

Female Client Perception, Experience, and Understanding of
Psychotherapeutic Change in Rural Appalachia Ohio:
A Phenomenological Study

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Female Client Perception, Experience, and Understanding of
Psychotherapeutic Change in Rural Appalachia Ohio:
A Phenomenological Study

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ABSTRACT

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Female Client Perception, Experience, and Understanding of Psychotherapeutic Change
in Rural Appalachia Ohio: A Phenomenological Study

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The purpose of this qualitative study was to explore the experiences, perceptions, and understandings of five female participants in the rural Appalachian Region of Ohio who reported psychotherapeutic change as a result of mental health counseling. The psychotherapeutic change process has been defined by multiple theorists, however in this study the meaning of change is explained from the participant's perspective. Data collection consisted of in-depth interviews, demographic, and counseling questionnaires. A combination of Colaizzi's (1978), Van Manen's (1984), and Moustakas' (1994) phenomenological methods was utilized for data analysis. The four themes that emerged from the participant's stories answered the central research question: *What are the Appalachian female client's experience, perception, and understanding of psychotherapeutic change?* Generated themes included: Experiencing Therapeutic Change in a Safe Counseling Relationship, Education as a Precursor to Experiencing Therapeutic Change, Experiencing Change as a Journey to Empowerment, and Experiencing Therapeutic Change as Modern Appalachian Daughters with Traditional Appalachian Mothers. Practice and research implications are discussed.

DEDICATION***Women of Resiliency***

*Steel mind,
Bend me
And I straighten*

*Iron spirit,
Melt me
And I solidify*

*Granite soul,
Chip me
And I reconstruct*

*Diamond nerves,
Crush me
And I radiate*

*Ruby heart,
Pierce me
And I revive*

*Copper body,
Tarnish me
And I glisten*

*Golden voice,
Silence me
And I speak louder*

★Poem by Melissa Martin

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Deep appreciation is given to the participants of this study, resilient rural Appalachian women who learned that change is a choice; courageous women who sought out counseling to overcome emotional pain; compassionate women who wanted to share their personal change journeys via mental health counseling so other female sojourners may benefit.

I thank the Appalachian women in my family tree who embody the gentleness and creative beauty of a flower petal, yet symbolize the strength and durability of a stone. And when a gusty wind blows, the blossoms sometime scatter while the sturdy stem bends but does not break. And when the rock is pressurized it does not shatter, but instead transforms into a brilliant gemstone of resiliency. The legacy of these pioneer women follow me wherever I roam; their collective spirits breathe belongingness into my soul; their fiery courage bids me to rise when I plummet; their kindness of heart whispers into my essence; their humbleness walks before me; and their hardy work ethic challenges my hands and feet. I am who I am and what I have become due to the role models of my upbringing; salty women who sweetened life with laughter and tears, joy and grief, hard work and play. A colossal message of appreciation goes out to my husband for his endurance. His support is written between the lines.

I want to offer colossal appreciation to my doctoral dissertation committee members for their patience and understanding: Dr. Tracy Leinbaugh, Dr. Tom Davis, Dr. Gregory Janson, and Dr. Peter Mather. Thank you!

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CHAPTER ONE: INTRODUCTION

It is widely accepted that psychotherapeutic change is the theoretical foundation and the underpinning philosophy for practitioner, counselor, counselor educator, theorist, and researcher (Bergin & Garfield, 1994; Duncan, Miller, Wampold, & Hubble, 2010; Hubble, Duncan, & Miller, 2003) and theories of psychotherapy and counseling are constructed to facilitate dimensions of change in the client (Bergin & Garfield, 1994; Blow, Sprenkle, & Davis, 2007; Overholser, 2005). Change has been studied from the viewpoint of the theorist and the therapist, but is yet to be deeply explored from the viewpoint and understanding of the client (Castonguay & Beutler, 2006; Cummings, Hallberg, & Slemon, 1994; Duncan, Miller, Wampold, & Hubble, 2010). However, in the present naturalistic inquiry the meaning of the psychotherapeutic change process is investigated from clients' perspective and understanding. According to Hubble, Duncan, and Miller (2003), "Within the client is a theory of change waiting for discovery" (p. 431).

This chapter introduces the background of the study, rural Appalachian female clients as the participants, the statement of the problem, the purpose of the study, significance of the study, research questions, limitations and delimitations, overview of qualitative methodology, and conclusion.

Background of the Study

The counseling relationship is composed of a client, a counselor, and the change mechanisms (Blow, Sprenkle, & Davis, 2007; Duncan, Sparks, & Miller, 2006; Greenburg & Pinsof, 1986). What are these change mechanisms and why is it essential

for researchers, counselor educators, and counselors to identify and understand them?

Researchers have asked this question from the beginning.

Bohart and Tallman (1996) asserted, “The field has over focused on the importance of the therapist interventions” (p. 25) and “No matter what happens in therapy, however, it is ultimately the active client who makes changes in the way he or she actually lives life” (p. 20). Duncan and Miller (2000) concurred and stated, “Within the client is a uniquely personal theory of change waiting for discovery, a framework for intervention to be unfolded and utilized for a successful outcome” (p. 180). Why is it important to understand the meaning of change from the client’s perspective? The professional literature was reviewed to try to find the answers and clients will be interviewed to try to find their answers in this study.

Appalachian Female Clients as Study Participants

This present study invites the participants to share personal experiences through conversational interviews relating to psychotherapeutic change and their understanding of how change occurred before, during, and after counseling services. The cultural context of Appalachia is explored through the eyes of the participants. A phenomenological approach is utilized to fully explore core meanings (Moustakas, 1994) of the counseling experiences of participants. Because little is known about the understandings of Appalachian female clients in reference to psychotherapeutic change mechanisms and cultural counseling commonalities, phenomenology is a suitable research method for this present study (Giorgi, 1997). There are limited qualitative studies describing the lived experience of female clients in Appalachia (Keefe, 2005; Helton & Keller, 2010; Salyers

& Ritchie, 2006). How do Appalachian female clients perceive, experience, and understand psychotherapeutic change?

Statement of the Problem

This study was designed to investigate the participants' experiences of their psychotherapeutic change process within the Appalachian context. The cultural voices of women who attend mental health counseling in rural Appalachia Ohio are absent and a void in the literature exists on their experiences of psychotherapeutic change. In addition, the American Psychological Association (APA) reported the research on rural women to be "almost nonexistent" (APA, 2002, p. 2). Rural women in poverty have been identified as "both at-risk and underserved by mental health professionals" (Myers & Gill, 2004, p. 225) in combination with barriers to using existing services (Belle & Doucet, 2003).

Purpose of the Study

The purpose of this study was twofold. First, this study utilized a qualitative, phenomenological design to explore clients' perceptions and understanding of psychotherapeutic change. This research was an endeavor to add qualitative data concerning individuals who experienced psychotherapeutic change during the course of counseling to the body of research knowledge. The purpose of this research was to ascertain the varied experiences of rural Appalachian women and understand how they experienced psychotherapeutic change from their perspective. This research based on the client's perspective may advance understanding of the change process for rural clients in the areas of counseling and psychology. Treatment effectiveness may be enhanced.

Second, this study explored the understanding of psychotherapeutic change by a specific population: adult females in Appalachia Ohio who have completed mental health

counseling. This study aimed to gain in-depth and rich description of the personal experiences, perceptions, and understanding of these clients. The purpose was to determine shared experiences among Appalachian women who completed counseling and reported psychotherapeutic change. Cultural counseling commonalities were explored. The findings will better equip mental health counselors in rural settings to improve treatment for Appalachian women. Clinicians may become more intentional in the process of psychotherapeutic change and treatment effectiveness. The researcher hoped to give an empowering voice to female clients in the rural Appalachian region, both individually and collectively. The study will provide useful information to rural practitioners and additional research and knowledge for the counseling professions (e.g., clinicians, counselor educators, counselor trainees, theorists, and researchers) in regard to psychotherapeutic change in rural mental health settings and can improve client care and treatment efficacy. The findings will add to the literature knowledge base.

A qualitative methodological framework utilizing a phenomenological approach is appropriate for exploring, describing, and gaining deeper understanding of the psychotherapeutic change process for clients (Elliot & Shapiro, 1992; Rennie, 1992).

Significance of the Study

How do rural Appalachian female clients perceive and understand psychotherapeutic change? No one has asked them. There is a void in the research that examines how female Appalachian clients recognize, understand, and maintain psychotherapeutic change. Clinicians are providing mental health services to rural Appalachian women without knowing the clients' understanding of the psychotherapeutic process of change. What are the cultural barriers to counseling? How does the context

shape their processes? How does the Appalachian context of gender inequality, oppression of women, and cultural identity intersect with seeking counseling and desiring change for the rural Appalachian female? The information gathered may add breadth and depth to the existing literature and may benefit clinicians who provide counseling services in rural areas, counselor educators who teach in rural universities and theorists who conduct research in rural mental health settings.

Clients' descriptions (in their own words) may generate knowledge and application for both future clients and mental health clinicians. The results of this present study may provide rural practitioners with new knowledge about a marginalized population. Analysis of each client's counseling experience may better inform professional mental health therapists about the process of change, challenges, cultural strengths, and barriers of Appalachian women who attend counseling. Client answers may improve treatment effectiveness by giving helping professionals insight about their understanding of the change process and change outcomes. There are research findings which found that clients who attribute change to their own efforts experience longer lasting change (Bohart, 2000; Lambert & Bergin, 1994). Do female clients in the rural Appalachian region attribute psychotherapeutic change to their own efforts?

In addition, in the era of outcome measures important to third-party payers, receiving feedback from clients may improve and enhance counseling services (Brown, Nace, & Dreis, 1999). Positive treatment outcomes may increase. Treatment goals may be achieved in fewer sessions. Clinicians may seek clients' opinions and suggestions during the course of therapy about self-change and self-efficacy. Therapists who better

understand the complex and multifaceted mechanisms of psychotherapeutic change may utilize more intentional change factors to guide and inform the counseling process.

The ongoing debate surrounding psychotherapeutic change was explored in a specific population by listening to their stories to find commonalities. The participants were Appalachian women in Ohio and their understanding of counseling experiences and change factors (process and outcome) was examined. Change as a continuum was explored from the perspective of the client. Consequently, the client's unique voice was heard and validated. Without a client there would not be therapy or a therapist (Duncan & Miller, 2000). Without the smallest degree of change, counseling would not be effective (Duncan, Sparks, & Miller, 2006).

This study was important to this researcher as well. As a native Appalachian female and a professional counselor residing and practicing in rural Appalachia, this study increased self-awareness and other-awareness in regards to the pursuit of knowledge and application. I hope to better counsel and empower Appalachian women who sit in the opposite chair for counseling services. I am able to better teach counseling students about the needs of rural Appalachian clients and change mechanisms.

Research Questions

One central research question and four secondary questions were selected:

- A). What are the Appalachian female client's experience, perception, and understanding of psychotherapeutic change?
 - 1). What are clients' beliefs concerning change during their course of therapy?
 - 2). How do participants describe/make meaning of changes that occurred before, during, and/or after therapy?

- 3). What do participants attribute change to: themselves, therapists, or others?
- 4). What suggestions would the participants like to make to clinicians about their understanding of the psychotherapeutic change process?

Questions about access to mental health services for women in rural Appalachia, the challenges, and the barriers were ascertained as well. Socioeconomic factors that affect mental health issues were discussed (e.g., poverty, housing, transportation, health insurance, lack of mental health services) as well as cultural issues. Information learned from the participants may further our knowledge base concerning their understanding of the therapeutic change process of Appalachian women in rural Ohio.

Limitations of the Study

This study did not attempt to be representative of the total population of Appalachian females who have completed counseling and experienced change. This was a small sample size and consequently, the small sample size is a limitation.

The initial aim for this study was to interview ten Appalachian women with representation from five rural Ohio counties. This did not happen even with intensive recruitment. Five additional rural counties were added with the same recruitment procedures. The researcher sent letters and follow-up phone calls to directors and clinical directors at community mental health agencies in the ten counties. With the aid of counselors, clients residing in remote regions without telephones or computers may have been contacted. One mental health agency responded, however flyers were placed in waiting areas and counselors were not involved in the recruitment process based on decisions made by the director and board members. Letters and follow-up phone calls to residential recovery facilities for women, outpatient recovery counseling centers, and

hospital psychiatric inpatient units were included. Domestic violence shelters and task forces in the ten counties were contacted for participation. Letters were mailed to private practitioners, psychologists, social workers, psychiatrists, and faith based counselors. Flyers were sent to county health departments, women's medical clinics, women's cancer centers, Job and Family Service agencies, social service agencies, homeless shelters, support groups, and church support groups. Flyers via email were sent to college health clinics and counseling centers at universities, to student groups, and student support services. With permission flyers were posted on bulletin boards at university and local public libraries. Flyers were posted at post offices and community buildings. Despite extensive recruitment efforts, this study was composed of five Caucasian women, native to Appalachia and residing in the United States, specifically the state of Ohio in the rural region. This study was reliant upon participants who were willing to share their experiences and to verbally articulate their stories.

The following section provides an overview of the qualitative methodology selected for this study. The phenomenological framework is presented.

Overview of Methodology

Ethnography, phenomenology, hermeneutics, narrative analysis, participant observations, interpretative research, field study, inductive research, case study, and grounded theory are well suited to the process oriented study of therapeutic change in the mental health field (Corbin & Strauss, 1990; Denzin & Lincoln, 2000; Patton, 1990).

Qualitative research refers to the description of social phenomenon (Bogdan & Biklen, 1992; Glesne, 1999; Lincoln & Guba, 1985) and explores meanings and experiences of phenomena (Guba, 1990; Miles & Huberman, 1994; Rossman & Rallis,

1998). According to Marshall and Rossman (1999), “qualitative researchers are intrigued with the complexity of social interactions as expressed in daily life and with the meanings the participants themselves contribute to these interactions” (p. 2). Qualitative research provides an ideal framework for inquiry as it naturally focuses on the process of understanding experiences by way of design flexibility. “Thick description” (Geertz, 1973, p. 5) coupled with systematic inquiry and detailed analysis yields an expansion of knowledge for theorists, researchers, counselor educators, graduate students, and practitioners.

Qualitative research focuses on both the essence and the underlying meaning of experiences (Creswell, 2007; Locke, Spirduso, & Silverman, 2000; Moustakas, 1994) and necessitates alternative approaches of gaining and explaining knowledge that focus on human perspective, meaning, context, and relationship (Creswell, 1998; Glesne, 2006; Miles & Huberman, 1994). Therefore, seeking out clients and generating conversation and discussion on the therapeutic change process remains salient to understanding their experiences and understandings (Bohart & Tallman, 1999; Duncan, Miller, Wampold, & Hubble, 2010; Kazdin, 2005). Exploring mechanisms of change with clients in rich detail will determine how to improve mental health services (Sprenkle & Bischoff, 1995).

After reviewing qualitative studies where clients were viewed as active participants, Rodgers (2002) posited, “Instead of trying to control ‘experimental variables’ and produce ‘statistically significant’ results, qualitative inquiry attempts to get as close to each participant’s experience as possible, and to allow the participant’s own voice to be heard in the research results” (p. 28). Likewise, qualitative studies on clients’

perception of mental health issues are needed in the mainstream of research (Duncan, Miller, Wampold, & Hubble, 2010).

Phenomenological Framework

“What human experience do I feel called upon to make topical for my investigation?” (Van Manen, 1990, p. 41). Van Manen’s (1984) qualitative, phenomenological approach conveys the study of “lived experience” through essences, attentive practice of thoughtfulness, a search for what it means to be human, and a poetizing activity (pp. 1-2). He suggests four procedural activities: (a) “find a phenomenon which seriously interests and commits the researcher,” (b) investigate the experience “as we live it rather than as we conceptualize it”, (c) “reflect on the themes which embody the phenomenon,” and (d) “describe the phenomenon through the art of writing and rewriting” (pp. 2-3). Van Manen further asks the researcher to embrace the nature of the lived experience by learning about the phenomenon, formulating the research question, and declaring assumptions.

A qualitative methodology framed by a phenomenological inquiry was selected to answer the research questions in this study. Phenomenology underpins qualitative inquiry, in that it explores the core meaning of individual experiences through in-depth interviews (Giorgi, 1997).

Wertz (2005) selected phenomenology to explore repeated hospitalization of mental health consumers. Qualitative narratives were developed and portrayed the experience of treatment recidivism. In another study, the experiences of battered women were examined within a phenomenological framework (Buchbinder & Eisikovits, 2003). Davidson and Strauss (1992) conducted phenomenology interviews with 66 individuals

diagnosed with severe mental disorder, the majority with schizophrenia. Davidson (1994, 2003) found improvements in clients' sense of self when the disease-model view was replaced with a strength-based view. Davidson also conducted phenomenology studies (1994) on storytelling and schizophrenia. He explored the meaning of schizophrenic delusions in the context of the adaptation to change and suggested that delusions serve a purpose as individuals strive for a sense of belonging and a sense of self apart from the disease.

Summary

Understanding how psychotherapeutic change occurs is crucial to each helping professional in the fields of psychology and counseling, yet, a debate continues regarding a common definition for change (Kazdin, 2005; Sprenkle & Blow, 2004; Sprenkle, Davis, & Lebow, 2009) and how to effectively measure change (Kazdin, 2008; Lambert & Ogles, 2004; Sexton, & Whiston, 1994). The psychotherapeutic change process has been defined by multiple theorists with many definitions (Hubble, Duncan, & Miller, 2003; Sprenkle, Davis, & Lebow, 2009); however change has not been defined by clients. In addition, change has not been defined by Appalachian women who attended counseling.

The counseling profession and the literature continue to pose fundamental questions: How does therapy work? What is responsible for psychotherapeutic change? Who is responsible for psychotherapeutic change? What do clients change? How do clients perceive and understand psychotherapeutic change? How do Appalachian clients understand change, particularly, females? How does the Appalachian culture impact the female client's perception of therapeutic change?

Chapter one presented the introduction, background of the study, statement of the problem, purpose, and significance. The following chapters elaborated on the phenomenon being studied. Chapter Two reviewed the literature in the areas of counseling, psychotherapeutic change, factors and components of change, and mental health counseling with Appalachian female clients, the population from which the participants were selected. Additionally, Chapter Two explored both quantitative and qualitative research studies in order to gain knowledge, critique information, identify gaps, generate implications, and provide continuity to this study. Historical and contemporary literature was reviewed. The qualitative methodology, specifically phenomenology, was explained in Chapter Three, including participant selection, sampling strategies, procedures for data collection, and analysis. The data were analyzed by using a combination of Moustakas' (1994) phenomenological research model and Van Manen's (1984) phenomenological approach. Chapter Four reported the phenomenological exploration and explication of the data. Personal stories gathered during face-to-face interviews were explored to allow participants to fully describe their understanding of the change process that occurred during the counseling process. Participant descriptions answered the research questions. Additionally, participants filled out a demographic form and a counseling form. Chapter Five presented the generated themes from the data. Chapter Six integrated the findings of this study within the existing literature and provided a discussion on the conclusions drawn from the data.

CHAPTER TWO: REVIEW OF LITERATURE

Introduction

Chapter Two provides an extensive review of the literature related to the areas of psychotherapeutic change and mental health counseling with rural Appalachian female clients. The chapter is divided into five sections that include: (1) nature of general change, (2) phenomenon of psychotherapeutic change, (3) specific components of psychotherapeutic change, (4) rural Appalachia, and (5) rural Appalachian females. Lastly, the conclusion is presented. Gaps in the literature are highlighted to generate future directions for research. This chapter concludes with an outline of major themes found in the literature and a discussion of implications. Discussion of relevant findings is presented.

Nature of General Change

In exploring the general nature of change, one can posit that human beings have been involved in both intentional and unintentional change processes since prehistoric times (Miller & C'de Baca, 2001). Before understanding psychotherapeutic change, it is beneficial to briefly learn about general change models in order to build a foundation (Murray, 2002) for the researcher. Some change models view change as linear with phases, stages, and small increments occurring over time while others view change as a sudden "ah ha" moment of insight (C'de Baca & Wilbourne, 2004). William James, one of the founders of American psychology, studied two opposite forms of change (Miller & C'de Baca, 2001). One is the gradual movement encompassing steps, stages, and phases and the second is sudden transformational change (Myers, 2001).

Chaos theory, a model about gradual and turbulent change, emerged in the 1980s as a scientific paradigm and was eventually applied to the social and behavioral sciences (Butz, 1995). In addition, Goerner (1995) conveyed that chaos theory could explain what drives change and how order eventually follows chaotic circumstances and events. In counseling and psychology literature, chaos theory is found in counselor education (Bussolari & Goodell, 2009; Wilbur & Kulikowich, 1995), brief therapy, and group process (Warren, Franklin, & Streeter, 1998), family and couples/marital therapy, chemical dependency treatment (Ayers, 1997), and lifespan development and learning (Duke, 1994).

