

“I Get It, I Totally Get It”: Narrating Mental Health Care in Appalachia

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INTRODUCTION

Treatment of mental illness requires careful, multifaceted approaches that target not only factors relating to the mind and body, but that also address social and environmental causes such as family influence, living conditions, and perceived stigma associated with mental disorders. Although much has changed in the way of health care progress throughout the past few decades, there is still a great disparity between how these improvements have played out in rural and urban areas. The prevalence rate of mental illness in rural and urban areas is similar, but utilization of mental health care services is much lower in rural places than it is in urban and suburban settings.

The rural population of Appalachia, a mountainous region of the eastern United States stretching from New England to northern Mississippi and encompassing a belt of 13 states, exemplifies this gap. Forty-two percent of Appalachia's population is rural, a rate that is much higher than the national average of a 20 percent rural population. This estimate, coupled with the knowledge that over half of all rural counties in the United States do not have any practicing mental health care professionals and of those that do, many have only one practitioner providing services for the entire county (Hutzel 10), reveals a desperate need for innovative approaches to serving the rural population. Of the services that are available, challenges that have historically marked Appalachia- extreme poverty, lack of awareness of available social services, and a general mistrust of help that lies outside the family circle- further impede access to the already questionable availability and accessibility of mental health care.

Currently, extensive efforts are being employed to address the problems posed mental health care access by hindrances such as geographic isolation, brain drain, and the stigma of mental illness held by many in the region, as well as the stigma outsiders hold for Appalachians.

Some clinics use telehealth, a tactic I will return to in more detail at a later point, to make psychiatric care available when distance creates too much of a burden, while other clinics employ traveling psychologists that move between practices and offer services in multiple locations. Both efforts, though, have associated challenges that undermine the effectiveness of such solutions. These innovations, while steps in the right direction, are purely systemic changes, and such measures do not perform any work in the way of addressing stigma, stereotyping, and differences in point of view.

Drawing on my own personal experiences as a student research assistant in The Ohio State University's Childhood Mood Disorders Laboratory, I can personally attest to notable differences in how rural clients think about mental health care as compared to urban dwellers in addition to noticing holes in therapists' knowledge of life circumstances unique to Appalachia. Appalachians oftentimes must cross an imaginary border from the region they call home into urban spaces, such as traveling from southeastern Ohio to Columbus, Ohio, in order to receive the healthcare they need. This moving across borders creates truly dynamic interactions between Appalachian insiders seeking aid from outside the region, and outsiders who perhaps risk imposing commonly circulated regional stereotypes on clients. From my own observations within the clinical psychology research lab setting, this movement across boundaries not only adds a burden to already burdened lives, but also places people into contact who may have no prior basis for approaching life experiences in ways that are meaningful to both parties.

I myself have deep family roots in the Appalachian region; my mother's side of the family has lived in Kingwood, West Virginia for at least four generations, and my father's family all moved to Ohio from Kentucky. As such, I make several annual trips to West Virginia and have developed a great love for the misty mountains and tucked-away villages of Appalachia, as

well as a great fascination for the history and folklore of the region. My own home is located in one of thirty-two Appalachian counties in Ohio, though most in my hometown do not identify closely with the region. As such, I have grown to stand with what I like describe as having a foot in two different worlds, one stuck in the history and legacy of my coal mining great-grandparents, and the other planted firmly in modern rural America; this advantaged position as both an insider and an outsider allows me to move between the two worlds easily. I am able to speak with true insiders such as the three narrators interviewed for this project with enough credibility and empathy to understand what they are expressing in their narratives, while simultaneously being able to contrast insider Appalachian knowledge (of how certain systems work) with views imposed from outsiders to the region. This is a vantage point I drew upon when analyzing the narratives presented here and that I will use to articulate my overall understanding of how identity, content-specific knowledge, and geographic location work to produce meaning.

The interactions I have witnessed and the cases I have worked with lead me to question how we can begin to discuss the kinds of knowledge that may exist inside Appalachia. I believe that understanding an unfamiliar group of people requires a new point of view, a deep understanding of how people communicate and what their style of communication can tell us about the overall meanings such communication expresses. An answer to this requires greater insight into how professionals talk about the work they perform and close evaluation of noticeable patterns common across speakers. My research aims to pull together existing knowledge from various disciplines- narrative analysis, clinical psychology, and Appalachian studies- in order to better understand how mental health care professionals narrate their experiences and how they talk about issues facing their clients. Further, my research pulls

together ideas from these disciplines to examine how health care is affected by geographic location and in turn how the interaction between location and identity affect how a person participates in the mental health care system.

Narrative theory teaches us that much can be learned from close, formal analysis of how stories are constructed and that attention to nuances in each narrative's structure can reveal deeper meanings than can attention to content alone. As such, I have analyzed a set of narratives collected from professionals who work in the Appalachian region to identify structural patterns and themes common across stories and across narrators. Additionally, I have attended to how narrators position themselves according to their own identification with the people they serve, with their clients' life situations, and with the area in which they provide mental health care services.

My analysis reveals that therapists use narrative as a space to think about and express concern surrounding problems of accessibility in their field, ranging from small issues like accessibility to convenient clinic locations, to larger issues like accessibility to credible physicians who ensure that proper diagnoses are being made. I have also identified themes that are useful for understanding how Appalachianness is identified in the professionals' roles. Such themes raise the question of how we are to actually interpret an understanding of what Appalachia is. If we are not just identifying Appalachia as a geographic region, but further as an imaginary construct that encompasses understandings of the self, one's family history, and of all the political influences that have shaped the region, we must ask how such a complex identity manifests through narrative, if at all. Thorough knowledge of all the variables that play into understanding the challenges of accessibility in a particular geographic area like Appalachia

comes from a deep understanding of how people in a common space verbalize their own understandings of who they are and the memories of their experiences.

REVIEW OF LITERATURE

In his text *Forms of Talk*, Sociologist Erving Goffman dedicates a chapter to discussing changes in alignment during conversation, or what he calls “footing.” Goffman’s work argues that linguistic changes in conversation- such as formality, tone, addressee, etc- mark changes in how speakers, hearers, and participants in an encounter are positioned, and that analysis of linguistic elements are what allow us to truly understand and analyze such switches in alignment. He states that “a change in footing implies a change in the alignment we take up to ourselves and the others present as expressed in the way we manage the production or reception of an utterance,” and that “a change in our footing is another way of talking about a change in our frame for events.” He notes that “footing is in question when a participant’s alignment is at issue” (Goffman 10), that shifts in speech, both large and small, can imply subtle shifts, and that code switching are all indicative of footing.

Goffman’s work highlights the need for linguistic analysis in deciphering moments in narrative where positioning informs interpretation of the content and of the interactions between characters in a story. As such, an aim of this project is to closely attend to moments where changes in alignment signify a change in how mental health care professionals view themselves, their clients, and other characters in the stories they share. Because the particular women I have interviewed occupy a professional status somewhere between that of physicians and clients, as well as occupy the position of being Appalachians themselves, changes in alignment are frequent

and provide great insight into how they perceive their own identities and how they orient themselves to the field of mental health care.

“Footing,” then, serves as a useful theoretical framework for thinking about how a view of self and professional status is subject to change during conversation, depending on who is present in a narrative and what the specific situation may be. To explore these changes in footing and alignment, I have employed the analytical tools of narrative theorists Elinor Ochs, Lisa Capps, and William Labov, whose scholarly work serves to nuance the elements of narrative that collectively create dynamic and meaningful stories. “The Transformation of Experience in Narrative Syntax” in Labov’s *Language in the Inner City: Studies in the Black English Vernacular* was particularly informative for my analysis of mental health care professionals’ narratives. In this work, Labov outlines very technical definitions of the parts that make up a full narrative structure, describing a complete narrative as being composed of the following elements: abstract, orientation, complicating action, evaluation, resolution, and coda.

While his work is mainly concerned with the completeness of narratives and the moments when stories deviate from this form, my own analysis draws mainly on his theories of orientation, evaluation, and resolution in narrative, the three elements that seemed to be most pervasive across the stories of all three narrators. Orientation is defined as the narrator’s efforts to establish time, place, people, and situation. This section of a narrative helps cue listeners in to the important aspects of the forthcoming story as well as lays the groundwork for the actual “what happened” moment in a narrative. It provides us with the necessary information for grasping the full implications of the story being shared. Evaluation picks up where orientation leaves off and, though not present in every story I collected, is often useful for pointing out exactly what it is that a narrator wants listeners to take from the narrative at hand. Labov defines

evaluation as “the means used by the narrator to indicate the point of the narrative” (Labov 366). He goes on to further explain that evaluation can be external, where the narrator steps outside of the narrative to address the listener directly, or can be embedded within the story, offering evaluative moments in the dialogue of the narrative or as evaluation that the narrator was thinking in the action of the story. Evaluation answers the “so what?” question, telling us exactly why a story is important, either explicitly or implicitly. Resolution, quite simply, is the way that narrators bring their narratives together. This is the part of a story where the narrator is wrapping up the outcomes of climactic action, perhaps reemphasizing their own evaluation, and making sure that listeners are left with the vital points to a story.

Labov’s work argues that narrators who fully master the narrative techniques outlined above create stories with deeper meaning that “succeed in making a point” (Labov 396). My analysis supports this and, while not adhering as strictly to observation of formal elements as Labov’s own work, reveals how such technical elements truly work to divulge intended impact and how they work to position different characters that arise in the stories, particularly the professionals and their clients. My attention to these Labovian narrative elements hones in on linguistic moments where a change in footing occurs. Labov’s work describes the narrative tools that Goffman would argue imply a change in footing and thus require special regard.

Similar to the implications of Labov’s work are the narrative elements outlined by Elinor Ochs and Lisa Capps in *Living Narrative*. Their work discusses formal elements that are common to casual, conversational narrative, such as the use of foreshadowing and backshadowing to explore moments that are not in line with the typical understanding of a narrative’s events as linear. Importantly, their work also makes the statement that “conversation is the most likely medium for airing unresolved life events” (Ochs and Capps 7). This rings true

for what I will argue is a function of narrative within mental health care- that discussion of unresolved issues within the system, such as problems with prescription abuse, allows narrators to articulate where they see themselves in an otherwise complicated system, where a therapist's identity can sometimes become blurred between practitioner, ally, intermediary, and hero. Narrative, as per my own analysis, creates an oral arena for making sense of the world and identity.

Ochs and Capps also outline more formal elements of narrative that give deeper meaning to the actual content and that qualify a story as a useful narrative, elements such as tellership, tellability, and embeddedness. An understanding of embeddedness is important to my analysis. Embeddedness refers to the degree that a narrative is involved with surrounding discourse and other stories as opposed to existing as a story that stands alone. The narratives shared by mental health care professionals are very highly embedded narratives, some more so than others, that are dialogic with other stories of health care and particularly that are dialogic with stories of social justice issues arising from the Appalachian region. Attention to the embeddedness of a single narrative within the common discourses of mental health care helps us to understand the importance of a particular narrative to the field as a whole.

In addition, Ochs and Capps describe what they call reported speech. Perhaps the most important formal element to be found in my collection of narratives, reported speech is the main linguistic hallmark that shows changes in positioning and an understanding of the narrators' identification with their clients, other characters in the stories, and the Appalachian identity. In these narratives, moments of reported speech are often moments of code switching and of setting up an insider-outsider situation. The formal elements discussed in the works of Ochs, Capps, and Labov comprise the essentials of what a narrative actually is and, when considered along with

Goffman's work on footing and positioning, show how micro analysis of narrative can yield macro-level meaning.

Such broadly understood discourse, though, must be read from these narratives with a note of caution. While my intentions with this project are to derive a greater understanding of the insider perspective of mental health care in rural Appalachia, we are warned against making such assumptive conclusions from a small collection of narratives by Alan Batteau's *The Invention of Appalachia*. Batteau's text begins by stating that "Appalachia is a creature of the urban imagination" (Batteau 1). His work seeks to show all the forces that have had a hand in shaping the region into the imaginary "creature" that it is today. According to Batteau, Appalachia is a set of symbols and archetypes that have come to represent the region over time in accordance with the dominant narrative being tied to a loosely defined geographic region.

Traditionally thought of in the geographic sense as three mountain ranges- the Blue Ridge, Allegheny, and Cumberland mountains- that extend across the southeastern states (Batteau 2-3), the mountainous region invokes in the imagination images of coal miners, moonshine, impoverished families, one-room schoolhouses, banjos, etc. These symbols come to represent what Appalachia *is*, in both the mind of the outsider and in the image those living in what is termed as Appalachia must live with, as a place that is 'other' in comparison to other parts of the nation. Shaped by fiction by authors such as Mary N. Murfree to be a romantic, timeless place, by federal influences and funds whose aims were to preserve the ideal of an invented landscape (such as with the creation of the Great Smoky Mountains National Park), and by well-intended political moves of the likes of John F. Kennedy to be the battle grounds for war on poverty, Appalachia has time and again been the image for new causes and the location of

public speculation and imagination. Batteau's text goes to great lengths to tease out the chronology of influences on the region and to unpack the popular images of Appalachia.

