefs. Andy had a similar experience when she first started working in the homes of area adolescents:

Sometimes I would challenge the client occasionally for listening to rap music.

I thought it was really strange considering her feelings and her family’s feelings about race.

Gram tells of a similar reaction to the open racism in the area, as she recounted,

It was a real shock for me, and I am still affected by the whole race issue here.

The kids that will use the “N” word, and what reaction that causes. This is stuff I would have never even have considered where I grew up.

Nevertheless, diversity issues such as class and gender are more prevalent in the area, according to the participants.

Gender roles. Gender roles were the most commonly mentioned cultural component. Many clinicians I interviewed share a common vision of men being in a dominant role yet not providing emotional or parental support. According to Elle, a clinician who grew up in the area,

Women put up with a lot of abuse, uh, the stereotypical ‘you don’t tell me what to do, I’m the man here. I do whatever I do and you pick up the pieces’ kind of thing. That’s personally and professionally – I’ve seen that since I was a child.

Like Elle, many participants found that men in the area are abusive, especially when it comes to discipline -- if they participate in the family at all. Conversely, several clinicians saw the area as a matriarchal system. Sumner described the typical life and attitude of his matriarchal clients:

It seems to be more matriarchs...they are often the type of woman that will set boundaries to protect their children, or protect their siblings, or protect their space...often she’s escaped an abusive relationship and or he’s lost all of this teeth so to speak, so she’s taking over the family, and um, I don’t recall seeing or hearing that with the patriarchs; they are the predators.

From this point of view, women are “strong” and “tolerant,” doing what they have to do” in order to survive and to raise their children. These depictions of the area gender roles may appear stereotypical; however, very few participants avoided making these generalizations in light of the amount of domestic violence and parenting issues with which they see their clients struggle. The participants consistently supported their observations with specific case examples. This point is significant because I did not sense that the clinicians felt they were being judgmental, which offers a view of how

these clinicians visualize and conceptualize their clients' lives. Both male and female therapists seemed to empathize with their female clients; whereas, they very rarely had positive reflections on male clients in the NRV. Furthermore, the clinicians made these statements on a catchment level and did not see differences in gender roles on a county or community level, thereby seeing this as a regional phenomenon.

Religion. Religion was another cultural factor that seemed prevalent throughout the entire NRV, according to the interviews. Everything from mountain witchcraft to fundamentalism emerged when I asked participants to tell me what cultural factors were distinctive in both their professional and personal experiences. When describing their first impressions of the area, several self-described "newcomer" clinicians voiced their surprise at the area's overall emotional attachment to churches and the large number of people affiliated with organized religions. Another similar regional distinction they found explicit was the lack of separation between church and state and the open discussions of religion in public places and during secular events. Toni's initial reaction to the fundamentalist religious climate was, "We have some work to do here." She described her assimilation into the area's culture after having lived a more liberal state:

What we found was, uh, more fundamentalist values that were quite different from what we were used to. For example, prejudice against gays and lesbians um, and realizing that, uh, well, just going to a dinner and having them start the dinner off with a prayer -- the separation of church and state, um, was a problem here. It felt inappropriate to me.

Surprisingly, the clinicians who noted religion did not distinguish difference between the more populated counties and the more rural counties in regard to practices and attitudes.

Arts. Art and music also emerged as a regional cultural component, primarily in Floyd County, and many of the clinicians discussed their personal experience with this community's music and visual arts either via retail or events. This point surprised me considering the various arts organizations, festivals, outlets, and activities that occur throughout the NRV. When I made this observation to one of the participants after the interview, she said that she felt that her perspective on those types of cultural factors was influenced by her clients and that she has very few clients in other areas who are involved in the arts like those she sees in Floyd. Her observation reinforces the recursive relationship between clinician and the multiple sources of knowledge (explored later in this chapter). I also surmise from the data that the other counties celebrate art periodically while many of Floyd's daily activities and commercial venues rely on the arts throughout the year.

Language. When I asked the participants what they noticed about the region when first moving here or in comparison to other places they had lived, most of them immediately mentioned language (vernacular and accent). For example, when I asked Micky what she had to get used to when she first moved here, she quickly said "the language – accent" without having to think about it. One of her first clients was from one of the more rural areas in the region:

I had a client and it was a three-year old boy, and I didn't have a clue what he was saying. He could talk – he wasn't just learning his language – it was that

his accent was so thick I just could not understand what he was saying, and I felt horrible. Because I felt like by me questioning over and over what he was saying or looking to his parents to explain what he said to me, I felt like I was somehow saying that they were stupid or you know....And also there are just differences in language. I've had a lot more women call me "honey" or things like that, and to me, it's just fine, but I have friends that would feel like that was demeaning or they are somehow talking down to you.

Talking about the inability to understand their clients at times made several clinicians, including Micky, uncomfortable -- almost as if it was a form of cultural insensitivity.

Attitudes toward education. There are several institutions of higher education in the NRV, two of which are four-year universities; consequently, many participants reported attitudes toward education as a major cultural theme. According to the data, there are groups of residents who resent the college students, professors, and some university staff members in the area. In result of this perception, several clinicians feel that their clients are often acutely aware of their level of education and see the clinician as "uppity" or superior. Sal reported having to adjust the way she talks with and approaches some of her clients "so they can see I'm just common folk." Rae put a different spin on the educational divide between her and most of her clients:

I think that being educated doesn't make you better, and I think that I've learned that from people. You know there are positive sides of these kinds of things -- like there are some families I work with are strong...and having an education isn't a resiliency factor, either. Mental wellness isn't about being smart or stupid.

Education as a theme surfaced from the data as a factor the clinicians overtly recognize, yet the participants presented attitudes and biases concerning their clients' level of education both indirectly and directly. Comments that began with phrases like, "Even educated families..." are common in the interviews, which could be interpreted as the clinicians' bias. Similarly, there was a consensus regarding lower educational expectations in some areas. Sumner's observation regarding his client base is an example of this point:

I think in Giles and, um, Pulaski -- I am surprised how many of my clients from these places only have an eighth-grade education, or less they go to eighth, ninth grade, tenth grade and quit before they finish.

Like Sumner, several participants perceive that education is valued less in many remote parts of the NRV.

Regionally-Shared Behaviors and Beliefs

Clinicians in the study consistently observed regionally-shared behaviors and beliefs by comparing the region to other areas and by considering the within group differences between counties.

Resistance to growth. When comparing the NRV inhabitants' attitudes to other regions of the country, the participants saw a resistance to growth and change, a "backwardness," and a loyalty to services and the "good 'ole boy system." Sal described this view as,

It's like they [the people in the region] don't recognize that there's a rest of the world out there. There are a whole lot of clusters of backwards folks – it seems

like there are folks who are pretty simple and not as educated and who seem to not strive to be anything more than they already are.

Chris spoke about a local judicial system that one must be part of to “gets things done”:

You know, in Floyd everyone there has been there forever and ever, so everyone knows everyone. So, I think there’s a lot of behind the scene deals and stuff like that. You have to be part of that.

When comparing Pulaski’s progression to the other counties, Rae said,

I mean Pulaski is always trying to catch up. I mean it seems like it’s always two generations behind everyone else, you know, that, that they’re in a hole and they’re trying to get out.

Attitudes toward treatment. Another commonly shared regional trait appears to be a reliance on medications, what several clinicians called “help-seeking” and a “learned helplessness” culture. Sumner has had many clients who would rather take medication than have therapy, many saying to him, “I don’t want to be depressed, so I’ll take this pill. I’ve tried [therapy] and it’s not going to make any difference.” From this point of view, clients generally are distrustful of mental health treatment, including talk therapy. According to the data, the client base of most of the participants is either forced into therapy by social services or the court system or they are driven by desperation to seek help. According to the literature, rural populations are resistant to mental health treatment and more open to a more familiar medical model of care due to stigma and distrust (Roberts et al., 1999; Weigel et al., 2002). To overcome the resistance, Jesse feels that it is important to understand and anticipate the lack of trust in the region:

...people can be really friendly but not necessarily trusting of outsiders and the helping systems, and that's a good example of how in clinical practice, the client comes in like, "well, you know it's not going to be easy for me to talk to you. I don't really trust anybody." And I think there's some truth to that being in, you know, more isolated communities.

Transgenerational. Transgenerational behaviors and beliefs dominated the list of common traits on a county-level, including drug use and disability status across generations. Andy described her experience with Pulaski's transgenerational drug use:

It's somewhat acceptable to do drugs...it doesn't seem like anyone really cares to change that in the family or figure out a way to do that. And you see the parents, kids, and everybody doing it, um, it's passed down behavior -- everybody in the family is doing it. The kids are taking drugs to school and their parents and grandparents are smoking and taking drugs at home, whatever the case may be.

Most clinicians either knew directly or had heard of a family that "passed on" behaviors through a shared belief that individual lives and fates are predetermined. Reni sees this predetermination as a family pattern:

I see, um, an acceptance of life in which the child grows...the lack of concept of that one does not have to establish the same kind of household as the adults the child is experiencing...There is an overarching belief that one can not live a different life from what you are now experiencing. I hear the teenagers verbalize it -- they duplicate their parents' situations.

Elle addressed this topic from her regional native's vantage point:

You see a lot of patterns around here. People don't change very fast, um, so if grandpa was an alcoholic and beat his wife, well, most likely so does his son...To change those [patterns] means to go against the family rules, um, and you don't do that here. People are loyal to families no matter what a lot of times.

Elle and other participants mention the need for clinicians new to the area to be aware of the region's resistance to change and the reasons for those attitudes.

Transgenerational "disability syndrome" is a related theme that appeared in many of the interviews. Twelve out of the 15 clinicians know of and/or have directly experience with clients who subsist on social security disability, some legitimately but many not. Several participants justified this trend by emphasizing the transgenerational predetermination and further explained that many families found this to be the only alternative to the high unemployment. This theme also relates to work ethic, a code that appeared in several interviews. Reni recounted her experiences with families with this mindset:

I've seen children whose parents are on disability and they tell me that "when I'm 18 I will apply for disability." And I say disability from what? You haven't even worked yet, you have to demonstrate first that you can work! And they say "I'll get \$500 a month" – they are so happy about that. I have seen many children whose goal is to go on disability.

According to clinicians, reliance on the government for assistance may also be a result of the industrial and mining history, which provided for families whose members had been injured during work. Considering the fact that mines and many factories have

closed in the area, this trend appears to be a systemic “holdover” from the past. Chris explained:

I think it [culture of disability] exists because there seems to be a lot of factories and people actually did get hurt really badly when they were open.

Several clinicians referred to it as “learned helplessness.” Only two clinicians considered this type of behavior to be a form of fraud and appeared to judge this segment of the population harshly. This point is directly connected the client-centered approach all of the clinicians appeared to use (discussed later in this chapter).

Reasons for living in the NRV. As I analyzed the interviews, I saw the participants attempting to understand why someone would not move from the area if there were no ways to support themselves or their families. The motivation for clients/residents to stay in the area, even in the face of poverty and destitution with few means of self-sufficiency, surfaced as another common theme. Clinicians in the study commented on the tendency for residents to stay in the area and/or purposefully move to one community from another. The most common reasons they observed include the desire for isolation, the slower pace, proximity to family and support systems, and the beauty of the area. However, the majority of the participants found that some residents do not choose to live in the area but are unable to move for various reasons. Dee observed this dilemma as he stated,

The economic base in Pulaski is eroding, and, uh, I think that stereotype [being downtrodden] comes from the feeling that anything really good has already left the county and the only people that are still there are there because they can't go anywhere else.

The participants also noted their own reasons for residing in the NRV, which seemed to draw a comparison between their own sense of place and regional identity to their clients'. Sal's reflection on her choice to live in the NRV revealed her connection to the regional culture:

It seems a lot of people who started here or grew up here, settled here or eventually returned but living in [name omitted], it's so much a faster pace of life, and I actually craved coming back here because of the slower pace and because it was more of a country environment, and I like the rednecks more than the city folks.

Most participants did not recognize the parallel between their own motivation to live in this region and their clients'.

Tolerance. Tolerance to others' behaviors was another common regional trend the participants discussed. These observed behaviors tend to involve human rights violations and various forms of abuse. The most commonly observed were a tolerance to child abuse, infidelity, violence, substance abuse, teen pregnancy, incest, and "freeloading." The majority of participants identified child abuse as a major problem in the area, with many of them having to work with parents who believe that spanking and beating their children is an acceptable form of discipline. Gram stated,

I've had moms actually say to me, "well, I know that I can get away with spanking my child, even using some kind of belt or paddle or switch – whatever – just as long as I don't leave marks."

She goes on to say that she no longer goes to Wal-Mart because of all of the child abuse she has witnessed there.

Community tolerance to corporal punishment varies across the communities, but according to the participants, families tolerate it transgenerationally regardless of the ramifications. Chris explained:

It amazing to me how many people just don't have any idea about basic behavior modification stuff. There's a fair amount of spanking, and a lot more spanking in areas outside of Blacksburg than in Blacksburg, and I think it's mostly because of education. I think also in areas outside of Blacksburg, um, there's more use of extended family. There's a huge epidemic of grandparents raising, um, you know, their grandchildren as their own, but I think because there's grandparents and aunts and uncles taking care of people's children and they're more old school about that kind of stuff and have more of a tendency to spank.

Dee's reflection echoes the various observations other participants make regarding behaviors families and residents tolerate:

It is all very transgenerational, uh, the oppression of women and going on into the incest and the sexual abuse, particular to women but a lot of men too...drug use is also rampant.