In contrast to chaos theory is the quantum change premise which depicts a sudden transformation of change. C'de Baca and Wilbourne (2004) conducted a study in 1991 on the topic of quantum change. Fifty-five participants shared stories of sudden change and personality transformation described as a one-time event that changed their daily functioning. The researchers referred to this type of change as quantum change which produces instant insight from an experience resulting in sudden and enduring transformation which alters an individual's understanding of priorities in life, personal significance, and perception in purpose and meaning (Miller & C'de Baca, 2001). The most common changes reported were relief from "fear, depression, anger, release from destructive behavioral patterns, deepening or healing of relationships, authentic spirituality, self-actualization, a sense of self, and trust in the future" (p. 532). Ten years later, thirty of the participants were reinterviewed which yielded similar results (C'de Baca & Wilbourne, 2004). Spirituality and compassion were reported as the most valued among the ten values of "spirituality, family, compassion, humor, growth, self-

knowledge, genuineness, healthy, hope, and inner peace” (p. 533). According to the participants, the dramatic (quantum) change continued, evolved, and endured.

Interestingly, Miller and C’de Baca (2001) asserted their primary reason for writing a book on quantum change was to help people share experiences and overcome fears that quantum change experiences are a sign of mental illness. Although religion and spirituality are not a prerequisite for quantum change, the theorists initially discovered quantum change immersed in early theological writings (C’de Baca & Wilbourne, 2004) of the Christian faith.

An example of life-changing spiritual transformation is found in the Alcoholics Anonymous (AA) philosophy of Bill Wilson (Alcoholics Anonymous, 2002) via individual and personal life stories that are qualitative in nature. For example, in *The Big Book of AA*, Chapter One is titled Bill’s Story and presents an alcoholic’s struggle with addiction, brokenness, shame, and self-despising. Wilson’s life is changed by the help of fellow alcoholics. Part one contains forty-two personal stories about forty-two individuals who achieved sobriety and made changes. The *Big Book of AA* contains narratives describing both chaotic and quantum types of change experiences. Changes can occur gradually or suddenly. According to Wilson, a spiritual transformation changes self-perception, personal significance, managing of emotions, and interpersonal relationships, and produces inner peace (Alcoholics Anonymous, 2002). Emrick, Tonigan, Montgomery, and Little (1993) conducted a meta-analysis of 13 studies showing that active participation in AA as opposed to mere attendance was significantly predictive ($r = .19$) of positive outcomes when attending AA after therapeutic treatment.

According to Kasjutas (2009) studies on the effectiveness or non-effectiveness of AA is dubious and research has yielded contradictory findings and AA critics point to a lack of rigorous experimental studies and recidivism rates (Bufe, 1991).

Another avenue of change was found in the literature. Religion has a history of producing dramatic changes via the process of conversion in the lives of seekers (Mahoney & Pargament, 2004). Moreover, Smith (2006) reported the findings from The National Spiritual Transformation Study (NSTS) in America. His study examined individual experiences of spiritual or religious change by exploring characteristics of participants and the nature and process of change. The NSTS module was administered to 1,328 participants. The most common outcomes of spiritual or religious transformation are the strengthening of faith and changes in character and behavior.

Studies into the nature of change, in and of itself, shed light upon basic principles (Lyddon, 1990; Rice & Greenberg, 1984) and “the discovery of common and universal principles of change seems fundamentally relevant to the understanding of how psychotherapy works” (Murray, 2002, p.167). How do clients view the general nature of change and do they bring this viewpoint to therapy and to the mechanisms of psychotherapeutic change? Clients make a conscious choice to seek and attend counseling and they decide to make changes (Duncan, Miller, Wampold, & Hubble, 2010). The choice to change via therapy is powerful and intentional in contrast to general change. Do clients experience therapeutic change as gradual or sudden? (Hubble, Duncan, & Miller, 2003; Murray, 2002). How do clients perceive and understand psychotherapeutic change?

Phenomenon of Psychotherapeutic Change

This section explores and highlights the culmination of research findings over the last 50 years on the phenomenon of psychotherapeutic change. Historical studies and contemporary literature are reviewed. This section presents literature addressing how the profession of counseling/therapy has responded to the quandary of how therapeutic change occurs. Both process and outcome studies are reviewed. Process research is used to investigate the interactions between clients and counselors during counseling and to identify the active ingredients of change factors and mechanisms (Levitt, Butler, & Hill, 2006; Woolley, Butler, & Wampler, 2000) while outcome studies focus on whether counseling is effective (Walz & Bleuer, 1993). The Transtheoretical Model based on stages of change (DiClemente, McConaughy, Norcross, & Prochaska, 1986) is discussed in detail. The phenomenon of therapeutic change is presented within a framework describing the four common change factors: 1) therapeutic relationship factors, 2) theory/model/technique factors, 3) client factors, and 4) extratherapeutic factors of placebo, hope, and expectancy (Lambert, 1992) and numerous therapeutic change components reported in the literature.

History of the Change Debate

In order to present a historical foundation, some of the cited research is dated earlier than five years ago. However, the sequence of occurrences in the psychology and counseling fields will give the reader knowledge in regards to landmark studies, the development of theoretical orientations (theories/models/methods), change modalities, and the 50-year debate in regards to how psychotherapeutic change occurs, how to measure treatment efficacy, and how psychotherapeutic change occurs in the client. Most

importantly, the perception and understanding of psychotherapeutic change by the client will be explored in the literature and in this study. What is the client's view of change?

Hans Eysenck (1952), a British psychologist, reported on a study by another researcher who reviewed 500 files of patients with neuroses who had been treated by general practitioners and he reviewed 19 studies in the literature consisting of treatment for neurotic patients. He claimed that half of the clients with neurosis improved (experienced change) with therapy and the other half of neurotic individuals improved (experienced change) without therapy and Eysenck concluded, "The figures fail to support the hypothesis that psychotherapy facilitates recovery from neurotic disorder" (p. 323).

According to Lambert and Bergen (1994) Eysenck's claim sparked a debate and caused mental health professionals to examine and expand treatment efficacy, psychotherapeutic change processes, and outcome measures. Researchers explored three basic questions: (1) how can the effectiveness of therapy be defined or measured, (2) how effective is therapy, and (3) what is the comparative efficacy of different theories and treatment approaches (Kazdin, 2008).

Subsequently, the past debate sparked by Eysenck was laid to rest. Over 40 years of outcome research unquestionably assert that indeed, therapy works (Asay & Lambert, 1999; Duncan, Miller, Wampold, & Hubble, 2010; Hubble, Duncan, & Miller, 2003; Lambert, 1992; Lambert & Bergen, 1994; Roth & Fonagy, 1996; Seligman, 1995). Smith and Glass (1977) utilized meta-analysis and explored 375 outcome studies and reported participants in the treatment groups were better off than 75% of the untreated groups. Likewise, (Smith, Glass, & Miller, 1980) applied meta-analysis to 475 studies with the

same results. Lambert and Ogles (2004) concurred after another meta-analysis of the efficacy of treatment. Progressive history shown in the professional literature on randomized clinical trials guides researchers to assert with confidence that therapy is effective (Kazdin, 2008; Wampold, 2001). “However, it is one thing to say that we know psychotherapy is effective but quite another to say that we know *why* psychotherapy is effective” (Sprenkle, Davis, & Lebow, 2009, p. 52). Is therapy effective? Paul (1967) posited the global therapy question: “What treatment, by whom, is the most effective for this individual with that specific problem, and under what set of circumstances?” (p. 109). It is the twenty-first century and counselor researchers continue to search for answers (Kazdin, 2008). Why and how does therapy work and who and what is responsible for psychotherapeutic change? Other known and unknown counseling factors exist (Asay & Lambert, 1999; Duncan, Miller, Wampold, & Hubble, 2010; Frank, 1973) and need diligent examination (Kazdin, 2005) to understand the change processes. Contemporary literature affirms the client as the central component in change process (Duncan, Miller, Wampold, & Hubble, 2010; Hubble, Duncan, & Miller, 2003; Sprenkle, Davis, & Lebow, 2009). How does the client change? How does the client perceive and understand psychotherapeutic change?

The subsequent result of the Eysenck argument in the 1950s was the increase in the development of various theoretical orientations (Lambert, 1992) and a new debate ensued concerning which theory works best: psychoanalytic, Rogerian, behavioral, cognitive, rational emotive behavior therapy, cognitive-behavioral, emotions-focused, Gestalt, reality therapy, and so forth (Sprenkle, Davis, & Lebow, 2009). An example would be the classic Gloria film, in which counseling pioneers Carl Rogers, Fritz Perls,

and Albert Ellis demonstrated three different theoretical approaches to psychotherapy in sessions with a woman named Gloria (Moon, 2007). Each theory offered a different explanation on the constructs of therapeutic change, improvement, and effective outcomes. However, several researchers argued that one theory or model is not superior to others based on findings of no difference in the therapist's use of various theories/models (Duncan, Sparks, & Miller, 2006; Luborsky, Singer, & Luborsky, 1975; Smith, Glass, & Miller, 1980). According to Duncan, Miller, Wampold, and Hubble, (2010), clients make changes and improve regardless of the theory or treatment approach utilized.

The role that theory plays in the psychotherapeutic change process and outcome of psychotherapy has been a subject of discussion, and sometimes intense debate, for almost as long as psychology and counseling have been professions (Bergin & Garfield, 1994; Lambert, 1992; Thomas, 2006) and more questions are being asked (Duncan, Miller, Wampold, & Hubble, 2010; Rennie, 1992; Sprenkle & Blow, 2004a). What are the other change components? What are the variables of change that are most important to measure? Psychotherapeutic change is viewed as complex, multidimensional, and confusing (Castonguay, 2000).

Sprenkle, Davis, and Lebow (2009) discussed the two paradigms of psychotherapeutic change. The traditional theory/model-driven change paradigm postulates that change occurs because of elements unique to each theory. In contrast, the contemporary common change factors-driven model emphasizes the universal change ingredients of all effective theories. Does theory promote psychotherapeutic change? Do common factors promote psychotherapeutic change?

Subsequently, members of the counseling community turned their attention to the questions: how does therapy work (Roth & Fonagy, 1996)? what is responsible for psychotherapeutic change (Sprenkle, Davis, & Lebow, 2009)? and how are therapeutic variables measured uniformly across treatment approaches to render results about differential effectiveness and psychotherapeutic change (Kazdin, 2008)?

Saul Rosenzweig (1936) is credited as the first theorist to speculate that there are common change components among different theories/models which influence effectiveness of treatment. In response to the theories and models debate, Jerome Frank searched for the most common change factors across theories and models in order to better understand psychotherapeutic change. He reported results in his three classic editions of *Persuasion and Healing: A Comparative Study of Psychotherapy* (1961, 1973, 1991) and continued to study and report on the commonalities in psychotherapy (Frank & Frank, 2004). The “big four” (Hubble, Duncan, & Miller, 2003, p. 8) labeling for common change factors was motivated by Michael Lambert (1992) who recommended a four-factor model of change based upon his review of empirical studies of outcome research (Norcross & Goldfried, 1992). After 1980, writing on common factors ensued (Weinberger, 1995). Hubble, Duncan, and Miller (2003) invited researchers and practitioners to analyze the literature on common factors of psychotherapeutic change. They alleged it is the commonalities that bring about change in counseling, not the specific theories or models.

In the ongoing debate, researchers ask the question: how do clients change? (Lebow, 2008; Miller, Wampold, & Varhely, 2008) and as this debate continues, research is being consistently added to the counseling and psychology literature base and a more

specific question is being generated and asked. How do clients perceive and understand psychotherapeutic change? (Duncan, Miller, Wampold, & Hubble, 2010; Sprenkle, Davis, & Lebow, 2009; Pinsof, 2005).

The common change factors debate has led a number of researchers (Duncan, Miller, Wampold, & Hubble, 2010; Goldfried, 1982; Highlen & Hill, 1984; Lebow, 2008; Norcross & Newman, 1992; Pinsof, 2005) to an integration orientation which emphasizes process and action in the counseling relationship over theoretical orientations (theories/models). The objective of the common factors approach is to create a more practical and effective treatment based on psychotherapeutic change components and the change factors common to all effective theories/models (Frank & Frank, 2004; Goldfried, 1991; Sprenkle & Blow, 2004a).

Sexton and Ridley (2004) argued that the common change factors approach devalues the uniqueness of different theories, models, and methods in the field of marriage and family therapy. In a contrasting commentary about the theory/model-driven change paradigm versus the common change factors-driven paradigm, Kazdin (2005) argued that experimental studies need to be conducted before a universal change model is chosen over theoretical orientations by practitioners and the counseling profession. Sprenkle and Blow (2004b) argued that the common change factors work through theories and models. However, the literature continues to ask questions. What is responsible for psychotherapeutic change? Who is responsible for psychotherapeutic change? How do clients change? How do clients perceive and understand psychotherapeutic change? In order to answer these questions, process research is needed to study the dynamics between clinicians and clients during counseling sessions

(Manthei, 2006). Greenburg and Pinsof (1986) postulated that the process of change eventually leads to outcome and therefore process research is the study of change factors and mechanisms and they stated, “Emphasis is on the description, explanation, and prediction of change” (p. 5).

The common factors movement has intensified and is ongoing in the fields of psychology and counseling (Manthei, 2006; Sprenkle, Davis, & Lebow, 2009; Thomas, 2006) along with the search for the elusive tenets of psychotherapeutic change in regards to what makes therapy effective (Kazdin, 2008). Sprenkle, Davis, and Lebow (2009) published a volume promoting common change factors for the practice of marriage and family therapy. To date, Duncan, Miller, Wampold, and Hubble (2010), editors of the second edition of *The Heart and Soul of Change*, continue to promote the common psychotherapeutic change factors approach.

Client as Self-Change Agent

“It has often been argued that it is the helping activity as the client understands, experiences, and later remembers it, which results in the client’s change and growth” (Elliott, 1979, p. 285). There are research findings which report that clients who attribute psychotherapeutic change to their own efforts experience longer lasting change (Bohart, 2000; Lambert & Bergin, 1994). A client’s expectation of making changes may in and of itself initiate and facilitate the change process (Miller, Hubble, & Duncan, 1995; Polkinghorne, 1994) and “as therapists have depended more upon the client’s resources, more change seems to occur” (Bergin & Garfield, 1994, p. 826). Thomas (2006) concurred and reported findings that substantiate longer durations of change in clients

who attribute change to their own diligence and determination. Bohart (2002) asserted, “The primary client activity that facilitates change is their productive thinking” (p. 61).

Using a narrative approach, Adler (1998) interviewed three adults who believed they had experienced therapeutic change. Their autobiographies, written at the beginning of therapy, were used as data along with face-to-face interviews. He identified the common themes: “(1) clients took responsibility for reinterpreting their life stories, (2) clients increased acceptance of self and others, and (3) clients became an active participant in own lives” (p. 265).

Cline (2003) conducted a single case study with one client diagnosed with depression. He videotaped/audiotaped 12 therapy sessions and utilized a tape-assisted recall method whereas the client reviewed the tape and discussed her/his perception of significant change. The findings included: “(1) the importance of the therapeutic relationship, (2) the use of cognitive and behavioral techniques, and (3) the client’s motivation” (p. 196).

Mabery (1993) conducted a qualitative, ethnographic study and interviewed 11 couples to gain their perspectives of therapeutic change via the strategic therapy model. Findings reported the majority of couples attributed change to therapy experiences (i.e., the strategic model and the therapist).

Murray (2007) studied the relationship of the significant other to the therapeutic change process. In separate dialogues, Murray interviewed eight clients, followed by their partners who had not attended the therapy. Results found both the clients and their partners were influenced by therapeutic change which influenced the change process for the client. Post-session conversations between client and partner improved

communication and improved the relationship. The partners described how the clients discussed the therapy session conversations at home.

Stuart (2002) investigated the client's perception of the emotional experience as an active change agent in therapy. She interviewed nine adult clients (6 females, 3 males). Her findings resulted in eight themes: (1) understanding emotions, (2) volatility, (3) avoidance, (4) negative influence of emotions, (5) dealing with emotions, (6) resolving emotions, (7) integration, and (8) connecting to self. Three main components were found: coping strategies, increased emotional awareness, and reorganization.

Swint (1994) interviewed 13 previous clients (three family units) of a family therapy center where the therapists used a collaborative language systems approach (also known as therapeutic conversation). Six common themes were found: (1) therapy as a conversation, (2) therapist as friend, (3) therapy as being comfortable, (4) therapists' use of questions and tasks, (5) therapist giving suggestions, and (6) factors other than therapy involved in change.

Terry (1995) interviewed seven clients who had completed two years of therapy with the same therapist. She investigated change as a fundamental transformation. The findings included: (1) connection with one's core self, (2) self-acceptance, (3) personal power, and (4) inner peace. The transformations improved relationships with others, aided spiritual renewal, produced a sense of well-being, and increased creativity.

Young and Ensing (1999) conducted a study by interviewing 18 clients individually and in focus groups. Clients were diagnosed with various and serious psychiatric disabilities (i.e., anxiety, major depression, bipolar, schizophrenia, and schizoaffective disorder). Five themes were derived: (1) overcoming stuckness, (2)

discovering and fostering self-empowerment, (3) learning and self-redefinition, (4) returning to basic functioning, and (5) improving quality of life. Many participants reported spiritual development as a central factor in their recovery process. The following section provides information on the location and the participants in this study.

In-depth research on how the client maintains psychotherapeutic change is lacking in the literature of the counseling profession (Hubble, Duncan, & Miller, 2003; Manthei, 2006; Thomas, 2006). The mysteries of the psychotherapeutic change process need diligent and thorough exploration from the client's viewpoint (Manthei, 2006; Pennebaker, 1990; Sprenkle, Davis, & Lebow, 2009) and the change process needs to be studied from clients' perceptions in order to understand change as they experience and understand change (Murray, 2002; Rice & Greenberg, 1984; Sprenkle, Davis, & Lebow, 2009).

Historically, empirical research focused on how therapists facilitated psychotherapeutic change, viewing helping professionals as originators and initiators of change (Bohart & Tallman, 1996; Hubble, Duncan, & Miller, 2003; Rennie, 1992). However, some researchers in the field of psychotherapy attempted to examine and understand how psychotherapy facilitates self-change in the client (Bohart & Tallman, 1996; Goldfried & Davila, 2005; Lebow, 2008). Several authors assert the client is the most important common factor of all theoretical orientations and psychotherapies (Bohart & Tallman, 1996; Duncan, Miller, Wampold, & Hubble, 2010; Orlinsky & Howard, 1986; Thomas, 2006) and that clients are the originators and initiators of psychotherapeutic change (Duncan & Moynihan, 1994; Hubble, Duncan, & Miller, 2003; Lambert, 1992).

Hubble, Duncan, and Miller (2003) challenged the traditional counseling theories/models in regards to psychotherapeutic change and concluded that clients are the agents and experts of change, self-healers, and the “locus of change resides within the client” (p. 119). They analyzed 50 years of literature, both quantitative and qualitative, in order to answer the question: how do clients change? The main premise is that individuals possess the capability to self-change and most do; however, some individuals become clients and need a therapist to assist them (Hubble, Duncan, & Miller, 2003). In addition, Duncan and Miller (2000) suggested that clinicians should learn the client’s own personal theory of change. They recommend the use of the following questions with clients in therapy sessions: “(a) Do you have a theory of how change is going to happen here? (b) How does change happen in your life? (c) What do you and others do to initiate change?” (p. 181). Moreover, Hubble, Duncan, and Miller (2003) point out the lack of qualitative research in regards to in-depth perceptions and viewpoints of clients and change mechanisms and other researchers have concurred (Murray, 2002; Sprenkle, Davis, & LeBow, 2009).

Murray (2002) conducted a qualitative study and interviewed seven participants on second-order change. Whereas first-order change is connected to problem solving and a decrease in symptoms, second-order change is connected to insight and gaining a new perspective. She selected clients who reported meaningful change during their psychotherapy sessions which lasted two years with the same therapist. Murray assumed that long-term continuous therapy would increase the likelihood of profound change. She employed Giorgi’s phenomenological method (1985) and followed the four basic steps for data collection and analysis. In the first stage, each participant described her/his

experience of fundamental change. In the next stage, participant interviews were transcribed and analyzed. Texts were read multiple times to grasp descriptions and meanings. In the third stage, imaginative variation was utilized to determine the essential components of the psychotherapeutic change experiences of participants. In the fourth stage, meaning units derived from participants' statements were synthesized and integrated to develop commonalities of the experiences. The primary emerging theme was labeled transcendence of relationship to self and included self-acceptance, personal power, inner peace, and spiritual transformation, which is viewed as second-order change (Murray, 2002). Both first-order and second-order change needs to be further studied to see if results vary for other groups.