If Appalachia is as Batteau says and exists not only as a geographic region but also as an imaginary construct, then we can understand just how difficult a task it is to describe individual ties to something as elusive as the identity of a somewhat undefined and impossibly complex regional space. What the set of narratives I have collected demonstrate, though, are definite moves that shift the footing of all the different people involved in the narrators' stories and attempts on their parts to position themselves in very specific, masterful ways. The positioning that occurs in these stories indicates enough of an awareness of self and of one's position in relation to others to justly cause listeners to infer that a relationship must exist between the Appalachian construct and the day-to-day health care services the narrators provide. Thus, while Alan Batteau's text most definitely complicates the ways we can think about Appalachia as it appears throughout this set of narratives, it also brings to mind the caution with which ethnographic research must be approached and reminds us that these narratives are not moments that have occurred in a vacuum, but rather are situated within a region with a rich history.

My work is certainly not the first project to approach mental health care ethnographically, nor is it the first to think about medical services in tandem with a geographic region. A report collected by Ohio University's Voinovich School of Leadership and Public Affairs put together various interviews of people receiving mental health care treatment in the rural areas surrounding Athens, Ohio. This report synthesized the content of each interview in order to gain a better understanding of how clients actually were affected by their living situations and how Appalachianness influenced their experience of living with a mental illness. This work was extremely informative to my project in terms of becoming more familiar with the demographic

of the southeastern Ohio region and in terms of learning the kinds of questions that interested other researchers. My project differs from this report in the way that I have approached the content I collected. As I have stated, narrative theory informs how I read the information of each narrative, and it is through structural analysis that I hope to gain better insight into all that is to be learned from these narratives. My work enters this conversation where the various disciplines- sociological thinking, structural narrative theory, Appalachian studies, and ethnographic mental health care research- all converge. This analysis continues the conversation started by each of the scholars reviewed here by bringing together various disciplines to hopefully pave the way for providing better health care services.

METHODS

To obtain the narratives for this project, I contacted and interviewed multiple mental health professionals in southeastern Ohio and West Virginia. My main source for locating interviewees came from contacts provided by various National Alliance on Mental Illness (NAMI) Ohio chapters, who put me in touch with psychologists, therapists, psychological nurses, graduate students, and others involved in the system of mental health care. After corresponding with contacts, I narrowed my interviews down to two therapists, a police officer with extensive psychiatric training, two cases workers, a nurse, and a family navigator for children with mental illness. I mainly based my interviewee choices on location, availability for interviews, and expressed comfort level for discussing their work. The narratives shared by the case workers, the officer, and the nurse, although vastly interesting and highly telling for understanding important aspects of mental health care, were mostly unrelated to my project as a whole and so I have chosen to exclude their stories from my analysis. The choice to focus my

analysis on professionals with similar positions in the mental health care system allows for further understanding of one specific niche.

The family navigator, Narrator M, resides in Athens, Ohio, and is employed by Ohio University's College of Osteopathic Medicine. Her role in the mental health care system is unique and vitally important for the clientele she serves. Essentially, she is the gateway for families with children in need of who seek mental health care. Clients are referred to her in many ways: through a medical doctor, an educator, a school psychologist, or a family friend. Once in contact, a parent and the navigator will work together to maneuver what can be a complicated and daunting process toward the end goal of achieving appropriate aid for the child in need, be it therapy, medication, or family education. Her role is to be an intermediary, a resource in an otherwise difficult to navigate world. The two therapists I interviewed, Narrators E and D, are employed by Westbrook Health Services in Fairplain, West Virginia. One of the narrators is a cousin of mine, so I am very familiar with the area the two women work in and the general feel of Fairplain. All three narrators grew up in Appalachia, and narrator M was raised in the same town where she is now employed.

My first interview brought me to Athens in the early fall of 2012, where I met with narrator M and recorded our conversation using a pre-loaded program on my laptop computer. Our conversation was fairly informal; I had prepared a set of question but allowed the narratives to lead themselves and only interjected when I felt that elaboration on a particular topic would be useful or especially telling. I began our talk by briefly describing my project to the narrator (as described in this paper's introduction), explaining my own interests in Appalachia, my personal ties to the region, and of my interest in mental health care in rural settings. I then asked to hear a bit about her background and reasons for entering the mental health care profession and learned

that she was raised within five miles of her current home and had lived for a time in Washington DC and Columbia, South Carolina, working as a nurse before returning once again to Athens, Ohio. Her return after such extensive travel is not surprising, given that eight generations of her family have lived on the same hill in the same town where she herself was raised. As such, the narrator maintains a close relationship to Athens to the demographic she works with, connections that have allowed her on several occasions to gain the trust of the families she serves and to sympathize with their plight in a way that newcomers to the area are not always able to do. Narrator M shared stories dealing with many aspects of rural life, rural mental health care, health care in general, and how her own personal understanding of herself as an Appalachian affects her own self-perception.

The interviews I conducted with the therapists in West Virginia occurred a bit later, near the end of October, at their clinic in Fairplain. I arrived and was immediately given a brief tour of the clinic and introduced to the therapists, case workers, and receptionists in the office. Before beginning our interviews, one of the therapists explained to me a new addition to their clinic, telehealth therapy sessions. The Fairplain Westbrook clinic is affiliated with a larger practice in Parkersburg and is one of several branch clinics. A small number of psychologists travel between the different locations. When a psychologist is not in-house, clients rely on the telehealth system to receive prescriptions from a satellite psychiatrist, a process which is overseen by an on-site nurse.

Following this glimpse into their working environment, we began our interview sessions in one of the therapist's offices, which I again recorded fully on my laptop computer. This interview was slightly different than the others, given that I interviewed both women at once, which enabled me to collect an interesting mix of both individual and mixed dialogue stories

from our time together. This set-up was arranged to fit their schedules and to allow me to gather more narratives in the small space of time available for our meeting. Again, I explained to them what the aims of my project were, discussed how I came to be interested in such a topic, and requested they tell me about their own journeys that led to their careers as therapists. Both women had lived in West Virginia for the entirety of their lives and both had attended West Virginia University before becoming therapists, but unlike narrator M they did not work in the same cities as those in which they were raised. I approached the conversation with a set list of questions but adhered to the list more strictly in this interview session than in the previous one, as it proved useful in the multi-person discussion setting of the interviews.

With all three women, talk was very casual at times; the moments between each narrative were supplemented with stories about our shared Appalachian roots. After I had finished collecting the narratives in both interviews, the women spoke candidly with me of their own experiences growing up in poverty, in large Appalachian families, and of how their own identity as Appalachians were formed. I have included (with the narrators' permission) these more personal narratives in appendix A of this paper, as they are still of interest and of relevance to anyone who wishes to further his or her understanding of life in an Appalachian region. I chose not to include these narratives in their entirety in my actual analysis, however, as they are tangential to the focus of my project, and instead I refer to ideas, motifs, and relevant sections of in the final segment of my narrative analysis that focuses on Appalachian identity.

Although each of the narrators shared unique stories, all three displayed areas of overlap in the subject matter they discussed. Such overlap directs us to understand a collection of similar stories as being part of a particular mental health care discourse, which we can also think of as fitting a motif. As the smallest unit of meaning in a story, motif serves us well as a descriptor for

the common sets of words and subjects that appear in the narratives and tie in some important way to the content of each. This analysis is organized according to motif, starting with narratives that give us multiple views of Appalachian clients and then moving on to narratives that are more sympathetic to the rural client's plight. The trajectory of the four different motif collections- medication, transportation, success stories, and finally Appalachian identity stories- move us from stories in which we can see the narrators and the clients separately to stories in which narrators and clients are aligned together as Appalachian.

The first motif section is medication in mental health care. Though stories dealing with medication and prescriptions are complex in the way that they display different modes of positioning, common words such as "prescription" and "drugs" are threaded importantly throughout three stories. The common key words, or motif words, emerge as a way of understanding part of rural mental health care and of contributing to the overall picture of health care in Appalachia.

MEDICATION NARRATIVES

All three women I interviewed had at the ready what I have termed a medication narrative- that is, they each recalled experiences that fit within a larger theme of medication stories. Generally speaking, these narratives are exactly what they sound like- narratives about medication practices in mental health care. Each narrator utilizes a similar set of narrative tools to create meaning and to craft their stories in ways that clearly communicate the intended message. However, each story is also unique in its narrative structure; a single narrative model does not fit all three. For example, one of the narratives I will discuss splits its narrative space between re-enactment of the narrative moment and external evaluation, and the events that

transpire. Another of the stories strays from what we may think of as traditional narrative format as outlined by William Labov and instead embeds narrative within conversation. As such, I have approached each story with a different form of analysis so as to fit the varied nature of the medication stories. Despite the differences apparent in narrative structure, the three selections I have included in my analysis raise important points to be considered in piecing together a picture of rural mental health care. Additionally, each story contains hallmarks that tie it to the others in a way that creates the unifying motif that is the medication narrative. One such story can be seen below.

#13, Narrator E

1 Let's say you go to the doctor and you get a someth-a controlled substance or i-i-i- if you hurt your back
 2 and you get pain pills
 3 If a doctor suspects or if a doctor's just being very careful they'll do a board of pharmacy
 4 And they'll see ok (.) have they gotten this stuff before what are the pres-prescriptions they filled in the
 5 last however many months you know
 6 And we have someone who filled pain pills pain pills pain pills you know?
 7 And you have to sign a contract when you come here
 8 And many doctors you can only get pain pills or opiates or whatever from one doctor and one pharmacy
 9 Unless there's an emergency or something like that
 10 And (.) this person had four or five different pharmacies four to five different doctors in the tristate area
 11 within one month
 12 So the doctor fired her
 13 Cause doctors can fire I mean we can fire our clients
 14 And so as soon as that happened of course she walked out in a huff denied the whole thing denied denied
 15 Of course she's not coming back to me for therapy
 16 Yeah
 17 because (.) why do I need therapy
 18 Im just here for my xanax what what are you talking about
 19 So that's (.) thats a lot of the resistance I feel like we see here versus(1.0)
 20 I mean I mean that's just something we experience a lot and I think that if we didn't have a psychiatrist
 21 we would be better off
 22 I don't mean that in that I just I mean therapy-wise
 23 Because there would be no motive I dont feel like
 24 I don't know I don't know how you feel about that

This particular narrative tells the story of a client who abuses a prescription and, ultimately, stops seeking therapy because she is no longer able to get medication out of her therapy sessions. What

I want to note is the way that our narrator situates us, the listener, in her story. She begins by placing us as the actor in a hypothetical situation of abusing a prescription (line 1), starting with “Let’s say you...,” and tells a very general narrative that is able to be applied to many situations. However, her narrative structure changes in line six, with a switch to an actual narrative moment. The next line switches back to the hypothetical, and then switches again to the specific, actual narrative in line 10 which creates an interaction of different narrative realms of sorts. We have this mixing of narratives going on, one being general and the other being very specific. It is not until line 12 that we learn the client being discussed is a female, and I would argue that line 15 is the first moment we get that tells us what the entire story is even about. The narrator states “Of course she’s not coming back to me for therapy,” placing herself in the narrative and going as far as to place herself in the position of the client who first abused her medication privilege and then is refusing therapy. She uses what Ochs and Capps call reported speech at multiple points in her narrative, explaining her story through the hypothetical speech of a doctor and the client/ type of client she is talking about, instead of simply presenting the information in a general manner or in her own voice.

The story combines narrative as described by Labov and also combines other forms of talk resulting in a mix of structures that work in a number of ways. By placing listeners in the narrative, we come to understand that manipulation of pharmacies to receive extra medication is not a rare occurrence; it is one that the therapist sees often enough that she has been able to develop a general structure for how the event will unfold. Another way this mixing of structures works is seen through how the narrator places herself in the role of the client. While she may not agree with the client’s actions or motivations, the therapist demonstrates her own understanding of why these clients are deviant, a tactic that positions the therapist as knowledgeable of her

clientele and of the issues that thwart the progress of mental health care. Overall, this method of delivering a single narrative through multiple speakers, points of view, and levels of generality provides insight into the psychology of what each actor in the story may have been thinking, and of the motivations they may have been acting upon.