Behavior regulation seems to vary per county and often according to SES. Andy noted,

They [people she has observed in a specific area] will tolerate a certain level of behaviors. What is not necessarily tolerated in Montgomery County, the police would be called or not called in a different setting or situation. Or, you know, infidelity is tolerated more in one place more than another. Well, this is going to

sound bad, but I feel like there is a lot of child abuse, sexual and otherwise in Giles, as weird as it sounds. It's almost to the point that, okay, that's just something everybody goes through...I've seen in Montgomery a level of acceptance when it comes to selling drugs in the house and parents doing drugs, and that's sort of okay. And that sort of depends on socioeconomic status that I have experienced.

Several clinicians furthered their observation about tolerance by saying that the families they had worked with had not only put up with "bad" behaviors but show love by protecting or fiercely defending others. Dee, a clinician who works quite a bit with substance abusers, observed,

Among the nonusers maybe the parents generation or something like that, there's an inclination to protect rather than to get help for the person whose life maybe negatively affected, you know, because they're getting into legal trouble and acting out and in trouble. They can't support themselves because they are addicted....of course it's a family problem, and yet the instinct like a lot of smaller communities is to very insolent and protect rather than seek help.

Parents or family members can even be "fierce" in their protection. Reni observed the interaction between parents and children when the child gets in trouble at school:

If the parents feel that the child has been wronged...the parent without knowing the whole story would, um, load up every weapon he or she could think of and take the arsenal to the school or the, I'm talking about psychological weapons...and stick up for the child and then the child feels loved

and will later say, 'My mother loves me, she came to school; she fought for me,' or 'My dad beat the other dad; he loves me.'

Children from more remote areas in the region appear to replicate this fierceness by being "mean" when dealing with any type of opposition. According to Dee, parents see these "mean" children as superior to more gentle children. One clinician linked this apparent need for children to be aggressive with the clients' "mountain heritage."

Personality Traits

Clinicians also recognize collective personality traits among the residents of the NRV, including lack of personal boundaries, tendency to hug strangers or people the client has just recently met, pride in the area, lack of insight, emphasis on cooking and food, responsibility to older adults and disabled children, and a general lack of trust. The traits on this list focus on client/resident deficits, which reflects the overriding tone of the interviewees' view of their clients – very few noted the strengths of their clients in regard to ecological influences and collective behaviors. This fact may be a result of the relative lack of solution-focused, strength-based models the clinicians report using, or it may be a view of the typical clients' level of acuity from the clinician's perspective. One participant explained this negative tone of the data as an artifact of the "negative macro-level stuff that goes on," but stated that "when it comes to the individual client, I'm much more positive. I hope each time that they will be an exception."

Clinicians' Recognition of Own Regional Identity

When asked about their own regional identity, many participants appeared to struggle with what that meant; even though, this question followed an extensive

discussion about their recognition of regional identity both in and out of the therapy room.

I separated these two processes in the data because the participants describe their initial exposure to the region (assimilation) and identify the cultural traits they have acquired across time (acculturation). Only two participants grew up in the NRV, so the majority began their reflection of their regional identity with their assimilation and acculturation experiences in addition to their places of origin.

Assimilation. From the data, it appears that assimilation into a new context begins very soon after the person moves into the region, especially if the area is culturally different from the person's previous context. This trend seems to point to the clinicians' acute sensitivity to and awareness of place. Aside from the natural beauty, the region's pace is one of the first aspects of the area that many clinicians notice. Upon reflecting on the speed of life in which he was used to prior to coming to the NRV, Dee says,

It [the fast pace] created such a, a, there wasn't much space for standing back some, having some distance to really reflect and to be present in my own life. So, I brought with me an awful lot of speed...And that's good to know that difference; it's good to be able to adapt to those differences.

Other clinicians use words like "comfortable" and "relaxing" to describe the regional pace and attitudes. Like Dee, many participants moved to the NRV from larger, more urban areas, and they seemed to understand the connection between the need to alter their pace in their lives and in their therapeutic relationships.

Regional vernacular is another common difference for many newcomers. While many clinicians were willing to adjust their own language to close the distance between themselves and their clients, several clinicians stated the “county accent” made them feel that most area residents were less intelligent. This is a bias many report having to address. Sumner speaks to this initial reaction to the local accent and vernacular:

I will admit that the severe Southwest Virginia accent that you see in almost all of the counties made me prelabel someone as less of something, maybe intelligence.

Micky was afraid to admit to clients at first that she did not understand them because she feared it would imply that she thought they were “stupid.” She also did not understand why her clients assumed that she knew the area when her own accent was clearly different from theirs. In addition, some clinicians with distinctively different accents report feeling more of an “outsider.” One clinician who has lived in the NRV said that “he talked too fast” when he first moved here and had to slow down so that others could understand him.

As noted earlier, many clinicians recognized a difference in demeanor and trust in the region in comparison to other places where they had lived. Sal recalls feeling more comfortable with the slower pace, with the more “country environment,” and with the rural “folks.” Lou, who moved to the NRV from another rural area in Virginia found only subtle differences, which she believes has helped her “meet people and accept them for who they are.”

Acculturation. After the clinician is exposed to the regional culture, many describe the process of selecting and rejecting personal identity factors from their new context.

Several clinicians found it necessary to change some of their behaviors and beliefs because some of their previously held identity factors did not transfer well. Jesse's story of her acculturation is similar to others' experiences:

When I moved from [name omitted], I was doing some business transactions, and I just assumed I could be professional and look and act the way I was up there and that I needed to do the same down here. I looked like a big joke as I, you know, walked out and was prepared for this meeting. The person that was with me said, "You're not going to get very far if you look and act like that," so I immediately had to make some adjustments. In my opinion, it's been very good for me.

Others found it difficult to adjust to the slower pace and to some of the more conservative attitudes. For example, Toni recognized her difficulty with conservative religious attitudes, the tendency of some areas toward exclusivity, and the negative attitudes toward therapy. She joins others who also found it difficult to adjust to the regional attitudes toward exercise and diet.

Acculturation seems to occur as the clinician and their families participate in the community. However, there is a group of clinicians that do not feel they have acculturated. While C.J. embraces his "Southwest Virginia identity," he states,

I feel kind of like an outsider in [his current town of residence]. I don't really feel like I rally around their thing or, you know, like saying, "I'm from [name omitted]" like someone might say 'I'm from Blacksburg' or somewhere else. I haven't embraced that because there is sort of this clique in the town that I'm not a part

of and don't really want to be part of...I'm a little bit on the fringe of that, so I don't know if I've resisted or what.

C.J. is part of a sub-group of participants who saw themselves as "newcomers" and "outsiders" both professionally and personally. I found this perception interesting, considering the fact that only one of those in this group had been in the area less than ten years.

Accumulated identity is another common theme in regard to acculturation. Most of the clinicians feel that they have accumulated identity factors from the other places where they have lived, even if they feel fully acculturated in the NRV. One participant called it "blending the old with the new." Reni stated,

One thing I brought that I use from living other places, especially outside the United States is that I can make generalizations with great confidence.

Gram is more specific as she believes that she will always be a Hoosier; even though, she has lived in the NRV for many years and has raised her children here. Like others, she has difficulty articulating what being a Hoosier means in her current context. These findings are consistent with Schachter's (2004) research on the purposeful retention and rejection of identity factors across time and context.

Systemic Origins of Regional Distinctions

Beyond the recognition of regional distinctions is an acknowledgment of the contributors to the region's collective identities and shared behaviors. A majority of the clinicians I interviewed provided common rationales for what they are seeing in their practice and through personal interactions across the region. The data follow ecological theory according to the connections the clinicians made between contextual influences

and individual/family functioning (Bronfenbrenner, 1979, 1986). Most of the clinicians shared the belief that clients' ecological systems directly and indirectly influenced their behaviors and beliefs.

Clinicians identified a variety of regional systems interacting with the family systems throughout the NRV, the most common being schools, social services, and the legal system. In addition, various social and political issues seem to have an impact on all of the systems, including families and individuals. The following discussion of these systems will begin with common perceptions of helping systems in general and then move to the three most frequently mentioned systems from the data.

Distrust of helping systems. Clinicians observe a general distrust of most helping systems among their clients and residents, even if these clients do not have direct contact with that system. This point shows the influence local knowledge and social interaction has on perception and reflects the interconnectedness of the systems and the family (Antwieler, 1998; Bronfenbrenner, 1986). Participants seemed to be in agreement about the reasons for this distrust, which include: regionally-shared attitudes toward help-seeking, barriers to treatment due to intra- and interagency problems, the tension between policy and practice, the perception that the systems protect the wealthy, the unequal funding across the region, and the intrusive tendencies of some systems. Many of these points confirm a lack of community capacity and the influence that these systemic deficits have on individuals and families (Mancini et al., 2005).

Distrust appears as an observed personality trait above; however, the way this trait influences help seeking through the system emerges in this category, as well. Jesse considered how distrust of systems originates and interferes with help seeking:

It [the distrust] may be that somebody in need from the New River Valley went to the Department of Social Services to apply for something and someone treated them poorly, and they said, 'Oh, I can't trust how these people treat me.' I know that's not uncommon. Also what feeds the distrust is that families stay within themselves and to ask for help outside is not something that is culturally appreciated or approved of, um, especially transgenerationally.

Several clinicians observed gradual change in the way families are beginning to respond to the helping systems. This change appears to be due to global and commercial influences that are slowly touching the more populated areas. According to several participants, these subtle shifts in attitude also occur in result of technology, which one clinician believes has "blurred the differences between our region and the outside world." Throughout the interviews, however, there seems to be the sentiment that there is a regional resistance to change.

Level of services. Clinicians concurred on a general low level of services available to the NRV residents. These findings also resonate with the concept of community capacity considering how the perceived low levels of services prevent individuals, families, and other systems from attaining what they need. Words and phrases, such as "benign," "broken system," "low capacity," and "failure to protect," showed the participants' empathy for client needs as well as frustration with what emerged as an extensive local problem. One clinician said that the message from many public and private systems is "we can't help," so clinicians have to shift and alter their strategies in order to assist their clients. "Sometimes it's okay, but a lot of the time, it's frustrating because I have to take on a lot more responsibility," stated Elle in reaction to

the level of service in the area. Sumner also criticized systemic service delivery in the area:

Well, I think some of the systems or the systems I work in or social services or the legal system, I think all those systems tend to be patronizing and, uh, go back and forth on being helpful and then being damning or critical or punitive.

While there does seem to be a lower level of service, many of the participants justified some of the problems on the “overload” of need and limited funding and resources. Limited health and mental health in rural areas is the norm (Baldwin, 1999a, 1999b; Blackeney, 2006), and the NRV seems to be no exception according the data in this study.

According to the participants, there are additional services needed in the region. A number of clinicians lament the lack of psychiatrists, the need for more funding for social services in more remote areas, and the need for additional drug treatment centers.

Family systems. The majority of the clinicians in the study recognized the family system as the most influential on an individual’s behavior, beliefs, and identity. As mentioned above, many families in the New River Valley participate in transgenerational behaviors and beliefs. Clinicians also see the family as insular in their attitude toward services. Furthermore, families in the NRV protect the individual. Lou recognized the family as a support system, another common subtheme in this category:

Here, the family unit works together a little more to get where they need to go.

So, yes that’s a factor, there’s no question...we find these extended

families, you know, they really come together to get things and the services that they need. They rely on resources among themselves.

School systems. Directly related to the family system in the NRV are school systems. Fourteen out of the 15 participants had first-hand experience with the area schools systems, as parents, teachers, and clinicians. Many were familiar with the various school districts in the NRV, either directly or indirectly. From their experiences, the lack of discipline, the inconsistent level of care provided according to the child's SES and other social factors, and the inequality of resources available in some counties all affect the way families interact and children develop. Having worked with many of the schools in the NRV, Chris possesses a seasoned, yet critical perspective on the educational systems in the area:

I don't think that they [the schools] can get a foothold [on drugs]. I just don't think they can get a handle on it. The level of resources they would have to have – it would take ten drug dogs. I think they are overwhelmed, so they turn a blind eye sometimes.

Gram also has first-hand experience in the area schools both as a teacher and a therapist. She drew several comparisons in result:

There are flavors that the different schools seem to have, um, for instance, Blacksburg High tends, because of all of the Tech families, tends to be super-academically-focused. Kids from lower socioeconomic groups kind of drop through the cracks....Um, the stories the kids tell about life in Pulaski High is very different than anything else I hear of the other schools. It is a much more violent environment. And they also say that they just don't have support anymore; used

to be there was really good support with the counseling department, but they say they are too busy with other things now.

C.J. observed the cultural clashes that may occur when the family system or the surrounding cultural values are in contention with the school systems':

...you got a more rural family and it's okay for the kid, the family believes that it's okay for this kid to take off from school to help work on the farm. It may not be okay with truant officers or visiting teachers, so you see a clash in culture in a larger system where you've got maybe a farm family that believes it's okay for the kid to take off for even hunting or something.

He continued by saying that there may be discrepancies between the counties on these value issues: "Something like that would be very different for a kid maybe in Blacksburg," which he identified earlier as a more urban, "elitist" area in the region. He echoes a shared sensitivity to the county-level differences and their influences on the family.

Social services systems. The social services systems are the second most frequently mentioned system that clinicians identified as both regionally distinctive and influential. All but one of the clinicians had interacted with at least one of the local Department of Social Services (DSS), and most felt strongly about the differing levels of service. In the NRV, DSS offers a variety of services to families, children, older adults, and other individuals. The majority of the clinicians I interviewed mentioned Child Protective Services (CPS), a division of DSS, most often. According to the participants, lax attitudes, a slow reaction to child abuse, systemic impotence, and a loose definition of imminent danger plagues some counties in regard to their local DSS. Conversely,

other counties' DSS agencies seem too aggressive and "at odds with family values" in others. Even though Shaun expressed difficulty seeing regional differences during the interview, she was able to offer several personal and professional experiences she had had with local social services. Regarding CPS, she recounted:

When I've made CPS complaints, um, it's like I am bothering the person who takes the call, and I have to report it, and plus, you should report. But I can't imagine if someone is a neighbor and doesn't have to if they are treated like that – it may be the last time they do something like that. The only place I have had a good outcome is Botetourt [a county outside of the NRV].