Transtheoretical Model - Stages of Change

DiClemente, McConaughy, Norcross, and Prochaska (1986) studied the change process and developed the Transtheoretical Model (TTM) which includes stages of change. The TTM is a model of intentional change that focuses on the decision making of the individual. The model involves emotions, cognitions, and behavior (DiClemente, 2003). There are three dimensions to the model: the processes of change indicate how change occurs, the stages of change indicate when change occurs, and the levels of change indicate the domain of the changing behaviors (Prochaska, & Norcross, 2006). There are ten processes of change in TTM: (1) consciousness raising, (2) dramatic relief, (3) environmental reevaluation, (4) self-reevaluation, (5) social liberation, (6) self-liberation, (7) contingency management, (8) stimulus control, (9) counter conditioning, and (10) the helping relationship (Prochaska, & Norcross, 2006). There are six stages of change: precontemplation, contemplation, preparation, action, maintenance, and

termination. Each stage has challenges and movement from one stage to the next represents progress. Precontemplators resist change, lack information about their problem, refuse to talk about it, and feel the situation is hopeless. Change readiness is assessed in the first stage along with change resistance. Contemplators acknowledge and try to understand the cause of their problem. They become stuck without action, which may ensue for a few years. When they do begin to transition to the next stage they focus on solutions and the future instead of the past. In the preparation stage, individuals take action within the following month after making small behavioral changes along the way. However, they still experience ambivalence. In the action stage, individuals commit time and energy to making behavioral modifications and changes. Changes are more concrete and recognizable in this stage. Maintenance is an ongoing process consisting of relapse prevention. Individuals in this stage consolidate accomplishments and focus on continuing new skills. Termination is the ultimate goal (DiClemente, McConaughy, Norcross, & Prochaska, 1986; Prochaska, DiClemente, & Norcross, 1992). The TTM addresses resistance to change by assigning it to the precontemplation stage. Readiness to change is assigned to the contemplation stage and maintaining change is an ongoing process (Petrocelli, 2002). The determiners of change are comprised of two indicators that designate where an individual is regarding change: (1) decisional balance which is the weighing of the pros and cons of changing the behavior, and (2) self-efficacy/temptation regarding high-risk relapse situations (DiClemente, 2003). The five levels of change are: symptom/situational, maladaptive cognitions, interpersonal conflicts, family systems problems, and intrapersonal conflicts (Prochaska & DiClemente, 1984). The levels of change refer to what change is required for what

problem. Included in the levels of change are (1) cognitive experiences, (2) affective experiences, (3) behavior or the actions or reactions of persons in response to external or internal, and (4) environment factors (Prochaska & DiClemente, 1982).

Questionnaires and scales have been developed to try to measure the behavioral change concepts in the TTM. The five leading measures associated with the TTM are: University of Rhode Island Change Assessment, Processes of Change Scale, Decisional Balance Scale, Abstinence Self-Efficacy Scale, and Temptation to Use Drugs Scale (Nidecker, DiClemente, Bennett, & Bellack, 2008). McConaughy, Prochaska, and Velicer (1983) developed the Stages-of-Change Questionnaire, later to be called the URICA-University of Rhode Island Change Assessment Scale. The URICA was modified to be used specifically with substance abuse clients. The majority of research with TTM has been in the substance abuse/addiction field and with smoking cessation.

Critics of TTM (Etter & Sutton, 2002) argue that the measurement of change in the stages is not specific enough and therefore does not adequately account for which change variables influence which stage. They assert that change does not follow exact stages and some individuals may not experience change at each stage.

As the TTM is widely used in the field of substance abuse/addictions, studies need to be broadened to include psychiatric disorders and other issues brought to therapy. While the TTM addresses behavioral changes, more research on cognitive and affective changes within the model are needed. Do clients in mental health counseling experience the stages, processes, and levels of change as indicated by the TTM? How would clients perceive and understand the TTM stages of change?

The following section focuses on specific components of psychotherapeutic change mechanisms found in the professional literature. Examining the literature on each of the nineteen therapeutic change groupings (categorized by this researcher) provides further understanding of the complex therapeutic change process and change mechanisms. Categories were developed by analyzing the literature.

Specific Components of Psychotherapeutic Change

This section explores the literature on numerous therapeutic change components: (1) outcome measures of psychotherapeutic change, (2) psychotherapeutic change and theoretical orientations (theories/models/techniques), (3) common factors and psychotherapeutic change, (4) relationship factors and psychotherapeutic alliance, (5) client and extratherapeutic factors, (6) placebo, hope, expectancy, and psychotherapeutic change, (7) psychotherapeutic change and client characteristics, (8) psychotherapeutic change and counselor characteristics, (9) client readiness for psychotherapeutic change, (10) client resistance to change, (11) pretreatment change, (12) within-session change, (13) between-session change, (14) post-treatment change, (15) maintaining change, (16) client satisfaction and psychotherapeutic change, (17) self-change elements and clients, (18) symptom reduction and psychotherapeutic change, and (19) psychopharmacology and psychotherapeutic change. Each psychotherapeutic change component is reviewed and the literature varies as to whether the perspective is from researcher, therapist, or client.

Outcome Measurements and Psychotherapeutic Change

Do clients understand how change is measured? How can clients use instruments to measure self-change? Would a client evaluate change differently than her or his own therapist? These questions are not answered in the literature.

Multiple standardized outcome assessments and measures have been developed and used by researchers in the field of psychotherapy and counseling and are necessary to measure client change (Ogles, Lambert, & Masters, 1996). According to Lambert, Hansen, and Finch (2001), outcome measures are developed to track change in therapy. Standardized outcome assessment measurements are vital to psychotherapy research, including the psychometric considerations of reliability, validity, and sensitivity to change (Kazdin, 1991; Lambert, & Ogles, 2004). In addition, Kazdin (1999) suggests the importance of knowing the difference between perceived change and actual change and the need to explore the relationship between these two factors. Furthermore, Kazdin (2007) argued “after decades of psychotherapy research, we cannot provide an evidence-based explanation for how or why even our most well studied interventions produce change, that is, the mechanism(s) through which treatments operate” (p. 1).

Elliott, Watson, Goldman, and Greenberg (2003) devised the use of standardized outcomes measures to elicit client information before therapy and every 8 or 10 sessions to demonstrate the occurrence of change. In addition, they developed the use of the Change Interview (Elliott, 1999), a qualitative interview questionnaire containing questions about change processes. However, this tool is not widely used or researched and validity and reliability have not been established.

The Psychotherapy Change Project developed the Systemic Therapy Inventory of Change (STIC) to determine how people change in psychotherapy. The system tracks client change and gives feedback to the therapist. Validity and reliability studies are being conducted (Pinsof, Zinbarg, Lebow, Knobloch-Fedders, Durbin, Chambers, Latta, Karam, Goldsmith, & Friedman, 2009). There is a lack of established results.

In regards to measuring change after treatment is completed Mintz (1981) surmised that symptom reduction accounts for most of the variation in outcome measures and Connolly and Strupp (1996) emphasized the need for outcome scales to measure change in reference to insight, self-esteem, and interpersonal relationship functioning. However, the client perception on change measurements continues to be missing.

Hoglend, Bogwald, Amlo, Heyerdahl, Sorbye, Marble, Sjaastad, and Bentsen (2000) developed five scales (friendships and family, romantic/sexual, tolerance of affects, insight, problem-solving capacity) to assess pretreatment and post-treatment changes in brief dynamic psychotherapy. Seven raters (6 psychiatrists and 1 clinical psychologist) evaluated 50 clients (24 men and 26 women ranging in age from 26 to 58 years) before therapy and 35 clients at the termination of therapy services. The researchers reported that statistically significant changes ($p < 0.0005$, paired t -test, two-tailed) during brief dynamic psychotherapy were valid. According to the Reliable Change Index criteria by Jacobson and Truax (1991), the largest amount of change during individual psychotherapy and the highest ratios of patients with reliable changes tended to be in the areas of insight and tolerance for affects. A limitation is that the findings are in the preliminary stage and the five scales need continued research to establish reliability, validity, and sensitivity to change.

An outcome measure is intended to measure change due to a psychotherapeutic intervention with a client (Ogles, Lambert, & Fields, 2002). Practicing clinicians can use outcome measures and evaluative tools before, during, and after therapy to gather feedback about therapeutic change (Lambert, Whipple, Vermeersch, Smart, Hawkins, & Nielson, 2002); however, standardized measures and surveys have limitations (Moustakas, 1994; Polkinghorne, 1989; Rennie & Toukmanian, 1992). For example, survey data is limited due to possible inaccurate responses of participants. While it is not disputed that quantitative outcome measures are imperative to study and guide treatment efficacy and best practices (Kazdin, 2008), qualitative studies are essential in gathering more in-depth information from the clients themselves (Davidson, 2003; Giorgi & Gallegos, 2005). The literature continues to document the difficulty in developing instruments that contain the three critical components of reliability, validity, and sensitivity to change to determine and measure psychotherapeutic change (Kazdin, 2007).

Another issue in regards to outcome measures is the lack of usage by practicing clinicians. Hatfield and Ogles (2004) found that only 37% of 874 practicing clinicians used some form of standardized outcome measure. The explanations for not using outcome measures included: increase in paperwork, takes extra time, is not helpful to clients, and resources are limited. Among the clinicians who used outcome measures, tracking client progress was selected as the most important reason for use. According to Kazdin (2005), an outcome measure needs to consistently track client progress and change throughout the duration of therapy. Lambert, Hansen, and Finch (2001) found increased therapeutic outcomes for clients at risk for early termination from treatment

when clinicians received feedback about client change via outcome measures. However, outcome measurements by client self-report is lacking.

Psychotherapeutic Change and Theoretical Orientations & Techniques

What do clients think about the use of theories/models in counseling? Do clients think that theories and models produce and promote change? These answers are not addressed in the literature.

Kazdin (1986) identified over 400 theories/models/therapies, each with a representation of the mechanisms of change. Roth and Fonagy (1996) categorized theories/models into six paradigms: (1) psychodynamic, (2) behavioral and cognitive-behavioral, (3) interpersonal, (4) systemic, (5) experiential, and (6) group. Each model operates by interpreting the process of change based on a variety of theoretical orientations and philosophies. For example, a solution-focused theoretical orientation posits that, “(a) change is not only possible, but it is inevitable; (b) only minimal changes are needed to initiate solving the problems clients bring to therapy, and that once change is initiated, further changes will be generated by the client-system; and (c) a change in one element of a system, or in one of the relationship between elements, will affect the other elements and relationships, which are the system” (de Shazer & Molnar, 1984, p. 298). The client’s voice remains absent in viewpoint on theories that promote change.

Sommers-Flanagan and Sommers-Flanagan (2004) categorized theoretical orientations into twelve major perspectives: (1) psychoanalytic/psychodynamic/objects relations theory, (2) Adlerian/individual psychology theory, (3) Jungian/analytic theory, (4) existential/Gestalt theory, (5) person-centered theory, (6) behavioral theory, (7) cognitive theory, (8) reality/choice theory, (9) feminist theory, (10) constructivist theory,

(11) multicultural and Eastern theories, and (12) integration or eclectic theory. But, what is the client's perspective?

Most theoretical orientations focus on some form of change in cognitions, emotions, and/or behaviors. Cognitive-behavioral therapy (CBT) targets the primary thought processes and behavioral mechanisms associated with disorders and problems (Beck & Alford, 2009; Ellis, 1969).

Although current emotionally focused theories approach emotion in different ways, these therapies posit that the successful therapeutic changes among clients are due to changes in clients' emotion schemes (Damasio, 1994; Lazarus, 1991). Emotionally-focused therapists (Greenberg, 1999; Greenberg, Rice & Elliott, 1993) argue that therapeutic interventions must address problematic emotions.

Three major areas of contemporary behavior therapy include classical conditioning, operant conditioning, and cognitive therapy (Corey, 2005). The development of specific goals and target behaviors is important in behavior therapy.

Describing and presenting the individual change mechanisms undergirding the therapeutic philosophy of each of the twelve major theories/models are beyond the scope of this study. Furthermore, my study seeks to explore clients' perception and understanding of therapeutic change factors and mechanisms.

The debate over which theories and models and techniques work best continues to be addressed in the literature. Comparative studies have shown no differences across modalities (Sexton & Whiston, 1994; Shapiro & Shapiro, 1983; Smith & Glass, 1977). Wampold, Mondin, Moody, Stich, Benson, & Ahn, 1997) conducted a meta-analysis of outcome studies comparing models/theories and no differences were found. The

researchers concluded that the use of models and techniques do not account for treatment efficacy. Additionally, it is suggested that models and techniques account for only 15% of improvements in therapy (Lambert, 1992). What do clients think about techniques?

In contrast to a universal change model, researchers (Chambless, & Hollon, 1998; Chambless & Ollendick, 2001) defend empirically supported treatments for specific mental health disorders. The American Psychology Association, Division 12 Task Force on Promotion and Dissemination of Psychological Procedures has conducted research determining evidence-based practice for treatment efficacy for particular psychological disorders (Chambless, 1996). Were any clients on this taskforce to discuss change?

Common Factors and Psychotherapeutic Change

Would clients agree with the common change factors? What common factors would clients attribute to therapeutic change? (Hubble, Duncan, & Miller, 2003).

Frank (1991) identified common factors shared by effective therapies: (1) “confiding relationship with a helping person,” (2) “healing setting,” (3) “rationale...that provides a plausible explanation for the patient’s symptoms and prescribes ritual or procedure for resolving them,” and (4) “ritual or procedure that requires active participation of both patient and therapist and that is believed by both to be the means of restoring the patient’s health” (1991, pp. 40-43). Previously, Frank (1974) reviewed 25 years of clinical empirical research and asserted that client-related factors were the most significant determinants for improvement and change. Do clients agree?

Likewise, Goldfried (1991) described several common factors: (1) giving clients hope, (2) helping clients to connect thoughts and feelings, (3) encouragement of corrective experiences, (4) providing reality testing, and (5) developing a positive

therapeutic alliance. He viewed an increase in self-esteem and self-efficacy as the end result of the therapeutic change process. However, Goldfried did not solicit direct descriptions from clients on their perceptions of common factors.

Grencavage and Norcross (1990) examined 50 publications (publication dates of 1936 to 1989) to find commonalities among the projected common factors. They identified 89 commonalities and investigated the most frequent factors. Factors in common were divided into five categories: (1) client characteristics, (2) therapist qualities, (3) change processes, (4) treatment structure, and (5) relationship elements. Client characteristics included: “positive expectation/hope or faith, distressed or incongruent client, and patient actively seeks help” (p. 374). Therapist qualities included: “general positive descriptors, cultivates hope/enhances expectancies, warmth/positive regard, empathic understanding, socially sanctioned healer, and acceptance” (p. 375). Change processes included: “opportunity for catharsis/ventilation, acquisition and practice of new behaviors, provision of rationale, foster insight/awareness, emotional and interpersonal learning, feedback/reality testing, suggestion, success and mastery experiences, persuasion, placebo effect, identification with the therapist, contingency management, tension reduction, therapist modeling, desensitization, and education/information provision” (p. 375). Treatment structure included: “use of techniques/rituals, focus on inner/exploration of emotional issues, adherence to theory, a healing setting, participants/an interaction, communication (verbal and nonverbal), explanation of theory and participants’ roles” (p. 376). Relationship elements included: “development of alliance/relationship, engagement, and transference” (p. 376). However, client feedback was not solicited.

Change processes were listed most frequently as the common factor among different theories/models at 41%. A therapeutic relationship/alliance was the most frequent commonality reported. In contrast, 6% of the commonalities found were client characteristics. The most frequent commonalities across categories included: “development of a therapeutic alliance, opportunity for catharsis, acquisition and practice of new behaviors, and clients’ positive expectancies” (p. 372). The researchers reported their results demonstrated a positive step towards finding common change factors for therapeutic change processes (Grencavage & Norcross, 1990). Were clients surveyed?

An empirical analysis of commonalities in therapy (Lambert, 1992) identified the following common factors and the portion attributed to therapeutic change: “(1) Therapeutic alliance/relationship = 30%, (2) Theories/Models/Techniques = 15%, (3) Extratherapeutic change = 40%, and (4) Expectancy (placebo effects, hope) = 15%” (p. 97). What do clients attribute to the commonalities?

Mahoney (2000) reported the results of 50 years of research findings that show three factors to be predictors of effective outcome: client variables, therapist variables, and theory and techniques. Moreover, the field of psychotherapy is continuing to move toward integrative theories and techniques, including a pursuit of universal principles of change (Goldfried, 1991; Mahoney, 1991; Sprenkle, Davis, & Lebow, 2009). However, client feedback was not addressed.

Advancing the research on cross components/factors of therapeutic change, Castonguay and Beutler (2006) reviewed research findings. Instead of focusing on particular theories/models of psychotherapy and treatment techniques, they suggested utilizing 60 therapeutic change principles. Treatments are applied to depression, anxiety

disorders, personality disorders, and substance abuse disorders by utilizing these 60 principles of change. However, clients were not asked to review these change principles for their feedback.

In contrast to the common change factors approach, Beutler and Hodgson (1993) disagreed with landmark studies and reported a disregard for “an analysis of how clients with different characteristics might respond differently to different psychotherapies” (p.151). Other critics (Arkowitz, 1992; Mahrer, 1988) called for more research on common factors and argued that all therapies are not identical in how they operate. Kazdin (2005) argued for efficacy research for “laboratory, controlled, and rigorous studies” (p. 187) in regards to the ongoing common change factors debate. However, Castonguay (2000) suggested integration of common change factors/principles within the traditional theories/models and techniques. He argued the counseling field needs both traditional theories/models and common change factors, not one or the other. However, input from clients in reference to their view of theories or common change factors is lacking.

Subsequently, the common factors debate is being explored in marriage and family therapy (MFT) programs. Nelson and Prior (2003) wanted to find out if accredited degree MFT programs educated students on change modalities and how to integrate change concepts into existing theories. Prior to their study, MFT programs began to require knowledge and practice of change models based on the literature that reported therapists who are able to conceptualize and understand change processes are better prepared to assist clients (Taibbi, 1996). Questionnaires were sent to 78 MFT program directors. At the end of data collection, 46 programs had responded (59%). The results

revealed that nineteen programs (41%) did not include theory of change modalities in their programs and 60% of MFT programs did include coursework on a theory of change modality. A major theme divided the data into two categories: change in general and change in therapy. The researchers concluded the strategies and tenets of change models may be effective in teaching novice therapists; however, further research is needed. The solicitation of client feedback on change modalities is lacking.

Relationship Factors and Therapeutic Alliance

How do clients perceive and understand the therapeutic alliance in the change process? Do clients believe the relationship with the therapist is the vehicle for change?

Foremost, the client and counselor form a therapeutic alliance/relationship, which is the vehicle for psychotherapeutic change to occur (Horvath, & Bedi, 2002; Rogers, 1961; Sprenkle, Davis, & Lebow, 2009). The professional literature confirms the effectiveness of psychotherapy (Kazdin, 2008; Lambert & Ogles, 2004; Smith & Glass, 1977) and demonstrates the importance of the relationship/alliance between therapist and client (Duan & Hill, 1996; Horvath, 2006; Sexton & Whiston, 1994). For example, the foundational values and core conditions of client-centered therapy developed by Carl Rogers stated that individuals will self-heal through self-growth and self-change if the therapist possesses certain characteristics: is congruent (self-aware, self-understanding, self-accepting), provides unconditional positive regard, and treats the client with respect (Rogers, 1961). Similarly, Bordin (1979) stated “the working alliance between the person who seeks change and the one who offers to be a change agent is one of the keys, if not the key to the change process” (p. 252). What do clients think?

Researchers have demonstrated that a positive relationship between therapist and client is positively correlated with outcomes (improvement and change) showing relationship factors as consistent predictors of outcome (Alexander & Luborsky, 1986; Sexton & Whiston, 1994; Sprenkle, Davis, & Lebow, 2009). Luborsky (1984) theorized on five characteristics that are relevant to the therapeutic alliance. First, the client must perceive the therapist as supportive and empathic. Second, the therapist is perceived as helpful. Third, the client expects change to occur. Fourth, the client perceives the therapist as not violating client values. Lastly, the client believes the counseling will be effective.

Horvath and Symonds (1991) conducted a meta-analytic review of 24 former studies (based on 20 distinct data sets), from the adult psychotherapy literature regarding the alliance and outcome. Results ($r = .26$) indicated a modest relationship between therapeutic alliance and outcome. The research studies dated between 1978 and 1990 with the mean sample size being 49 ($SD = 39.8$) and an average of 20.6 sessions ($SD = 12.36$). A statistically significant result was found, $r = .26$ ($F = 8.48, p > .001$). Horvath (2006) reviewed data from 60 studies to determine whether the client, therapist, or observer impacted the relationship between alliance and outcome in therapy. He found the client and observer alliances show comparable outcome relatedness ($r = .21$ and $.18$, respectively) and therapist-rated therapeutic alliance showed less relationship to outcome ($r = .10$), concluding that client-rated therapeutic alliance is more foretelling of outcome than the therapist-rated alliance. Tests of significance were not reported for the outcomes. The findings support the former study by Horvath and Symonds (1991) which found that

client-rated alliance is more predictive of outcome than therapist-rated alliance in regards to the therapeutic alliance/relationship. Alliance and outcome are connected.