Another narrative, shared by the same narrator, expands on the medical narrative topic in a slightly different way. The two stories begin to set up our understanding of drugs and prescriptions as medical narrative motifs that are recognizable as part of rural mental health care. The following story also works through positioning, but draws more upon characterization of clientele to do so.

#12, Narrator E

- 1 You had mentioned what made people maybe come to therapy and more open to it
- 2 And I was tellin Sarah at lunch
- 3 And I think you see more of this maybe than I do
- 4 We have the people that come in and they think I'm gonna get xanax
- 5 Im gonna get clonopin im gonna get valium or whatever from the doctor
- 6 And I had uh told Sarah um and then but the doctor says hah you you have to go to therapy too and then
- 7 we'll see
- 8 And then we get some clients that are like pssh and then they blow off their therapy sessions
- 9 And then they eventually don't get the medicine (1.0) sometimes (1.0)
- 10 Or you have those clients who come in and they're like I really don't think I need therapy I just need the
- 11 medicine
- 12 But then they they become more receptive they're like OH (.) well you know it actually felt kind of good
- 13 last week to talk about this and so that's kinda
- 14 I mean I feel like you probably see that too the people that I don't tell anybody anything I don't trust
- 15 anybody everybody's already you know
- 16 And we have a lot of people too and I don't I don't know if you see this a lot
- 17 Like the kids that are like well I told my guidance counselor and then my guidance counselor told my
- 18 mom everything so why am I gonna tell you anything
- 19 You know but then they realize (.) there's that trust

The above narrative participates in the conversation of medication in mental health care by presenting the motivation to receive a prescription in a different way: as an act of deviance. In this story, the subjects attempt to procure drugs through a prescription, seeking to obtain

medication for purposes other than maintaining a proper mental state. While this kind of narrative is very telling of a particular population that participates in the mental health care system, it is also captivating narratively-speaking because of the way it breaks down and in categorizes the population in question. The previous story dealt with a specific individual and a specific narrative moment, and this story adds to the picture of how deviance plays out in the medication narrative. It creates a sort of narrative map that directs our thinking in how we should categorize the characters presented in the story and shows the path certain individuals have taken in the health care system. The narrator starts off by placing the listener, yet again, in the mindset of a hypothetical person whose goal is to receive a prescription for a certain drug. When confronted with an ultimatum in lines 6 and 7- to either take part in therapy along with the receipt of a prescription or to not receive the prescription at all- the hypothetical splits into those who “blow off” therapy (line 8) and those who go ahead and take part in the doctor’s prescribed sessions. Those who take part in the sessions assumedly receive their desired prescription *and* benefit from therapy (lines 12-13).

The therapist’s narrative is incomplete, though, as we can see from the switch in topic she makes in line 14, right before one would expect to hear a resolution and coda moment. She instead addresses another therapist present during the recording, requesting confirmation that her own experience is similar to the one shared. Again, her speech switches to that of a hypothetical individual, this time acting out the voice of a person who is reluctant to comply with his or her therapist’s attempts at discussion. She ends though with “You know but then they realize (.) there’s that trust.” This topic switch reveals an issue that had been on the narrator’s mind throughout her story on prescription abuse- trust. By employing hypothetical reported speech and exploring the different thought patterns of a subset of the clientele she sees, the narrator cleverly

brings us full circle through the barriers that keep a person from fully benefitting from therapy sessions. Trust seems to be at the core of fully releasing to the power of therapy according to this narrative.

As stated, the story does not really offer a retelling of one moment, but rather is a generalization of prescription abuse and the reaction the therapist expects to see from subgroups of her clients. Both of these stories are embedded in the overall conversation surrounding medication as a treatment for mental illness. Instead of telling one story about prescription issues, the narrator chooses to cover all bases and touches on incidents demonstrating mistrust, skepticism of therapy, and manipulations of the existing system. Referring back to the final moments of story #12, which are seemingly out of place in comparison to the larger topic at hand, we can see how the out-of-place section is actually a return to the broader topic in which this particular narrative is embedded. This seemingly detached moment is in fact embedded in the overall discussion of medicine and is the narrator's attempt to tie her own work, providing therapy, to the discussion of medicine at large. Her narrative argues for the necessity of therapy in combination with medication and shows the pitfalls of prescription treatment, addiction and abuse. By demonstrating control of knowledge of this abuse through the categories she is able to so easily explain, the therapist expresses power and authority.

Moving away from client drug abuse, the following narrative places responsibility on the health care providers and characterizes the client as the victim of a flawed health care system. Similar patterns as those present in the other two stories can be identified- repetition of phrases, reported speech as a means of re-enacting a moment, and evaluation of the action occurring in the story. Beyond carrying out a similar discussion of these elements, I found it useful to adopt a slightly different approach to understanding how this narrative works. Unlike the general nature

of the previous stories, the following is an account of a specific moment the narrator encountered and re-creates. Because of this difference, her style of talking about the experience is also quite unlike the others.

#6, Narrator M

1 You know I mean I I had a conversation with a doc one time
 2 where the kid uh it was an older kid probably fifth or sixth grade and the parents called me >I don't know
 3 how they got my number< but somebody (.) gave it to them
 4 and they the dose of medication that this child was on for adhd was so high I mean I never seen it that
 5 high
 6 and I finally went over and I said why (1.0) is this kid (.5) on this medication
 7 well we just can't get it to work (.) you know its adhd and we just can't get him to settle down in school .
 8 so I call the school and I had a with the moms permission and I had a consent and the child had an iq of
 9 fifty four (.5) fifty (.) four
 10 You cannot (.) medicate away an iq of 54
 11 And (.) the physician had no idea that was his iq
 12 The kid was just actin up in school
 13 I was furious
 14 I(.) was(.) furious(.) ((hit desk with each word))
 15 Instead of giving (.) services for this child that they needed in school
 16 Child the the kid hadn't even (.) didn't even have an IEP!
 17 Maybe a behavioral one
 18 But had never even been evaluated and subsequently you know I said could could we please get this kid a
 19 full evaluation in the school system and they did he had an iq of 54
 20 Blew me away
 21 Blew me away I was furious (1.5) furious.

Before discussing the narrative tools utilized in this story, I want begin by unpacking the story a bit and pointing to the ways the narrator chooses to orient us to the action occurring. She first alludes to a conversation she had with a physician (line 1) before leaving this detail to provide background information about a child she was working with. She then switches to reported speech and re-enacts the previously alluded-to conversation with the doctor. The rest of the narrative is in part a retelling of the events that resulted from the conversation between the narrator and the physician and in part evaluation of the events in the story.

The action happening here is first narrated in lines 6-9. The narrator, appalled by the strength of the prescription the child had been prescribed, takes action and demands on behalf of

the family she's working with for an explanation from the physician regarding the high dosage of medication. Even though the only in-moment reenactment we are given occurs in these four lines, the action is told through reported speech and, like in previous stories, works to create a good-guy-bad-guy distinction. In the middle of this action, line 8 begins with the word 'so.' This word is fascinating because it signals a shift in positioning and in footing. All of a sudden, the narrator is the person who takes action to solve problems in mental health care, and she is the one who eventually figures out the answer to the child's problems. With this change in footing, indicated by a single word and a slight change in tone and narrative trajectory, the doctor is positioned as incapable of providing the services the child in the narrative needs. After line 13, the narrative is mainly evaluation, with the narrator expressing fury through repetition and verbal emphasis.

As is demonstrated by these three stories, medication narratives are not focusing on how prescriptions interact with therapy and play a part in mental health care, but instead create a motif that depicts a system that for some reason is not working. My analysis shows that these women are not attributing failure to themselves. Quite the contrary, their stories present them as interveners and as the only forces who are able to provide quality care or a trust-worthy practitioner-client relationship. They are attributing the failing aspects of mental health care and the pitfalls of medication to forces outside their own sphere of influence. The narratives do not really deal with inside-outside understanding of medication and rural mental health care, but instead serve to position the narrators, people who are confident in their abilities to know the types of people they are working with, as knowledgeable and as able to create change.

TRANSPORTATION

In my discussions with the narrators, a regularly occurring story thread seemed to be one of narratives that explained irregular therapy attendance. One particular motif present in these narratives was that of transportation. Feeding into the larger theme of the narratives, accessibility, transportation stories discussed particular moments that highlight the difficulties of establishing a regular form of transportation to and from therapy. Woven into these narratives are deeper issues that are tied to the rural mental health care experience, such as poverty, how rural people sometimes orient their physical location in different ways than the general population, and the stigma of using public transportation. The following narrative shows differences in understanding a place, the different codes people use to navigate a space, and how these differences become problematic.

#3, Narrator M

1 I think the resources (.) .available to parents
 2 Um you know in South Carolina even the very (.8) po:or parents had transportation
 3 they could get on a bus (.5) you know we could give em a bus pass
 4 uh or whatever and there was always transportation to the hospital to see their kid or to the doctor's
 5 offices
 6 But when you get in this area and people are coming from 20 and 30 miles away
 7 And there are no buses
 8 Um you know there are no cabs (hhh)
 9 I was tryin to get transportation for a child who lives way out I mean way: y out (.) um and tryin to get
 10 their>manager care company< to provide transportation
 11 and I'm trying to explain that there is no street address there that this is just where they live
 12 And there's no phone her cell phone wouldn't work until she walked to the top of the hill
 13 and so: I said >you know you have to call and leave a message and then she will call you back<
 14 well that didn't happen (.5) so they kept sayin well we can't get ahold of her=well we can't go pick her up
 15 because we don't have a street address and I'm try- I say
 16 I've been there I can give you directions and she said (.4) well can't? she just (.) catch a bus to the
 17 nearest corner? an(hhh)d and I said I want you to go online
 18 I want you to look up and I gave em the little name of the town (.3) the closest town (.) and I said now do
 19 you see this street anywhere near
 20 And she goes no
 21 And I said now (.) that's because it's ten miles away from where you are now
 22 And you know and she said you don't understand we're in Tampa Florida
 23 And so that's where they arrange the transportation for our rural (1.0 sec) yeah

In its simplest form, this story tells of the narrator's experience scheduling a client pick-up. Several structural elements give complexity to the narrative and create a more compelling tale that expresses the narrator's frustration with transportation arrangement and elevate the meaning of the story beyond just an event that took place. The story recounts a conversation between the family navigator and a representative from a manager care company, with the focal point of the tale hinging on the representative's lack of understanding of the client's situation. Emphasis is given to the story and this lack of understanding through reenactment of the narrative moment as a back-and-forth exchange, what Ochs and Capps call reported speech. This reenactment serves to both place the listener in the moment of the narrative and to highlight different levels where misunderstanding occurs. Here, the representative is acting on the norms she is familiar with to locate a client, things like a street address. Special instructions are offered by the intervening narrator as to how the client should be contacted, but the two speakers in the story are not operating with the same understanding of how to remedy the issue at hand.

Reported speech also works to reveal a miscommunication in how different groups of people think about geographic location. In her turn, the representative talks about location as a place with a physical address that can be mapped and located accordingly (line 15), but the client and the narrator hold an understanding of location that is informed by geographical markers, distances, and familiarity with the space a particular piece of land occupies and fits into. For instance, the narrator describes her client's place of residence as being "way out" and uses relativity to describe where the house is, by mentioning which small town it is closest to.

Reported speech functions in this narrative to place two opposing understandings of a situation side by side in a way that a summary of the narrative's occurrences could not do. This story is re-enacting the interaction, a move which very powerfully places listeners in a moment

of confusion and aggravation. In addition, reported speech functions to create space in the story for the narrator to place herself in the action. Although she is a key player in the narrative, the main gist of the story is not about her but rather is central to how an outside service provider fails to serve a client appropriately. Quite literally, the narrator is the intermediary, and her story presents her as such. Reported speech allows her to clearly define her own role in the whole process as the character in between who can speak to the proper way of contacting and locating the client. It works to show that lack of cooperation with the narrator's insider knowledge complicates health care for clients in rural areas and creates confusion.

Another element that is working to create meaning and depth in this narrative is its use of repetition, a tool that ties geographic location and health care services together and brings location to the forefront of the narrative. As was previously stated, phrases associated with location appear frequently in the narrative, phrases like "street address," "nearest corner," "where they live," "directions," "nearest," and "way out." These terms are used by both speakers in the story and certain phrases like street address are repeated throughout. We can see how both women are trying to come to a place of mutual understanding of how to locate a person in a place that clearly requires special language and ways of speaking about place. Twice, the narrator reports the representative as stating that the client does not have a street address, repetition that emphasizes just how bewildering this deviation from the norm is for the manage care company.

This is the issue at hand- how do professionals deal with clients and situations that deviate from the norm? More importantly, how do professionals unfamiliar to rural discourse orient themselves to new ways of talking about a subject? We may even ask how are the ways that outsiders deal with distant clients complicating the accessibility of medical services? Though

the narrative ends neatly with the statement “And so that’s where they arrange the transportation for our rural (1.0) yeah,” there is no finality to the story, no clear solution to providing transportation for a client without a street address.