Her comparison to Botetourt underscores the differences in regional services across the state, as well.

Several clinicians feel very strongly about the philosophies of specific DSS agencies, especially Montgomery County. Chris observed these differences between the systems:

The DSS systems are so different here, um, Giles does not mess around. Giles will pull a kid immediately, and they make people go through a lot of hoops to get their children back. Um, Montgomery, uh, what they say is that they're service oriented, but we feel that this is not good. It really takes an act of Congress to pull a kid out. I mean horrible things happen before they will pull a kid out.

Pulaski tries, but they are overwhelmed and there's no supervision, so they drop like flies over there. They can't keep up.

In the same vein, several clinicians mentioned the need to know where their clients lived in order to anticipate the type of reaction DSS would have regarding their

needs. This common acknowledgement of systemic discrepancies points to a widely-held ecological perspective the participants share.

Legal systems. Law enforcement and judicial systems also emerged as common contextual factors influencing regional residents. Study participants used their client reports and direct experiences to inform their beliefs that the jurisdictions varied in their treatment of offenders, and several asserted that these systems negatively affect families' and individuals' behaviors. Conversely, Sal, who has extensive professional experience with the legal system, had some positive observations about the jail system in Montgomery County:

Actually, Montgomery County is the most respectful and the most helpful, um, in providing resources, and I don't know if being understanding is the right word or concept but they just provide more. Radford has some of these resources...Even though the conditions are less than what we would want them to be, there's still the attitude of the officers, the attitude of the jail in general, is not quite as depressive from that the inmates tell me as the one in the regional jail.

Sal goes further by recounting all of the mental health and health accommodations made at Montgomery County, which she associates with the jail staff and resources. Her observation about the relative lack of treatment and indifferent attitudes toward the inmates in other localities echoes what other clinicians in the study asserted.

Regarding the court system, Dee recognized the "terrible reputation" the systems have across the NRV for being either "adversarial" or "benign." She stated that the courts treat the offenders like "sub-humans." Dee pointed out that

...there's a whole lot of disrespect for people who get caught up in the system. And I think, uh, that effects the way people look at the legal system but, uh, look at themselves. You know, they see themselves outside of the mainstream, us and them kind of....there's a certain amount of stereotyping of families that occur, and there's a lot of extended families, especially in Giles, multigenerational kinds of problems with the families that have had contact with the legal system.

Dee's description not only shows the regional distinctions in the legal system, but it also articulates the affects interactions with the systems have on families and individuals. Once again, this system not only represents the participants' recognition of difference and corresponding cause for distinct behaviors, but it also confirms Bronfrenbrenner's notion of systemic influences.

History and heritage. Only three clinicians mentioned the areas' histories and heritage as rationales for clients' regionally-distinct behaviors, which I found surprising. The literature points to cultural heritage and the historical imprint typically made on culture, especially in rural areas (Sugar, 2002). I anticipated more recognition of this factor in result of the rich history many of the areas in the NRV have. This omission may be explained by the fact that many of the clinicians are not natives of the area. There were a couple allusions to history as clinicians made observations about the distinctive cultures on the county-level and in relation to the aforementioned transgenerational factors. Rae noted one of these connections between Radford's history and present behaviors:

People in Radford think that because they were the beginning of the settlement, you know, that started the whole city and really the economic growth was because the railroad went through there first. The first railroad was there, and then it went on to Roanoke, so people in Radford really do have a sense of entitlement.

Origins of Regional and Ecosystemic Knowledge/Perspectives

Another set of themes that prevailed throughout the coding iterations revealed an epistemological facet: where and how the clinicians accessed their awareness of their client's environment and their comprehensive view of regional cultural factors. The open codes formed two axial coding categories: 1) professional sources, and 2) personal sources. Clinicians explicitly identified a variety of sources for their knowledge and perspectives. Their heuristic processes emerged primarily through my analysis of the interviews because very few participants acknowledged the way he or she processes knowledge regarding regional context.

Professional Sources

All the clinicians I interviewed identified professional sources from which they attained knowledge and opinion about the region. Interaction with clients and colleagues composed a large portion of the bank of knowledge they access for their clinical work.

Clinical experiences. Clinical experiences across mental health fields are dominate sources for regional knowledge, according to the data. Clinicians in this study have experiences from a variety of clinical settings, including fieldwork as case managers and emergency services workers, outpatient therapy, and in-patient treatment. The sample represented a mixture of public and private clinical experiences;

however, the majority currently practice in a public setting. Each person connected his or her job setting with specific information and experiences. For example, those who work primarily with children have more insight into the school systems; whereas, those who work as caseworkers in the community seem to have a more comprehensive grasp of the auxiliary services required by severely mentally ill adults. Sal's experience as a case manager informs her knowledge of the community's resources. While discussing the employment services for inmates, Sal stated,

There's no connection to the Department of Rehabilitative Services that serves the entire catchment. It's located in Montgomery County; therefore, more folks from Montgomery County are likely to use it. I'm not sure that other localities are really aware of its existence.

Similarly, Shaun's work at a local resource center informs her view of local law enforcement:

I remember when I worked at [name omitted], um Pulaski was horrible. We knew that when we got a call to go to the Pulaski Hospital, we didn't even want the Sheriff's Department involved because they weren't going to do anything anyway.

Several clinicians draw on other professional experiences, such as teaching, which they see as enhancing their clinical experiences.

As noted earlier, all of the clinicians have lived and/or hailed from outside of the NRV at some time in their career; consequently, many spoke of prior clinical experiences in other regions as sources for their knowledge. They also compared these previous experiences to their current jobs. Direct contact with other systems in the

region, including school, social services, and the legal systems also dominated their point of view. When talking about how she would address the racism she recognizes in the region, Micky recounted,

I had a client in [name omitted] who was a racist. And he would say things sometimes that were, um, hateful, and I would call him on it definitely, and I would ask him about it.

She told this story to illustrate how her prior experiences informs her current practice, just as many clinicians in study told stories as a way to explain their current perspectives and practice.

Several clinicians felt that their supervisors' values and opinions influenced their view of regional culture. Andy articulated her experience with a supervisor who espouses the region's more conservative religious views:

There's one supervisor who really ascribes to that conservative, traditional level of Christianity, and I have occasionally asked her is this [the clients' presenting problem], um do you feel this is something that is sort of religious, is this based on their religion or something else?

Client report. Concerning the heuristic of professional experiences, most of the clinicians reflected on client interactions. From the data, client report is a primary source of information, which is congruent with the overwhelming evidence that the clinicians in the study all work from a client-centered perspective. Clinicians across the study seem to listen for clues about their clients' lives in order to help families "get where they want to go." This information appears to come from client narratives about their family systems. The participants also learn from their clients' reports of direct and indirect

interactions with the systems and from “hearsay.” Lou articulated the value of regional knowledge and the family system as she reflected on the intake process:

It’s quite informative for me to know where they are calling from. I am particularly sensitive to where they are calling from....That makes a difference. If they are calling from, uh, Floyd even versus Montgomery County – it makes a difference, uh, versus or even Southwest Virginia versus Montgomery County. In my mind, in my mindset, I deal with it differently...I zero in on the family situation a little differently at that point. I want to understand what family they have because immediately, I would see that as a resource. Do they have any family around at all, do they have friends, do they have neighbors...

Several clinicians asserted that even though they “listen for” these contextual clues, they do not use the contextual information unless the client finds it important. All but one clinician provided multiple examples of regional information they gleaned and used from client report, which may show that most clients in the region consider contextual influences central to their lives.

Several clinicians felt that they learned by “running across” certain bits of information without purposefully probing for it while working with a client. C.J.’s anecdote regarding a regional trend he recognized illustrates this “by chance” way of gaining knowledge. He explained,

...having worked maybe a couple of decades in this field and all of kinds of different settings and thinking that I’ve heard most every story that you could imagine, running into stuff that I’ve never run into before...and then running into it again within the same semester and you run into a couple of episodes!

Regardless of the way the clinician frames the process of gaining knowledge from client report, they all seem to look to the client to inform them, which is consistent with the client-centered model they appear to use (discussed later in this chapter).

Client observation. Clinicians in this study also access information by observing their clients. Many clinicians used words such as “seems” and “appears” when describing clients’ cultural context and regional systems. Regarding the needs of her clients, Elle stated,

Access to services is pretty limited, but it seems like there’s this massive need for an increase in psychiatric services around here. Um, it seems like it’s, to me, it’s like almost everybody we see needs to see a psychiatrist or everybody needs to get in with a therapist.

Dee used similar language as he observed the “mean child” trend several mentioned by several other participants:

One of the things that strikes me, uh, a lot of folks refer to their children, even from a very early age, and I mean a couple of months old, uh, with approval as saying, “oh, they’re mean.” That seems to be a very great need in folks to see the kids as “mean.”

This type of indirect analysis of the clients’ life informs the clinician and mirrors inductive research processes (Echevarria-Doan et al., 2005).

Colleague report. Colleague report is another influential professional source of information revealed in the interviews. Clinicians report hearing about regional differences from other clinicians during case reviews, group supervision, and informal

conversations. When I asked Sal how she accessed her regional knowledge, she explained,

I mean we would share war stories when we were working emergency work and, um, talk about, you know, Giles and how small it is and like their ICU has three beds in it and you have to knock on the door to go in there. And so we just share those kinds of stories, and then I think that all of that together formulates an opinion.

While this access to information is often unintentional, several clinicians actively seek information about the region from coworkers, supervisors, and other professionals in related helping fields. Rae illustrated this process by telling the following anecdote:

For instance, we had a referral, a crisis referral on a guy in the nursing home in [name omitted]. Instead of trying to figure out what the heck was going on, I mean well I did do that, but I went straight to my officemate who grew up there... and I accessed her because I see her as an indigenous helper and a mental health professional...And so I'm apt to utilize, um, folks from within their culture to help them and help that person. You know, give that person information so they can go back and problem solve within their own environment and their own culture.

Learning from colleagues' experiences with regionally distinct cultures appears to be a widely-shared value among the participants. Only one of the participants voiced discomfort with this information sharing because she construed it as stereotyping. The fact that she was the only one who perceived it as a negative, unethical behavior surprised me in light of the disdain many voiced for stereotyping in general.

Diversity training. According to the demographics, all of the clinicians had some form of diversity or multicultural training either in school, through some form of conference, or in their work setting. There appeared to be a consensus regarding diversity training; most participants felt that it did not prepare them to work with clients from distinct cultures, especially regionally-constructed cultures like those found in the NRV. Rae, stated,

You can't just come here and right off the bat, just because you have multicultural training in college, and know exactly what you are talking about.

Academic training. Even though most respondents felt that their direct experience with clients was the most valuable, several, including Rae, felt that it was necessary to access the theories they had learned in their academic training in order to deliver "informed practice." Over half of the clinicians related their academic preparation to their current practice, seeing varying degrees of value. Elle felt that due to the client base being higher in SES at her academic training site, she was not exposed to the degree of diversity she currently sees in her practice. Consequently, she did not feel that culture was emphasized comprehensively in her training. C.J., on the other, found several sources for cultural competency training in his academic work, including professors who guided his work with distinct cultures. Similarly, Toni called her multicultural training "superb" because

...it took a very broad view of what, uh, different cultures were – ageing populations, disabled population, you name it. I mean there are all kinds of populations....My biggest concern is that you teach all of this cultural stuff, and people make assumptions in the other direction.

Whether or not participants valued their cultural competency training, most talked about the cultural competency principals that informed their practice. The most commonly noted principals include the need to acknowledge the strength of the culture, to seek similarities instead of differences, to be self-aware, and to be “politically correct.” When I asked if these principals came into play often when working with clients who seem to be influenced by their regional contexts, only a few clinicians could come up with examples. This trend contradicts participants’ statements addressing the value of local knowledge and their ability to provide case examples when discussing the direct professional experience they have had with regionally-distinct clients. I believe this incongruence is due in part to the lack of emphasis on region in cultural competency training and the fact that clinicians acknowledge the individual components of regional cultural (e.g. gender, class, education, and social resources) instead of seeing all of these as part of a regional cultural context.

Personal Sources

Personal sources and experiences emerged as the other axial category in this section of data analysis. I identified six personal information sources informing their perspectives on regional distinctions.

Direct experiences. Direct personal experience with residents or in a particular area was the predominate theme in this category. The most common of these personal contacts resulted from the clinicians’ residence in one or more of the region’s counties. Participants reported interactions with community systems while in their role as a resident, parent, family member, public figure, church member, etc., all of which seem to shape their view of their community. For instance, Gram has been what she called an

“activist” in her community and seemed less critical of her county as she was others. C.J., however, alluded to his negative experiences as a parent and resident of his community, calling his town “elitist.”

Some clinicians noted their personal status in the community, which could be considered a bias. Many do not seem aware of this bias, however. For example, even though Sumner observed his clients having difficulty “negotiating” the school systems in his area, he stated, “I haven’t personally encountered the school systems being hard for me to negotiate when I’ve had to call or something.” He does not follow this comparison with insight into the reason for this discrepancy. Very few clinicians seemed aware of their bias when describing neighboring communities or counties, especially when drawing comparisons to their own place of residence. Just like C.J., many clinicians frequently used the word “elitist” when describing Blacksburg and Radford (see Appendix E). Yet, Chris, who lives in one of these towns, did not acknowledge its elitism; she spoke about the diversity and equality most residents in her town present in comparison to other parts of the NRV.

On the other hand, Elle is acutely aware of how her childhood experiences in a regional town have biased her view of it. When comparing the differences in school systems throughout the region, she said,

...and then as far as [name omitted], you know, I have my own kind of personal views of what it was like being in school there, and I don’t have many clinical, so I don’t know which one is influencing the way I see it.