In a related line of research, Weiss, Rabinowitz, and Spiro (1996) reviewed 23 studies on therapist-client agreement on their evaluation of problems, the process, and outcomes (change). In regards to therapist-client agreement on outcome, both perceived change as a result of therapy. However, the researchers also found the results depended primarily on the various measurements used for agreement, and consequently they recommended more valid and reliable research methods.

Along the same line, Tyron, Blackwell, and Hammil (2007) conducted a more recent meta-analysis of the working alliance by utilizing 53 studies published between 1985 and 2006. Studies based on the meta-analysis criteria of Horvath and Symond were included. Results included a moderate correlation (.36) between counselor and client ratings of alliance and client ratings were higher (.63) than counselor ratings.

Bachelor (1995) utilized phenomenological analysis and examined clients' perception of the therapeutic alliance. The participants consisted of 34 self-referred clients (27 females, 7 males; mean age = 31.8 years). Length of therapy sessions ranged from 1 to 26 sessions with clients being counseled weekly. Information was gathered from clients in three phases: pretherapy, initial session, and a later phase. Participants' descriptive experiences were analyzed by four judges using Giorgi's five-step content-analytic procedure (Giorgi, 1985). Judges compared the 66 descriptive statements in order to determine commonalities. Three alliance types were found and labeled as (a) nurturant alliance, (b) insight-oriented alliance, and (c) collaborative alliance; the 66 descriptive statements yielded alliance types to be 46%, 39%, and 15%, respectively. The

nurturant-type alliance valued therapists' friendliness, respect, nonjudgmental, empathy, active listening, and trust, which lead to self-disclosure. The insight-oriented alliance valued their own self-awareness, self-understanding, self-expression, and self-revelation brought about via therapy and relational trust with the therapist. The collaborative alliance type valued involvement in therapy and accepted responsibility for self-change through self-analysis, self-discovery, self-disclosure, finding solutions, expecting feedback from therapist, and a trusting relationship. Commonalities across the three types of alliances included the characteristics that clients value in therapists: respectful, being nonjudgmental, active listening, empathy, trust, and interventions that cultivated understanding and therapist expertise. All three alliance types valued client self-disclosure. An important finding in regard to clients' perspectives is that the therapist is primarily responsible for the quality of the alliance (Bachelor, 1995). The participants wrote their perceptions after reading the statement/questions. Males were underrepresented. A verbal interview may have elicited more description and feedback.

Relationship power, another component of the therapeutic alliance, has been studied (Guilfoyle, 2002; Lerner, 1999) and some therapists address the power differential with clients (Lerner, 1999) in order to minimize the power imbalance (Guilfoyle, 2002). However, qualitative studies from the client viewpoint on relationship power in counseling and the influence on client change were absent in the literature. How do clients perceive and understand relationship power in counseling and how is it related to therapeutic change?

The literature review revealed a scarcity of studies with children and adolescents pertaining to the therapeutic alliance. However, a meta-analytic review of 23 studies

involving children and adolescents (Shirk & Karver, 2003) reported preliminary results showing an alliance outcome of $r = .20$. The Child's Perception of Therapeutic Relationship survey was utilized in only one of the studies. Due to variability in measurements across the studies, the researchers assert the need for a universal psychometric measure to gauge the alliance between children and therapists. Shirk and Karver recommend that therapists build an alliance with both the child who is the client and the child's parent/guardian. More research is needed to determine how the alliance in this population influences therapeutic change mechanisms. In-depth discussion of children and adolescents was beyond the scope of my research study. Adult females were the selected participants in this present study.

Client and Extratherapeutic Factors

What other factors influence therapeutic change for clients? How do other factors affect improvement outside of counseling sessions? Do clients read self-help books to make changes? Client answers need to be explored.

After five decades of outcome research, researchers have identified multidimensional factors for effective treatment (Duncan, Miller, Wampold, & Hubble, 2010; Frank & Frank, 2004; Garfield, 1981, 1992; Goldfried & Newman, 1992; Kazdin, 1980; Lambert, 1992; Lebow, 2008; Norcross & Newman, 1992; Smith & Glass, 1977; Thomas, 2006). Research supports the premise that client factors and extratherapeutic events (i.e., client strengths, support network, motivation, ego strength, and the ability to identify a focal problem) account for 40% of improvement (Lambert & Anderson, 1996; Lambert & Asay, 1984). Bohart and Tallman (1996) emphasized that "change is primarily a product of the active client, who makes therapy work; regardless of what

therapy he or she is using” (p.17) and clients are “experts on themselves” (p. 23). What would clients attribute change to in the change process?

The extratherapeutic factor, client motivation level, is viewed as an important component for effective treatment and outcome (Friedman, Granick, & Kreisher, 1994). For example, motivation is shown to be salient in the therapeutic treatment of mood disorders (Fowles, 1994) and eating disorders (Wilson & Schlam, 2004). In the same vein, Strupp, Fox, and Lessler (1969) conducted a landmark study surveying 131 clients and applying case histories. They found that motivated clients cancel sessions less, are more willing to work on problems, and are able to process painful emotions in contrast to less motivated clients. Research shows that clients value the expression of painful feelings and being able to understand emotions (Timulak, 2007).

In regards to clients feeling understood, Howe (1996) conducted a qualitative study and interviewed 22 family members about their experiences and understandings in family counseling. Responses were analyzed and categorized into three themes. Clients stated they want to be engaged in therapy by the counselor, understand the process of therapy, and feel understood by the therapist.

The client resilience factor is being studied and current literature examines both the individual and the family in relation to resiliency and disaster, loss, and poverty (Rutter, 1993). Resilience refers to adapting in spite of threatening conditions (Masten, Best, & Garmezy, 1990); the person’s ability to adapt to change as a result of the stressor (Rutter, 1993); and the resulting empowerment (Walsh, 2003). Studies soliciting client feedback on resiliency factors are lacking.

Orlinsky, Ronnestad, and Willutzki (2004) summed up 40 years of psychotherapy research and postulated that client participation is the major factor that determines change and outcome. Client feedback needs to be further researched via qualitative inquiry to examine participation mechanisms in relation to change factors and improvements.

Placebo, Hope, Expectancy and Psychotherapeutic Change

Lambert (1992) attributes placebo, hope, and expectancy to a portion of client improvement and therapeutic change. Likewise, Frank (1973) focused on the factors of expectancies and hope, which facilitate change and help to overcome demoralization (i.e., feeling hopeless or helpless, loss of self-esteem, and/or feeling incompetent).

Additionally, Dew and Bickman (2005) reviewed thirty-six journals and provided an overview for understanding client expectancies about therapy. Expectancies are first viewed as a client characteristic. The authors identified two types of expectancies in the literature: (1) role expectations, and (2) outcome expectations. Role expectation refers to how a client views the therapist as a professional helper and outcome expectation refers to the client believing that change will occur as a result of counseling. The results of Dew and Bickman's study show support for the relationship between expectancies and client improvement. Given that, a client's expectation of making changes may initiate the change process (Arnkoff, Glass, & Shapiro, 2002).

Research on self-referred client expectancy versus court-ordered client expectancy may reveal different outcomes, in that self-referred clients may express increased desire to make changes. More research is needed to further explore these factors.

How do clients view hope and expectancy as change factors? How do clients perceive the placebo as a change component? These questions can be answered by asking them.

Change and Client Characteristics

Do client-related characteristics influence or determine therapeutic change? How do different client characteristics influence therapeutic change? Do clients perceive their individual qualities as aiding in the change process?

Quantitative studies have focused on different demographic aspects of client characteristics that may influence improvement, change, and outcome: educational level (Garfield, 1986), gender (Hansen, Gama, & Harkins, 2002; Luborsky, Mintz, & Christoph, 1979), age (Luborsky, Christoph, Mintz, & Auerbach, 1988), ethnicity (Atkinson, 1985; Cross, Smith, & Payne, 2002), intelligence (Garfield, 1994), marital status (Schrader, 1994), socioeconomic status (Casas, 1984), general emotional health (Luborsky, Christoph, Mintz, & Auerbach, 1988), and personality (Petry, Tennen, & Affleck, 2000). Findings revealed these factors do not significantly affect treatment outcomes. Three organizational elements appear to make little difference in treatment outcomes: paying a fee (Pope, Geller, & Wilkinson, 1975) individual or group therapy (Schmidt, 1982), or occurrence of sessions (Pope, Geller, & Wilkinson, 1975). Understanding the client factors that influence change and the factors that do not influence change may lead to more specific areas of research on change mechanisms. The older literature is a limitation and new studies need to be conducted and compared.

Other research on client-related factors have shown that outcomes are enhanced when clients develop a problem-solving attitude (O'Malley, Suh, & Strupp, 1983),

attribute problems to themselves instead of outside events (Schauble & Pierce, 1974), maintain high and consistent expectations (Craig & Hennessy, 1989), and possess motivation (Strupp, Wallach, Wogan, & Jenkins, 1963). Duncan and Miller (2000) suggested the inclusion of clients in case conceptualization by asking clients their views on what caused the problem and how to change it.

Understanding the intricacies of client-related factors may improve treatment approaches by giving clinicians knowledge and insight into how clients experience the change process. Current studies need to be conducted on client-related factors and compared to earlier research findings.

However, other research concluded that the client-related factors of self-exploration and insight were not related to effective outcomes (Morgan, Luborsky, Crits-Christoph, Curtis, & Solomon, 1982) and client motivation received mixed support (Prager, 1971). Current and more in-depth research is needed on client motivation to determine how it influences the change process. Asking clients what motivates them in therapy is a starting place, however research is lacking in this area.

Change and Counselor Characteristics

Do clients make changes based upon the diverse qualities and characteristics of their counselors? How do clients perceive counselor characteristics in the change process? Rogers (1961) asserted that counselor characteristics of empathy, warmth, genuineness, and positive regard improved positive client outcomes and later studies validated Rogers' findings (Ackerman & Hilsenroth, 2003; Hilsenroth & Cromer, 2007). By reviewing research on the personal attributes of therapists, Ackerman and Hilsenroth (2003) found "flexible, honest, respectful, trustworthy, confident, warm, interested, and

open” (p. 1) to be beneficial for the therapeutic alliance to flourish. Likewise, Hilsenroth and Cromer (2007) reviewed research and concluded that therapists who convey warmth, understanding, appreciation, and a sense of trust are more likely to establish a stronger alliance with clients.

There is a scarcity of literature on the effects of counselor self-disclosure on client change or improvement via the client’s perception. However, a study by Barrett and Berman (2001) found that counselor self-disclosure can strengthen the counseling relationship; clients like their therapist more; and clients reported less distress. In addition, humanistic and existential therapies emphasize the relevance of counselor self-disclosure as important in building an authentic therapeutic relationship (Norcross & Goldfried, 1992).

Client Readiness for Change

Do clients know when they are ready to make changes? What factors impact a client’s readiness for therapeutic change and can clients verbalize the change process? Will change occur if a client is not ready to make a change?

One article from 1950 was found (Grant & Grant, 1950) which investigated the researchers’ hypothesis of “therapy readiness” (p. 156) for clients. Grant and Grant interviewed nine clients and each separately ranked the answers. The rank-order correlation between the two rankings was 92. Exploring client attitude toward psychotherapy and “appropriate attitude changing techniques” (p. 157) were posited as significant as they ranked them highly.

The Transtheoretical Model assesses client readiness and resistance to therapeutic change (DiClemente, 2003) and motivational interviewing also addresses readiness and

resistance to change (Miller & Rollnick, 2002). Readiness for change is also related to motivation and Miller and Rollnick (2002) point out that “motivation for change arises in an accepting, empowering atmosphere that makes it safe for the person to explore the possibly painful present in relation to what is wanted and valued” (p.12).

In one study, Rochlen, Rude, and Baron (2005) sampled college students attending treatment at a university counseling center and found that a client’s readiness for change (assessed by using the Transtheoretical Model - stages of change) influenced the outcome of short-term therapy. Results found that clients in the precontemplation stage reported less symptom improvement and less involvement in the therapeutic alliance. The researchers surveyed 400 college students from 46 universities in the United States. Of the 373 who reported gender, 131 (35%) were male and 242 (65%) were female. The study found no significant differences in age, sex, or class rank. Students attended between 4 and 20 counseling sessions. The instruments used included the Stages of Change Scale (SCS) with Precontemplation, Contemplation, Action, and Maintenance subscales; Working Alliance Inventory (WAI); and the Outcome Questionnaire (OQ-45). Participants completed measures of readiness to change, psychological symptoms, and working alliance. Results for the SCS data set of the Precontemplation, Contemplation, Action, and Maintenance subscales found Cronbach’s alpha to be .78, .80, .82, and .85, respectively. The central implication from the results implies that counselors need to assess the client’s readiness for change and identify the barriers and challenges at the beginning of therapy to avoid early termination by the client. Readiness to change from the clients’ perspective via qualitative studies will elicit more in-depth information and add to the counseling literature.

Client Resistance to Change

How do clients understand their resistance to making changes in therapy? How do clients decide to make changes? What factors do clients think impact change? Miller and Rollnick (2002) developed the method/technique of motivational interviewing (MI) in order to prepare the client for change during the assessment process. This method addresses resistant clients, especially in regards to substance abuse and addictions. Motivational interviewing is a client-centered counseling style to assist clients to resolve ambivalence about behavior change (Treasure, 2004). The four main principles of motivational interviewing are:

1. Express empathy by using reflective listening to convey understanding of the client's point of view and underlying drives.
2. Develop the discrepancy between the client's deeply held values and his or her current negative behaviors.
3. Ignore resistance by responding with empathy and understanding rather than confrontation.
4. Support self-efficacy by building the client's confidence that change is possible (Treasure, p. 331).

The motivational interview method has been applied in the field of substance abuse and addictions. Utilization of MI in the mental health arena is limited until studies confirm validity and reliability with other populations. What do clients think about motivational interviewing in the initial change process?

Pretreatment Change

Do clients make any changes prior to attending counseling sessions? Do clients decide to explore change before scheduling the very first counseling appointment? Are clients self-aware of pretreatment change? Weiner-Davis, de Shazer, and Gingerich (1987) studied pretreatment change in solution-focused therapy and found that 66% of clients reported experiencing change before their first session. Thirty families seeking counseling at a community mental health center were surveyed. Of the parents ($n = 30$) who were surveyed, 20 reported having observed pretreatment change. Participants were asked the following three questions in order to gauge pretreatment change. Some individuals notice that during the time they make the counseling appointment and before the first session things seem different. What have you noticed about your situation? Do these changes relate to the reason you came for therapy? Are these the kinds of changes you would like to continue to have happen?

Lawson (1994) replicated the study by Weiner-Davis, de Shazer, and Gingerich (1987) and found 60% of clients reported pretreatment changes. He surveyed 82 clients in a three-month period from a university marriage and family counseling center. Participants were asked the same three questions. Approximately 62.2 percent of the clients ($n = 51$) reported pretreatment change and 37.8 percent ($n = 31$) reported either no change or that problems seemed worse. Of the 51 clients who reported pretreatment change, 49 stated the changes were expected and positive. Other solution-focused researchers (Beyebach, Morejon, Palenzuela, & Aris, 1996) reported that clients who made pretreatment changes were more prone to successfully complete therapy. The literature on both quantitative and qualitative studies in regards to pretreatment change

addressing the client's experience, perspective, and understanding needs to be expanded.

This information will benefit both therapists and clients (Lawson, 1994).

Within-Session Change

The questions are asked: how do clients translate what is learned in the session about change and how do they apply this to their problems during the therapy sessions? (Elliot, 1985).

Cummings, Hallberg, and Slemon (1994) examined the change process in therapy by using the Important Events Questionnaire (IEQ) and the Target Complaint Technique (TCT) for client-recall. After each of nine therapy sessions, 10 Caucasian female undergraduate students filled out the IEQ and the TCT in regards to the major events/happenings in the sessions with the 10 therapists. The qualitative data were analyzed by four judges. Three types of change were recognized: (1) consistent change, (2) interrupted change, and (3) minimal change (p. 1). Consistent change included: Understanding how thoughts and feelings are related, working on issues between therapy visits, asking family and friends for input, steadfast hopefulness, using a change model, and developing a trusting relationship with the counselor (pp. 466-467). Interrupted change included: emotional distress, not doing homework between counseling visits, and developing an "intense" (p. 467) relationship with the counselor (pp. 467-468.) Minimal change included: lack of motivation, a positive therapeutic alliance with counselor, and planned change but lack of implementation (pp. 468-469).

The researchers concluded that clients gained new insights that changed self-perception, learned to tolerate and resolve painful emotions, and tried out new behaviors

outside of the sessions (p. 469). The therapeutic alliance was referred to as supportive by the clients (Cummings, Hallberg, & Slemon, 1994).

Between-Session Change

What do clients do during the time between counseling sessions in reference to change? Do clients perceive the change process outside of the counseling office as important? The value of what clients do between counseling sessions was studied to determine how it influences change (Manthei, 2006). Client-initiated self-help efforts between therapy sessions promote effective problem-solving and resourcefulness (Bohart & Tallman, 1999). Clients use outside resources, practice behaviors learned in therapy, draw on insight to make changes in daily living, and increase creativity in solving their problems at home. Likewise, Bohart (2002) asserted, “The primary client activity that facilitates change is their productive thinking” (p. 61) both inside and outside of the therapy sessions. When clients apply what they are learning in sessions to their daily lives, change becomes a conscious choice (Manthei, 2006). Research in regards to what and how change is happening between therapy visits is limited. Knowing how change occurs outside the counseling office will benefit both therapist and client by increasing awareness of intentional choices and decisions to make changes.

Post-Treatment Change

Can clients articulate what changes occurred when counseling is completed? What happens during the last therapy session before counseling is terminated? Do clients talk about their changes and how to maintain change? While some clinicians use a variety of instruments and tools to assess therapeutic change such as pretests and posttests (Kazdin, 1991a), or standardized outcome measures at therapy termination (Hatfield &

Ogles, 2004), some clinicians do not utilize any outcome measures (Hatfield & Ogles, 2004). While some researchers call for the use of quantitative measures to assess change during therapy (Kazdin, 2007), others recommend qualitative tools (Rennie, 1992). However, Hubble, Duncan, and Miller (2003) recommend that a clinician assess change before, during, and after therapy and use the client's own theory of self-change.

Maintaining Psychotherapeutic Change

How do clients with mental disorders and other issues maintain long-term change? Are clients able to verbalize the process of maintaining therapeutic change? A gap in the literature was found on longitudinal studies and maintaining psychotherapeutic changes.

Studies on maintaining behavioral change were found in the literature in regards to the Transtheoretical Model (TTM) which focuses on preventing relapse in clients with alcoholism, drug addiction, and smoking cessation (DiClemente, 1999). The findings of this dissertation study could be used as a springboard to encourage further research on how clients maintain change. Clinicians may become more intentional about teaching clients to think about maintaining long-term change before therapy is terminated.

Client Satisfaction and Psychotherapeutic Change

Are clients satisfied with the changes they make in counseling? How do counselors know if clients are satisfied with treatment outcomes? In a project about client satisfaction, Strupp, Fox, and Lessler (1969) reported the results of two major studies that asked clients to reflect upon completed therapy experiences. Their questionnaires used both quantitative and qualitative items and the findings utilized the unedited commentaries of clients. Over 90% expressed satisfaction with therapy and reported

increased self-awareness and self-acceptance due to the therapeutic experiences.

Greenfield (1983) utilized the Client Satisfaction Questionnaire (CSQ) and surveyed clients over a period of five years at a university clinic. The CSQ relationship between client satisfaction and variables: expectancy, problem type and severity, length of treatment, and counselor differences were found, $r = .53$ ($p < .001$). However, these studies are limited because detailed descriptions from clients about how they initiated change or perceived change was lacking. Current research is needed on satisfaction and therapeutic change in order to better serve clients.