From this narrative, we are able to see the limitations of the available services. Another story I collected fits the transportation motif as well, yet contributes a different way of considering issues relating to transportation. The following story presents pre-arranged transportation as a service that is readily available yet simultaneously unavailable to clients in need. It deviates from the chronological pattern seen in the previous story and instead embeds narrative within conversational talk, discussing issues at hand in more generalized terms. Nevertheless, narrative techniques are still apparent in the text and still work to create significance and to communicate quite a profound message about transportation to and from therapy.

#15, Narrator D

- 1 We find ourselves kind of fighting to be like nope they’re coming back
- 2 Nope not closing this chart they’ll be back because (.) that’s just how it is
- 3 Not everything is cut and dry
- 4 Yeah this person might cancel three appointments in a month and that stinks for our billing but (.) They
- 5 might not have a car right now
- 6 So that’s another issue with our rural setting
- 7 And we have a bus that runs three days a week
- 8 But you have to pay to get on it
- 9 Granted it’s a dollar but some people
- 10 Do they wanna choose their dollar to come here (1.0)
- 11 On a bus
- 12 And then stay here for probably two hours
- 13 And then ride back with a bunch of people you don’t know
- 14 Or that you probably do know
- 15 And they know where you were why you went
- 16 Or do you wanna save your dollar and just go ahead and get a pop
- 17 Or or save that toward your cigarettes
- 18 [Co pay for your medicine]
- 19 Right I mean and you never know and you hear that a lot
- 20 We ha-we have started to provide transportation
- 21 Which I think has been really helpful
- 22 That’s a big big issue
- 23 Um I don’t know if you saw that in Athens

- 24 The transportation cause like (.) with us (.) with our doctors
 25 We can drive wherever we want and I know that (.) ill go to Charleston
 26 Because its closer to me
 27 I I kinda have more of a (.) an option
 28 I have different options I don't know the person
 29 Likely

Perhaps the third line of this narrative expresses the key idea of the entire story- “not everything is cut and dry.” Whereas the last story’s focus was more centered around a particular experience, the narrator uses this space to explain many of the unforeseen hindrances that inhibit utilization of services arranged to make mental health care more accessible. She outlines different situations that might hinder a person’s choice to utilize transportation, first stating that her clinic’s bus runs three days a week, already limiting the availability of the transportation. She then states that the bus costs money and discusses various reasons why a client may not wish to invest their money in an activity they already dread, like a difficult therapy session. Here, we see that access to transportation is not so much the problem as is the stigma attached to using a public service and that it is often the intangibles that keep potential clients out of the clinic.

Repetition is used for emphasis and also for a means of organization within the story. Whereas the last narrative’s repeated phrases were all motif words, the repetition here all happens with the first words of each line. The words “and,” “or,” and “but” mark moments where the narrative presents a new problem or a new impedance to think about when considering transportation. For example, line ten presents one choice a client has to consider when thinking about using public transportation. In the following lines, these words I have marked as the key repetitive phrases guide us through the different options a client may consider in making their decision regarding the choice. Quite literally, this narrative method works to take us through the psychology of utilizing this “available” service and shows just how much thought and struggle goes into each and every aspect of using medical services.

Of course, this motif and the presence of multiple stories on the same topic, across narrators, keys us in to the importance of transportation as a piece of what is involved in quality mental health care. As in urban areas, public transportation can be unreliable, costly, and, plainly put, embarrassing. The two narratives I have discussed here are pieces of what I termed the transportation narrative, those stories that shed light on the complexities of rural transport, encompassing issues of long travel time, poverty, and effectiveness of therapy once a person is even able to reach a clinic. As Ochs and Capps would term it, these stories are embedded stories, here within the larger narrative of accessibility prevalent throughout rural Appalachia. As with the medication narratives, transportation difficulties emerge as a motif and a way of recognizing a piece of what it is to seek mental health care in a rural space.

SUCCESS STORIES

The following two narratives were shared to illustrate moments of change in a client's life and moments in which the mental health care professionals felt they had made a significant difference. Both differ significantly in nature from the other stories discussed thus far because of their uplifting plots and the hope they inspire for the professionals, and also because of the *way* the impactful moments are shared. In both, the moment meant to make the greatest impact functions in a way so that it also serves as a summation of the entire narrative and as an explanation for why the professionals continually accrue negative memories in trade for these much-treasured moments of success.

#10, Narrator E

- 1 I was a very young social worker and I had this kid I think he was (.) maybe fourteen or fifteen
- 2 His mother and father had both been in prison his father uh for stealing cars and choppin them and sellin
- 3 parts
- 4 And (.) I can't remember what his mother was in prison for

5 But He was in trouble for some little (.) stuff (.) I don't know like skippin school or something
 6 And I had to take him before the judge and (.) I (.) you know asked the judge for probation for him
 7 And the judge basically threw the book at him and sent him off to salem for an evaluation
 8 And (.) you know I kinda felt that was pretty hard
 9 And um(.) so when the kid got out you know I arranged placement and stuff for him
 10 But at one point he ended up at davis child shelter because (.) you know we didn't have a place for him to
 11 go briefly
 12 And I took him a birthday cake on his birthday and the kid cried
 13 And um (2.0) it really kinda surprised me
 14 You know (.) I guess nobody had ever really paid much attention to him you know on his birthday and he
 15 stayed outta trouble for several years and
 16 I felt like maybe I made an impact on him
 17 He eventually I think did end up in prison for a few years
 18 But (.) he stayed out for awhile
 19 So I felt like I made a difference

Here, we have a story about one of the therapists going out of her way to perform an act of kindness for her client, an act which shocked and deeply touched the person receiving the gesture. In this narrative, line 12 essentially serves to tell the main point of the text as a whole- "And I took him a cake on his birthday and the kid cried." The story is quite remarkable in that this one sentence is packed with meaning- it provides us with the action of giving a birthday cake, the act of receiving the cake, and a reaction on the part of the recipient that creates a dynamic, deep moment with many implications as to what it is about the action that caused such an emotional response. All that precedes this line and all that follows could be cut away, and we would still have a complete story.

The narrator did not choose to tell a one-lined story though. The lines sandwiching this moment serve to strengthen and add depth to this small piece of the overall story. Recall that William Labov's narrative model understands stories as being more than just a memorable plot, as being all the little pieces of a story that equip the listener to fully understand the background and implications of the tale being shared. As such, his model is very useful here as it allows us to appreciate the way these extra lines prep the listener for the single line of action and to see why

the narrator chose to include background information and even her own reactions to the occurrence in addition to this piece. The first ten lines of the narrative provide what Labov would call orientation and background, elements that are necessary to understanding the client's emotional response to something as trivial as a birthday cake. We learn that he comes from a family whose history is peppered with skirmishes involving the law and that he himself has had run-ins with the legal system. These dealings with the court system resulted in a harsh punishment, despite his social worker's attempts to gain leniency in terms of his sentence.

All of this orientation serves to create an understanding of a young man with a hard life who really has no one looking out for him and who is, in fact, homeless at the time this narrative occurs. Line 8 is a moment where the therapist steps out of her narrative and offers external evaluation of what she sees as a harsh decision and foreshadows the action she takes to remedy at least in part the injustice of her client's sentence and really the injustice of his life circumstances. By reading line 12 in context, we can understand that it is the "what happened" of the story, that the preceding lines are the "why" of the story, and all that follows is the "so what." In this way, the "what happened" becomes small compared to why it happened. Without the why, there would be no significance to this story and the therapist's choice to share the memory would be pointless.

The lines that end the narrative, lines 13- 19, express the narrator's shock at the client's reaction and show her efforts to match what she knows of the boy with his response, as well as her belief that perhaps this small act of hers helped to change his path in life, even if only for a short period. The narrator steps out of the realm of the story here to offer her take on how she directly influenced this life. Lines thirteen and fourteen in particular show her surprise at the effect her actions had on the boy. Then, she offers the cause of such a positive effect, the

possibility that her gesture made such an impact on his life that he “stayed outta trouble for several years.” This is a very humble way of pointing to the success of her work and a clever way of positioning the court system as harsh, uncaring, and ineffective in comparison with the weight of a small kindness.

The resolution of the narrative fills in more background information pertaining to the years that followed in this boy’s life and, though not creating a lasting effect, the narrator concludes that her efforts did create a significant impact in her client’s life, as expressed in her final line. The main impact of this narrative does not come through the moving storyline, or the touching ending in which the narrator concludes that she made a difference in a life, but rather is portrayed through the *way* all of this information is organized and shared. It is the work of building up a sad history, the presentation of an iron legal system, and the process of exploring how these circumstances coincided with a kind gesture that creates meaning in the narrative.

The second success story shares many of the same features and maneuvers of the previous, in the way that it sets the narrative up. In particular, three aspects of the story interest me and really work to make this an exceptional narrative: the story’s orientation, use of evaluation, and its overall structure.

#1, Narrator M

1 Yeah: I there are there are some (.) and um (.) what I’ve learned about this job is not to hold too many
 2 memories of it Um:
 3 because I I I can’t
 4 You know there are so many (.) bad things that happen to people
 5 that happen to children that I kind of (.) focus on what I need to focus on for the moment.
 6 get the referrals done (.) and then that’s it. I’m done with it. I can’t (.) I can’t carry (.) all of that Um
 7 But there have been some very ea:sy simple: you know those are always the dream cases
 8 Where: the mom comes in and the child’s in trouble a:nd um ah you know
 9 and it ended up being a simple ADHD because there was a huge family history of it
 10 Because everything fit
 11 We did get the evaluation done
 12 We did get her put on (.) uh ‘propriate meds and to have that mom walk back in my office
 13 I mean she she come back and found me
 14 she didn’t call me

15 she just come down the hall my office was somewhere else at the time and um: brought her little girl with
 16 her
 17 whom I never meet I almost never meet the kids it's all about family history and parent report
 18 there are times when they go to the clinic that I do and we can talk more about that in a minute but (.) um
 19 she just walked into my door and she said do you have a minute and of course I'm thinkin oh no what's
 20 (.) what's happened
 21 and she said (.) I wanted her to meet you because you're the person who saved her (.) saved my life and
 22 saved her future o:r something like that because she now was doi:n great in school
 23 she went from d's to a's and you know she's like in the fourth grade so:
 24 you know that that's one of those uh make my day: um kind of experiences (hhh)
 25 and that was an easy fix it was just makin sure she got the right diagnosis um :
 26 and that the mom clearly understood what that meant
 27 you know it's not uncommon for people to say >I'm not givin my kid meds<
 28 um that's just the kind of feeling they come in with and (.) for the most part I I agree that meds (.) aren't
 29 always the answer an:d
 30 if you don't have to do meds let's don't do meds but sometime they are (.) required.
 31 and so getting over that hump and that was one of those moms who had been recommended that the
 32 child had meds and said no but(.) after a lot of teaching and a lot of understanding her concerns we were
 33 able to get there

The first six lines of the narrative serve as an orientation to the story. Like the other success story, these lines provide relevant information that add emphasis to the actual “what happened” part of the narrative, but they do so in a different way. This story’s orientation works to set up a stark contrast between what a successful case looks like and what the hard realities of her work actually are. She first gives us seven lines-worth of narrative that explains the extreme mental load associated with a career in her field and why she needs to block such memories from her consciousness. After, she makes a very purposeful switch into a discussion of the positive experiences and cases in line 7. Here, the use of ‘but’ indicates a switch in gears and a transition into an alternative concentration in terms of subject matter. We could even say this is a change in footing, as she moves her position from one of a person weighed down by the tragedy of the work she does to that of a person whose work is meaningful and sees success. In the following lines, we are given a sort of script for what a “success story” case will look like- proper medication, accurate diagnosis, education plans, etc. The narrator is clearly adept at what she

does; her ability to outline a successful case position her as an authority on the steps to be taken in providing proper health care.

In comparison to the vagueness of the first seven lines, this portion of the narrative gives very concrete examples of that which comprises a success story, a move that lets us formulate a fairly solid mental schema for such a case. The lines preceding this section avoid outlining horrific experiences and what they might look like. This difference makes the bad experiences feel much more mystifying and terrible and the good moments in contrast are built up to be even more worthy of retaining as memorable cases. Overall, the orientation works very hard to situate the actual narrative that follows in as positive a light as possible and, quite literally, orients the listener to the understanding and mindset we need to adopt in order to fully appreciate the forthcoming narrative.