The participants often indirectly connected their personal experiences to their knowledge or opinions. For example, many clinicians described their thoughts about a

specific town in the region by telling a story about a personal interaction they had there. When I asked Micky, a “newcomer,” what she knows about the differing communities, she immediately thought of a personal experience she had:

I like driving to the Cascades...people wave at you from their porches, which I love, but also it's strange – there's some confederate flags flying in people's yards driving out there. I was a little uncomfortable, and, I mean, I wondered if people really know what they are supporting or what they mean by this...I've seen black families and white families, um, and they are, you know, different races that live on that street, and it seems like a peaceful place. I am struck by how orderly everyone's yards are, and they all mow in the same direction, and they all have porches that they sit on and wave at people driving by, and it's just really sweet. But I also see the flags...and it seems strange to me.

In her story, Micky revealed her struggle with what she sees and what she thinks she knows about racism. This personal reflection seems to inform her evolving vision of the region.

Self exploration. Self exploration is a common self-of-the-therapist practice associated with the origin of the clinicians' knowledge and insight (Hardy et al., 1995). The clinicians who reflected on their own regional identity, beliefs, social status, and personality traits seemed more aware of their role in the system and how their identity directly affects their relationships with their clients. For instance, Andy described how she processes an issue or difference that emerges with a client:

After work hours, I think and process in my head – “why am I disturbed this?” or “why can’t I change this?” or “is there a place for me to change this?” or “Should I leave this alone?” – a lot of after hours work.

Several participants emphasized the need to increase their “self consciousness” when facing “disturbing” cultural distinctions in their practice. These findings reflect the cultural competency concept of “cultural sensitivity” (Hardy et al., 1995).

Family and friend report. Family and friend report is another type of personal experience that contributes to the clinicians’ knowledge base. When I asked Gram about cultural distinctions she has found in the area, she identified gender. In describing what she sees, Gram described a friend from the region who told her about “Southern” women:

She informed me that Southern women are the strongest women on the planet, and here’s why, and this is the kind of things they have to overcome, and that she considered herself stronger than most....That’s the first time that I’ve ever heard it or considered it. Since then...when I meet a Southern woman in the area, I think, ‘hmm, this is one that she is talking about.

This is an example of place identity, which is the process of exchanging and espousing information from others about one’s physical setting (Dixon et al., 2000). In this way, the clinicians’ heuristic processes mirror their clients’ development of regional identity. In a cultural competency training program, clinicians could explore this parallel in order to better understand their clients’ and their own construction of identity (Falicov, 1995).

Local knowledge. Closely related to family and friend report is local knowledge, another widely-shared source for information about the region. In almost every interview, participants cited hearsay as the source for a fact or belief they have about a particular regional culture. The origin of local knowledge is usually difficult to establish, which was a consistent ambiguity in this study's data. Many participants would say, "I've heard" or "It is known that" or "People say" when referring to perceptions or supposed facts about a specific area or population. Several clinicians mentioned good sources for local knowledge, such as "indigenous helpers" or "cultural brokers." There was a consensus that local knowledge is helpful when attempting to help a client from an unfamiliar part of the region. One clinician stated that local knowledge makes her more comfortable when trying to gain services for her clients and that without it, she feels "impotent." Jesse feels that therapists with local knowledge are more affective in regionally-distinct areas:

It's much more helpful to have a therapist... who knows the area – they know the people and particularly referral sources amazingly. If we do that even in terms of prevention programming, it is much easier to put someone in a program in a school or in another community organization if people know and trust them and had some experience there.

By acknowledging the value of local knowledge, the participants validated regional culture as distinctive and worth exploring.

Sense of place. During the early stages of the data collection, I adjusted my protocol to initiate more narrative information from the participants. Consequently, I began asking participants to describe how they felt while driving or riding through

specific parts of the region. This question allowed me to learn more about participants' sense of place, a concept that emerged in the pilot interviews. Most clinicians used landmarks, both natural and man-made, to recreate their view of the landscape, many of which illustrated their opinion or perspective of that particular place. They also noted "feelings" they derived from the physical and atmospheric aspects of these places.

During her virtual journey, Chris described how it feels to drive into Pulaski:

Pulaski is just sad – it's just a sad, sad oppressive feeling because you know it used to be, um, there were factories where people could actually support their family and work there their whole lives, and um, you know, make a decent living. As they moved out -- all of the factories left – you can see all of those Victorian houses that are literally falling down and all of those antique malls and spaces. It's just sad. Sad people walking all hunched over and just really depressed.

Similarly, the excerpt from Micky's experience at the Cascades in Giles County recounted earlier in this chapter is a good example of sense of place. Micky's feelings about the place contradicted her worldview, so she voiced difficulty in making sense of her view of the area.

The interviews showed the participants' recognition of relative economic status as they surveyed the housing, retail, and other structures lining the streets. These cues from the environment appear to influence the participants' "feelings" about the place. From a personal experience point of view, Toni identifies Gillie's, a local restaurant in Blacksburg, as one of the landmarks that gave her a feeling of the area:

We walked downtown to find a place to eat, and we saw Gillie's and went in.

There was a bluegrass band playing, and we realized we could get vegetarian

food here, and it was a funky place, and we loved it. I said, “Okay, if this element is here, I can make this work.”

Several clinicians noted their lifelong “sensitivity” to place, which had influenced their perception of all of the places they had lived and visited.

Not only did these virtual journeys bring forth visual sources of information, but they also initiated emotions. Like Chris’ feeling of sadness, all of the participants in this study revealed at least one place in the region that they connected with a feeling or emotion. These themes confirm the influence sense of place has on the individuals’ perspective on a community. They also reveal one of the layers of information a clinician adds to the clients’ landscape when constructing a mental map of the clients’ life. For instance, throughout Chris’ interview, she noted many social, economic, and behavioral problems in Pulaski, which are coherent with her description of her sense of Pulaski as a place. In contrast, Shaun stated that she does not see very many distinctions in the area’s region, yet it was a good “feeling” about a town in the NRV that led her to move her after college.

Stereotypes. Stereotypes inform most of the participants’ view of the residents in the region. For me, this theme was one of the most surprising and illuminating aspects of my research. There was very little if anything in the cultural competency literature to prepare me for this revelation. Ten out of 15 clinicians felt comfortable discussing the way stereotypes have informed their cultural competency; even though, almost all of the participants apologized at least once in the interview for making generalizations. Reni made it clear that she would not apologize for “generalizing,” in light of her many years of personal and professional experience. She stated, “I feel I can speak with authority

from years of experience and, you know, as a parent and as a professional.” Elle noted how stereotypes are not always “hurtful” because they can be a practical source of information and provide client context. Rae “does not subscribe to stereotypes,” but she said that all of us come with preconceived notions about other people – “it’s a part of our experience.” Several clinicians felt there is an amount of truth in stereotypes and that they are to be acknowledged in order to be “debunked.” Most of the participants agree with Jesse, who stated,

There are stereotypes that are true and they are real and you do see them, but there’s a lot that aren’t and yet you see some in pockets and you see some, not at all. And I think it’s really up to us as professionals not to make assumptions and to um to check things out. Whether it’s with our clients directly or with groups of people before we leap and make assumptions that aren’t real. And I think that’s true anywhere you work.

Two clinicians decried stereotyping all together and denied its validity for any purpose. I believe that some of the reticence to confirm stereotyping behaviors comes from previous cultural competency training. Most of these programs admonished clinicians for their human tendencies, yet generalizing is a common way humans make sense of complex environments (Carter, Carney, & Rosip, 2006; Prentice et al., 2007;)

It is important to note that over half of the respondents felt that stereotyping is “bad” and is something they attempt to avoid. Almost all of the clinicians felt that there are as many exceptions to stereotypes and generalizations as there are people who fit into them. However, after analyzing the data, this same portion of the sample consistently generalized people by characteristics, geography, and other identity

factors. They use words and phrases like, “we,” “them,” “those kinds of people,” “type of person,” “enclaves,” “pockets of people,” and “dominant culture.” While not overtly stereotyping, it is still categorizing others by like traits, which is one definition of stereotyping. Furthermore, every clinician I interviewed was able to identify stereotypes across the region, which means that it is part of their awareness.

Media. Media as a source for information about the region was the least salient code in this category. It came up in almost half of the interviews, but more in result of a prompt. Most of the respondents felt there was a relative lack of regional representation in the media, especially in the *Roanoke Times* and the local television news programs. Conversely, Reni felt that there was too much emphasis on local news and not enough on global issues, thus highlighting the region’s isolation. Andy felt that the slower pace of the region is reflected in the lack of urgency and “bad news” presented by the media in the area. Two respondents felt that the media presented a narrow view of the NRV.

Depictions of isolated rural areas on television, in movies, and in fictional literature also fed preconceived ideas the NRV. Micky talked about what she expected the area to be after reading Southern literature prior to moving here. Most of the clinicians commented on how experience in the area erased, refuted, or confirmed these portrayals. Nevertheless, these accounts point to the way people apply preconceptions about regions and their residents and how it takes experience and awareness to keep from applying unfounded perceptions (Hardy et al., 1995).

Clinical Models and Philosophies

The third emergent axial category of themes concerns how clinicians address regional culture in practice. This category was saturated quickly considering the number

of clinicians using a similar model when working with culturally-diverse clients. I combined the open codes into two major categories: 1) Clinical models and philosophies and 2) Adjustments. All of the participants emphasized both clinical skills and self-awareness when asked about their work with clients from regionally-distinct cultures. The use of region, however, varied according to the value the clinician placed on contextual influences and issues. The findings in this group of themes resonate with cultural competency literature and research considering the way in which the clinicians used their clinical skills and knowledge, adapted their models to meet the clients' needs, and re-conceptualized their perspectives on their clients' identities and contexts (Ridley et al. 2003).

Clinical Models

Client-centered model. All of the participants identified what many called a "client-centered" model. Only one credited Erickson as an influence; therefore, there was not one particular theorist or model the participants identified specifically in the data. It appears that these clinicians integrate their model from several influences and adapt it to the unique needs of the rural region in which they practice. The surprising aspect of this theme is the consensus across the sample, which is composed of a variety of training and practice backgrounds.

There were commonalities among the clinical models the participants describe:

- Empathy
- Unconditional acceptance of the clients and their realities
- Client-directed intervention regarding needs, wants, and pace
- Clinicians' "not knowing", "meet the clients where they are" stance

- Attention to context and culture as clients presents it
- Clients identify the problem
- Clients are directly involved in the treatment

Most of these components are used in client-centered models (Corey, 2004), showing how basic clinical skills, regardless of the training background or mental health discipline, remain intact when practicing cross-culturally.

I was struck by the relative rejection of strategic approaches revealed in the data. I anticipated finding a variety of clinical models, including structural and strategic approaches, considering the diversity of the ages, number of years in practice, and the variety of training backgrounds. Several clinicians stressed the evolution of their clinical model through years of experience with regionally-distinct clients, which may explain the shift to more post-modern perspectives. However, the participants also noted occasionally adjusting their models to a more structural approach in order to accommodate a variety of client variables. For instance, Andy reflected,

For me, the way I do it is kind of go in and get information about the family, and I get a feel for the family, um, and I go with that from where they want to go. I am not much of a structural kind of strategic therapist, but occasionally, I have to go there depending on the family dynamic...I base it on where I feel the family needs are, but also on how I feel I can tap into them.

Not-knowing stance. Most of the participants say that they use a “not-knowing” stance to gain a better view of their clients’ experiences in an effort to “go where the client leads.” Using this approach is recommended in the cultural competency literature as a means to explore clients’ cultural experiences (Falicov, 2003). From this

perspective, the client is the “expert,” thereby determining the course of the therapy (Anderson & Goolishian, 1992). Most of the participants used metaphorical language alluding to a journey or map in regard to this client-centered approach. Sumner described what it felt like to challenge a clients’ culture as “violating their moral compass.” Allusions to mapping also appears in C.J.’s description of how he determines where to begin in therapy and what theories to apply:

Depending on the issues and what they are wanting and the theory, be it kind of a tool or road map to help you get from where they are to where they want to be or need to be.

Participants used other phrases associated with mapping, including “start where the client is at,” “meet them where they live,” “inhabit their world,” and “go where the client leads,” to describe the initial stages of therapy.

The majority of clinicians also emphasized the need to “listen” in order to explore the family systems and community systems with which clients interact. This attention to ecological context is consistent with recommendations made in the cultural competence and rural mental health literature (Blackeney, 2006; Coleman et al., 2003). Many clinicians use this information in their diagnosis and treatment plan. In contrast, more than half of the clinicians stated that they do not pursue context if the client does not identify it, yet this form of clinical bracketing is not consistent with the way they describe where they begin with the client and the information they extract from their clients’ descriptions of their lives. Lou, a social worker, describes the value of gaining ecological information:

Ideally, I would have like to have a conversation with someone aside from the client...you get a bit of perception from the neighbor, the friend, the family, whoever might be close to this person to present the picture from that person – you know, “what’s going on here.” That’s tremendous help to be able to gain a bit of control and understanding of the family situation.

Concerning regional context, Micky finds it valuable to ask questions, such as, “What is like for you to live there.” In the interviews, many of the clinicians stress the need to ask questions and listen carefully to the client without applying preconceived ideas and values. C.J. articulated his version of this process:

I’m probably more Ericksonian in a sense that I believe every person in every family is like their own model and it, you should allow for that person and persons to teach you about them and that you know I try not to go in with expectations. I try to be real open um about having clients and families help me understand them and where they are and where they come from and what’s you know, typically and atypically and that sort of thing so you know again going back to... it’s not a problem unless it’s a problem.