Self-Change Elements and Clients

By reviewing the counseling and psychology literature, the concepts of locus of control and self-efficacy were found. Both concepts allude to the client as the initiator of change. Do clients attribute change to themselves, the therapist, or others? Do clients view change as internal or external or a combination of both? The concept of locus of control (internal versus external) has been widely applied to various phenomena in professional fields, including psychology and counseling (Twenge, Zhang, & Im, 2004; Wood & Letak, 1982). Locus of control was developed by Julian Rotter within the framework of social learning theory of personality in the 1960s (Twenge, Zhang, & Im, 2004). Rotter viewed locus of control as internal and external residing on a continuum. Internal control is the term used to describe a belief in one's own ability and external control refers to the expectancy that control is outside of oneself and determined by chance, luck, or other unforeseen events. Individuals with internal locus of control tend to attribute outcomes to their own control while individuals with external locus of control attribute outcomes to external circumstances (Rotter, 1966). Literature on the relationship

between locus of control and self-reported mental health problems supports a relationship between external locus of control on Rotter's scale and self-reported depression (Ganellen & Blaney, 1984; Maltby, Day & Macaskill, 2007) and anxiety (Kennedy, Lynch, & Schwab, 1998).

Do clients with higher self-efficacy attribute therapeutic change to their own accomplishment of treatment goals? Bandura (1977) describes self-efficacy as the belief an individual possesses about capabilities, confidence, and resiliency in accomplishing goals. He posited that self-efficacy involves self-regulation and the ability to manage thought processes, emotional states, and behaviors and is related to motivation and self-determination.

In regards to therapeutic change processes, the concept of self-efficacy is embedded in the Transtheoretical Model (TTM) and DiClemente (2003) reports that it is a factor in the prediction of maintaining abstinence (change) for clients with substance abuse/addiction problems and in tobacco smoking cessation. DiClemente also relates self-efficacy to motivation.

Symptom Reduction and Psychotherapeutic Change

Do clients perceive a reduction in symptoms as a way to gauge change in therapy? How do clients understand symptom reduction and the change process? The disease/medical model measures symptom reduction in specific mental disorders as a method to determine treatment efficacy, clinical effectiveness, and therapeutic change (Kazdin, 2008) and researchers use the term clinically significant (CS) change to measure statistically significant change for evidence-based practices (Kazdin, 1999). However, current researchers (Karpenko, Ownes, Evangelista, & Dodds, 2009) assert that symptom

reduction alone does not describe meaningful change. Likewise, Bohart and Tallman (1999) posit the client's perception of change may be beyond a decrease in symptomology.

Psychopharmacology and Psychotherapeutic Change

Do clients attribute a portion of change to medication? What is the client's perception and understanding of psychiatric medications plus counseling in regards to therapeutic change? Several research studies have found that both antidepressant medications and cognitive-behavioral therapy (CBT) are comparably effective in reducing depressive symptoms (Hollon, DeRubeis, Evans, Wiemer, Garvey, Grove, & Tuason, 1992; Simons, Garfield, & Murphy, 1984). However, while CBT may first work to decrease cognitive symptoms, antidepressants work initially by reducing insomnia and increasing appetite (Overholser & Schubert, 1996). Therefore, complimentary approaches that utilize therapy, medication, and social factors may enhance each treatment modality (Dumont, 2009). Research on the client's view of medication in combination with therapy is lacking.

In contrast, Svenaeus (2007) discussed the differences between self-change influenced by antidepressant medication and self-change influenced by psychotherapy. Svenaeus posits, "That psychopharmacological self-change is chemical in nature, rather than psychological, does not appear to be an ethically relevant matter" (p.178). Client perceptions on change from medication and change from counseling would be beneficial, however studies in this area are lacking.

Grawe (2007) and his research team advocate for psychotherapy for clients who are prescribed psychiatric medications and they surmise that learning experiences in

psychotherapy will change brain connections and improve behavioral functioning. In agreement, Dumont (2009) discusses a “paradigm shift in psychotherapy” (p. 39) that forges a relationship between psychotherapy and the synaptic self which includes brain chemicals, synaptic pathways, and brain changes. Furthermore, experts from neuroscience fields (i.e., psychotherapy, psychiatry, and neurobiology) are calling for an integrated approach between psychotherapy, pharmacotherapy, and the brain. Given that, Grawe (2007) asserted that learning produces alterations in brain structures, which influence cognitions, emotions, and behaviors. Likewise, Linden (2008) deduced that any change in cognitions, attitude, beliefs, and perceptions must be accompanied by changes in the brain. Mizen (2005) concurred and discussed the development of new technologies that allow the functions and structures of the brain to be viewed. She outlined Kandel’s new psychiatry framework: (1) all mental process derive from operations of the brain, (2) genes and their products are important determinants of patterns and connections in the brain, (3) genes do not explain the entirety of mental illness; learning and experience produce changes in gene expression, (4) changes in gene expression influenced by learning effect patterns and brain connection, and (5) psychotherapy involves learning which produces changes in synaptic brain connections and hence structural changes in the brain. What do clients think about their brain and change?

Several articles discussed the integration of psychotherapy and pharmacotherapy from the perspective of psychotherapists, psychiatrists, neurobiologists, and neuropsychologists (Grawe, 2007; LeDoux, 1996; Linden, 2008; Mizen, 2005).

However, qualitative studies on the client's perception and understanding of psychiatric and psychotropic medication combined with psychotherapy were absent in the psychology and counseling literature.

The phenomenon of change factors and change processes remains complex and elusive. It is the twenty-first century and researchers continue to search for answers (Kazdin, 2008). Sprenkle, Davis, and LeBow (2009) posit that contemporary researchers are utilizing change mechanisms from a client perspective to find answers. Duncan, Miller, Wampold, and Hubble (2010) concur and report fifty years of research has promoted the search for the client's own personal theory of change.

Appalachia

The participants in this study are Appalachian women and the focus is on their experience with psychotherapeutic change. The final section of Chapter Two presents literature findings and information on (1) Appalachia, (2) women in Appalachia, (3) women in rural Appalachia Ohio, and (4) rural mental health professionals. In this study, Appalachia is framed within a geographic rural region and in a cultural context. The central research question in this present study is: What are the Appalachian female client's perception, experience, and understanding of psychotherapeutic change? Gaps in the literature are identified and limitations of studies are discussed along with implications. The following section presents findings on the Appalachian region, attributes of Appalachians, physical health of Appalachians, and mental health in Appalachia, rural client care and rural mental health professionals, suicide in rural regions, religion, and education in Appalachia.

Where and What is Appalachia?

“Appalachia is the magical, mystical, and powering intertwining of people, culture, region, and ancient mountains (Caldwell, 2007, p. 73). Geographic boundaries define the region of the United States known as Appalachia. The Appalachian Region as defined in Appalachian Regional Commission’s (ARC) authorizing legislation is a 205,000-square-mile region that follows the spine of the Appalachian Mountains from southern New York to northern Mississippi and includes 420 counties in 13 states. Appalachia includes portions of Ohio, Kentucky, Tennessee, Virginia, Pennsylvania, Maryland, New York, North Carolina, South Carolina, Alabama, Georgia, Mississippi, and the entire state of West Virginia. The region is further categorized into Northern, Central, and Southern Appalachia. Based on the 2000 US Census, 23 million people reside in Appalachia and 32% live in rural counties (Appalachian Regional Commission, 2009). Nearly half (42%) of Appalachia is rural when compared to the remaining regions in the United States (Appalachian Regional Commission, 2010). The Census Bureau's classification of "rural" consists of all territory, population, and housing units located outside of urbanized areas or an urban cluster (United States Census, 2000). Rural areas encompass open country and settlements with fewer than 2,500 residents. Deavers and Brown (1985) developed seven subcategories of rural areas based on three main categories of economic, social, and demographic information. Economic categories include agriculture, manufacturing, mining, and government; social facets include persistent poverty and growth of retirement population; and proportion of land in federal ownership.

How was Appalachia named? The Appalachian Mountains were named by Spanish explorers in the 16th Century. The word “Appalachian” was taken from an Indian village in northern Florida called Apalachee (Raitz & Ulack, 1984).

The Appalachian Regional Development Act of 1965 was created to address the region’s poverty level, low income, high unemployment, lack of education, and lack of jobs. A major factor of concern in Appalachia is poverty (Jones-Hazledine, McLean, & Hope, 2006). According to the 2000 Federal Poverty Guidelines, the annual income for a family of four at 100% of poverty was \$1420.83 monthly or \$17,050 annually (Bauer, Katras, Seiling, & Ovel, 2007).

The State of Ohio

As the participants in the study are adult females residing in Appalachia, it is pertinent to discuss the state of Ohio and the Appalachian Ohio context of the place they choose to call home. If home is where the heart is then their Appalachian hearts were born and raised in this rural region where they choose to remain.

Ohio is a state in the Midwestern part of the United States and it consists of 88 counties with the capital and largest city being Columbus, Ohio. The name "Ohio" means "great river" or "large creek" and originated from the Iroquois word *ohi-yo*’ (Ohio History Central, 2010).

The United States Census Bureau estimates that the population of Ohio is 11,544,225 (U.S. Census Bureau, 2012) and the state ranks 7th in national population. In 2005, the total land used for agriculture was 14,300,000 acres and the top commodities, respectively were, soybeans, corn, hay, wheat, oats, potatoes, barley, and tobacco (Online Encyclopedia of Ohio History, 2010).

Appalachia Ohio Region

Appalachia Ohio is categorized as being in the northern region of Appalachia. Appalachia Ohio refers to 29 out of the total 88 Ohio counties and is among the most rural and sparsely populated areas in the state of Ohio (Appalachian Regional Commission, 2009).

Appalachia Ohio counties are located in the southeastern portion of the state of Ohio (Governor's Office of Appalachia, 2010). The Governor's Office of Appalachia classifies the 29 counties of Appalachia Ohio into three smaller regions: East Central Ohio, Southeastern Ohio, and Southern Ohio. The 10 counties of East Central Ohio Appalachia include: Belmont, Guernsey, Muskingum, Coshocton, Tuscarawas, Harrison, Jefferson, Carroll, Holmes, and Columbiana (Governor's Office of Appalachia, 2010). Southeastern Ohio Appalachia includes eight counties: Meigs, Athens, Hocking, Perry, Morgan, Washington, Noble, and Monroe (Governor's Office of Appalachia, 2010). Southern Ohio Appalachia consists of eleven counties and includes Adams, Brown, Clermont, Gallia, Highland, Jackson, Lawrence, Pike, Ross, Scioto, Vinton, and Hamilton (Governor's Office of Appalachia, 2010). Southern Ohio Appalachia is considered part of the region's Tri-State area which includes certain counties in Ohio, Kentucky, and West Virginia. All three states border the Ohio River. The 11 counties of Southern Ohio Appalachia have access to bridges to cross the Ohio River.

Appalachia Ohio Counties in This Study

This present study included rural Appalachia Ohio counties: the eight Southern Ohio counties of Scioto, Lawrence, Pike, Adams, Gallia, Highland, Jackson, Vinton, and the two Southeastern Ohio counties of Athens and Meigs.

The following counties are where the five participants in this study reside: Scioto, Athens, and Meigs. Therefore, the characteristics and statistics of these counties will be described.

Scioto County is located in the south-central portion of the state bordering on the Ohio River. The Native American version of the word Scioto means "deer" (Scioto County Demographics, 2013). In 2010, Scioto County was populated with 79,499 people (U.S. Census Bureau, 2010). Of the 79,499 people, 40,241 are female, and 39,258 are males (U.S. Census Bureau, 2010). The residents in this county are predominately Caucasian 75,045 with 2,129 being African American. In reference to the industry workers, 8,851 are employed in educational services, health care, and social assistance and 3,348 are in retail trade. In 1997, the overall poverty rate was 21% and in 2010, the unemployment rate was 12.0 %.

Athens County is located in the southeastern part of the state of Ohio. The town and the county of Athens were named after Athens in the country Greece due to the learning environment created by the Ohio University which was established prior to the establishment of the town and county (Athens County data, Ohio State University Extension Data Center, 2009). The total population of Athens County is 64,757 with 32,427 males and 32,330 females. Caucasians number 92% with 3% African American (U.S. Census Bureau, 2010 Census). In reference to the industry workers, 10,933 are employed in educational services, health care, and social assistance and 3,672 work in arts, entertainment, recreation, accommodation, and food service.

The Ohio River forms the eastern and southern boundary of Meigs County (United States Census Bureau, 2010) and it was named after Return Jonathan Meigs,

military leader and Ohio Governor from 1810 to 1814 (Appalachia Ohio, 2013). The total population is 23,770 residents with 11,661 males and 12,109 women. Caucasians number 23,150 (97 %) with 206 being Black or African American. Of the 18,914 individuals 16 years or older in industry, 8,685 were employed with 1,406 being unemployed. In reference to the workers, 2,317 are employed in educational services, health care, and social assistance with 1, 299 employed in retail trade (U.S. Census Bureau, 2010 Census).

According to Census 2000 data, over 70% of Appalachians were residing in their birth states (Pollard, 2003) and this holds true for the participants in this study who were all born and raised in Appalachia Ohio. In 2000, 74% of Appalachians owned their own homes (Pollard, 2003); however none of the participants in this study owns her home.

The Appalachian Regional Commission monitors the economic status of Appalachian counties by using three economic indicators: unemployment rate, income, and poverty rate and in comparison with national averages. Counties are designated as distressed, at-risk, competitive, or attainment. Whereas, Athens and Meigs Counties are designated as Distressed Counties and Scioto is considered At-Risk (Appalachian Regional Commission, 2013). However, these three rural counties do provide resources for mental health to residents.

Mental Health Services in Ohio and the Appalachian Region

The Mental Health Act of 1988 is a law that established Ohio's commitment to addressing the mental health needs through a unified system of community-based services (Ohio Department of Mental Health, 2011) and was signed into law as Amended Substitute Senate Bill 156. The law defined the roles and responsibilities of the community mental health boards and the Ohio Department of Mental Health (ODMH) for

both rural and urban areas. Appalachian Behavioral Healthcare (ABH) provides inpatient care for acutely mentally ill adults from southeastern Ohio and includes the counties of Meigs, Athens, Hocking Perry, Morgan, Washington, Noble, and Monroe. Local mental health centers refer patients to ABH by determining whether someone meets criteria for admission (Ohio Department of Mental Health, 2011). Southern Ohio counties are not considered a part of ABH. While residents of Athens and Meigs have access to a hospital with a psychiatric unit, the residents of Scioto County (a southern Ohio county) must travel outside the area with the nearest inpatient psychiatric services located 25 miles north in Ohio, 25 miles to facilities in Kentucky, or 50 miles to West Virginia.

Each of the ten rural Appalachian counties (Scioto, Lawrence, Gallia, Pike, Adams, Highland, Vinton, Jackson, Athens, and Meigs) in this study has a community mental health center funded at the federal, state, and local level. These centers have local levies as a funding source. Athens County is rich in mental health history. The Athens Lunatic Asylum in Athens, Ohio, opened for mental health services in 1874 and housed 633 patients (Daniel, 1997). All ten counties have nonprofit alcohol and drug counseling agencies and Athens, Scioto, and Lawrence have residential treatment houses for individuals with addictions, both for men and women. Additionally, all ten counties have either domestic violence shelters or task forces.

Athens, Meigs, and Scioto Counties have community mental health centers that serve residents as well as private counseling practices, and counseling is offered at the three college campuses.

Attributes of Appalachian People

Coyne, Demian-Popescu, and Friend (2006) conducted a qualitative study by interviewing 61 participants from West Virginia ($n = 31$ women, $n = 30$ men) in ten focus groups. Sixteen participants were African American and the remaining 45 were Caucasian. Cultural norms associated with residents of rural Appalachia, such as faith, family values, and patriarchy, were examined. Participants in all groups attributed the following characteristics to West Virginians: kind, outgoing, openhearted, and helpful. The most frequent responses describing the strengths of West Virginians were spiritual beliefs or faith in God and family values. Other characteristics considered as strengths by most participants included: good moral values, a sense of community, commitment and dedication to work, mutual respect, hospitality, and pride. Terms used to explain the value placed on work included: a strong work ethic, loyalty, dependability, trustworthiness, and dedication. Attributes of people living in Appalachia voiced by participants included being friendly, God-fearing, proud, law abiding, hard working, clannish, and reluctant to share family problems. Participants reported that family problems are: (a) considered private and not to be shared in the community, (b) sometimes shared with extended relatives, and (c) sometimes shared with the church. Participants reported that domestic violence is dealt with the family rather than in social service agencies. Participants in this study rejected the patriarchal characterization and reported that economic changes have created egalitarian relationships in which decisions are jointly made by husband and wife. Fatalism was rejected by participants and reported as a stereotypical view of Appalachian culture.

The people of Appalachia are endowed with many values (Maloney, 1993) and Jones (1994) discussed ten unique cultural values of Appalachian people: (1) religion, (2) independence, self-reliance, and pride, (3) neighborliness, (4) familism, (5) personalism, (6) humility and modesty, (7) love of place, (8) patriotism, (9) sense of beauty, and (10) sense of humor. Jones, a native Appalachian, based his findings on living in the culture, observing and interacting with the people, and studying heritage and history. Appalachia is known for strong attachment to family and for traditional male-female roles (Rural and Appalachian Youth and Families Consortium, 1996). Fisher (1999) used the following words to describe people residing in Appalachia Ohio: family, patriotism, individualism, racism, sexism, illiteracy, and inclusive/exclusive. Appalachia Ohio is also a region characterized by lower levels of education, lower income, and higher unemployment rates (Fisher, Engelhardt, & Stephens, 2008).

The literature reviewed mainly focused on value elements commonly attributed to Appalachians: self-reliance, traditionalism, fatalism, and religious fundamentalism (Coyne, Demian-Popescu, & Friend, 2006; Jones, 1994).

Religion in Appalachia

The Appalachian region is well-known for being seeped in religious tradition, a strong attribute as well. The majority of Appalachia is located in an area recognized as the Bible-Belt. The largest religious groups are Baptists, Catholics, and Methodists (Wagner, 2006). Purnell (2003) reported most religious groups in rural Appalachia to be fundamental Protestants with the King James Version as the only Bible used. Being in a religious group is associated with Appalachian self-identity (Reiter, Katz, Ferketich,

Ruffin, & Paskett, 2009). According to Greenlee (1993), family, friends, and church are depicted as the social supports in Appalachia.

Education in Appalachia

Thirty-two percent of Appalachian adults aged 25 and older were high school dropouts, compared to 24% of their peers in non-Appalachia (Bureau of Public Health, 2006). Percentage of the adult population who are college graduates is 18% in Appalachia and 24% in the United States (2000 Census and Appalachian Regional Commission).

The Appalachian Access and Success Study found that 80% of high-school seniors surveyed in Appalachia Ohio wanted to attend college but only 30% attended. A parent's higher educational level influenced whether their child attended college. The study further revealed the strongest barriers to college participation to be low self-esteem, poverty, and lack of information (Spohn, & Crowther, 1992). The percentage of Ohio's population aged 25 and over with college degrees is 12% for Appalachian Ohio counties and 22% for Ohio non-Appalachian counties (2000 Census). The college attendance rate for Appalachian Ohio is 30% compared to 41% for the non-Appalachian Ohio counties, and 62% for the United States (Foundation for Appalachian Ohio, 2006). Family income is one of the main reliable predictors of completing a degree in higher education in Appalachia Ohio (Spohn, & Crowther, 1992).

Physical Health in Appalachia

Recent studies have identified higher rates of cervical cancer, heart disease, and premature mortality in the Appalachian regions (Behringer & Friedell, 2006; Haverson, Ma, & Harner, 2004). Rural residents have higher rates of chronic illness and experience

more disability and morbidity related to diabetes, cancer, hypertension, heart disease, and stroke. Lung disease and obesity is prevalent in many rural areas. Exposure to agricultural chemicals among female farmers has been correlated with higher rates of non-Hodgkin's lymphoma, leukemia, multiple myeloma, and breast, ovary, lung, bladder, and cervix cancers (American Psychological Association, 2002). Fetal, infant, and maternal mortality is higher in rural areas (American Psychological Association, 2002).

Blakeney (2006) reviewed rural health literature and found three major concerns: (1) accessibility of regional health care services, (2) education of professionals, and (3) need for culturally-sensitive services (p. 101). Risk factors in Appalachia include: (1) a greater proportion reporting no health insurance or being under-insured, (2) greater geographic isolation, (3) less public transportation, and (4) fewer physicians, clinics, hospitals, and cancer centers per capita (Appalachia Community Cancer Network, 2009). Concerns related to cancer education, research, and training are being addressed by the Appalachian Community Cancer Network which includes professional healthcare workers in Kentucky, Maryland, New York, Ohio, Pennsylvania, Virginia, and West Virginia (Appalachia Community Cancer Network, 2009).

Women in Appalachia Ohio exhibited a 37% higher rate of cervical cancer compared to women from non-Appalachia Ohio (Fisher, Engelhardt, & Stephens, 2008). A qualitative dissertation in regards to physical health, poverty, and women in rural Appalachia Ohio was found. Deardorff (2009) interviewed rural Appalachian women who utilized the free medical services provided by a mobile clinic. The clinic travels to 11 rural counties and is supported by the Ohio University College of Medicine's Community Health Programs in Athens, Ohio. Deardorff called upon the frameworks of

feminist and narrative to tell the stories of rural women and children in poverty and the resulting “damaged identities from the stigma and stereotypes associated with living in poverty” (p. 1). She found three themes which included: (1) narrative activity fosters healing and empowerment, (2) the storied nature of health care shapes the mobile nature of the health clinics, and (3) counter-narratives challenge the traditional biomedical and dominant scripts.