As we saw with the previous narrative, the “what happened” section here is also very short and concise in comparison to the length of the narrative as a whole. Unlike the first narrative’s “what happened” moment, this story’s main focus is interspersed with evaluation, both internal and external, that breaks up the story, and features as well multiple switches from one layer of the story to another. An example evaluative moment occurs in line 19, when the narrator says “and of course I’m thinkin’ oh no what’s (.) what’s happened.” This evaluation how ready the professional is for bad news to come her way regarding the progression of a case.

Along with evaluation, the narrator draws upon fluid switches between different realms of narrative to structure her story. The exact moment of switching is intriguing; the switches seem to occur quite naturally for the narrator, yet are unexpected and somewhat abrupt for the listener. They function to bring the narrative focus to a new place in the story and allow the narrator to provide information that primes listeners for what they will hear without interrupting

the story's natural flow. One such moment is the move from the section that outlines a script for success to the actual story the narrator chooses to exemplify her script, in line 12.

The final switch starts at line 23, when the narrator moves from the "what happened" to talking *about* the "what happened," like the story becomes a little less embedded. This moves us to the narrator's resolution, where she calls the story a "make my day" kind of experience. She uses the resolution to define the big difference between a case turning out successfully or not turning out well as being dependent on the level of knowledge a client's parents have access to in the mental health care system. The *switch* from not knowing to having a greater understanding is what she calls "getting over that hump."

All of the formal elements examined come together to create a really complex and layered story. It seems to serve a function that goes beyond having been shared just for the sake of sharing a narrative. Instead, the story is used as a way to explain the different types of encounters the therapist has and what it is about those encounters that makes them fall one way or the other. We can see very clearly that she creates schemas for how she interprets her first encounters with a case and that she has learned the cues that let her know how an experience is progressing. We see her familiarity with horrifying experiences and also her triumphs and know that she is a capable, experienced mental health care professional. We also see that she is not immune to the life situations she encounters and that she responds emotionally to the problems she must work to remedy. The narrative illustrates the bonds she forges with her clients, a hallmark of the Appalachia region and of rural interactions in general.

Phrases like "made a difference," an "impact," "success," and "changed a life" all create meaning in these two stories. These are motif words that, even on their own, are small units of meaning that convey hope and progress. Within these stories, they perform the larger role of

contributing *positively* to the large theme of accessibility being constructed throughout this collection. Other narratives I have examined largely question the accessibility of medical services in rural Appalachia, but these stories demonstrate a very clear avenue to accessing services: attentive professionals. The difference in these narratives, in terms of action, is that the narrator of both stories took extra measures to ensure that health care was accessible, or at the least ensured that they somehow lightened the burden of receiving social services. The service these two women describe was personal and intentional, and their narrative choices set the stories up to be read in this way.

APPALACHIAN IDENTITY

The last motif that I will discuss as having surfaced in the narratives deals with identity. Unlike the motifs that create meaning in the other narratives discussed, identity is not confined to one story or set of stories. In fact, I would argue that all of the narratives in this collection are part of a discourse on identity, in that the work described in the stories and the professionals' own descriptions of involvement with these tellable cases contributes to who they see themselves as and to their identity as part of the health care system. To illustrate this, I refer back to narrative # 12 (appendix). Recall that in this narrative, the narrator characterizes certain clients as deviant and groups them according to their behavior and the efforts they exert to obtain a prescription for non-medical purposes. She crafts their identity in a way that incorporates deviance into their lifestyle and becomes a marker for how she identifies her clients. In doing so, she simultaneously shapes her own identity as that of a professional who knows her clientele and who is knowledgeable of the way such deviance works.

What makes identity stand out significantly in a small body of stories is that a particular cultural identity, that of being an Appalachian, is verbally confirmed and very purposefully explained, whereas in many of the others identity is an intangible something that we infer from the similar ways that people discuss their experiences. This motif is about a conscious affirmation with a particular identity that each therapist sympathizes with.

Positioning works to establish identity in all of the stories I have collected, separating narrators from doctors and from the clients they serve. In spite of this separation of these different characters at play in the stories, there exist frequent verbal assertions by the narrators that expresses sympathy with their clientele and a level of “getting it”. A certain tension is created by this contradiction that makes analysis difficult for listeners. One may question how to reconcile the therapists’ identities with the ways they position themselves as being both separate from clients and at the same time being on their side, so to speak.

A number of the narratives address this more directly and resolve the tension created by the narrators’ professions and their expressed self-identification. These are the narratives I will focus on in exploring the motif of Appalachian identity. Unlike the other motif collections, the stories I will discuss here are not as concerned with sharing a particular moment in time. Rather, narrative is embedded in a larger discussion of how they view themselves, see their world, and sympathize with their clients in a verbalization of their identities that lifts the barrier between the client and the professional. In these discussions, all are Appalachians and all share a cultural history that can be felt and affirmed throughout the region.

Content-wise, both in terms of my discussion and in terms of the actual narrative content, the following analysis will stray slightly from previous concentration on mental health care and will instead train focus on the nature of the Appalachian identity as it is perceived by the

narrators. Though the separation between mental health care topics and discussion of the Appalachian identity may seem counterproductive to providing substantive support for a link between geographic location, identity, and health care services, my analysis will reveal that specific attention to verbalizations of the Appalachian identity outside of narratives specific to mental health care help us to understand how identity plays out more subtly elsewhere.

Regardless of the deviation in topic, these discussions still share similar structural patterns with stories that demonstrate other motifs and so are still working in the same way as the other stories in this collection to create meaning. Because of the differences in topic, I will include and discuss only relevant chunks in the body of this paper. The stories in their entirety appear in the appendix.

My approach to encouraging discussion of the Appalachian identity differed slightly from how I went about prompting for more specific health care stories, an intentional decision. To refer to the points made by Alan Batteau's scholarship, Appalachia exists in the imagination in part *because* outsiders viewed it as different from other areas of the country and termed it as 'other.' Of course, there are visible and marked differences between life in the hills of the Appalachian states and elsewhere, but Batteau's work cautions us against imposing an outside view of the region onto it at the risk of further alienating the region from American discourse. With the idea of this social construction in mind, the last thing I wanted my project to be was an attempt to "find Appalachia" by fitting narratives to a schema for the region I hold in my own consciousness.

Thus, I took great care to first ask each of the narrators about their own identification with the region before asking for narratives or examples of what working in the region was like. Before presenting close readings of the actual texts themselves, it is perhaps helpful to point out

that all three of the narrators strongly identified as Appalachians and felt that this identity played a definite role in their own lives as well as in their careers. This response is echoed in the ways the three women narrate their identity and in how they align themselves with their clients in a much more parallel sense than in any of the previous narratives. In this first chunk of discussion, the therapist is sharing what she feels is a characterization of Appalachian people in general. Of great interest to me is that her response does not demonstrate noun agreement to the question I asked, which was slightly more of an inquiry that could have opened a door for subtle positioning between the narrator and the client (which I did not do purposely). To illustrate this point, I have included the exact wording of my own question as well as the response given. The full story can be found in appendix A, number 16.

Um what do you think (1.0) makes working with Appalachian people
And working with this area different maybe than working in other rural places

- 1 I think we're (.) probably a little more fatalistic
- 2 Uh sometimes we don't expect to live a long life
- 3 I don't expect to live a long life
- 4 My parents both died in their early sixties
- 5 I expect to die in my early sixties if I live that long uh
- 6 (4.0) we don't expect to be rich
- 7 We (.) I think I expect to live comfortably
- 8 I don't expect to live poor (1.0) like a lot of Appalachians
- 9 Except (.) for my education
- 10 We're very (.) plain people
- 11 We don't expect a lot of fancy stuff

In my question, I ask specifically about working with Appalachian people, but right away, the therapist's response groups herself with everyone else in the region. There is no more therapist-client separation, because identity is explained in 'we' terms. She does separate herself in terms of socioeconomic status in line 8 and explains that this is due to opportunities afforded by her education (line 9), but I would argue that this has more to do with an acknowledgement of a difference in life situation rather than a difference in positioning. Instead, identity seems to be

tied intricately to expectations. Like in the narratives previously examined, this story uses repetition to hone in on what it is that listeners need to understand in order to take home the message of this narration. The narrator states that Appalachian people are fatalistic (line 1) and uses the subsequent space of her dialogue to spell out what this fatalistic view of life means in terms of how Appalachians see their lives. Repetition of ‘expect’ also imparts the understanding that Appalachians may accept life circumstances as just being the way the dice fall.

Though it may seem this narrator is simply describing a very humble view of life as it is seen by a particular group of people, the inference we can draw is that this view also affects important individual decisions being made about healthcare and livelihood. If an individual does not expect much out of their life, will they even question a disturbance like anxiety or depression? It would seem that mental illnesses, which are often attributed to a flaw with the self as opposed to an illness with a treatment, would just be accepted as a life situation to be dealt with rather than treated. The narrative is ideal for understanding how the insider view a person holds of his or her group characterizes how the group as a whole may react to circumstantial issues.

Another narrator talks at length about the family structure in Appalachia, and about how the Appalachian identity is formed by generations of family history in the mountains. For the story in its entirety, please refer to story number 7 in appendix A.

- 1 I I think what is specific about this area is that you have
- 2 You have Appalachian families who their who:le (.) lifestyle and ability to maintain day to day they get (.)
- 3 from that family unit
- 4 So if you're outta eggs this week somebody in the family's got eggs
- 5 If you need a ride (.) someone in the family will get you there
- 6 So it's that kind of reliant on the family to meet basic needs (.) and when you combine that with the fact
- 7 that
- 8 Well let me just tell ya after I came back here one of my I
- 9 One Christmas for gifts for everyone I researched both sides of my family tree
- 10 and put it in a book for people
- 11 Um >cause I didn't have much money< but (hah)
- 12 The time that this took was unbelievable (hah)

13 Unbelievable
 14 So what I found and I knew my (.) both sides of my family went back for years and years and years but I
 15 just really didn't know how much
 16 So what I found was that my: one of my first ancestor um came here in (.) early early 1800s about the
 17 time when the university was founded
 18 Um and they settled (.) not three miles from where I live now
 19 And the most the rest of majority of my family lives right there um within uh probably a five mile area of
 20 each and we have been there for seven generations um on both sides
 21 Both sides

This section of talk is fascinating and informative at the same time because of the way our narrator combines explanation with narrative in order to make a single point. Content-wise, two points are being made here to answer the initial claim of specificity to the Appalachian area made in line 1. The first is family reliance, which lines 4 and 5 in particular illustrate. The two lines work by posing a problem which is then resolved by the family, and the repetition of this formula makes the point stick. The second point made deals with the longevity of the family genealogy in Appalachia. The narrator works very hard to emphasize this, drawing on both repetition to exaggerate passage of time (line 14) and a personal story to illustrate just how long her own family has been tied to one area of Athens.

She enters into the personal narrative in line 8. There are several places where she dips in and out of the story, making switches similar to those seen in other narratives discussed previously. Lines 11-13 are such a place where she leaves the narrative to provide us with background information, explaining the choice to examine her family's history and mixing in brief evaluation of the event (line 12). The use of 'so' (line 14) brings us back into the narrative, only to leave again midway through the line and re-enter again in line 16. These quick switches are remarkable; they illustrate just how close she is to a very blurred line between her own personal narrative and the narratives of the Appalachian people she is describing. This switching back and forth between being the informant and the person being characterized works to do exactly what the previous narrator does in using 'we' instead of 'they.' Both women have

merged their perspectives from insiders discussing a population separate from themselves to those of the actual players in the stories.

Her narrative continues to reveal that both her paternal and maternal family had lived within a five mile radius of one another for about seven generations. Repetition of “both sides” indicates the marvel she herself feels about the revelation, and these final lines bring us the point of the personal narrative, to indicate just how closely Appalachian families are often tied to a piece of land. This, then, brings us back to line 6 where we are led to combine family reliance with a timeless attachment to the land, a combination that supports the initial point of the discussion- the identifying markers of what it is that sets Appalachia apart from other regions. This same point is echoed in story number 8, also found in appendix A.

As this story shows, a part of the narrators’ confidence in their Appalachian identity comes from how they know the issues they see, and oftentimes that knowledge comes from personal experience or the experiences of close friends. In tight-knit communities such as the ones where these women work, the people one encounters often become a part of the history one knows. In expressing why it is that she returned to Appalachia after spending so much of her adult life outside the region, Narrator M shared that she was able to empathize with the people she serves and that their life situations were once her life situations and, as she states in narrative #4 (appendix A), “I get it, I totally get it.”

These excerpts work to point to something the mental health care professionals all possess: knowledge and familiarity. They know the places they live and they express pride in knowing and connecting to the land in ways that many people cannot. In the same way they expressed mastery over knowledge of their clients and of the hindrances to accessibility, they express mastery over their connections to the people they work with and demonstrate an inside

way of knowing that newcomers to the region simply are not familiar with. Words like expectations and family imagery create the identity motif, and this motif is one form of accessibility that Appalachians are privileged to.