When I asked the participants what advice they would give a clinician who had just arrived in the area, many of them stressed getting to know the systems and the need for “networking.” Two clinicians, who have training responsibilities, take newcomers on a tour of the area, stopping to eat at local places and driving through the more remote communities. Exposure to local culture is suggested by Piercy et al (1982), especially when a region like the NRV has many distinct cultural “enclaves” (a word one participant used to describe the clusters of distinct cultural groups).

Clinical don'ts. Many of the clinicians provided a list of “don'ts” and “avoids” they attempt to adhere to, including “resisting” such tendencies as projection and misinterpreting the problem. Similar to C.J.'s point about paying attention to the clients' perception of the problem, Sumner sometimes has to “check” his interpretation of the client's needs. He stated,

Sometimes, I've got the problem. I mean outside of my value system or society's value system – if the problem is really that they can't keep a job, then that's probably what I should focus on. That they treat their wife like crap, as far as I'm concerned, well, if they are going to make changes, we'll probably have to first deal with what's most important to them.

Further, he revealed that he avoids a “be like me” attitude. Other tendencies the participants attempt to avoid include applying past experiences and making assumptions about the clients' systems.

Acceptance. Another frequent code under this category was acceptance. Participants stated repeatedly how important it is to accept the client for who they are, how they construct their reality, and for their cultural beliefs and behaviors. The social constructionist literature supports using this perspective to understand culturally-distinct clients' realities (Freedman et al., 1996). Furthermore, several participants asserted that respecting the clients' worldview is critical to ethical practice. C.J. stated that imposing his values on a client could be considered as “doing violence against the client.” Sal's experience with what she calls the “subclass” of people who are racists challenge her model the most, but she reflected,

I focus on the commonalities that we have, but I do have to keep a check on my own personal beliefs. And when you are dealing with those folks (racists), you have to understand that's where they come from and accept that's their world view and not try to your world view on them.

There is an "ethical line the clinician has to draw," according to many clinicians.

According to the interviews, the clinician has moral and ethical responsibilities. Yet, only two clinicians reported having to challenge a client's culture in result of their duty to report.

Variations on the model. While most of the participants see this model as the standard, there was a range of adherence to these principals. Their descriptions of their clinical processes and philosophies were often contradictory. Some clinicians like Reni and Gram believe that it is important for clinicians to use all of their knowledge and to be honest about one's human tendencies. To them, this perspective means that clients have only partial control over the therapeutic process. On this end of the continuum, there is a sub-group of clinicians who felt that in addition to their client-centered approach, their role is to "educate" clients. Dee reflected on this version of the model:

It [model of therapy] is much more geared to what I, uh, from the individual themselves to see where they are in their lives and whether they have any kind of, what the wishes they have for themselves and what their potential is...with some education, they might sense that change is possible. So, I think it's more geared to the individual than it is to their particular background.

He acknowledged his use of the clients' context and his prior knowledge of it as he conceptualizes his clients' needs: "I do think I try to process what an interaction with other parts of the system would look like for them."

Gram also feels that her role is to educate her clients. She seemed acutely aware of the information she uses and her role as she recounted a typical interaction with a client:

There is this instant reaction, but then I put it aside, and then I meet with the mom and talk to this mom to assess her level of education of insights as a parent, her skills as a parent...and I tend to hone in on your strengths. I'm going to pull out and use what I see whether you are, you know living on food stamps and other supports or, um, a trailer or if you are living in a mansion on the hill.

The concept of educating a client seemed at odds with the model that emerged in the data; however, this group justified it by noting that clients tell them what they want, and client education offers strategies for attaining those goals.

Others, like Toni and Shaun, feel that they are complying with their client-centered model by not acknowledging their awareness of their clients' cultural distinctions. Most clinicians in the study were more moderate regarding the flexibility required when working with culturally-distinct clients. After analyzing the data concerning the multiple levels of recognition and the sources for that knowledge, it was difficult to reconcile some of the clinicians' concepts of their practice with their recognition of and experiences associated with multiple layers of context.

Clinical Philosophies

During the axial coding process, I identified another category that revealed shared clinical philosophies. These codes include the clinicians' view of change and the power of the therapeutic relationship. Regional context appears to guide the participants' philosophies to some degree; the more a clinician practices in the NRV, the more the area's unique needs and features influence the clinician's clinical theories. Most of the respondents intimated the difficulties of change within the population of this region. Transgenerational behaviors and beliefs, the closed systems (both family and community), and the geographic and social isolation were the main contributing factors, according to the participants. From the data, most of the clinicians are aware of these regional issues (as noted at the beginning of this chapter).

View of change. The participants who identified their philosophies on change were split regarding their therapeutic role. One group feels responsible for change; these clinicians believe they are able to alter the culture by "breaking it down" or "challenging it." For example, when faced with racist clients, Andy initially felt that her role is to change the family. She framed her evolving view of her role:

Because I am a feminist therapist, the idea of helping to change the family or client, or what that meant to me, was important....And I recognize that, yeah, I'm in a different culture, but that doesn't mean I don't mean to challenge or I don't need to break that down a little bit more.

The other camp believes that clients are responsible for change -- if change is even possible. Dee's perspective falls on this end of the continuum, which is evident in his statement:

I have a lot of trepidation about my own ability as a counselor to be this agent of change. So, I come from the perspective that I am in the same boat, pretty much, as a human being, as the person who is on the other side of the desk, and that change has to come about very, very slowly...I think that we as counselors assume that making changes of a significant nature is hard but that it's possible, and I just don't believe that...they might make short-term improvements in their life, but overall, the direction of that person's life is not going to change a heck of a lot because of my intervention.

Regardless of where the clinician stands on this issue, most concurred that "change can not be forced" and that clinicians working with clients in most of the region should be prepared to "slow down" and lower their expectations and the pace of therapy.

Client identifies the goal. Similarly, the clinicians who used this client-centered approach allow clients to identify what change means – what the goal is. This concept is closely related to letting the client identify the problem. Rae spoke for many clinicians in the sample as she explained how this works for her:

I really start with the client, and what the client's goals are, and you know, some of that sounds pretty trite....but if the client says to me, "I want to move the hell out of here," then we work on that, we find out why, we find out what's going on and what their resources are. If the client says to me, "I want to stay in my trailer for the rest of my life because it's on my family property and the home place is a mile down the road and everyone is buried down there," then I'm going to help them stay in the their trailer even if it's a rat hole. We'll just figure out how to make it safe.

Adjustments

While most respondents felt strongly about their clinical approach, the majority also listed a variety of adjustments required when working with regionally-distinct clients. The most common codes associated with this theme were adjustments according to the clients' contextual systems, pace, expectations, and traits. All of these adjustments can be traced back to the participants' knowledge and perceptions of the regional distinctions (e.g. slower pace, common presenting problems and behaviors, and limitations of and barriers presented by the ecological systems). The participants' process of making these adjustments to their clients' distinctions and needs is consistent with the literature regarding the deductive and inductive processes many clinicians undergo when forming hypotheses about their clients' problems (Eschevarria-Doan et al., 2005). In addition, this type of flexibility and sensitivity is listed as a core competency by the AAMFT (2004).

Contextual systems. Clinicians appear to apply their knowledge of the clients' ecological systems to their interventions and treatment plans. While several participants noted how "helpless" they felt against the many barriers their clients face in more rural areas, most appear resolved to accept the limitations of the services and system.

Regarding the strength the family system has on the individual, Sal acknowledged,

You can educate someone into a different mind frame, but when they go back where they came from, almost immediately their family members will try to bring them back down...You don't want to set the person up for a negative consequence. That's why it's important to know where the person comes from.

In this excerpt, Sal described how she and many other clinicians adjust treatment expectations to what the clients' ecology will tolerate.

All but two clinicians in the study use regional identity factors in therapy to some degree. There seems to be a range of applications. Many of the 13 remaining respondents felt that regional context provides "valuable information" as they attempt to better understand the clients' needs, goals, challenges and strengths. Coping patterns also emerge from this information, according to several clinicians. Paying attention to coping strategies helps clinicians understand the cultural beliefs and practices underlying behaviors (Coleman et al., 1995). Not only does this understanding provide information, but it also helps the clinician prepare the client for the "systemic realities" they may face when trying to change. When describing how she uses regional contextual information, Elle stated,

Even if you are dealing with a client who doesn't fit into the stereotype, you know that a lot of people do in that area, so you get information about their environment, about their support systems, about the possibilities...you get a lot of information even if it's [clinician's preconception] not true and it doesn't fit for them. It gives you the idea of what they're up against and the choices they've made and what their strengths are. Um what their coping skills are. Obviously, there's something else for them that they have because they haven't resorted to what the majority of the population in that area has.

Clinician demeanor. Another set of adjustments many clinicians report making concerns the clinician's demeanor. Reni reflected on a personal change she has had to make with clients from this area:

The only adjustment I have had to make is an odd one, but it's being such a happy person. Since I am such a happy person all of the time, I realized one day that a client couldn't relate to me because I was too happy.

Reni also admitted having to adjust the level of "intimacy" she has with her clients in terms of touching them when they are upset. Dee echoes the need to adjust when he said that he has to "recognize the power differential" and "allow a lot of space...let them to come towards you rather than getting into their space a lot." Other clinicians described having to make similar personality adjustments to the "regional tone." Elle finds that she adjusts her dialect to reduce distance:

For some reason just the way I talk can put them [clients] at ease....I can turn it on big if I want to, or I can pull it back very easily.

Developing the clinical relationship. The importance of the clinician/client relationship surfaced as a means to facilitate change, no matter who is responsible for it. Clinicians noted having to make adjustments, since many found it more difficult to join with clients in this area than in other areas in which they had practiced. Lack of trust, negative experiences with other systems, and the cultural divide seem to be the most common reasons for client resistance. According to the data, the clinician focuses on developing the relationship as the central vehicle in helping the client "get where they want to go." Jesse tells new clinicians she supervises,

Your ability to do your job is about your relationship with your clients. That's all, that's what it's really all about. You have to slow down and take your time and pay attention. And if you don't do that, you won't get in the door. You won't begin to develop that relationship.

Gram addressed the importance of culture as a factor in the relationship:

An important piece for any of us in this field is to pay attention and recognize the regional identity, the culture, um, the aspects of what that brings to each of us, to honor that, and to include that in the work we do with families. If you really want to get to know that person or family, you have to have a relationship and a connection, and you have to honor that piece of who they are.

Building relationships despite the various regional barriers takes a great deal of work, according to the participants.

Self of the therapist. Awareness of one's own culture and origins of identity was a consistent theme in the cultural competency research and clinical recommendations for best practices (Hardy et al., 1995; Sue, 2006). In theory it should have emerged a salient theme considering my assertion that regionally-constructed distinctions meet the criteria for culture. To my surprise, many clinicians felt that awareness of their own regional identity was only important if it helped them join with the client.

Clinicians concurred on the client-centered model, which many assert requires a great deal of self-awareness and personal reflection. Without awareness of one's own biases, beliefs, behaviors, and other identity factors, helping clients from this model would be difficult. The data revealed varying levels of clinician self-awareness and use of self.

The participants describe using self-awareness in therapy in order to avoid some of the "don't" of their model. This theme is consistent with the emphasis the MCCs places on self-awareness (Arredondo et al., 1996). According to the interviews, clinicians are aware of how they are coming across in therapy and how their behaviors

and demeanor influence the therapeutic relationship. Micky was one of the most self-aware of all of the participants. She worries about the way her clients perceive their differences and interprets her thoughts about them through their actions. She explained:

I felt that there was a little more distrust from them [a family from West Virginia] than from the family associated with Tech because they feel like I can't relate to what their struggles have been. And I feel like there's almost a sense, um, that they see me as being in a different place, like I'm more privileged or my education would make me more like I was above them somehow.

Like several other clinicians, Jesse takes a more transparent approach in order to break down some of the misinterpretations inherent in the joining process. She explained that she often tells clients,

"You know, as you were sitting there talking about such and such, I was experiencing this, and I need to be able to check with myself to see what that means for me, and maybe if you see me doing something that you don't approve of or you think I'm having a reaction to, you'll let me know," and then I involve them in that process.

In light of the vast educational and economic differences between many of the clients and clinicians in this study, awareness of one's status emerged as a common concern. Micky articulates this concern in her reflection above regarding how the client perceives their differences. She, like many clinicians in the study, believes that a balance of power is necessary for a good therapeutic relationship; therefore, being aware of one's status plays a critical role. Similarly, Dee noted,

Recognize the power differential, that the cultural differential is so great that for a large number of people coming in [to therapy], we are seen as a person from another planet. We can't even appreciate how strong that differential is.

In the interviews, the discussion of power was often associated with the clinicians' discussion of the client-centered model and the role of both client and clinician. This concern regarding status is inconsistent with earlier findings regarding the clinicians' awareness of their status in the community. Whereas most articulated the need for this awareness in therapy, most did not acknowledge their personal status in their regional context.

Being aware of one's tendency to stereotype was another prevalent form of self-awareness clinicians discussed in the interviews. As noted earlier, many participants asserted that stereotypes can provide a place to start and offer some view of the person's context and systems. However, participants made numerous references to how preconceived ideas and stereotyping may interfere with the clinician's ability to "listen" to clients and perceive their lives clearly. C.J. provided an interesting view of how this works from an Addilarian perspective:

We need to be aware of unconscious motivations...so when you run into a situation you will know what your likely tendency will be, how you will see and hear things. So, it kind of like what you're tuned to see and hear what you're readily tuned to see and experience, and it based on your own background.

Several participants in this research showed an aversion when asked I asked them to reflect on geographic generalizations and stereotypes. Considering the fact that this subject requires disclosure of biases, I was expected some reticence. I did not

anticipate the caveats and multiple apologies for stereotyping or for what they perceived as a “bad” attitude.