The relationship between mental health, physical health, and well-being is acknowledged in the literature (American Psychiatric Association, 1994; Thorndyke, 2006) and the US Surgeon General reports that diseases of the physical body impact mental health issues (US Surgeon General’s Report on Mental Health, 1999). According to the World Health Organization, “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (World Health Organization, 2012, p. 1).

Mental Health in Appalachia

Poverty has been reported to impact mental health issues (Belle & Doucet, 2003; Keefe, 2005) and it is reported that 60 million people who reside in rural areas are affected by mental health issues (National Institute for Mental Health, 2002). Research suggests a relationship between mental health, gender, and poverty for the rural populations and that they are less likely to seek mental health services (Saadallad, 2002).

In 2002, President Bush’s New Freedom Commission on Mental Health also addressed access to and improvement of mental health services in rural communities (Mental Health Commission, 2002). Rost, Fortney, Rischer, and Smith (2002) conducted a comprehensive review of the literature and found the following components which

influence the perceived need for rural and nonrural mental health treatment and access to healthcare: (1) socioeconomic status, (2) social network of support, (3) health insurance and coverage, and (4) available community mental health services. The research revealed that individuals in rural areas, as compared to individuals in nonrural areas, wait longer when seeking mental health services and often wait until the disease has progressed. Perceived access to mental healthcare can be influenced by lack of transportation, unpaved country roads, and greater travel distances to community mental health centers in rural regions (Rost, Fortney, Rischer, & Smith, 2002). Individuals with mental illnesses in rural areas face three factors that may prevent receiving treatment. These factors include accessibility (knowledge, transportation, financing), availability (lack of mental health providers), and acceptability (overcome the stigma attached to mental illnesses) (Wagenfeld, Murray, Mohatt, & DeBruyn, 1994). Studies on mental health disorders and treatment outcomes in regards to women in rural Appalachian regions were lacking (Coward, Davis, Gold, Wright, Thorndyke, & Vondracek, 2006).

Rural Client Care and Rural Mental Health Professionals

A lack of qualified rural mental health professionals affects client care (Keefe, 2005). According to Kane and Ennis (1996), rural areas report a shortage of qualified and well-trained professionals, problems with both recruitment and retention of qualified mental health professionals, and rural workers receive less financial compensation compared to urbanized areas (American Psychological Association Office of Rural Health, 1995; DeStefano, Clark, Gavin, & Potter, 2005). For example, lack of rural cultural competence is a challenge to mental health professionals (Helton, 1995; Sawyer, Gale, & Lambert, 2006). Ethical concerns in rural areas have become a focus of

discussion due to multiple relationships (Behnke, 2008) as it is common for workers to attend the same church as clients (Helbok, 2003), their children to attend school with the clients' children (Brownlee, 1996), and they shop at the same local grocery store (Schank & Skovholt, 1997). Burnout occurs due to professional isolation (Kee, Johnson, & Hunt, 2002) reimbursement is lower due to lack of health insurance by rural clients (Jones-Hazledine, McLean, & Hope, 2006), and resources are limited (Coll, Kovach, Cutler, & Smith, 2007). Research on rural mental health professionals is valuable to the field of counseling, social work, psychology, nursing, and psychiatry (Kane & Ennis, 1996).

What do mental health counselors know about the regional identity of Appalachian clients? Sugar (2002) posited that regional background is a contextual factor in counseling and "attitudes appear to be culturally and regionally bound" (p. 163) and he recommended that counselors apply the Ecology model (Bronfenbrenner, 1976) to explore the client's environment and regional identity. Additionally, Hudgins (2008) conducted a qualitative dissertation on the topic of geographic place in a regional cultural context by surveying counselors. She explored regional identity as a cultural factor in order to help mental health clinicians become culturally competent in Appalachian rural regions. She explored race, ethnicity, gender, sexual orientation, and other contextual factors. Hudgins discussed "culture as a central component of client identity and as a contextual factor" (p. 2) and gender roles were the most commonly discussed. Both Sugar and Hudgins posited that within the same rural geographical region, residents can have differing attitudes and views on the same topic or issue. What is the Appalachian client's view of their multicultural counseling experiences? How do clients in rural regions with cultural contextual identities perceive and understand therapeutic change?

It is time to conduct research on the rural client's viewpoint, perception, and understanding of mental health services in rural Appalachia, specifically, qualitative inquiry to gather rich description (Keefe, 2005). Is there a regional model of cultural competency for counselors who provide services in rural Appalachia? According to the New Freedom Commission (2004) cultural competency training programs in rural areas are lacking.

Three papers from the American Counseling Association VISTA online were found. Russ (2010) gave 25 suggestions for counseling clients from Appalachia in a paper presented at an American Counseling Association conference. Ambrose and Hicks (2006) discussed facets of building a relationship with a client from Appalachia. In addition, Salyers and Ritchie (2006) presented a case study describing a client from Appalachia and Helton (1995) described strategies and interventions specifically for an Appalachian practice. However, an Appalachian female client's understanding of therapeutic change was absent.

Suicidality in Rural Regions

Hirsch (2006) reviewed the literature on rural and urban suicide and found suicide rates often greater in rural than in urban areas. He suggested that suicide rates in rural areas have been associated with: lack of neighbors due to rural living, lack of healthcare insurance and deficient access to mental health centers, loss of employment or underemployment, stigmatism attached to mental illness by the culture or religious affiliations, and accessibility of guns for hunting.

Geographic, psychological, and sociocultural barriers may impede the treatment of suicide in rural regions. Researchers have not rigorously examined the phenomena of rural suicide (Coward, Davis, Gold, Wright, Thorndyke, & Vondracek, 2006; Hirsch, 2006).

Women in Rural Appalachia

As the participants in this present study are adult females residing in Appalachia, the following factors found in the literature are discussed: poverty and Appalachian women, depression and rural women, substance abuse and Appalachian women, domestic violence and Appalachian women, elderly women in Appalachia, suicidality and Appalachian women, resiliency and Appalachian women, self-identity and Appalachian women, and education and rural women.

A team of researchers from 15 land-grant universities were authorized by the United States Department of Agriculture (USDA) to conduct a multi-state, longitudinal study known as *Rural Families Speak* to understand factors affecting the well-being of women and children from rural areas of poverty (Seiling, 2005). The three-year project collected both qualitative and quantitative data from 524 rural low-income families in 30 rural counties across 17 rural states using 238 variables. Face-to-face two-hour semi-structured interviews were conducted with the woman in the family unit. Areas of interest included: “population, household and family, housing, income, employment, industry, poverty, health and fertility, mortality, education, social support, child maltreatment, and crime” (Seiling, 2005, p. 21).

The final report summarized the findings from three areas: “labor force, health, and social support.” (Seiling, 2005, p. 25). The health data focused on: “health insurance

coverage and use of health services, barriers to employment and economic well-being related to health problems, including depression and the role of food security in family health and well-being” (Seiling, 2005, p. 27). Results from the health data reported that mothers and children were covered by Medicaid which also covered one third of the employed females. Approximately 40% of the mothers in the sample scored at risk for symptoms of clinical depression. In contrast, mothers who were employed had better mental health and fewer symptoms of depression. Another finding was the importance of social support to the economic, emotional, and physical well-being of rural low-income women and families. Most rural low-income families depended on their families and friends for access to vital resources (Bauer, Katras, Seiling, & Ovel, 2007).

Poverty and Appalachian Women

Rural women in poverty have been recognized as “both at-risk and underserved by mental health professionals” (Myers & Gill, 2004, p. 225). Limited access to mental healthcare, general healthcare, education, and employment are reported as increased risk factors for rural women in poverty (American Psychological Association, 2002; Coward, Davis, Gold, Wright, Thorndyke, & Vondracek, 2006). Access barriers to treatment include lack of mental health providers, lack of transportation, lack of child care, and lack of health insurance. It is reported that 46% of rural households are headed by women and 27% of these households are living below the poverty line (National Institute of Mental Health, 2002). The family unit of Appalachia is characterized by close family ties, loyalty, and distrust of outsiders. The family structure is viewed as strength when members seek physical, financial, social, and emotional support from within, however it can be seen as a barrier when it prevents necessary mental health treatment and services

(Beaver, 1988). Feedback from women in poverty needs to be addressed to find their perceptions on financial barriers to mental health counseling.

Religion and Appalachian Women

One qualitative dissertation was found which addressed religion, spirituality, and the intersection of patriarchy in regard to women. However, the participants resided in Cincinnati, Ohio, which is not located in the Appalachian region, but close to it. Webster (2007) reported that women were “constantly challenging, resisting, or accommodating in various ways around issues of equality” (p. 33) in religions that accept female gender oppression. King (2001) stated, “...oppressed position of women in society, in the churches, and in theology, means that women suffer intensity as victims of violence” (p. 103). Literature on religion or spirituality from the viewpoint of Appalachian females is scarce. When rural women seek out counseling, do they bring their religious beliefs as helps or hindrances?

Education and Appalachian Women

Atwell (2005) in her book, *Appalachian Women*, stated that while many rural women have always faced obstacles, many overcame obstacles because of the opportunities provided by education. For Appalachian women, gender is connected to both poverty and lack of education attainment (Flournoy, 1982; Latimer & Oberhauser, 1995).

Bradbury (2008) conducted a qualitative study on the factors affecting the integration of first-generation, first-term college students from Appalachia Ohio. She interviewed 7 female students and 2 male students who attended Shawnee State University located in Scioto County and found that the students stayed connected with

family and leaned heavily on the faculty for support. In the same vein, Powell (2008) conducted a qualitative study with 34 Appalachian students; half female and half male, attending Ohio University in Athens and Shawnee State University in Portsmouth, Ohio. He examined the perceptions of Appalachian students about post-secondary education. Results revealed that Appalachian students value education, experience socio-cultural and financial barriers to educational access, and need motivational mentors outside of their families.

Marcia Egan (1993) conducted a qualitative study of the educational experiences of 12 women in Appalachia. She found the women's decisions to attend college were influenced by the culture and the family. Educational differences between women and men are greater in Appalachia than the remainder of the nation which is influenced by gender inequalities (Shaw, DeYoun, & Redemacher, 2005).

Are higher education influences related to a rural woman's decision to seek out mental health counseling, participate in psychotherapy, and be willing to address and understand therapeutic change, and if so, how are the two factors connected?

Elderly Women in Appalachia

McInnis-Dittrich (1997) described the use of an empowerment-oriented model in a home-based mental health program for older women in the Appalachian region. The home-based approach addressed the following barriers: transportation, social barriers, and cultural barriers. According to Keefe (1988, 2005) the inability to drive or lack of transportation access is a major barrier for rural women, and especially elderly women. Although independence is a rural strength, not seeking mental health services when needed can be a weakness (McInnis-Dittrich, 1997).

The empowerment-oriented model was used with five rural Appalachian women (McInnis-Dittrich, 1997). The public health nurse, who provided in-home medical care one time per week, referred the women. The participants were elderly (ages 96, 70, 68, 67, 56), lifetime residents who lived alone, had mild health problems, and moderate depression and/or anxiety. In the first level or phase of the empowerment-oriented model, the counselor or social worker provided individual services weekly in the home and focused on self-awareness and powerlessness. In level two, the therapist brought the five women together for a self-help group, socializing, and empowerment. The group met monthly in a member's home for a potluck meal and emotional/social support. In level three, the women identified an issue in the environment or community and how to help change it. In the fourth level, the women as a group addressed a political issue of concern. For example, the group could register to vote and make plans for transportation to the voting location. The group developed the goals and the solutions. After six months, the social worker reduced her visits and interactions because the group was functioning well. The group continued without the social worker facilitator.

A limitation of this model is that long-term follow-up was not implemented to verify the maintenance of the changes. The transportation issue was not addressed for future group meetings. The participants were not interviewed on their understandings of change and how change occurred.

Depression and Appalachian Women

The American Psychological Association (APA) reviewed research published after 1975 in regards to rural women. They found that 41% of rural women are depressed or anxious compared to 13-20% of urban women; six percent of all women with

HIV/AIDS reside in rural regions; lesbians are often shunned in rural areas with fewer social supports; rural women with disabilities experience more obstacles in obtaining services; 40% of all visits to rural practitioners are due to stress; and rural women suffer unique stressors such as isolation and limited access to mental health services (American Psychological Association, 2002).

Probst, Laditka, Moore, Harun, and Powell (2005) conducted a study on depression in the rural population. Findings reported the prevalence of major depression was significantly higher among rural (6.11%) than among urban (5.16%) populations.

Twenty-nine Ohio rural families participated in the *Rural Families Speak* project from 2001-2002 and 23 Ohio rural families were interviewed in 2003. The adult females were interviewed in either the families' homes or a public library. The average Ohio rural family size was 4.4 members (with an average of 2.3 children) with an average total monthly income, not including food stamps, of \$1,300.15 or \$15,601.80 annually. Results found 85% of adult female participants ($n = 52$) low-income mothers residing in the Appalachian region of Ohio counties were at risk for clinical depression and 79% relied on their mothers for emotional support (Seiling, 2005).

Substance Abuse and Appalachian Women

The literature search produced a qualitative study on rural women's stories of addiction recovery. Grant (2007) interviewed 25 rural Appalachian women and explored how they make meaning out of recovery and sobriety. She explored self-perceptions, processes of change, strategies used, self-esteem, and social support systems. The criteria of the study included females over 20 years of age (mean age = 40 years) and in recovery for 18 months or more to establish stability. The participants reported 2 to 24 years in

recovery. Grant reported that 18 of the 25 women reported childhood sexual abuse and three experienced domestic violence with adult partners. Twenty-one women earned between \$10,000 to \$19,000 annually; three women had incomes over \$20,000; one female's salary was over \$50,000. Thirteen participants had some post-secondary education, one had a nursing degree, and half were students, retired, or unemployed. Eight women were married with the remaining being separated, divorced, or single.

Grant used 90-120 minute semi-structured interviews that were audiotaped. The participants were asked to describe their recovery process in detail and three categories were utilized: (1) preaddicted self, (2) addicted self, and (3) recovering self. Grant focused on the change processes and found the women experienced change through the following phases: (1) disgusted self, (2) aware self, (3) alternative self, and (4) stable self. The participants reported the emotion of fear due to suicide or dying from alcohol-drug related diseases prompted their recovery and action to make changes. Eight women reported family as a support system and did not attend counseling or Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). Ten women reported counseling and/or sponsors plus AA or NA attendance. Four women returned to church for support. The participants changed their view of self from self-despising to self-acceptance. They processed emotional expressions and responses, which influenced the process of change (Grant, 2008). Grounded theory was used for data analysis. Grant found the women compensated for lack of treatment centers in their Appalachian region through cultural contexts with help from family, church, friends, AA or NA, work, and school. The county where the research was conducted had a 32% poverty rate. A residential inpatient

and outpatient counseling center in the county addressed the gender-specific and cultural needs of Appalachian women with alcohol/drug addictions. The focus was addiction.

While Grant strived to fill a gap in the literature and was able to capture the subjective experiences of the participants, she did not collect other useful information. She did not report whether participants had health insurance or Medicaid. Transportation and childcare problems were not discussed.

Tatum (1994) discussed the Rural Women's Recovery Program (RWRP) and Women's Outreach Program, which are two substance abuse programs that address the specific treatment, prevention, education, and intervention needs of women and families in the rural Appalachian region of Ohio. The programs are located in Athens County in Ohio Appalachia. The obstacles to treatment/counseling include: (a) inability to pay for services, (b) lack of transportation, (c) unsafe and inadequate housing, and (d) child care needs. The cultural barriers include (a) general mistrust of outsiders, (b) fatalistic life attitudes, (c) a tradition of self-sufficiency, and (d) geographic and social isolation (Tatum, 1994, p. 1). The Ohio Department of Alcohol and Drug Addiction Services (ODADAS) have certified 98 chemical dependency treatment and recovery centers in Ohio Appalachia. In 2010, ODADAS allocated \$13,800, 68 to 75 gender-specific and culturally competent programs in Ohio that serve women and children (Ohio Department of Alcohol and Drug Addiction Services, 2010).

In addition, a quantitative dissertation (Blevins, 2008) investigated demographic and treatment variables (via intake data and follow-up reports) for 126 women who had successfully completed treatment at RWRP in Athens County, Ohio. The study explored residential substance abuse treatment outcomes and selected demographic and treatment

variables (i.e., housing status, education level, income level, single substance abuse diagnosis versus dual diagnosis, parent/child/pregnant participation/residence in treatment and employment status at the time of residential substance abuse treatment admission). The results indicated that pretreatment employment status was the only significant variable of those included in this study that was significant to treatment outcomes. The study examined the role of employment in increasing the chances of a woman staying sober following treatment (Blevins, 2008). However, direct feedback from clients was not elicited.

Domestic Violence and Appalachian Women

The literature search found some studies and articles about women and domestic violence in rural areas with the consensus of isolation, patriarchy, and poverty as contributing factors (Bosch & Schumm, 2004; DeKeseredy & Joseph, 2006; Lanier, 2009).

Some articles, dissertations, and information on the Internet in regards to domestic violence in Appalachia Ohio and counseling services are becoming available. Shoaf (2004) conducted a qualitative research study for the State of Ohio Office of Criminal Justice Services (OCJS) on what services are needed in the 29 Ohio Appalachia counties as perceived by adult female victims of domestic violence. OCJS received the Rural Domestic Violence and Child Victimization Grant. Three focus groups in three counties were conducted with a total of 22 participants. In regard to the findings, the female participants identified needs in six primary areas, respectively: (1) criminal justice services, (2) employment and related services, (3) housing services, (4) counseling and related services, (5) transportation services, and (6) education and awareness services. In

regards to counseling services, Shoaf (2004), found the majority of women reported seeking out and receiving services for victims, their children, and the abuser at various times (i.e., individualized therapy, support groups, Al-Anon, anger management, and services at local domestic violence shelters). How do female victims of domestic violence perceive the therapeutic change process?

DeKeseredy and Joseph (2006) studied collective efficacy (the level of social cohesion among neighbors combined with their willingness to intervene on behalf of the common good) by conducting a qualitative study in Appalachia Ohio pertaining to women and intimate abuse with spouses or partners. Results revealed that collective efficacy was not effective in interventions with abused women in rural communities due to patriarchy, keeping domestic violence inside the family unit, isolation from neighbors, and geographical distance from law enforcement. Spouses or partners forbade some victims from socializing with neighbors while other victims socialized but were embarrassed or ashamed to discuss the abuse. The victim's relatives rarely intervened in domestic disputes.

Suicidality and Appalachian Women

Suicide research on the specific population of adult females in the Appalachian region was not found in the literature. Suicidality research studies on the population of adult females in Appalachia Ohio were not found in the literature. The Ohio Suicide Prevention Foundation lists suicide by counties in Ohio; however, statistics for suicides in the Appalachian Ohio region as a whole were not listed. How do Appalachian women view suicidality and do they seek help?

Incest and Appalachian Women

While research on incest is plenty, there is paucity on studies about incest in Appalachia and in Appalachia Ohio. Cantrell (1994) investigated family violence and incest in Appalachia and she found relationships of family stress, educational attainment, and family process variables to abuse and physical violence. She found that over one-third of women in her four projects comprised of females from high school, college and young women reported at least one incestuous relationship. This author also addressed the stereotypical view that Appalachia families are riddled with incest. How do female incest victims in Appalachia utilize counseling for healing and how do they view therapeutic change?

Resiliency and Appalachian Women

Rutter (1987) postulated that resiliency includes the ability to change as a result of a stressor, while Walsh (1998) stated, “Resilience is forged through openness to experiences” (p.4). Helton and Keller (2010) conducted a phenomenological inquiry by interviewing ten women to explore what constitutes resiliency for Appalachian women. The results found a relationship between developmental resiliency assets during youth that indicated Appalachian women's cultural values foster their strengths and resilience. The researchers emphasized the importance of understanding cultural values for counselors. Is resiliency a strength that Appalachian women bring to counseling in order to make changes?

Identity of Appalachian Women

Tajfel and Turner (1986) studied Social Identity Theory and posited that group membership is part of an individual's identity. When the group social identity is

undesirable, individuals will leave their group, join another group, or try to change their existing group. Reiter, Katz, Ferketich, Ruffin, and Paskett (2009) conducted a quantitative study to explore Appalachian self-identity in 571 females residing in Appalachia Ohio. Results found that the length of time living in Appalachia, residing in a rural region county, religion, family, and community showed the strongest affiliation with Appalachian self-identity for women. Of the 571 women 201 (35.2%) identified themselves as Appalachian; 329 did not; and 41 were unsure. More research is needed on this population, specifically qualitative studies to elicit self-report.