CONCLUSIONS

In my endeavors to understand the intricacies of rural mental health care in a particular geographic region, I found it useful to combine my own knowledge of and experiences within Appalachia, the experiences of mental health care professionals, thematic topics, and close formal readings of how the narratives work. Knowledge of the culture, as understood from my own perspective and as supplemented by Alan Batteau's work, was a crucial component of this project. Without a thorough understanding of the political, historical, environmental, and socioeconomic influences that have shaped the Appalachian region, one cannot even begin to comprehend the unique situation in which these professionals must approach their work. Those living and seeking mental health care in the region bring an entire collective cultural memory into their therapy sessions that in part shapes their view of life, as was attested by the stories I collected. As Batteau writes, Appalachia is a complex, imaginary place, and public views and beliefs concerning the region are often imposed upon insiders.

Nevertheless, these impositions *have* shaped the people who make their homes in Appalachia and have created a complex personal identity that is brought into whatever life situations they may encounter, including the experience of living with a mental illness such as depression or bipolar disorder. It is clear from my research that therapists approach their work with this same complexity and with an understanding of who and what they are dealing with. By moving beyond the mere themes and topics addressed in each narrative, by looking at how they

tell each story, this complexity is visible in the nuances that show for instance how the professionals understand the problems their clients face. Attention to such nuances as these led me to develop an interest in *how* they showed the things they knew rather than what the things they knew were.

A few main points can sum up most of what is happening across each set of narratives and across motifs. The first is that reported speech performs numerous functions in all of the narratives in this collection. The following is a list of these functions.

- The narrators used reported speech to first and foremost establish authority. By re-enacting their stories with reported speech, they were able to position themselves in the light of one who has the answers and who is an ally to clients seeking mental health care.
- Reported speech allows narrators to take ownership over narratives and to take control over content.
- Reported speech is used to reveal places of miscommunication and places that assumptions are made by *both* parties. These places were the points in a case where lack of proper communication and adoption of another viewpoint hindered the progress of therapy.
- It provides a frame of reference for the listener.
- Lastly, reported speech creates opposing positions.

Essentially, reported speech is used by the narrators to position themselves, their clients, and other characters in ways that clearly demonstrate to listeners where alliances lie within the mental health care system. To return to Goffman's theories on footing, reported speech is a linguistic tool that lets the narrator move in and out of the different realms of narrative- within

the re-enactment, back to the position of narrator, then to evaluation. Each move is a shift in footing. Having attended closely to the body of narratives in this collection, we can also observe that narrators formed unofficial alliances, which we are cued in on by looking at the different modes of storytelling used. Code switching and reported speech are the main structural markers that let us know a shift is occurring and that set up alliances between those who are and those who are not Appalachian, as well as between clients and narrators and outside characters, like the court systems that are overly harsh and physicians that inaccurately diagnose patients.

However, it would be unwise to fall into cognition that sets up binaries in how we understand these different relationships. Again, Batteau's work as a whole asserts that Appalachia does not have distinct boundaries, and there is no one definition of what is and what is not Appalachian. In light of this work, we must understand that the alliances formed in these narratives are somewhat fluid and that boundaries are constantly blurring in an imaginary context like rural Appalachia. While certain narratives can be understood as setting up distinct alliances, such as between Narrator M and the child with ADHD in the medication narratives, we must also recall the physician in narrative # 12, who worked in the same alliance as Narrator # to ensure that patients received therapy before they were given a prescription. Additionally, we must remember that insider-outsider boundaries blur easily. For instance, Narrator M lived in metropolitan areas for extended periods of her life and only returned to her Appalachian hometown in later life. Such crossing of boundaries, even by "insiders," complicates our understanding of Appalachian identity and its effects on mental health care. Even within their own sets of stories, the narrators sometimes align themselves with their clients and at other times hold themselves at a distance, letting their education level and privileged position as practitioner keep them on separate footing.

In the same way, many of the situations discussed in these narratives are not specific just to rural Appalachia and may apply to rural areas across the nation. In the same way, certain hindrances, such as transportation issues, are prevalent in urban spaces, as well. The understanding to take away from this study, though, is that these issues and alliances *are* present in the Appalachian region and are a pieces of a multi-layer, pervasive hindrance to properly administered mental health care services. Listening to a therapist share a story about the cyclical nature of prescription abuse is eye-opening, heartbreaking, and even frustrating. These are subjects most anyone can sympathize with, and most anyone can understand from hearing them just one time that these are problematic occurrences. We hear about these happenings and know that something must be done to remedy them.

Listening to the stories that told specifically of living in Appalachia, however, was a completely different experience, at least for me. It would be denying the very arguments these stories are making to say that the Appalachian identity does not affect the ways that people in the region interpret their lives and classify themselves and the situations they encounter within medical services. Hearing how location shapes the process of receiving quality healthcare changes the game a bit and I think changes how the audience is able to relate to the stories that exemplify motifs like transportation and moments of success. Personally, the stories affect me in a very deep and resonant way; perhaps because they evoke memories of stories I have heard my entire life, perhaps because the speech patterns are so familiar. I believe, though, hearing these stories- of family dependence, of knowing every nook and cranny of the land a person lives on, of accepting one's life situations and understanding that they are just part of the self- is perhaps like listening to my own family's history. I know that I am not simply listening to a cliché, prime-example-of-Appalachia kind of narrative, but that these experiences are real and are

stories I have heard many times, whether or not perceptions of the region have been shaped by powerful outside forces.

My physical being even reacts to these stories. My heart beat a little more quickly, I sat up a little straighter, and I listened a little more attentively when memories of growing up in the hills were shared. I, like Narrator M, wanted to say “I get it, I totally get it.” I had to remind myself, though, that I do not get it. I was not raised in the hills of Appalachia, my family does not have to walk to the crest of a ridge to catch a cell phone signal, and I have never had to do without. Yet, these stories still feel like a history I know and a culture I am familiar with. As a person whose roots are deep in the Appalachian Mountains, I suppose this is somewhat to be expected- my family history is a part of who I am. Though I am fully confident in the power of these narratives and of the accuracy of the analysis I have completed, this understanding that feels to be in part inspired by familiarity brings me to question the degree to which these narratives can create meaning for readers who lack a connection to the region. I must consider whether others will react to the narratives in the same way I have. This is a question of epistemological differences- how does one even begin to explain a cultural mindset, a collective memory that is felt in a strange, deep way?

My own experience of having a foot within and a foot outside of Appalachia gives me hope. The stories that are so moving to me are sympathetic stories that I believe, as an individual with a partial outside perspective, can capture the fascination and move hearts. In the same way that Batteau recognizes “that Americans are richer for the recognition of the strange land and peculiar people that Fox, Frost, Kuralt, and Caudill (all key players in creating the familiar Appalachia) have supplied,” so too do I think that these stories convey the same kind of power today. I believe it is the stories illustrating Appalachian ties to the land that will open a

new door for creating awareness of how a geographic region can shape one's approach to life and, related of course, that will inform outsider understanding of how mental health care is intricately tied to this identity. Close readings of repetition, reported speech, evaluation, and switches in footing and positioning are the tools necessary for comprehending how it is that mental health care professionals view themselves, their work, and how they position themselves in their own minds and in the grand scheme of health care. It is these stories of life in Appalachia that do the work of explaining *why* they see themselves in certain ways, and why they see themselves as the only people fit for the services they provide. Structure and content unify to explain the big picture of mental health care, and without either, I do not know that outsiders looking in would be able to break through the barriers of the other at all. The recurring motifs of transportation, medication, success, and Appalachian identity all work to contribute to a larger theme that is at the core of issues facing the region and the key to improving medical services-accessibility. As effort is continuously being expended to further understand how people linguistically position themselves and narrate their experiences, the ability to provide quality services to people, regardless of geographic location, will be closer to within our reach.

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Appendix A: Narratives (includes conversational talk between narratives; distinct narratives are marked numerically according to where the natural breaks occurred)

Narrator 1; Family Navigator; Athens, Ohio.

#1

C: So um (2.0) one of the things I'd ask you is, I'm sure you've impacted so many lives and had so many experiences that just (.) got you (.) but is there are there any in particular, stories experiences that you felt were very impactful?

M: Yeah: I there are there are some (.) and um (.) what I've learned about this job is not to hold too many memories of it Um:

because I I I can't

You know there are so many (.) bad things that happen to people that happen to children that I kind of (.) focus on what I need to focus on for the moment. get the referrals done (.) and then that's it. I'm done with it. I can't (.) I can't carry (.) all of that Um But there have been some very ea:sy simple: you know those are always the dream cases Where: the mom comes in and the child's in trouble a:nd um ah you know and it ended up being a simple ADHD because there was a huge family history of it Because everything fit

We did get the evaluation done

We did get her put on (.) uh 'ropriate meds and to have that mom walk back in my office

I mean she she come back and found me

she didn't call me

she just come down the ha:ll my office was somewhere else at the time and um: brought her little girl with her

whom I never meet I almost never meet the kids it's all about family history and parent report there are times when they go to the clinic that I do and we can talk more about that in a minute but (.) um (1.)

she just walked into my door and she said do you have a minute and of course I'm thinkin oh no what's (.) what's happened

and she said (.) I wanted her to meet you because you're the person who saved her (.) saved my life and saved her future o:r something like that because she now was doi:n great in school

she went from d:'s to a:'s and you know she's like in the fourth gra:de so:

you know that that's one of those uh make my day: um kind of experiences (hah)

and that was an easy fix it was just makin sure she got the right diagnosis um :

and that the mom clearly understood what that meant

you know it's not uncommon for people to say >I'm not givin my kid meds<

um that's just the kind of feeling they come in with and (.) for the most part I I agree that meds (.) aren't always the answer a:nd

if you don't have to do meds let's don't do meds but sometime they are (.) required.

and so getting over that hump and that was one of those moms who had been recommended that the child had meds and said no but(.) after a lot of teaching and a lot of understanding her concerns we were able to get there

Um: And then there have been other cases where kids have been without services for year:s

um and um there have been a couple where both health mental health and development none of those had been addressed in (.7) years um

and to find a child who was severely delayed

uh was not ambulatory was at risk of all kinds of things and to move that child with the help of a lot of (.5) agencies and organizations in the community=I mean I can't do it all I can only get them there um

you know the child went from being not ambulatory at all um to go on to preschool at the public (.) school I mean it took a lot of work and to get a call back from the family and say >I just want you to know he was in the school play<

(1 sec) um you know it's those kind of things where you know you actually really made a difference in a child's life and in a family's life

And then there's all that space in between where some good things happen, some things get done appropriately and there are others where you're still fighting the same old (.) fight(.) about misconceptions or um chronic poverty that you can't fix

#2

C: How is stigma and people's misconceptions, how big of an issue is that

M: It's not as bad as it used to be I've worked in it long enough to see the progression from I'm not goin to any you know mental health center my kid's not crazy (.) to now um if once they understand what it is they're doing what the expectations are I I don't (.) meet (.) so much of that resistance any more I do meet resistance of the parents going and often that's a huge issue

C: Like parents getting training how to-

M: Well parents getting treatment

C: Oh ok

M: Yeah um a lot of the issues that we have with children are their parents' (1.2) issues not all of them by any means but you know parents who have their own mental health issues and expect the children to be the parents (.) or: ah Aren't able to be responsible and and guide children as opposed to punish children um parents with their own history of abuse or: whatever that has never been addressed that's probably one of the (.) biggest ones and I we have someone who tracks my data of the grant that I'm on and you know we we found that of the kids referred and I don't remember the exact number but it was high that probably 38 or 42 % somewhere percent of their parents had a history of trauma that had not been diagnosed or and or some mental health issues like depression and anxiety and those things: clearly impact (.) child development and those kinds of things so While their willing to get help for the problem which is: as they see it the child um it's less so (.) their their willingness to acknowledge that they may need some help as well but that's not always true I mean sometimes they do go and it makes all the difference in the world

#3

C: Is there anything that characterizes (.) working particularly in Athens and the Southern Ohio region

M: I think the resources (.) .available to parents

Um you know in South Carolina even the very (.8) po:or parents had transportation they could get on a bus (.5) you know we could give em a bus pass uh or whatever and there was always transportation to the hospital to see their kid or to the doctor's offices

But when you get in this area and people are coming from 20 and 30 miles away

And there are no buses

Um you know there are no cabs (hah)

I was tryin to get transportation for a child who lives way out I mean way out (.) um and tryin to get their >manager care company< to provide transportation

and I'm trying to explain that there is no street address there that this is just where they live

C: Wow

M: And there's no phone her cell phone wouldn't work until she walked to the top of the hill and so: I said >you know you have to call and leave a message and then she will call you back<

well that didn't happen (.5) so they kept sayin well we can't get ahold of her=well we can't go pick her up because we don't have a street address and I'm try- I say

I've been there I can give you directions and she said (.4) well can't? she just (.) catch a bus to the nearest corner? an(hahaha)d and I said I want you to go online

I want you to look up and I gave em the little name of the town (.3) the closest town (.) and I said now do you see this street anywhere near

And she goes no

And I said now (.) that's because it's ten mile away from where you are now

And you know and she said you don't understand we're in Tampa Florida

And so that's where they arrange the transportation for our rural (1.0 sec) yeah

C & M: (hahahaha)

C: That's interesting (hahah) how does how does that work? hah

M: Well it's a computerized system where they contract the people to pick the kids up and but they know nothing about our population (.) nothing about our area

C: That has tuh impact (.) how you work having people that just (.3) have no idea

M: Yeah what's goin on

it it really does it's very frustrating

and you know when I said you know you really need to pick her up at such and such time to have her at this appointment by nine and she said (.3) it's only 26 miles

and I said you have no idea what those 26 miles ((knocks with each syllable)) (.) look like they are not freeway (.) you know

they may not even be pav(hahah)ed

but that's the frustrating is we can't get people (.) there

and tryin to get gas cards with gas at four dollars 395 point 9 a gallon um

you know they have to get here first for us to be able to give them a gas? card

so: transportation is a huge issue

#4

C: So what keeps you here?