Like many participants, Rae framed stereotypes and other grouping behaviors as “part of our experience.” Similarly, Chris framed it as a way to make sense of the world around us. As one clinician stated, “Stereotypes happen, so we just need to deal with it.” In fact, several clinicians believe that some groups in the NRV embrace the stereotypes associated with their group or community as a form of identification. For example, the term “redneck” came up in all but one interview; several of the clinicians used the term in a positive sense, while others acknowledged it as a pejorative.

Clinicians felt that it is helpful to acknowledge the stereotypes they are aware of with clients so that they can discuss how these generalizations apply to them. In this way, it functions as a measuring stick. According to the participants, using stereotyping in this way does not mean that they support stereotyping – many felt that it is part of the awareness of bias and exploration of self and the client.

Bias checking. Closely related to self-of-the-therapist work is bias checking, which appears to occur when the clinician is faced with clients whose cultural identities are at odds with their own. For this reason, knowing one’s own values and beliefs was a theme that frequently accompanied discussion of bias. Sal acknowledged her bias and how she addresses it with clients:

I try to draw on the commonalities we have, um, I do have to keep a deep check on my own personal beliefs...you have to accept their [clients’] worldview and not try to force your world view on them.

Sumner's more "own it" attitude resonated with other clinicians who overtly saw the utility of stereotypes. He admitted, "I subscribe to some stereotypes, but it's certainly not all of them." When I asked what advice she usually has for new clinicians coming into the area, Elle eloquently stated, "Know your own stuff."

Most participants who spoke about bias turn to peers for guidance, or they "check" themselves. C.J. suggested being aware of one's "filters" and values before assessing a clients' behaviors or belief. Rae admitted to having difficulty in accepting her clients' goals because of her biases. She reports having to "check" herself when she is aware that her biases are interfering with her ability to provide client-centered treatment. Only two clinicians mentioned supervision as a means for addressing bias.

The Emergent Theory

After I completed the constant comparative method of analyzing the data, I developed the coding matrix from the iterations of analysis and synthesis. The following overarching theoretical statement emerged from the final selective coding process (see Appendix D):

Clinicians working with regionally-distinct clients combine a client-centered approach with multiple-layers of regional knowledge and self-awareness. This statement reflects the clinical processes as well as the personal processes both clients and clinicians experience in therapeutic relationships.

Concepts, Assumptions, and Theoretical Statements

The theory developed in this study incorporates the essential components of a theory, including concepts, assumptions, and theoretical statements (Shoemaker et al., 2004; Strauss et al., 1998).

Concepts

When at all possible, I used the participants' descriptions, words, and phrases as codes and categories, and many of the codes replaced more common words or phrases for similar concepts. In addition, some of the definitions provided in the introduction of this research appear as concepts in this theory; however, I re-aligned these definitions as needed to coincide with the findings. The salient concepts emerged in the coding matrix (see Appendix D) and were elucidated above in the previous sections of this chapter.

Assumptions

I identified several assumptions through an analysis of the concepts and their properties and dimensions. The following one-dimensional, analytical statements underlie the relationships between the concepts and the emergent themes (Shoemaker et al., 2004):

Clinicians working with regionally-distinct clients

- are aware of their clients' ecological contexts,
- recognize multiple levels of regional distinction,
- search for systemic causes for these distinctions and corresponding problems,
- access regional information from professional sources and experiences,
- access regional information from personal sources and experiences,
- are generally unaware of their own regional identities,
- are aware of and find use in stereotypes,
- acknowledge their own biases, including stereotypes,
- emphasize a client-centered model,

- adjust their model to their clients distinctions and needs,
- consider the clinical relationship important to the concept of change, and
- emphasize self-awareness.

Most of these assumptions are congruent with the literature and the theories used as foundations for this study. Several results were unexpected and relatively unexplored in the MFT literature, such as the consistent clinical model, the recognition of multiple layers of regional distinctions, and the use of stereotyping.

Theoretical Statements

Finding connections between the concepts and assumptions is central to the inductive process in grounded theory (Bengston, Acock, Allen, Dilworth-Anderson, & Klein, 2005; Creswell, 2003). While most of the theoretical statements emerged from the process of finding interrelated categories in the axial and selective coding stages, many also appeared in the memos generated throughout the data analysis. These relationships are as follows:

- Clinicians working with clients from distinct cultural contexts use an integrated client-centered model and approach the client from a “not knowing stance” in order to “meet client where they are.”
- As clients describe their lives, clinicians add detail from knowledge of the clients’ context while applying and retracting their own knowledge and perspectives.
- Clinicians negotiate the clinical process by attempting to bracket their own biases and by finding balance between their knowledge and identity and their clients’.

- Experienced clinicians adjust their model to their clients' needs, goals, personality, and regional identity factors to develop the clinical relationship and to meet their clients' needs and goals.
- The recognition and use of regional contextual information strengthens clinicians' abilities to help clients by identifying their strengths and challenges and validates aspects of the clients' lives that are typically undervalued and unacknowledged
- Clinicians vary in their acceptance of information sources, including stereotypes.
- Regional context provides a boundaried place to start the process of understanding the client's world and life. It is "important information," and clinicians treat it like other traditionally-identified cultural contexts.

These emergent concepts, assumptions, and propositions answered the research questions driving this research: What the clinicians know about regional distinction, how they access this information, and how they use that information when working with families in therapy.

Theory as Metaphor

In the process of developing the theory, a mapping metaphor emerged. This representation of the theory is appropriate to the topic of regional identity and clinical practice considering the geographic basis for this cultural distinction. The participants' words and descriptions informed this metaphor; many used metaphorical phrases, such as "start where the client is at" or "learn where they [clients] are" to describe their model of therapy. In addition, many described the process of attempting to understand the clients' contexts, strengths, and barriers as a "journey," and the clients' goals as "where

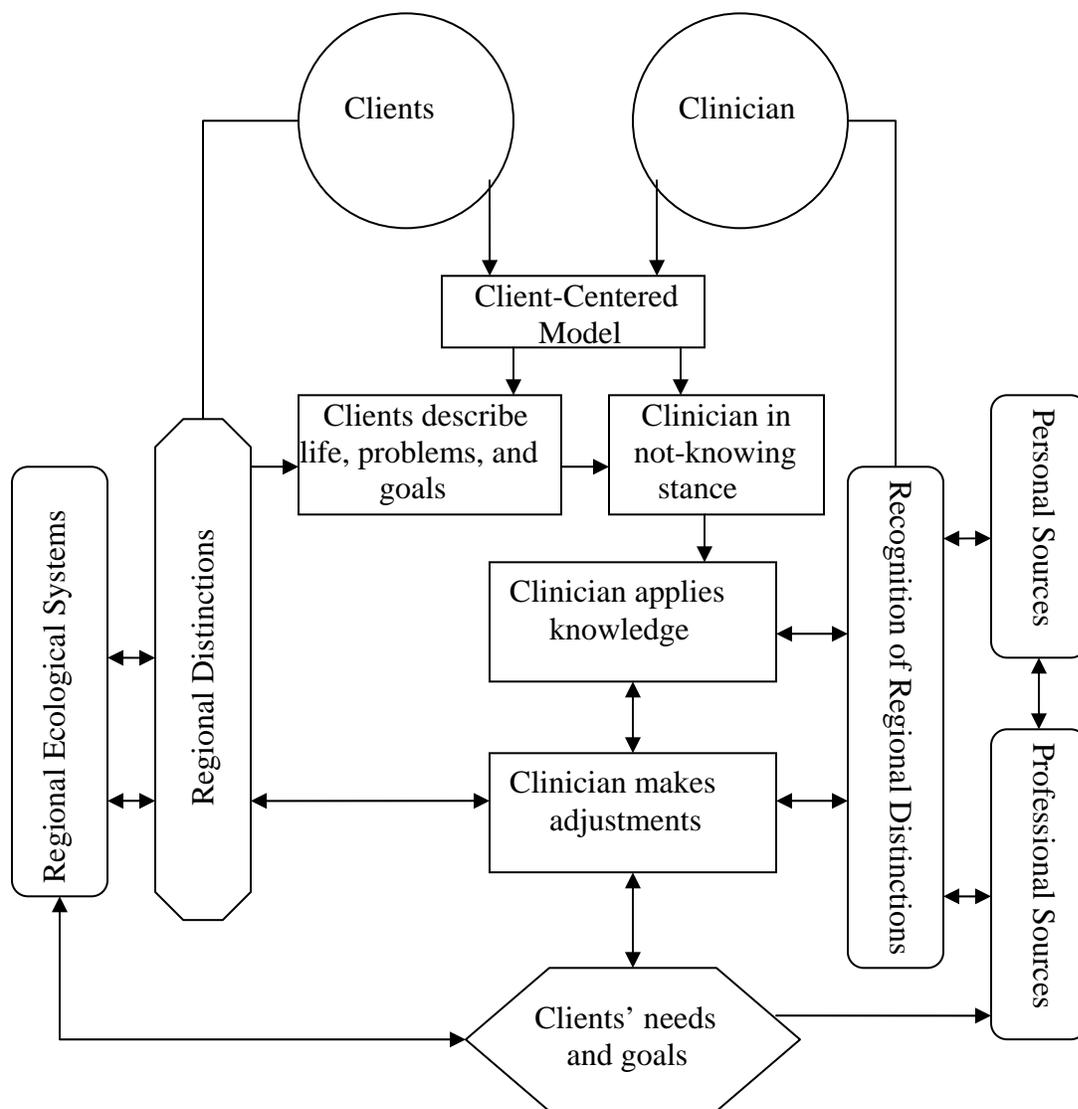
they [clients] want to be” or “where they want to go.” The following is a metaphorical storyline I developed to convey the resulting theory.

Clinicians use a client-centered approach and participate in a complex mapping of their clients’ identities. Clients identify “where they are” on the map and attempt to provide a description of their worldview. The landscape, lay of the land, landmarks -- all provide the clinician a view of the clients’ “terrain.” While the clinician asks questions from a “not knowing stance,” the clinician fills in the map with additional layers that include an interpretation of the clients’ words, prior knowledge of the ecology the clients inhabit, his or her own regional identity, stereotypes, and other knowledge required to complete the picture. The clinician works with clients to fill in the map, making refinements and corrections as clients continue to describe their strengths, challenges, and contextual barriers. The clinician navigates the map with the clients while listening to their needs and goals for treatment. Many clinicians are reticent to compare the clients’ map to previously traveled places, yet many see it as human nature to start with a familiar experience or point of origin.

Theoretical Model

Taken from the data, the following model (see Figure 4) represents the clinical processes clinicians undergo when working with regionally-distinct clients.

Figure 4: Model of clinical processes



This model tracks the flow of the client-centered approach identified in the research. In addition, it provides a view of the clinician's complex, recursive processes of accessing, adjusting, and applying regional factors to conceptualize and initiate therapeutic objectives. From the metaphorical perspective, this model tracks the ways in which clinicians interpret clients' positions and goals on their life maps.

CHAPTER V: DISCUSSION AND CONCLUSION

Implications of This Research

The results of this research provide an impetus for region to join other cultural contexts in MFT training, research, and theory. The clinicians who participated in this study offered a frank, honest look into their clinical processes and their personal and professional values. Through the recursive analysis of the data, the use of rich description, and other rigorous methods employed for trustworthiness, this research yields a wide range of opportunities for further study and clinical application. As a result, the findings of this research offer a “bridge” between research and practice (Rafuls et al., p. 79).

Research Implications

The findings and theory generated by this research may serve as a foundation for further investigation. For example, researching this topic from the client perspective would provide an additional view of the process of working with culturally distinct clients. Client-report research, such as Pope-Davis et al.’s (2002) study of client perception of multicultural counseling experiences, has been done on a small scale to support the culturally-diverse clients’ perspective on the therapeutic processes. Nonetheless, using a regionally-distinct sample in a similar study would expand the definition of culture and provide a more comprehensive look at culturally competent therapy from the clients’ point of view.

In addition, further study of similar rural regions would enhance and verify the theory generated by this research and allow for greater transferability. Because this study was one of the first to explore the clinical and personal processes of clinicians

working with regionally-distinct clients, comparative studies could follow a similar protocol and could be informed by the concepts and assumptions found in this research. Similar studies in different regions and communities, such as rural areas in other defined regions of the U.S. (e.g. Pacific Northwest, New England, and others) would add to the knowledge of how rural regional distinctions act as a cultural context in therapy.

Using a mixed-methods design to replicate and test the grounded theory generated by this research would further the transferability of these findings (Sells et al., 1995). Research using a bidirectional, mixed methods model, would enable the researcher to “verify” the findings from a qualitative phase of the study (Sells et al., p. 200). Such a project would incorporate qualitative methods and survey research methods as a means to plan, collect, analyze, and interpret data. Once the theory has been refined and a survey instrument developed, the theory generated by this research could be tested in other culturally-distinct regions.

From the different categories and themes that emerged, there are several worth pursuing as individual topics. First, the findings of this research point to the need to reevaluate the value and nature of stereotyping as a way for people to make sense of their world. Specific to MFT and counseling fields, looking closely at how clinicians generalize and how such generalizations function in the therapeutic process would allow for more understanding and acceptance of this human tendency in clinical work. As one participant stated, “stereotyping happens,” and research shows that stereotyping can be socially functional (Carter, Hall, Carney, & Rosip, 2006); therefore, it is an ethical responsibility to acknowledge it in a clinical setting. The political implications, both

negative and positive, of generalizing in clinical work would need to be explored in such a study. Psychological essentialism would function well as an established conceptual framework for this inquiry.

Similarly, the therapeutic model that emerged in this theory could be researched independently. Instead of attempting to define cultural competencies, perhaps a set of cross-cultural best practices could be developed from researching the models clinicians use with regionally-distinct clients. Similarly, applying other client-centered family therapy models, such as narrative therapy, to the data set generated in this grounded theory research would further expand the analysis of the processes revealed in this study.