Fiene (1991) conducted a qualitative study of 18 rural low-status women to gain an understanding of self-identity construction. She found that (1) expectations of their performance of their roles in their families, (2) behavioral expectations for interpersonal relationships outside their families, and (3) presentation of self through their positive characteristics and accomplishments were factors in self-identity and self-image.

Likewise, in another qualitative study Roades (2011) interviewed ten professional women from southern Ohio based on their authentic Appalachian heritage on the topic of identity construction. The themes which emerged were related to culture, personal identity, social identity, and leadership.

In a qualitative study (Kegley, 2011) interviewed fifteen Appalachian women who left partner relationships and became socio-economically stable and independent. Appalachian characterization, generational issues, children, economic independence, education, reasons for leaving, social support, and self-leadership emerged as the primary themes. Bateson (1989) posited that gender identity is interconnected to social identity and interactions in daily life and Ridgeway (2009) asserted, “gender is a primary cultural

frame for coordinating behavioral and organizing social relationships” (p. 145). How do female clients utilize counseling to develop cultural self-identities? How do female clients use the change process to redefine their identities?

Chapter Two concludes with identification of gaps in the previous literature, implications of the research, and how this study can add to the base of knowledge.

The literature review presents both historical and contemporary research in order to establish a foundation of knowledge and an encompassing view of therapeutic change mechanisms and factors. It is important to note the need for updated research as several studies were dated over fifteen years; however some of the findings are considered important landmark studies. The ongoing debate in the literature concerning the theories and models versus the common change factors approach was outlined to provide the logic, reasoning, and rationale for my dissertation study. Both process and outcome research studies were reviewed. In addition, both quantitative and qualitative studies were examined. A paucity of literature in regards to the clients’ understanding of therapeutic change was revealed. Additionally, no research was found pertaining to clients’ understanding of therapeutic change mechanisms in rural areas, specifically adult female clients residing in Appalachia and rural Appalachia Ohio.

A universal definition of therapeutic change was not found in the literature. Perhaps the enigma of human change is too complex to be divided and studied in the therapeutic context. The historical literature conveyed that researchers have searched for change factors and who is responsible for psychotherapeutic change by studying the therapist and the theory. Findings have advanced the knowledge on the effectiveness of

therapy and have established that therapy does indeed work. Researchers are beginning to study therapeutic change from the client viewpoint.

Gaps in the Literature

In reference to the lack of current research in the literature, Elkin (1991) reported that studies on change processes are time-consuming and difficult and funding resources are limited. However, current studies need to be conducted to update the knowledge base on the client's understanding of therapeutic change. This study addresses a portion of the gap in the literature on both the areas of therapeutic change from clients' understanding and therapeutic change from Appalachian female clients' understanding of counseling experiences.

The literature examined the outcome of change with the primary focus being on the clinician, theories, models, and methods. Limited quantitative research studies on the clients' perception of the process of therapeutic change were found. Given that, empirical studies lack detail about how change occurs and who is responsible for psychotherapeutic change, and qualitative methods in the literature in regards to client descriptions are limited.

This study extends findings by focusing on clients' understanding of change experiences, making meaning of self-change, internal and external changes, and the therapeutic change process during the course of counseling. Under investigation was the client's cognitive, affective, behavioral, and spiritual meaning-making of the change process as they understand and understood it.

Implications

Using a qualitative, specifically a phenomenological approach, provides the participants of the study the opportunity to reflect on their own experiences in therapy and to clarify their understanding of the change process and change factors. Participants answer who, what, where, when, and how much. Qualitative research generates discussion among counselor educators and offers insight into the development of a university course on counseling in the rural Appalachian region. Additionally, it adds to the knowledge for counselor trainees, therapists, and counselor educators in rural areas.

The findings of my study adds to the literature by revealing how clients perceive and understand change apart from counselor characteristics, the therapeutic alliance, specific theories/models, approaches, methods, and strategies. This study makes contributions to research in the following areas: (a) clients' perception and understanding of change, (b) client and counselor interaction with change from client's viewpoint, and (c) clients' perceived role and understanding of change mechanisms and the process of change factors.

Summary

Chapter Two provided an extensive review of the literature related to the areas of psychotherapeutic change and mental health counseling with rural Appalachian female clients. Gaps in the literature are highlighted to generate future directions for research. This chapter concluded with an outline of major themes in the literature and a discussion of implications. Discussion of relevant findings was presented.

The following chapter outlines the methodology, data collection methods, procedures, and data analysis for this present study.

CHAPTER THREE: METHODOLOGY

Introduction

This chapter lists the research questions, identifies qualitative methodology, discusses phenomenology in reference to history, research, and rationale, outlines the sampling strategy, and describes the data collection and data analysis procedures. This section presents a brief history of phenomenology and a rationale for conducting a phenomenological study. The approach to assure trustworthiness is discussed as well as limitations of this study. The steps to assure ethics for the protection of human subjects are presented and discussed. Researcher as instrument and researcher as self are presented.

Research Questions

The central research question (CRQ) guide this study: What are the Appalachian female clients' experience, perception, and understanding of psychotherapeutic change? Additional sub questions accompanied the CRQ:

- 1). What are clients' beliefs concerning change during their course of therapy?
- 2). How do participants describe/make meaning of changes that occurred before, during, and/or after therapy?
- 3). What do participants attribute change to: themselves, therapists, or others?
- 4). What suggestions would the participants like to make to clinicians about their understanding of the psychotherapeutic change process?

Qualitative inquiry was utilized as the method to attempt to explore and answer the research questions. The goal was to develop a deeper understanding of the experiences and perceptions of female clients in the rural region of Ohio Appalachia in regard to

psychotherapeutic change. This study was designed to better understand the lived experiences of the participants. Asking clients to discuss their strengths and how these strengths facilitate therapeutic change is possible in a qualitative study. Clients were asked to describe and elaborate on strengths and positive qualities.

The use of a naturalistic paradigm such as phenomenology best suits the goal of my research. According to Moustakas (1994), the first person stories of personal participant experience are what make phenomenology valid.

Phenomenology

This qualitative study aims to better understand how clients experience, perceive, and understand therapeutic change, mechanisms of change, the process of change, and change factors. The study is framed in a phenomenological design. Qualitative research and phenomenology reside on a continuum of methodological approaches and according to Streubert and Carpenter (2003) is being utilized in many disciplines (e.g., social sciences, anthropology, psychology, education, medical fields). Phenomenologists researchers, Giorgi and Gallegos (2005) asserted, “Although outcomes are not irrelevant, it seems that as much concentration should be put on the process of therapy as on its outcome” (p. 196). A phenomenological approach explored the essence of the lived experience of the participants (adult females in rural Appalachia) who experienced the process of psychotherapeutic change while attending mental health counseling. The phenomenological study is “one that focuses on descriptions of what people experience and how they experience it” (Patton, 1990, p. 71).

History of Phenomenology

Developed from the early philosophical backgrounds of Husserl, Heidegger, and Blanchot, phenomenology has evolved into a feasible research methodology for exploring the gist of human experiences (Van Manen, 1990).

This study utilizes the qualitative inquiry of phenomenology as developed by Edmund Husserl (1931). The German philosopher and founder, Husserl, defined phenomenology as "the reflective study of the essence of consciousness as experienced from the first-person point of view" (p. 20). Husserl's slogan, "to the things themselves" was infamous among his followers and he admonished researchers to "return to the thing itself" (p. 20). His basic assumption is that an individual can story his/her experience and the basic structure of the experience will be revealed (Cohen & Omery, 1994).

Phenomenology has evolved into two major styles, descriptive and interpretative (Giorgi, 1992; Moustakas, 1994). Husserl's phenomenology is considered descriptive and later, an interpretative track evolved into existential and hermeneutic (Moustakas, 1994).

For this study, the researcher chose a combination of descriptive and interpretative phenomenological approaches in order to thoroughly explore, examine, and analyze interviewers' responses and meanings of individual experiences.

Rationale for Phenomenology Study

The phenomenon of clients' experience of change as facilitated during psychotherapy is complex, multifaceted, and difficult to measure and quantify (Giorgi, 1997). This approach is appropriate for finding in depth information. Phenomenological research is both a creative and disciplined approach that uses systematic and rigorous procedures while allowing for discovery-oriented data to emerge (Giorgi & Gallegos,

2005). In the same line, Marshall and Rossman (1999) stated, “It rests on the assumption that there is a structure and essence to shared experiences that can be narrated” (p. 112).

The focus of phenomenology is on “descriptions of what people experience and how it is that they experience what they experience” (Patton, 2002, p. 107).

Method of Phenomenology

The qualitative exploration, organization, investigation, and analysis employed in this study are a combination of phenomenological approaches adapted and described by Colaizzi (1978), Van Manen (1990), and Moustakas (1994).

Colaizzi’s (1978) approach utilizes the concept of imaginative listening during interviews with participants and he declared, “The researcher listens to him with more than just his ears; he must listen with the totality of his being and with the entirety of his personality” (p. 64).

A recognized theorist Max Van Manen (1990) writes, “Lived experience is the starting point and the end point of phenomenological research” (p. 36). According to Van Manen (1984) phenomenological research is “the study of lived experience,” “the study of essences,” “the attentive practice of thoughtfulness,” “a search for what it means to be human,” and “a poetizing activity” (p. 1-2). Van Manen (1990, p. 88-93) suggests using a series of questions throughout the interpretive process of reading the transcriptions to garner thematic statements: “What sententious phrase captures, most clearly, the fundamental meaning of the text, holistically?”; “What statement(s) or phrase(s) seems acutely essential or revelatory concerning the phenomenon being described?” and “What does this particular sentence or grouping of sentences say about the phenomenon being described by the participant?” Phenomenological research visits

and revisits the experiences of participants to find comprehensive descriptions. To uncover themes, Van Manen suggests the researcher view the text as a whole, posing the question, “What does this mean?” Next the researcher writes a phrase that uncovers that meaning. After numerous readings, the researcher highlights significant descriptions of the phenomenon, which in this study are the experiences, perceptions, and understandings of female clients in the rural Appalachian Region of Ohio, who reported psychotherapeutic change as a result of mental health counseling. Then each sentence is investigated with the question, “What does this reveal about the experience?” (Van Manen, 1990, p. 93) The next task is to determine commonalities (themes) and select words and phrases that express and illustrate meanings. Identifying themes from the participants’ responses allows the researcher to “touch the core of the notion we are trying to understand” (Van Manen, 1990, p. 88).

Moustakas’ (1994) approach of phenomenological research facilitates the root of knowledge through Epoche, Reduction, Imaginative Variation, and Synthesis of Meanings and Essences. These steps are further explained.

Epoche is the process of setting aside assumptions, prejudgments, preconceptions, biases, or a viewpoint regarding the phenomenon under investigation which in this study is the understanding of psychotherapeutic change. The researcher brackets out her/his own experiences during the data gathering process.

Reduction is the process of examining the phenomenon and setting aside preconceptions, therefore “the entire research process is rooted solely on the topic and question” (Moustakas, 1994, p. 97). The analysis process allows the researcher to concentrate on and explicate textural meanings and to focus on the essential nature of the

whole phenomenon. Moustakas (1994) asks the researcher to explore deeply into layers of meaning and to continue to read and reread the descriptions by participants and to focus on core meanings, not generalizations or explanations. To achieve essences of phenomena, the researcher will unify the noema (external perception) with the noesis (internal perception). The generated themes are then clustered into a coherent textural description. Moustakas (1994) labeled horizontalizing as “every expression relevant to the experience” (p. 95). During the phenomenological reduction phase, the essence of the phenomenon is identified by the researcher as themes emerge. Clusters of themes turn into categories. Constructing a complete description of the phenomenon is the ultimate task of Reduction.

Moustakas (1994) describes Imaginative Variation as exploring “possible meanings through the utilization of imagination, varying the frames of reference, employing polarities and reversals, and approaching the phenomenon from divergent perspectives, different positions, roles, or functions” (Moustakas, 1994, p. 97-98). The researcher contemplates the data by considering the possibilities of varying meanings and then uses examples of unchanging individual textual descriptions and individual structural descriptions.

The last phase, structural synthesis, or the Synthesis of Meanings and Essences is the final process in phenomenological research (Moustakas, 1994, p. 100). Gathering information from several individual participants allows common meanings to emerge. The researcher integrates the composite textual and composite structural descriptions and describes the participants’ experiences of the phenomenon as a whole.

Trustworthiness of Study

Providing for trustworthiness of inquiry and accuracy of findings is important in qualitative research methods. Criteria for trustworthiness include credibility, dependability and confirmability, and transferability (Lincoln & Guba, 1985). In qualitative research, trustworthiness and credibility replaces validity; dependability replaces reliability; and transferability replaces generalizability (Patton, 2002). Trustworthiness is demonstrated by document triangulation, member checks, and bracketing of self-as-researcher during this study.

Trustworthiness of the data in this study is supported by a detailed interview and an opportunity for participants to offer sequential feedback for accuracy of content and context. Bronfenbrenner (1976) labeled participant feedback as a source of phenomenological validity. Field notes (raw handwritten) were taken during each interview with supplemental information added immediately after each meeting. A contact summary sheet was used to review the typed field notes for the purpose of reflecting on main concepts, themes, issues, and questions (Miles & Huberman, 1994). This summary of each interview, early analysis, permitted the researcher to organize and record early data and to make comments on issues that surfaced during the interview process with participants. I consistently utilized a journal to write thoughts, reactions, and ponderings concerning self-reflection and interactions with participants immediately after each interview. The journal became my personal feedback system.

Listening to audiotaped interviews while simultaneously reading transcripts allows the researcher to become immersed in the voices and experiences of participants

(Moustakas, 1994). The researcher listens for significant words, phrases, and statements that convey meaning to participants.

According to Maxwell (2005), researcher bias and participant reaction to the researcher can be one of the threats to a qualitative study. In the initial stages of this study, the bracketing process was used to examine researcher assumptions and presuppositions.

Additionally, researcher as instrument and researcher as self were described in detail, including qualifications as an interviewer. Transparency enhances the trustworthiness, credibility, dependability, and authenticity (Creswell, 1998; Patton, 2002) of the study.

Credibility

A technique to enhance credibility is the crosschecking of information called triangulation which also increases validity (Patton, 2002). By utilizing triangulation, I derived data from several sources: in-depth interviews, a demographic questionnaire, a counseling questionnaire, an optional written reflection paper by participants, and personal observations written as field notes. Incorporating and analyzing data-gathering techniques is another means for increasing truthfulness of sources (Creswell, 1998; Lincoln & Guba, 1985; Patton, 2002).

Lincoln and Guba (1985) consider member checking as important in qualitative inquiry to establish credibility. In this study, I asked participants to read transcript summaries regarding the accuracy of the researcher's interpretation of participants' quotes and textual descriptions.

Dependability and Confirmability

Dependability of the findings is strengthened by using several means of data collection. I utilized an open-ended interview, demographic form, and a counseling information form. Confirmability determines if the research findings convey the voices of participants as opposed to the researcher's own agenda (Lincoln & Guba, 1985).

I consistently performed the following activities as another means of establishing trustworthiness via dependability and confirmability: employed field notes to organize raw data during the interviewing process; reflected and wrote in a journal immediately after each audiotaped interview; utilized summary sheets to analyze typed field notes; and applied data analysis throughout the study instead of waiting until the end of the data collection process. Field notes were consistently used during interviews to specifically capture my impression about the participants' affect, emotional reactions, facial expressions, body language, and movements (Strauss & Corbin, 1998). Researcher field notes addressed the emerging concepts pertaining to data analysis. Additionally, keeping a reflective journal increased the confirmability as I wrote about my observations of participants and my own thoughts, perceptions, beliefs, feelings, and experiences. The observational data and reflexive journal (Patton, 2002) provide a description of what the researcher observes and a reflection about the content and context. In addition, memos were used; writing thoughts and reflections in the margins of transcripts with a colored ink pen while reading allowed the researcher another opportunity to interact with the data.

Additionally, I utilized an audit trail (Lincoln & Guba, 1985) for the purpose of authenticating the findings of this study. The audit trail is a record of detailed steps taken

throughout the research process. Dey (1993) asserts that the phenomenological researcher is obligated to show the readers the roadmap to the findings of the study.

Transferability

According to Lincoln and Guba (1985), transferability demonstrates the applicability of a study's finding to another context. To accomplish transferability, Lincoln and Guba (1985) reported the researcher "provides only the thick description necessary to enable someone interested in making a transfer to reach a conclusion about whether transfer can be contemplated as a possibility" (p. 316). However, Marshall and Rossman (1999) asserted "qualitative research does not claim to be replicable" (p. 195). Transferability or generalizability to other populations and settings is not the goal of the phenomenological study.

Data Collection Procedures

The following section presents details on sampling procedures, selecting participants for the study, data collection information, protection of human rights, ethical considerations, trustworthiness factors, interviewing, self as instrument, data analysis, self as researcher, and a summary.

Data Collection Methods

Many qualitative researchers combine data collection methods after identifying strengths and limitations (Marshall & Rossman, 1999). In this study, data collection consisted of semi-structured interviews that allowed for flexibility as participants' experiences were revealed. A rigid formula is not adhered to in discovery-oriented inquiry. The following interview formats were utilized: first contact by telephone calls or electronic mail, demographic questionnaire, counseling questionnaire, face-to-face

interviews, an optional written reflection paper, and follow-up communication as needed for clarification after the interview, and a second follow-up meeting. See appendix for data collection documents.

Supplies consisted of a digital voice recorder, a tape recorder for backup, batteries, a flash drive, binder notebooks, white computer copy paper, colored paper for flyers, colored markers, colored labels, stapler, hole puncher, and paper clips. Data from each participant were organized into separate notebooks and stored in a locked filing cabinet in my home office.

Interviewing

Patton (2002) categorizes qualitative research interviews into three types: the standardized open-ended interview, the general interview guide approach, and the informal conversational interview. Interviews can be informal, yet purposeful conversations. Rubin and Rubin (2005) posit that “Qualitative interviews are conversations in which a researcher gently guides a conversational partner in an extended discussion” (p. 4). Through interviews, participants can describe and explain their perceptions, meanings, and understandings of experiences (Kvale, 1996). In this study, open-ended questions were utilized to solicit personal participant experiences and to allow them to narrate their counseling stories (Appendix H).

However, while interviews have merits, they also possess limitations (Marshall & Rossman, 1999). Obtaining considerable amounts of participant data in a limited time period is a definite strength, however, an inexperienced interviewer may not be able to obtain in-depth answers. Therefore, the purpose of a pilot interview is to allow for practice and improvement in order to gather rich information (see Appendix L).

Data for this study were collected through semi-structured interviews: a combination of the interview guide approach and the informal conversational interview (Patton, 2002). Lincoln and Guba (1985) discussed both structured and unstructured interviews. Structured interviews use established questions and do not deviate from the selected questions while unstructured interviews use an accommodating guideline of questions. A semi-structured approach, selected as the best approach for this study, allowed the interviewer the freedom to ask supplementary questions and to explore additional relevant information discussed by participants. An interview protocol was prepared in advance, however communication remained flexible between the researcher and the participants as the co-researchers (Kvale, 1996). Probing questions were used to elicit more detailed information when needed. According to Rubin and Rubin (1995), “Probes signal the interviewees that you want longer and more detailed answers” (p. 148).

The strength of phenomenological interviewing “is that it permits an explicit focus on the researcher’s personal experience combined with those of the interviewees” (Marshall & Rossman, 1990, p. 113). In contrast, this type of interviewing is labor-intensive. Thinking, pondering, and reflecting upon time spent with interviewees is required for in-depth analysis. I utilized a semi-structured interview protocol with a list of questions for participants (See Appendix H). Interviewing was the primary means of data collection for this study. The participants of this present study are considered to be co-researchers, co-collaborators, meaning-makers, and vessels of self-knowledge. Both participant and researcher interact to learn from each other and develop a story of the research experience.

Active listening, observing both verbal and nonverbal body language, and utilizing open-ended questions are counselor skills that also qualify as skills for the qualitative interviewer. Qualitative researchers validate the importance of active listening, open-ended questions, and the use of empathy (Kvale, 1996; Rubin & Rubin, 2005).

Sampling Procedures

Using the rationale that it is important to select participants who could articulate answers to the research questions concerning counseling and psychotherapeutic change experiences, purposeful sampling was used (Maxwell, 1996; Patton, 2002). Through the use of criterion sampling, a form of purposeful sampling, the participants were intentionally chosen based on their experiences with the phenomenon being explored (Patton, 2002). Participants were females born, raised, and currently reside in rural Appalachia Ohio who were able to articulate therapeutic changes. The essential criterion for selecting participants in a phenomenological study was that the co-researchers must have experienced the phenomenon, which is the understanding of psychotherapeutic change in this study.