M: Um (3.0) it it's my home, number one, I know people I'm familiar with people I'm comfortable here uh

My mom is here she's elderly and so I pretty much she lives

I built a home for her on my property so

So that's probably one of the big reasons

But I think the bigger reason is that I kind of feel like I grew up here

I grew up here poor

Um I grew up here with a lot of problems in my family

And I kind of feel like I know (1.0) I know what this is about I I can understand them

When they come in and talk to me about their stories often (.) it it's my story and I I can relate to them and I can

I feel like not judge them (.5) wherever it is they are

C: You're makin me tear up

M: I I know and it's it's the ability to understand that that could have been me and in many ways that that was me or that was my sister (.) or that was my cousin or (.) whatever is that I get it, it tot(haah)ally get it

#5

C: The people that you serve do they typically have houses that are not-

M: This is a very high poverty area and it's also a very low adequate housing area so you see a lot of mobile homes um and I don't mean double wide nice mobile homes

I mean mobile homes that often don't have windows in em (.) that are plastikced over boarded over that actually have holes in the floor um that you have to walk around they'll tell you don't step there you know that'll go through

Um often no heat in the summer time er during the winter time (.4) almost never no air conditioning I mean the heat wave that we had here in July um how we didn't find people dead in their mobile homes is beyond me

It was horrid

And it's very common in disordered (.) chaotic lives for houses not to be clean

to have food all over the place that's rotting I mean it's just sometimes:

and I don't think that's much different in rural or urban I think when your life is disrupted and you're very depressed and you don't have the (.) whatever (.) to care

that's just what you get I mean there are days you probably come in my house in the past and think

O:H MY: GO:D (hahah) will you clean your house!

so you know I get that! you know

what are you gonna do you you you can't not provide the hope that the child will not live in that environment

will be able to manage their lives better in the future than the parents have and that's always the goal that the child is able to do better then what they had growin up I mean I think that's primarily the goal

and I call that I finally realized after awhile that I'm not just trying to help families and other kids

it's like if I could go back in time what would I have done for myself you know and that's what is is

that I wish someone would had (.) done this or done that

and gee! what a difference it would have made if one of my teachers had said you know you're smart enough to go to college

you know if someone had given uh the hand up and um you know but I didn't get that but I managed to fight through and do ok um

but gee what a difference that would have made

and to know that there's not a reason people can't do that there's not a reason in the world why people ca:n't you know

look at kids with an attitude of just because you're you're poor or your dirty or you're this or that doesn't mean that you're not a worthwhile person and you can't have a future um

and you know so it long story long answer (hahah) for a quick question why are you still here uh I think that's it

you know I feel like this is my job this is what I should be doing and uh

C: It's a calling

M: It really is it it and it took me a little while to get here

I could see where it was going before it's like you know where this is going don't ya?

you know and it's like oh yeah well we'll see and sure enough that's exactly what it turned out to be. and I think on some level

I knew that the moment I moved home so

and it's still there and you know I I don't there are a lot of times I say gee I wish I could retire cause I'm sick of getting up at six fifteen in the mor(hahah)ning! but I don't get tired of what I do so.

#6

M: You know I mean I I had a conversation with a doc one time

where the kid uh it was an older kid probably fifth or sixth grade and the parents called me >I don't know how they got my number< but somebody (.) gave it to them

C: Mmhmm

and they the dose of medication that this child was on for adhd was so high I mean I never seen it that high

and I finally went over and I said why (1.0) is this kid (.5) on this medication

well we just can't get it to work (.) you know its adhd and we just can't get him to settle down in school .
 so I call the school and I had a with the moms permission and I had a consent and the child had an iq of fifty four (.5) fifty (.) four
 You cannot (.) medicate away an iq of 54
 And (.) the physician had no idea that was his iq
 The kid was just actin up in school
 I was furious
 I(.) was(.) furious(.) ((hit desk with each word))
 Instead of giving (.) services for this child that they needed in school
 Child the the kid hadn't even (.) didn't even have an iep!
 Maybe a behavioral one
 But had never even been evaluated and subsequently you know I said could we please get this kid a full evaluation in the school system and they did he had an iq of 54
 Blew me away
 Blew me away I was furious (1.5) furious.
 See it all the time kids on all kind of meds
 But the real issue really is just not even asked
 People don't ask (.) is there domestic violence in your home
 People don't ask (.)you know: do you have a history of abuse
 People don't ask that kind of things cause they don't wanna know then they have to deal with it
 Can you imagine our physicians in their fifteen minute office visit and they say you know are you safe at home and
 As you begin to have a conversation about being afraid when your husband comes home (.) or whatever you know you're getting this ((looks at watch))
 We:ll I gotta go see my next patient now
 You know what does that say I don't wanna hear that I don't have time for that I don't wanna hear anything about that

#7

C: Does Appalachia have any specific bearing on rural mental health care? Cause I'm sure you could find the same kinds of situations (.) anywhere but what's specific about this area (.) that makes it different?

M: I I think what is specific about this area is that you (have

You have Appalachian families who their who:le (.) lifestyle and ability to maintain day to day they get (.) from that family unit

So if you're outta eggs this week somebody in the family's got eggs

If you need a ride (.) someone in the family will get you there

So it's that kind of reliant on the family to meet basic needs (.) and when you combine that with the fact that

Well let me just tell ya after I came back here one of my I

One Christmas for gifts for everyone I researched both sides of my family tree and put it in a book for people

Um >cause I didn't have much money< but (hah)

The time that this took was unbelievable (hah)

Unbelievable

So what I found and I knew my (.) both sides of my family went back for years and years and years but I just really didn't know how much

So what I found was that my: one of my first ancestor um came here in (.) early early 1800s about the time when the university was founded

Um and they settled (.) not three miles from where I live now

And the most the rest of majority of my family lives right there um within uh probably a five mile area of each and we have been there for seven generations um on both sides

Both sides

So there and so I think that's why there's a sense of coming home is that everyone that I knew before me in my family (.)

Lived here

And we know the families of the families of the families.

So there's that sense of closed in this is my community

This is my family and so where you get your information

Where you get your ideas about how to parent

Where you get everything everything that you are comes from a group of people who basically have been in the same spot forever don't know the outside ways

Don't read studies on child development

And so you get the same ideas and thoughts and behaviors of a hundred years ago that are still um very solid

I mean I still hear uh not recently thank goodness but in the past ten years (.) kids who have had head lice and parents soaking their hair in kerosene to kill the head lice

Um or giving castor oil for (.) you know for whatever

Sickness and stuff

Yeah so there is a lot of very very old ways of doing things um where it was it's common in the whole family to beat your wife

that's just what you do when they act when she acts a certain way its accepted by the whole extended family

Um child abuse is accepted it's not abuse they see it as ya know >spare the rod spoil the child< um you know where incest is a common thread throughout families and it's not talked about but its approved in the family

So you have those kinds of things to overcome generation to generation of (.) of teaching and knowing it's okay and then how do you in a two hour meeting begin to flip that

#8

M: If people leave they don't stay gone very long um and often they come back um uh you know just because of that (.) generation upon generation of knowing and what I found when I moved back (.) um oddly enough I walked up on a piece of property and my son had said there's some land up there for sale and I said I wanna see it and I walked up on the property's eight miles out of town and all I did was walk up there and I said ill take and I I I bought it that day

So come to find out years and years and years ago one property line >I've got about eighteen acres< one property line was owned by my father's (.) forefathers and the other one like my mother's forefathers and it meets like this right here in the middle and I had no idea

C: Wow that's really neat

M: So again when you talk about being attached to the land or being attached to an area and all your family has been there since the 1800s you know I think there's something >I'm not sure what that is< um but there's there's something that pulls you back the familiarity of the seasons and the land and (1.0) you know (.) that this road is a back road to Parkersburg if you've had too much to drink

C & M: (hahah)

M: back in the day

C: that's fantastic

C & M: (hahah)

M: You know you know those things! um what areas to stay away from late at night

C: Mhm

M: And (.) You just know and I think it gives you confidence that you can navigate your world because you know it so well as opposed to being in a place you're
 And I've lived in many many places being in the military we were overseas we were you know in six different states so:
 That that was a real change for me and really all I wanted um was to get back to that familiarity.
 So so people want it they need it they don't want to I I people just want to be where they know and I think that's especially true of rural (.) Appalachian (.) culture uh because of all the things that go into that

Narrators 2 & 3; Therapists, Fairplain, West Virginia.

#9

C: Can you start off by telling me how you got into the work you're doing now?

E: When I was a senior in college um (.) I was I was raised in the church basically
 and when I was a senior in college I kinda (.) had a renewed interest in religious my upbringing
 and um it was like God said I want you to be a counselor
 and I'm like but I cry at the drop of a hat how am I ever gonna do that
 and he said to me my strength is made perfect in your weakness
 and so um (.) in lookin at jobs and things well I also have um a two year degree in business
 administration
 just because I thought I needed some skills to go along with the English degree just because I didn't
 get an education major
 so in lookin at the kind of jobs I could do took a civil service test
 and I was able to get a job at human services in social services
 so I went to work at the department of human services as a social service worker
 and um after workin there for a few months I um (.) entered the social work program at WVU and (.)
 eventually got my masters degree in social work
 and so I've seen a pretty wide range of what social workers do
 I've worked as um a generic social worker with adults and children and in with DHHR
 and uhh I worked as a child protective service worker
 I've worked as a residential um worker um for Presley ridge
 I've worked um as a juvenile probation officer
 and (.) I've worked in a hospital for twenty years
 and (.) I've worked here
 so I've I've seen pretty much a wide range of what you do as a social worker
 and I'd say this is one of my favorite jobs although (.) it doesn't pay very well
 um and the stories can be very heart breaking
 at one point I was probably nine months to a year behind in writing my notes (.) because (.) the
 stories (.) can break your heart
 and its um sort of um (.) overloads you with the trauma that your clients experience
 um and and its like you re-experience the trauma when you go to write the notes
 so I would just id take like little rough notes when they're telling me their stories
 you know I would take the rough note and stick it in the drawer
 it's like I didn't have to think about it anymore (1.5) until I would take it out to write the note
 and then it's like experiencing the trauma over again

so I got like so many months behind and I kept saying to people I'm behind in my notes I'm behind
In my notes

and it's like nobody was payin attention and for a long time I was the only full-time therapist here
until Erin came

so huh um (1.5) finally somebody took note and said well just how far are you behind and I showed
em my stack and they're like

they put me on adminisitrative duty for what two months (laughter) until I got all my notes caught up

D: Tried to put her on administrative duty and she saw people anyway

E: Yeah well I would see my substance abuse clients because some of em had to be seen every week in order
to maintain their relationship with their doctor

And so uh there were certain clients I would see regardless of what people said so (.) yeah

#10

C: Can you tell me about a time you feel like you really made a specific difference in someone's life like
anything that really just resonates with you that you you can't get off your mind?