In addition to ecological theory, other theories, such as symbolic interactionism, could be applied to the data to explore the development of regional identity. As Charmaz (2006) points out, the theoretical framework must fit the purpose and the audience of the study; therefore, applying differing theories to the data set offers cross-disciplinary opportunities to situate the research. Similarly, exploring individual concepts arising from the analysis, such as place identity, could provide deeper and more focused attention on the topic of regional identity construction.

Finally, this study should launch more studies regarding “hidden cultures,” as one participant described regional culture. Regional culture is easily discernable if the clinician is sensitive to it (Sugar, 2002). Otherwise, as several clinicians stated, it takes time to recognize, especially if the clients’ race, ethnicity, national origin, and class are not overtly different from the clinician’s. Further, the unacknowledged biases regarding these less overt cultural distinctions could be explored qualitatively to better understand

the phenomenon. Learning more about clinical self-awareness and how clinicians define and recognize cultural distinctions would allow the field to develop training and practice models focused on these “hidden cultures.”

Training Implications

The findings of this research support a good deal of the cultural competency research and training literature regarding the importance of self-awareness. There are, however, specific differences between region as a cultural context and other cultural contexts. As noted earlier, regionally-distinct cultures are often indiscernible initially because the usual cues may be absent, such as obvious dress, language, accent, skin color, or physical features. A greater sensitivity to the existence and nature of geographically-developed culture needs to be added to current cultural awareness training exercises, in result. Providing a discussion and exercises on ecological theory and family systems that include region as a context would help clinicians conceptualize region as a cultural context. In addition, many of the participants noted how their awareness of the unique needs and features of regional groups increased with experiences, exposure, and education from others with local knowledge. Exercises, such as attending community events and meetings, having dinner or shopping in local businesses, and reading local newspapers (Piercy et al., 1982), would allow clinicians to experience and become more aware of their own reactions to and perceptions of their region.

The literature and these findings support the need for clinician self-awareness when treating clients from cultures different from their own. Self-awareness is one of the most important facets of culturally-competent therapy (Sue, 2006) and should be at the

center of any training, regardless of the area or population for which the therapist will serve (Kitaoka, 2005). The participants in this study revealed not only their biases but also the stereotypes and generalizations they recognize and use in their practice. From these findings, I believe training programs should look closely at the human tendency to categorize clients and their contexts and explore how clinicians perceive their own contexts and regional identities.

I composed a sample training program using the findings from this research and from corresponding cultural competency literature (see Appendix F). This training model is built on the fundamentals of cultural competency, with a focus on participants gaining awareness of cultural identities and contexts. This facet of the training follows McGoldrick et al.'s (1999) recommendation that student practitioners/researchers “look beyond social roles to the social/community contexts in which we all live” (p.191). Modules emphasizing important cultural knowledge and cross-cultural counseling skills are included in the training. The training employs experiential methods to offer trainees more opportunities to deeply examine their subjective, inner worldview, and tap into the emotional experiences surrounding their past and present cultural contexts (Watson, Greenberg, & Lietaer, 1998).

Practice Implications

Several important implications for practice emerged from the findings of this research. Primarily, the client-centered model the participants described provides support for the use of context when working with culturally-distinct clients. The fact that these clinicians from differing training and clinical backgrounds developed a similar model in response to the diverse needs of a distinct region shows the interrelatedness

and power of this ecological context. This model also focuses on the influence regional culture has on identity and family functioning. These adjustments to clients' needs meet the competency standards outlined in psychology's MCCs (Arrendondo et al., 1996) and the MFT CCs (AAMFT, 2004).

This research could help clinicians practicing in regionally-distinct areas learn how to recognize both their cultural distinctions and their clients', how to access local knowledge, and how to use their knowledge of ecological systems in their practice. By acknowledging region as a cultural context, supervisors could help their supervisees address biases, stereotyping behaviors, client distrust and resistance, and the tendency to pathologize cultural norms (Sugar, 2002).

Limitations

Since "no researcher enters the process with an empty mind" (Strauss et al., 1996, p. 294), there can be a tendency in grounded theory research to interpret the data with an a priori agenda instead of an inductive process of discovery. This threat to trustworthiness is a common criticism of this method of theory building. Strauss et al. (1998) support the use of rigorous, systematic methods but concede that to some degree, all research is driven by the researcher's accumulated knowledge and interests during the research process. Admittedly, I hoped to find clinicians who acknowledged and applied region as an overt, cultural context. The data supported this hope overall, but the complexities of this topic and consistency with which the clinical processes emerged were unanticipated discoveries.

Another limitation concerns the participants' attention to the political correctness of their feelings and perspectives. This universal reluctance to the human tendency to

stereotype has been observed by social psychologists (Carter et al., 2006). The participants' responses ranged from guarded to completely transparent and forthright about their attitudes and processes. Many clinicians made statements like, "I know this sounds bad" or "I know I shouldn't be saying this," which alerted me to their reticence. Even though I felt that most of the participants seemed constrained when discussing their biases and stereotypes, I did not challenge them during the interviews. Consequently, I believe that the data may have been somewhat compromised by the restraint participants exhibited because of their clinical and social sensitivity against stereotyping and generalizing.

Conclusion

When I started working in the field during my internship, I asked various types of mental health professionals to describe the best clinician they had ever worked with. I wanted to know the definition of competency from the perspective of these seasoned clinicians. There was an undeniable consensus; they all described clinicians who put their clients' best interests before all other considerations. According to these professionals, community and office politics and the clinicians' biases and personal issues are often in conflict with helping the client. One clinician described competency as "putting the client at the center of the room." In order to maintain the focus on the client, clinicians have to care about the clients' identity, needs, and wants, challenges, and strengths. These competent practitioners explore their clients' identity compositions in addition to their own, especially those aspects that influence behavior and interaction (Sue, 2006). Awareness of these contexts has become a best practice in cultural

competent treatment (Heppner, 2006). The model and processes revealed by the participants in this dissertation reflect many of these basic principals.

The need to increase competency standards is an important issue for MFT as a field, especially in the face of third party reimbursement and varying requirements for licensure (Miller, 2005). Marriage and family therapists are ethically bound to provide the most competent, respectful treatment to the best of their ability (AAMFT, 2001). According to the trends in MFT training programs, cultural competency is an essential tool for ethical care (Lawless, Brooks, Julye, 2006). Other behavioral health fields are aggressively working toward identifying and operationalizing cultural competency best practices. Although findings from cultural competency research are empirically inconsistent, there are foundations for theories and practice in both the MFT literature and across mental health disciplines. Perhaps cultural competency is not a construct that can be wholly operationalized and measured. Nevertheless, the quest for culturally-sensitive practice has the potential to bring researchers, educators, and clinicians together from all disciplines in an attempt to provide better treatment.

The goal for this research was to acknowledge and employ the power of the regional contexts in which people reside, interact, and grow. Because people develop in relation to their environments and gain parts of their identities through interactions, culturally-sensitive therapists need to acknowledge and value both their own and their clients' ecological contexts. When clients leave their service provider's office, both clients and clinician return to the systems that influence their beliefs and behaviors.

Ideally, this research marks the beginning of further conversations about the importance of region as a cultural context. Awareness of region as a cultural context

“extends family history and adds another significant dimension to our clinical awareness, treatment approaches, education programs, research endeavors, as well as policy considerations” (Sugar, 2002, p. 176). These concepts are familiar to many clinicians working in areas where their clients’ regional identities are central factors in their lives and in therapy. Cultural competence to these clinicians means allowing clients to identify where they are on the map, what their worlds looks like, and where they want to go. As one participant stated, “How can you help someone if you don’t know who they are and where they come from?”

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Appendix A: Semi-Structured Interview Protocol

1. You mentioned that you offer services across the New River Valley. From which counties and/or cities/towns do your clients live?
2. There are many definitions of culture. What is your definition of culture?
3. What stereotypes are you aware of in the New River Valley? Stereotypes specific to each county or city? Which stereotypes seem to be based on truth and which are not?

4. What cultural factors do you find distinctive in each county?

Prompts:

- Spirituality?
- Art?
- Food?
- Sports?
- Behaviors (time orientation, gender roles, substance use/abuse, speech, dress, etc.)
- Other beliefs and attitudes regarding medical care, education, government?

5. Do you find that families and individuals have distinct behaviors, beliefs, and other types of identity factors in each county/city?

Prompts:

- Views on gender?
- Ways of regulating others' behaviors?
- Ways of dealing with and observing death?
- Disciplining children?
- Views on caring for elderly and extended family?
- Views on gender roles?

6. Do find these distinctions easily discernable between areas? How do you access and acknowledge these differences?

Prompts:

- In therapy?
- From stories told by families about their own area or other areas?
- Through local media?
- Through anecdotal stories exchanged by residents in social conversations?
- From direct experience as a resident?
- From other service providers?

Can you give me some examples? How do these factors influence the family systems?

7. Do you adjust your treatment according to where your clients live? How so?

Prompt:

- Model?
 - Who you have in the room?
 - Your overall treatment plan or diagnosis?
8. Would you please give me some examples of these distinctions (maintaining confidentiality, of course).
9. How would you describe your own cultural distinctions that have emerged from the region or regions in which you have resided?
10. What other systems in the clients' regional do you feel contribute to the regional identity? Can you give me some examples of how family systems are influenced by these systems?

Prompts:

- Social Services?
- School Systems?
- Medical Services?
- Retail?
- Law and Judicial Systems?
- Arts?

11. Does your self awareness as a therapist change when working with clients who are culturally different than yourself? How so?

Prompts:

- Self-of-the-therapist work?
- Use and or need for additional supervision?
- Staffing with other clinicians and peers?

12. What do find most important when working with clients with regionally-distinct culture?

Prompts:

- Clinical skills?
- Awareness of self, including biases?

Appendix B: Informed Consent Form

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY**Informed Consent for Participants in Research Projects Involving Human Subjects**

Title of Project: **Regional Identity as a Cultural Context: Implications for Practitioners Working with Families**
Investigators: Margaret Keeling, Ph.D. and Cathy M. Hudgins, M. A.

I. Purpose of this Study

The purpose of this study is to explore region as a cultural context and to learn how family clinicians use this identity factor when working with families.

II. Procedures

You can ask questions about this study. Once your questions are answered, you will sign two copies of this form. One copy will be for the researcher and one will be for you to keep. Then, you will complete an interview. Your answers to the interview questions will be audiotaped. It should take you approximately 90 minutes to finish the interview. When you finish the interview, you are finished with the study.

You will complete the interview at a place that you choose. This could be at your home, an office, or some other public location (e.g., a library or church). One or two researchers will come to the place you choose.

III. Risks

The risks of participating in this study are very small. However, you might have some uncomfortable feelings such as embarrassment or guilt. You do not have to answer any questions that make you feel uncomfortable. You can stop at any time.

IV. Benefits

While we cannot promise that you will benefit from being in this study, you might learn more about your cultural competency and your experience with regional identity in your practice.

V. Extent of Anonymity and Confidentiality

Your participation in this research study is confidential. Only the researchers will hear your answers to the interview questions. After your interview, the audio recording will be separated from this informed consent form (which includes your signature). After this happens, you will be assigned a pseudonym. Once you have been assigned this pseudonym, we will not know which interview is yours.

During the interview, we will audiotape your voice. After the interview is done, the researchers will type out what you say. When researchers type your answers to the interview questions, they will leave out your name and any other identifiers.

All information collected during this research study will be stored in locked file cabinet in the researcher's locked office. Following the end of the study, the audiotape of your interview and this informed consent form will be destroyed. A written version of your answers to the interview questions will be kept for future use, but only the researchers will have access to this data.

We will protect your confidentiality unless we learn about current child abuse or elder abuse. This information must be given to the authorities. Also, if we think you are a threat to yourself or someone else, we must tell the authorities. These are the only times when your confidentiality would not be protected.

VI. Compensation

There is no compensation for participation in this study.

VII. Withdrawal Procedures

You do not have to be a part of this study. Once you start the interview, you can stop at any time. If you stop, there is no penalty.

VIII. IRB Contact Information

If you have any questions about this study, contact Cathy M. Hudgins, M. A. at (540) 961-8400 or hudginsc@vt.edu.

If you have questions about how people in this study are treated, contact David Moore of the Research Compliance Office at (540) 231-4991 or email him at moored@vt.edu. His mailing address is CVM Phase II (0442), Virginia Tech, Blacksburg, VA, 24061-0442.

I HAVE READ THIS INFORMED CONSENT FORM AND HAVE HAD THE CHANCE TO ASK QUESTIONS ABOUT THIS RESEARCH STUDY. I UNDERSTAND WHAT IS BEING ASKED OF ME AND I AM PREPARED TO PARTICIPATE IN THIS STUDY.

Participant's Signature

Date

Participant's Name

Researcher's Signature

Date

Appendix C: Demographics Form

Thank you for participating in this research project. Please complete the following demographics questionnaire prior to the interview. You may either send this form back to me as an attachment or bring it with you to the interview. Please skip any questions that you would prefer not to answer.

Age _____

Gender _____

Years in practice _____

Years living in the New River Valley _____

Please list other places you have lived if applicable _____

In what county or city do you currently reside? _____

In what county, counties, and/or city is your practice or service located? _____

In what area of service are you trained? _____

Are you licensed in your field? _____

If so, what type(s) of licensure do you have? _____

Have you had cultural competency training? _____

If so, please describe your training _____

Appendix D: Coding Matrix

*Adapted from Anfara, Brown, & Mangione, 2002.