E: I was a very young social worker and I had this kid I think he was (.) maybe fourteen or fifteen

His mother and father had both been in prison his father uh for stealing cars and choppin them and
sellin parts

And (.) I can't remember what his mother was in prison for

But He was in trouble for some little (.) stuff (.) I don't know like skippin school or something

And I had to take him before the judge and (.) I (.) you know asked the judge for probation for him

And the judge basically threw the book at him and sent him off to Salem for an evaluation

And (.) you know I kinda felt that was pretty hard

And um(.) so when the kid got out you know I arranged placement and stuff for him

But at one point he ended up at Davis child shelter because (.) you know we didn't have a place for
him to go briefly

And I took him a birthday cake on his birthday and the kid cried

And um (2.0) it really kinda surprised me

You know (.) I guess nobody had ever really paid much attention to him you know on his birthday
and he stayed outta trouble for several years and

I felt like maybe I made an impact on him

He eventually I think did end up in prison for a few years

But (.) he stayed out for awhile

So I felt like I made a difference

#11

C: Could you tell me about maybe a case where you had a lot of difficulty getting through to your client. Im
really interested in people getting into therapy...

E: Well I had one couple come in for what's called an employee assistance program where their employer
actually pays to send them in

They had had some problems

Both of em were nurses and he had had an affair with somebody else at work they both worked for
the same hospital

She was extremely angry um and shut down
 She would not talk (.) um at all
 Actually neither of them talked very much
 So it was really pretty uncomfortable
 Um it's hard when you feel like you're the only one talking in a session
 You know and so (.) I tried to give em some pointers on communication
 You know (.) how you don't say never and you don't say always and you know those kinds of things
 when you're trying to communicate with each other
 And uh things about forgiveness and trust uh those kinds of things
 Later learned she also (2.) lost her license because she (.) used opiates that were for the patients
 So she had more issues than just the problems in the relationship

#12

- D: You had mentioned what made people maybe come to therapy and more open to it
 And I was tellin Sarah at lunch
 And I think you see more of this maybe than I do
 We have the people that come in and they think I'm gonna get xanax
 I'm gonna get clonopin I'm gonna get valium or whatever from the doctor
 And I had uh told Sarah um and then but the doctor says hah you you have to go to therapy too and
 then we'll see
 And then we get some clients that are like pssh and then they blow off their therapy sessions
 And then they eventually don't get the medicine (1.0) sometimes (1.0)
 Or you have those clients who come in and they're like I really don't think I need therapy I just need
 the medicine
 But then they they become more receptive they're like OH (.) well you know it actually felt kind of
 good last week to talk about this and so that's kinda
 I mean I feel like you probably see that too the people that I don't tell anybody anything I don't trust
 anybody everybody's already you know
 And we have a lot of people too and I don't I don't know if you see this a lot
 Like the kids that are like well I told my guidance counselor and then my guidance counselor told my
 mom everything so why am I gonna tell you anything
 You know but then they realize (.) there's that trust
 So just to kind maybe add on I guess or see what you think about that
- E: Yeah (1.0) we used to have um a physician that would give anybody clonipin and xanax
- D: Mostly xanax
- E: And things have tightened a lot uh due to changes in our physicians
 And now if they are gettin any kind of medication the physicians are pretty much requiring that they
 also have therapy
- D: And they're like (1.0) uh-uh (1.0) hahah and an-I had a person last who week that (.) she
 Do you know what a board of pharmacy is
- C: Uhm-mm

#13

- D: Let's say you go to the doctor and you get a someth-a controlled substance or i-i-i- if you hurt your back and you get pain pills
 If a doctor suspects or if a doctor's just be very careful they'll do a board of pharmacy
 And they'll see ok (.) have they gotten this stuff before what are the pres-prescriptions they filled in the last however many months you know
 And we have someone who filled pain pills pain pills pain pills you know?
 And you have to sign a contract when you come here
 And many doctors you can only get pain pills or opiates or whatever from one doctor and one pharmacy
 Unless there's an emergency or something like that
 And (.) this person had four or five different pharmacies four to five different doctors in the tristate area within one month
 So the doctor fired her
 Cause doctors can fire I mean we can fire our clients
 And so as soon as that happened of course she walked out in a huff denied the whole thing denied denied
 Of course she's not coming back to me for therapy
 Yeah
 because (.) why do I need therapy
 I'm just here for my xanax what what are you talking about
 So that's (.) that's a lot of the resistance I feel like we see here versus(1.0)
 I mean I mean that's just something we experience a lot and I think that if we didn't have a psychiatrist we would be better off
 I don't mean that in that I just I mean therapy-wise
 Because there would be no motive I don't feel like
 I don't know I don't know how you feel about that
- E: I don't know um (.) I think medication and therapy go hand-in-hand
 I mean depression I don't think you can cure without medication
 And (.) I think you have to have some talk therapy to go along with that
 You know to gain insight on on what's causing the depression
 And um (1.0) yeah try to get some insight on it and (.) growth
- D: I think maybe what I wish I woulda what I meant to say was I wish there weren't these medications that were so addictive and that people
 Like she had said we had a doctor that oh ok xanax ok oh ok xanax
 Oh you failed you're your last drug test ok well ok xanax
 a-and (1.5) and they knew they knew to come (.) here
 oh get with this doctor
 and that was our only doctor at the time (.) for a long time
 um (.) so I agree that it goes hand-in-hand
 but but sometime I wish I knew the motive
 but that's part of therapy
 we gotta figure it out see if its real or not
- E: well and (.) another issue with that particular provider was he wasn't treatin in psychiatry
 D: he was a (.) ER physician
 C: Huh

D: But he did he (.) I can't remember how (.) he did (.) ok
 I'm not totally sure how that (.) it was all billable
 and that's (.) what was really important

#14

C: Do you have any specific stories of people embracing/ not embracing therapy or maybe like a story of a person that you've gotten to come around to therapy? An example of that of what you just said

E: I have a very interesting client

I say if I have (3.0)

If I've ever seen a client with uh (.) dissociative personality disorder it would be her

And um (1.0) she's very um inconsistent

But she'll come in and she'll talk and you'll feel like she's really gettin somethin out of session

And you may not see her again for six months

But when she comes

And when she is the person that you expect

She really seems to benefit from the session

There's probably at least three personalities

Sometimes I'll have to go with her to the desk

Because she doesn't always understand and she's a little scared sometimes

Um one of the personalities

And uh (3.0) so she's a little resistant

but sometimes she's very accepting

She's real interesting to work with

She suffers extremely from Post traumatic stress disorder

D: Have we talked about her before

E: You've seen her (.) some

D: (2.0) I'll have to think about her

E: (1.0) From Florida

D: Ah ok

We've talked about that before

It's like when she's here she's in it and you're going ah yeah ive got this

And you know you make a difference but

We've got (.) some rules that if there's a certain amount of no shows or cancellations from a client they want us to close the chart (.) after three times

Well situations like that (.) we don't typically do that and sometimes we find oursel--

Tell me if I'm telling this correctly

E: Mhmm

#15

D: We find ourselves kind of fighting to be like nope they're coming back

Nope not closing this chart they'll be back because (.) that's just how it is

Not everything is cut and dry

Yeah this person might cancel three appointments in a month and that stinks for our billing but (.)

They might not have a car right now
 So that's another issue with our rural setting
 And we have a bus that runs three days a week
 But you have to pay to get on it
 Granted it's a dollar but some people
 Do they wanna choose their dollar to come here (1.0)
 On a bus
 And then stay here for probably two hours
 And then ride back with a bunch of people you don't know
 Or that you probably do know
 And they know where you were why you went
 Or do you wanna save your dollar and just go ahead and get a pop
 Or or save that toward your cigarettes

E: Co pay for your medicine

D: Right I mean and you never know and you hear that a lot
 We ha-we have started to provide transportation
 Which I think has been really helpful
 That's a big big issue
 Um I don't know if you saw that in Athens
 The transportation cause like (.) with us (.) with our doctors
 We can drive wherever we want and I know that (.) ill go to Charleston
 Because it's closer to me
 I I kinda have more of a (.) an option
 I have different options I don't know the person
 Likely

#16

C: So what do you think about Appalachia
 Do you identify with that a lot

E: I'm an Appalachian

C: Ok

E: Yeah

Born and raised

C: Some people (.) it's maybe not really a thing they they think about but you consider that a part of your
 identity

E: Yes

C: Um what do you think (1.0) makes working with Appalachian people
 And working with this area different maybe than working in other rural places

E: I think we're (.) probably a little more fatalistic
 Uh sometimes we don't expect to live a long life
 I don't expect to live a long life
 My parents both died in their early sixties
 I expect to die in my early sixties if I live that long uh
 (4.0) we don't expect to be rich

We (.) I think I expect to live comfortably
 I don't expect to live poor (1.0) like a lot of Appalachians
 Except (.) for my education
 We're very (.) plain people
 We don't expect a lot of fancy stuff

C: Do you think people bring that into therapy

Like is it just
 Cause I spoke with another lady in Athens
 And she mentioned how (.) if it's not something your family supports it's not something you should
 do
 Do you see anything like that

E: Yes

Yeah if family's not ok with it a lot have a hard time goin ahead with it
 I've always been a little independent when it comes to that kind of thing
 I do what I want regardless of who says
 But most people in Appalachia won't buck the family
 If the family says no they won't do it

#17

D: I had a person come in (.) college age um (.) that

(1.0) I'm making sure confidentiality isn't violated (2.0)
 They were very concerned (2.0) because (.)
 They had insurance and they didn't want (.) parents knowing they were coming to therapy
 So it was
 You're actually gonna get this person because
 That's the one
 His girlfriend doesn't want him seeing me because (.)
 Apparently I'm (.) irresistible I dunno

(Laughter)

Um (.) nah he's (.) not allowed to see anybody (.) closer to his age uh
 Oh um (.) he he didn't tell oo (.) uh well
 They didn't tell uh (.) their parents they were coming here at all
 Cause they were worried about judgment
 And then it was like well I'm gonna have insurance copays
 So I'm gonna go in see how the intake goes see if I'm feeling comfortable with it
 Then ill I'll come back

C: And that judgment being uh (1.0) stemming from (.)

That he might have something like a mental illness
 Or like have problems or just that it was (.)
 An unconventional new thing that his family didn't know a lot about

D: Pride

C: Ok

D: This family's fairly (.)

I think they would identify with Appalachian as well

But (.) they are very very comfortable (.) financially (.)
 Um but I think a lot of it would probably be a pride thing
 Or a lot of people are very offended
 Why don't you just talk y-y-you can talk to your family
 Just talk to just talk to us about it give us a call
 Well no (.) they might be the problem
 You know or or they might (1.) tell aunt sue
 Haha and then aunt sue might tell grandma
 And grandmas gonna call you and say you know
 As in our family you call

C: One woman all the women know

D: Did you know...?

Well it's not and it's it's funny cause with our family it's not a gossipy thing
 I mean I
 Not really
 It's more of
 And I always joke around
 Nana's in South Carolina
 You're in Columbus
 In then mamaw and them are in Georgetown
 And mom's in Preston county near Morgantown
 We all know that we sneezed
 Nana calls to make sure you have a tissue
 But Nana grew up in Appalachia
 Mamaw grew up
 We all the all the women in our family grew up in the same county
 They all moved

C: Except for me

D: Right and um that's what's wrong with you

(Laughter)

D: But they

They all are very much like
 It's its' not gossi-it's more like worry
 Like if my mom is having a problem I'm gonna get the phone call
 Is your mom ok are you sure when you saw her is she ok
 And then
 Our mamaw
 Will then call her mom and say(.)
 Now have you you talked to your sister is she ok
 It's just that chain it's constant
 And she and I will call each other
 Cause we're the that same generation
 And we'll call each other (.)
 Ok what about what about grandma or nana
 But that's I think that's a very significant Appalachian characteristic

E: Tommy used to say

My husband used to say

There's telephone telegraph and teleReba

Reba was his mom

Laughter (5.0)

Cause if you told Reba, everybody would know

And most of the time Reba would tell you multiple times in the conversation

D: But it's not a bad thing it's a good thing

Appendix B: Transcription Keys

: Colon(s): - Extended or stretched sound, syllable, or word.

Underlining: - Vocalic emphasis.

(.) Micropause: - Brief pause of less than (0.2).

(1.2) Timed Pause: - Intervals occurring within and between same or different speaker's utterance.

. Period: - Falling vocal pitch.

? Question Marks: - Rising vocal pitch.

[] Brackets: - Speech overlap.

! Exclamation Points: - Animated speech tone.

- Hyphens: - Halting, abrupt cut off of sound or word.

> < Less Than/Greater Than Signs: - Portions of an utterance delivered at a pace noticeably quicker than surrounding talk.

OKAY CAPS: - Extreme loudness compared with surrounding talk.

ye(hh)s parentheses mark within-speech aspirations, possible laughter.

hah Laugh Syllable: - Relative closed or open position of laughter