Research Questions		
What is the practitioners' recognition and awareness of regional distinctions as a context when working with families in their practice?	How do practitioners learn about regional identities and form their own view of their clients' ecosystem?	What are practitioners' clinical processes when working with clients from distinct regional backgrounds?
Theoretical Statement		
Clinicians working with culturally-distinct clients combine a client-centered approach with multiple-layers of regional knowledge and self-awareness.		
Third iteration: Selective Codes		
Recognition and awareness of regional distinctions Client-centered processes		
Second Iteration : Axial Codes		
Multiple levels of regional distinctions Systemic influences	Professional sources Personal sources	Clinical model and philosophies Adjustments
First Iteration: Open Code Categories		
country-level county-level community-level neighborhoods urban vs rural southern culture Appalachian culture levels of services and needs	clinical experience client report client observation local knowledge sources training supervision colleague report stereotypes	client-centered models not-knowing stance view of change use of region in intervention ethical responsibilities interpersonal skills and relationships bias Checking

<p> definition of culture common behaviors NRV characteristics history poverty/SES other social/political issues racial issues clients' motives for residence school systems social services legal systems family systems acculturation assimilation accumulated identity language self-awareness perception of self perception of others awareness of Bias </p>	<p> cultural competency principles personal experience friends and family sense of place Other factors informing perspective Self-awareness Self-exploration media </p>	<p> stereotyping adjustment of model in therapy adjustment of self in therapy </p>
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Appendix E: County-level Distinctions and Stereotypes

Participants	Montgomery County	Pulaski County	Floyd County	Radford City	Giles County
Andy	<ul style="list-style-type: none"> • Diverse 	<ul style="list-style-type: none"> • Drug culture • Conservative religion • Parrot – racist • New River – close but drug culture; tight knit but untrusting 	<ul style="list-style-type: none"> • New age feeling • Alternative healing • Hippie 		
CJ	<ul style="list-style-type: none"> • Blacksburg – elite 	<ul style="list-style-type: none"> • Uneducated 	<ul style="list-style-type: none"> • Hippies 	<ul style="list-style-type: none"> • Blacksburg wannabees 	<ul style="list-style-type: none"> • Mountain
Jesse		<ul style="list-style-type: none"> • People not motivated 	<ul style="list-style-type: none"> • Alternative community • Old family • Marijuana smokers 		
Shaun	<ul style="list-style-type: none"> • More educated 	<ul style="list-style-type: none"> • Heavy into drugs • Parrot – Racist 			
Sumner		<ul style="list-style-type: none"> • Methamphetamine and prescription opium abuse headquarters • Dumbest people in the state • Ugly and fat 			<ul style="list-style-type: none"> • Poor county

Rae	<ul style="list-style-type: none"> • Blacksburg – University community; more affluent 	<ul style="list-style-type: none"> • Drug addicts 	<ul style="list-style-type: none"> • Combination of hippies and farmers • Counterculture 	<ul style="list-style-type: none"> • Entitlement • Higher opinion of themselves 	<ul style="list-style-type: none"> • Bootlegger • Wild people that you don't mess with • Rebel people • Rebel flags • Guns in the back of their trucks • Fiercely independent
Sal	<ul style="list-style-type: none"> • Blacksburg – anomaly, diverse, mixing pot 	<ul style="list-style-type: none"> • Drug area 	<ul style="list-style-type: none"> • Redneck or hippie town • One stoplight • Backwards • Hillbillyish 	<ul style="list-style-type: none"> • Uppity • Blue bloodish and little snooty 	<ul style="list-style-type: none"> • Simple way of life • Isolated
Toni	<ul style="list-style-type: none"> • Blacksburg – student based, more money 	<ul style="list-style-type: none"> • Oxycontin capital of the world 	<ul style="list-style-type: none"> • Artsy 	<ul style="list-style-type: none"> • University town 	
Reni		<ul style="list-style-type: none"> • Drug use • Juvenile justice system is hands-off 			
Chris	<ul style="list-style-type: none"> • Blacksburg – more wealthy and huge class discrepancy • A bubble because of the university • Christiansburg – A little part of Blacksburg 	<ul style="list-style-type: none"> • They sit home, watch TV and eat oxycotin • Sad • Really violent 	<ul style="list-style-type: none"> • Stoner hippies • Racist people 		<ul style="list-style-type: none"> • Independent

Micky	<ul style="list-style-type: none"> • College town 		<ul style="list-style-type: none"> • Going back in time 		<ul style="list-style-type: none"> • Slower • Strange to see confederate flags
Elle	<ul style="list-style-type: none"> • Christiansburg – people that just couldn't make it out • Blacksburg – Yuppie kind of fun, hip, cool, liberal 	<ul style="list-style-type: none"> • Drug users • Every one is a loser • Divided 	<ul style="list-style-type: none"> • Liberal hippies • Down home family, comfortable, pretty, safe 	<ul style="list-style-type: none"> • All the girls with STDs 	<ul style="list-style-type: none"> • Country
Dee		<ul style="list-style-type: none"> • Working class • Down trodden • Backward losers • Parrot – Drug activity 	<ul style="list-style-type: none"> • Dirty hippies 		<ul style="list-style-type: none"> • Redneck • Drug addiction shifted from Pulaski to Giles
Gram	<ul style="list-style-type: none"> • Blacksburg High – cliques • Counseling lax • Shawsville – Home-focused, family focused 	<ul style="list-style-type: none"> • In breeding • Does not feel comfortable there • Needy people • Depressed community 	<ul style="list-style-type: none"> • Middle class • Artistic community • relaxed 	<ul style="list-style-type: none"> • Radford High – tight group of kids • Elitist 	<ul style="list-style-type: none"> • Down to earth • People on farms • Hunting • Solid, honest folks
Lou	<ul style="list-style-type: none"> • Resources more accessible • Access to education 	<ul style="list-style-type: none"> • More violent • On guard when entering Pulaski 	<ul style="list-style-type: none"> • Simple lives • Family unit works together 	<ul style="list-style-type: none"> • At home • Safe • Comfortable 	<ul style="list-style-type: none"> • Beautiful countryside • Calming • Peaceful

Appendix F: Cultural Competency Training

Region as Cultural Context Model

Participants and staff

Staff and supervisors leading this training should be familiar with cultural competency literature and research. In addition, leaders should have a good grasp of ecological theory. All staff should have completed many if not all of the exercises outlined in this training.

Format

The format for this training is as follows:

- Time required: approximately 8.5 hours
 - Introduction (1 hour)
 - Module 1 (2 hours)
 - Module 2 (2 hours)
 - Module 3 (2 hours)
 - Module 4/closing (2.5 hours)
- Introduction and closing will include entire group
- Modules will be conducted in small groups of no more than 4 people
- Participants will be allowed to discontinue or refuse to participate in any activity at any time.
- Participants will be required to be respectful of each other's opinions and feelings.

Introduction – Where ya' from?

The training will begin with an icebreaker that will ask the participants to introduce themselves by telling a story that reflects something unique about their

hometown or town in which they have lived in the past. The story must include themselves and may also include other members of their families. The purpose of this opening is to introduce the concept of geographically-distinct culture and to explore the meaning of those distinctions in relation to one's identity. The leader should encourage discussion regarding how those unique beliefs, behaviors, vernacular, and values influence their current worldviews and are accumulated or discarded when they leave that area. Another question may be, "Do people from outside your community/hometown notice these differences?" "When did you first realize that people from other places did not [eat, speak, behave, worship, etc.] like you?" "Were you ever socially penalized or ridiculed for being different in that way?"

Following the icebreaker, the leader will provide some basic information about the training (schedule, goals, outline of activities, and participant's rights, and the group rules) and ask for questions and concerns.

Module 1 -- Cultural self-awareness: Community genogram

Purpose: To initiate participant self-awareness of contextual influences on his or her identity and current worldview.

Materials needed: Large sheet of paper and colored markers or pencils.

The leader will present a short introduction to community genograms and will provide an example, preferably his or her own to show the construction of the model. Other variations are included in the book *Community Genograms*, which the authors encourage therapists to modify for the sake of creativity and individual needs (Rigazio-Digilio, Ivey, Kunkler-Peck, & Grady, 2005). The leader will explain the basic theory behind this type of ecological genogram: how individuals develop their identities over

time and through a web of social and systemic contexts typically centralized in a geographic space (Rigazio-Digilio et al., 2005). The community genogram activity employs narrative therapy techniques as participants reflect on the strengths and unique resources they gained from their cultural context and how their family and friends translate those influences into their interactions, beliefs, and coping strategies (Freedman et al., 1996).

The group will break into smaller groups of no more than four people in order to build trust and become better acquainted with other members of the training group. Participants will be given a large sheet of paper and a variety of colored pencils or markers and will have one hour to work on their model. Dialogue is encouraged between the participants but is not required. This exercise has the potential to bring up some potentially painful memories and/or emotions, and the leader should monitor each group closely to help participants process feelings.

During the last 30 minutes of the module, group members are asked to discuss their experience with each other. They may present their genogram to the small group or choose parts that seem to help them understand their community-based cultural identity. The leader should visit each group and ask questions about their self-awareness and what they feel they have maintained or given away from their community context.

Once the small groups have completed their discussions, the leader will bring all participants back into the larger group for discussion and questions. At this time, the leader will find opportunities to talk about the way communities interact and influence identities.

Module 2 – “Overlapping Maps”

Purpose: To provide opportunities for clinicians to consider the knowledge they have of their clients' ecological contexts and challenge stereotypes and biases; to find the contextual intersections between their ecological maps and their clients.

Materials: poster board, large tracing paper, and markers.

This module is adapted from Falicov's (1995) concept of “overlapping maps” (p. 380). The exercise will use some of the information the clinicians generated from the first module and incorporate it into Bronfenbrenner's (1979) ecological model. The leader will briefly introduce Bronfenbrenner's concentric circles model and provide a diagram for the group to follow. Participants will be given a piece of poster board and a variety of colored pencils or markers and will have one hour to work on their diagram. Dialogue is encouraged between the participants but is not required. Participants will first select an area in their region of practice in which one or more of their clients reside. They will then represent the clients' contexts in the concentric circles to show clients' relationships with their ecological systems. Once they have filled in the circles to reflect the family and their relationships with the various ecological contexts and systems, participants will draw their own family's ecological context model on a large piece of tracing paper. The models should be the same size so that they will overlap when the tracing paper is placed over the poster board. Once participants have completed their own, they will be given 30 minutes to meet with another participant to present their diagrams and discuss the overlapping ecological contexts. Participants are encouraged to challenge each others' and their own stereotypes and biases they incorporate into the hypothetical family's ecological model in addition their own model. They should also

look for intersections in their models and discuss the meaning of these “areas of consonance and dissonance between the family and the therapist” (Falicov, 1995, p. 180).

Considering the discomfort most people have when revealing stereotyping behaviors (Carter, 2006), the leader should briefly talk about the utility of stereotyping and ask the participants to consider the human tendencies to categorize and how generalizing functions in therapy with culturally-distinct clients.

Module 3 – “My family’s version of culture: the cultural genogram”

Purpose: To help participants examine his or her transgenerational cultural background and identity and increase cultural sensitivity and awareness (Hardy et al., 1995; Jordan, 2001)

Materials: Paper and pencils or markers

The module will follow Hardy et al.’s (1995) recommendations for creating a cultural genogram. The leader will give each participant a copy of the article to use as a reference. Participants will complete this exercise as a large group. After introducing the basic premise behind cultural genograms, the leader will have the participants use the article to create their own. The basic steps include “Defining one’s culture of origin,” identifying “principles of pride/shame” in the family (p. 229), “Creating symbols” (p.230), “Selecting colors,” and “Identifying intercultural marriages” (p.231). Participants will then create a “cultural framework map” (p.231), which is a type of legend for the genogram. The leader will use the list of questions included in the article on page 232 for discussion and interpretation of the genogram. Due to time constraints, the group will break into small groups to discuss selected questions. For the purpose of cultural

competency, the participants may consider questions such as “What were/are your group’s experience with oppression?”, “What issues divide members within your group?”, “What are/were the dominant religions in the group?”, “What role does regionality and geography play in the group?”, “How are gender roles defined within the group?”, and “How is social class defined in the group?” The participants should consider how their answers influence their current lives and their practice.

Module 4 - “Getting to know my client: Experiencing community first-hand”

Purpose: Provide therapists with strategies for accessing knowledge of rural culture. This module stresses the knowledge facet of cultural competency.

Materials: local, rural newspapers, inserts, flyers, brochures, advertisements, phonebook, and any other type of directory of services, civic organizations; and other community artifacts.

The leader will distribute the community artifacts to small groups of two or three and ask that the participants compile some general observations and opinions regarding the community’s mores, lifestyle patterns, government infrastructure, economy, and so on. The group as a whole will list these observations on a white board or large sheet of paper. The group will discuss their observations and make connections to what they have learned through the other modules about their own lives and communities. Participants will also be asked to think about how their observations and what they know influence their work with the residents of the community.

Participants will come up with strategies for gaining knowledge about the region’s culture, including civic and social forms of involvement.

If the format of the training can be extended, participants will then be asked to go out into the community in their small group to complete two of the following three assignments (adapted from Piercy et al, 1999):

- Explore the informal and formal infrastructures (Bagarozzi, 1982) by visiting local social services, local commerce, government, or educational administrative offices and interviewing at least one official from that office.
- Attend one or more of the events listed in the artifacts they reviewed at the beginning of the module, including festivals, meetings, dances, auctions, etc.
- Visit and preferably receive services from at least 6 businesses or place of worship in the community (e.g. church from a denomination different from one's own, popular restaurant or diner, feed, hardware, or hunting equipment store, barber shop or beauty salon, drug store).

Participants will come back together the following week and discuss their observations.

The leader should stress that even though immersion into the community allows for better understanding, "there may be some things about members of other cultures that we can never know because we have not lived their lives..." (Lee and Everett, p. 92).

The training will close during this module with a general wrap-up of what the participants found about themselves and others during the course of the day.

Participants will also consider further directions and complete a short evaluation of the training.