The selection of participants was based on the following criteria:

1. Be females from Appalachia Ohio and reside in rural Appalachia Ohio.
2. Be over the age of 18 years old.
3. Have voluntarily attended and completed 10 or more individual sessions and mutual termination with therapist or be currently attending counseling.
4. Attending or attended counseling at a location in rural Appalachia Ohio.
5. Report psychotherapeutic change during the counseling experience.

6. Be willing to fill out a demographic questionnaire and a counseling questionnaire.
7. Be able to participate in one 90 - 120 minute audiotaped semi-structured interview.
8. Be willing to attend a second meeting of 30 – 60 minutes to clarify accuracy of transcripts.

Participants were given the opportunity to write a reflection paper about their change experiences and asked to email or mail their papers to the researcher prior to the second meeting.

Entry and Recruitment of Participants

The original research design proposed recruitment of a range of 5 - 10 women from five rural counties in Appalachia Ohio as the sample size; however I ended up with five. Although an extensive recruitment effort was initiated: directors, clinical directors, and therapists at community mental health centers, private practices, women's residential recovery centers, university counseling centers, domestic violence shelters, vocational rehabilitation agencies, and faith-based counseling offices did not respond and those that initially responded later declined to participate. Directors of social service agencies, health departments, and women's centers did not respond. No potential study participants responded. A form was sent to the Institutional Review Board for permission to alter recruitment efforts. Therefore, five additional counties in rural Appalachia Ohio were selected and the same extensive recruitment process was repeated. Recruitment advertisement flyers were placed in local libraries, university libraries, women's centers, and emailed to various nonprofit agencies.

Because clients may have perceived change when therapists did not, flyers were posted at or emailed to health departments, transitional housing, homeless shelters, community service organizations, women centers, pregnancy centers, and medical clinics in the ten selected counties in order to recruit self-selected interviewees. Flyers were emailed and mailed to the local chapter of the consumer support organization identified as NAMI (National Alliance for the Mentally Ill) and the researcher followed-up with a telephone call. Five self-selected interviewees were drawn from the rural region of Appalachia Ohio. One self-selected participant from a university contacted the researcher from a flyer and met criteria for inclusion. One self-selected participant responded to a generated email and met criteria for inclusion. Three self-selected participants from community mental health centers in various rural counties responded to flyers found in the consumer waiting area and met criteria for inclusion.

According to Moustakas (1994) phenomenological research involves studying a small number of participants through extensive communication to develop patterns and relationships of meaning. In a phenomenological study, a set number for participants is nonexistent according to the literature, which gives examples ranging from one participant (Dukes, 1984) to 325 participants (Polkinghorne, 1989). In addition, Polkinghorne (1989) suggested that a phenomenological study include enough participants to provide varied experiences according to the phenomenon being explored and examined. The phenomenological researcher attempts to explore and identify the “lived experience” of the participants concerning a specific phenomenon, as described by the participant’s own words.

The process of saturation was utilized in this study and the gathering of information ceased with repetitive themes (Rubin & Rubin, 2005). As the intent of a qualitative study is to understand and describe, a small sample size is appropriate and consistent with the literature.

Ten counties of the 29 Ohio Appalachian counties were utilized for recruitment of participants in this present study: Scioto, Lawrence, Gallia, Pike, Adams, Highland, Vinton, Jackson, Athens, and Meigs. These ten counties are located in rural Appalachia Ohio, and each county has a community mental health center and a substance abuse recovery agency which was utilized for sampling in this study. In order to find community mental health agencies and private practice behavioral health centers in the ten Ohio Appalachian counties, I gathered information from the Ohio Department of Mental Health (website), Internet phonebooks, local phonebooks, county Alcohol, Drug, and Mental Health (ADAMH) board websites, and various other web searches. Counselors and psychotherapists in private practices were specified recruitment sources. I contacted directors, clinical directors, and therapists by way of telephone/email and requested face-to-face appointments to discuss my research study. Directors were mailed participant information packets. I asked them to mail a letter or give a letter to identified clients who completed ten or more therapy sessions and who experienced therapeutic change. Due to legalities, privileged communication, and the ethics of confidentiality, therapists are not allowed to provide researchers with client names or information. Therefore, therapists were asked to give the information to their former or current clients. Postage was to be paid by the researcher. The directors, clinical directors, and therapists

would not be informed on which clients participated in the current study in order to maintain confidentiality. This information was also given to the participants.

Appropriateness for the study was determined by the criteria and researcher by way of a brief telephone interview or email response when a potential participant made initial contact. Participants were given my cell phone number and email in order to maintain confidentiality, as I am the only person with access. At first contact, participants who met the stated criteria and parameters were asked to schedule one 90 – 120 minute face-to-face interview at their convenience. The dates, times, and meeting locations for the interviews were arranged during the initial contacts. With permission, reminder emails were sent to participants to verify interview meeting information.

Interviews

The interviews took place in reserved private rooms at local or university libraries. After initial introductions, I discussed the participant's role in the study. The consent form was read by participants and then reviewed. I asked for questions and clarification of the consent form. The participants signed the consent form and then filled out the demographic questionnaire and counseling form. Confidentiality of the study was revisited and any questions were answered. I discussed the audiotape procedures and informed participants that I would be writing notes during the interview. Although a semi-structured informal interviewing process was adhered to, the researcher remained flexible and allowed the conversation to flow and expand. I presented the following statement in the beginning of the interviews: "Please describe for me your experiences about change in therapy, starting from the beginning and taking me through your experiences until the very end."

The participants were invited to elaborate. While the interviews were unstructured, there were specific sub-questions that were asked of participants (Appendix H).

The interviews were audiotaped and varied in duration from 60 - 90 minutes or more. Concluding each interview, the researcher intentionally discussed the participant's thoughts and feelings to gauge any distress attributed to the interview process. At the end of the interview, participants were given the option of writing a reflection paper about their change experiences prior to the second follow-up meeting. I thanked each participant for their time and helpfulness.

After each interview, I found a quiet place to reflect and document thoughts and reactions in a journal. I wrote observations about non-verbal body language, facial expressions, eye contact, body posture, and comfort level. I listened to the audio-tapes without typing or writing.

Each interview audiotape was transcribed within the same week and checked for accuracy. I listened to the audiotapes simultaneously while reading the transcripts in order to immerse myself into participant's experiences and perception of meaning. Data analysis began immediately by typing field notes and using summary sheets.

Follow-up meetings were arranged 2-3 weeks after each initial interview. Participants received transcripts from their individual interview and feedback for accuracy and clarity was requested. Participants were given the opportunity to expand on details to provide more in-depth descriptions. New information that was relevant and non-repetitive was incorporated into the data analysis. Participants were given an Ohio University coffee mug and a book.

Location of the Study

This study was conducted at various locations based on the comfort level of participants. Privacy and confidentiality is essential for conducting interviews and for audiotaping sharpness. Three interviews and the three follow-up meetings were conducted in reserved rooms at university libraries. The remaining interviews and follow-up meetings were conducted at local libraries in the participant's county of residence.

Demographic & Counseling Questionnaires

The participants filled out structured questionnaires at the first face-to-face interviews (Appendix F & G). The factual information was verified and clarified at the interview as well. Each participant was given a number and the same number was recorded on the demographic and counseling forms in order to assure confidentiality.

Time Frame

The interviews spanned a 3-month period which allowed the researcher time to transcribe each interview immediately and reflect upon the data. Six months was allocated for data collection, analysis, and completion.

Protection of Human Rights

Participants read, discussed, and signed an Informed Consent Form that explained the study's purpose, confidentiality, anonymity, risks, benefits, and other pertinent information (Appendix B). Protection of the participants was accomplished by: (a) names not appear on the demographic or counseling questionnaire, audiotapes, computer files, transcripts, field notes, summary sheets, or written reflection paper; (b) participants were identified with a letter and number: P1, P2 respectively, to identify the information obtained in the study and later the participants were given alias; (c) an electronic file of

each participant's transcription was created, labeled with an assigned number, backed up onto a flash drive with password security; (d) proper data storage was maintained throughout the research study by storing items in a locked filing cabinet solely accessible to the researcher.

I transcribed all interviews verbatim, including pauses, but excluding paralinguistic such as um, uh, well, and like. Microsoft Word was used to record, label, and store information elicited from the participants. Participants were asked to refrain from using names or identifying information in the interviews, however, transcripts were checked and any surnames were deleted. Names of counselors and agencies were not used in transcripts or in the completed dissertation. Therapists and institutions did not have knowledge of client participation. When consulting with professors and faculty about dissertation procedures and data analysis, names and identifying information of participants were not disclosed.

The benefit of helping counselors and future clients by sharing therapeutic change experiences was conveyed to the five women. Participation in this study was voluntary and informants could withdraw at any stage without consequences from the researcher.

Ethics

During the research process, it is essential to maintain ethical standards (Creswell, 1994; Miles & Huberman, 1994). Prior to submitting the IRB proposal, the researcher was required to successfully complete online training modules concerning the rights and protection of human subjects.

Although my role in this study is as the researcher, as a licensed professional clinical counselor with supervisor status in Ohio, I adhere to Ohio Social Worker,

Counselor, and Marriage and Family Therapist board's ethical considerations and policies and the American Counseling Association Code of Ethics.

Potential risks to participants may be emotional triggering from memories of past trauma happenings and events. I discussed risks with participants prior to data collection. Additionally, my educational and professional work experiences included crisis intervention training. Appropriate mental health clinic referrals were made available for any needed crisis intervention for the local community mental health providers in each of the ten counties if necessary.

Potential benefits for participants may be the sharing of personal stories which may evoke deeper self-reflection and increased understanding of change. As co-constructors, participants received positive feedback from the researcher about the importance of their involvement. Another benefit may be the contribution of knowledge to the counseling profession. Participants were not financially compensated for being involved in this study; however they were given an Ohio University mug and a copy of the book, *Who Moved My Cheese?* by Spencer Johnson. The core focus of this book is about constant change and how to adapt and adjust. This is one of my favorite books on the process of making changes and I wanted to share it with the participants.

Gay, Mills, and Airasian (2006) provided ethical guidelines for qualitative researchers:

- 1). Informed consent needs to be discussed thoroughly with participants.
- 2). Researchers need to communicate their professional information as contributing members of a larger body.
- 3). Qualitative researchers need to conduct research to minimize any potential harm.

- 4). Researcher actions need to conform to ethical standards.
- 5). Qualitative researchers need to focus on the relationship between researcher and participants.

Participants in this present study were treated with respect in reference to ethical guidelines and procedures.

Researcher as Instrument

The researcher is the instrument and data collection is an interactive and shared process (Patton, 2002). The role of researcher is fundamental in qualitative research (Lincoln & Guba, 1985) whereas he/she is able to rely upon “intuition, imagination and universal structures to obtain a picture” (Creswell, 1998, p. 52).

As a practitioner, I called upon many of the same helper skills used in therapy sessions (i.e., rapport building, unconditional positive regard, empathy, cultural sensitivity, respect, active listening, observing body language, voice tone, emotional affect, open-ended questions, and prompts). Participants were offered a short break during the first interview session as the time period was a range of 90 to 120 minutes.

The phenomenological interviewer writes a full description of her/his own experience prior to interviewing participants for the purpose of self-examination and to explore assumptions. Bracketing these experiences from those of the interviewees beforehand is referred to as the epoche phase. Examining preconceptions is part of the “ongoing process rather than a single fixed event” (Patton, 1990, p.408). According to Maxwell (1996), researcher bias and participant reaction to the researcher can be threats to a qualitative study. Therefore, in the initial stages, the bracketing process was used to examine researcher assumptions and presuppositions. My biases were identified and

written in a personal researcher journal: a written record of reflections, perceptions, and insights. A continual and consistent practice of personal journaling was used throughout the study (Marshall & Rossman, 1999). Reflexivity and self-reflection was considered throughout this study and according to Patton (2002) reflexivity is “a way of emphasizing the importance of self-awareness, political/cultural consciousness, and ownership of one’s perspective.” (p. 64).

Revealing pertinent information about the researcher’s personal and professional experiences acts as a bias buffer for any effects on “the data collection, analysis, or interpretation” (Patton, 2002, p. 566) and employs “empathic neutrality” (p. 50) as a way to step into a participant’s shoes to understand her/his lived experience without compromising data accuracy. Based upon this reasoning, qualitative researchers often present their own background as it generates interest in the studied phenomenon (Locke, Spirduso, & Silverman, 2000). Life stories function as the basis for inferences and interpretations by the researcher who is also an active participant.

Allowing the reader to reflect upon my personal and professional journey and meaning-making experiences will add to the trustworthiness of the current study. Readers may examine my assumptions as they investigate the data analysis, results, and conclusions.

The reader is also involved in the process of the study and can employ her/his critical thinking skills to analyze, synthesize, summarize, and reflect upon the aspects of my qualitative research study.

The healing process was evident in the words, upbeat emotions, and stories of all five participants in this study. During the interviews, they did not relive nor revisit the

emotional pain that first catapulted them to counseling. During the process of counseling, changes had occurred. Therefore it was easier to keep the researcher hat on and not defer to my counselor hat. However, researcher worries abounded. What if the digital voice recorder was not recording? What if I am asking the wrong questions? What if the participant does not return for the second meeting? Albeit, I was able to calm my qualms and focus on the participant and her story. My learning curve increased with every sequential interview and I became more comfortable with the interviewing mechanics. Participant five provided the most information because I had gained experience in eliciting both quality and quantity. Transcribing the interviews was a tedious and frustrating process of rewinding, listening, and typing. In hindsight, I would pay to have the interviews transcribed by a professional. Throughout the research process, I continued to return to the data so as to allow the participant voices to speak.

Researcher as Self

Strauss and Corbin (1998) recommended three techniques to institute sensitivity within a qualitative framework: (1) the use of personal experience, (2) the use of professional experience, and (3) the use of literature. Being a native Appalachian woman provides insight into the participants of my study. To a degree, my personal experiences as a former client will serve as a bridge to the participants' experiences. Given that, it is the meanings associated with therapeutic experiences which are unique to each individual, yet similarities are also present. Additionally, my professional experiences as a counselor added insight into the *modus operandi*. Reading books, journals, and Internet resources provided knowledge and insight in my topic. The findings of my study are contrasted to the findings in the literature.

One of the participants in this study alluded to a modern version of the traditional Appalachian woman. There is no doubt that I represent an evolved and contemporary version of the pioneer women of rural Appalachia as well. Every subsequent generation is accompanied by more choices and options. I have chosen the route of equality and education, career and independence, relocation outside of the family circumference and yet, I have returned to rural Appalachia to reestablish my roots. I am an Appalachian female living and working in rural Appalachia. I am an Appalachian counselor providing mental health services for Appalachian clients. I am a product of Appalachian heredity and the rural environment. Both nature and nurture planted the seed, cultivated the soil, and provided the ingredients to grow a rural Appalachian woman. Clark (2009) captured my same experiences with Appalachia: Many of us leave and return to Appalachia to live because our roots grow deep, and because growing up in these mountains means no matter where we go in the world, we are anchored spiritually to that place of voice and story and song (website, p. 2).

Assumptions

Assumptions materialized based on my years of experience as a therapist, my own experiences as a former client in treatment, being a native Appalachian and residing in southern Ohio, knowledge gained as a doctoral student in counselor education, and from examining the literature. The following are my assumptions:

1. Therapeutic change can happen before, during, and after counseling.
2. Clients experience change as self-changers and self-healers.
3. A choice to change is more powerful than general change and self-referred clients make a conscious choice to seek a therapeutic experience to embark on change.

4. Most change happens outside of the counseling office.
5. The therapeutic alliance is the vehicle for change and is responsible for a portion of client change.
6. Female participants will discuss change in regards to an increase or decrease in moods, depressive symptoms, and emotional catharsis.
7. Female participants will discuss change in their relationships. A portion of clients in this study will discuss domestic violence, childhood sexual abuse, and substance abuse.
8. Female participants will allude to common factors in their understanding of change.
9. Emotional pain, in varying degrees, prompts a client to attend therapy.
10. When therapists challenge cognitions and belief systems, learning takes place in the client and new ways of coping and responding are developed by the client.
11. Some clients will experience and describe change as spiritual transformation.

My assumptions will be discussed again after completion of data collection and analysis.

I am an Ohio licensed professional clinical counselor with supervisory status. Previously, I held a professional counselor license in both Kentucky and West Virginia and I have provided counseling services in all three states. I completed my Master's degree in Community Counseling at Marshall University in Huntington, WV. Formerly, I held a credential in Ohio as a Licensed Independent Chemical Dependency Counselor with supervisory status and I worked as a clinical director. I have provided counseling at rural locations in Appalachia for a private for-profit community behavioral health practice, a nonprofit community counseling center, and in a private practice. My clients

are both females and males. Over the years, I have functioned as group leader/therapist for many therapy groups consisting of women and some co-ed groups in both rural and nonrural areas. I have worked extensively in the field of domestic violence. In the beginning of my counseling career, I held a credential as a Licensed Social Worker in Ohio. Previously, I held the credential of National Certified Counselor with the National Board for Certified Counselors.

During my professional years, I have counseled many clients from Appalachia and listened to their stories. Therapists have the opportunity to view different perspectives of individuals. Clients need to speak and compose their narratives in the safe and trusting environment of a therapy office; then they move on with their lives. Helpers are left behind with stories, secrets, confessions, and memories of temporary relationships.

As a clinician of over twenty years, my counseling skills were utilized during the research interviews. My purpose for dialogue with the research participants was to understand and not to diagnose or to provide intervention or treatment. I was not in the counseling role.

Use of Literature

The phenomenological approach calls for the researcher to discuss how she/he gathered information and searched for facts, knowledge, and relevant literature (Moustakas, 1994). Sharing this information helps the reader to understand the gradual process of collecting and examining data.

In preparing for qualitative research, I completed graduate courses at Ohio University: Qualitative Research, Ethnographic Methods, Qualitative Interviewing

Methods, Qualitative Research and Design, and a research statistics course. I also read books on qualitative inquiry and professional journals, including *Phenomenology & Practice*, *Journal of Phenomenological Psychology*, *Phenomenological Inquiry*, *Qualitative Research in Psychology*, and *Qualitative Social Work*. Information was gleaned from the following websites: phenomenologycenter.org and phenomenologyonline.com. I completed a doctoral writing course in the counselor education program and I read other qualitative dissertations. I also shared conversations with other doctoral students whose research was qualitative in nature.

As an adjunct instructor for both undergraduates and graduates in a counseling program at a university in Kentucky, I traveled to various university branches in Appalachia. Many students discussed the poverty rates, the coal industry, and a deficit of mental health professionals in Appalachia. The majority of students were females, born and raised in rural regions. I gained a deeper understanding of the rural Appalachian culture and viewpoints from students who would become future counselors.

Prior to this study, I reviewed the following journals to learn more about Appalachia from other professionals and to increase my own understanding: *Journal of the Appalachian Studies Association*, *Appalachian Journal*, *Journal of Rural Community Psychology*, *Rural Sociology*, *Appalachia*, *Rural Community Mental Health*, *Journal of Cultural Diversity*, and the books *Appalachian Cultural Competency: A Guide for Medical, Mental Health, and Social Service Professionals*, edited by Susan Keefe and *Rural Women's Health: Mental, Behavioral, and Physical Issues* edited by Thorndyke. Many of contributing authors presented qualitative data and described stories of Appalachian challenges and barriers. I read *Appalachia's Children: the Challenge of*

Mental Health, by David H. Loeff, in which experiences of helping professionals in psychiatric clinics in eastern Kentucky were recounted. I also searched for dissertations on Appalachia and found several qualitative studies which addressed poverty, history, and culture. The Ohio University library has a website with resources about Appalachia and the Appalachian Studies Association is located at Marshall University in Huntington, West Virginia.

Due to sparse professional literature on the population of Appalachian women and mental health counseling, I reviewed the following Internet resources: Appalachian University Local Research Projects, Office of Rural Mental Health Research (ORMHR), and The National Association for Rural Mental Health (NARMH), American Psychological Association-Rural Health, and South Carolina Rural Health Research Center. In an effort to better understand the views from Appalachian people themselves, I turned to first-hand accounts. John O'Brien (2001), a native Appalachian, discussed Appalachian fatalism in his book, *At Home in the Heart of Appalachia*. Appalachian fatalism is the cultural belief that the people are inferior to others and efforts to overcome poverty and life's obstacles are useless. O'Brien discussed how his grandfather tried to commit suicide three separate times with poison, a knife, and a gun. O'Brien validated the cultural belief in fatalism. I also perused a reproduction of Emma Bell Miles book, *The Spirit of the Mountains* (1905, 2010) and a book about her life by Caston (1985). Emma was an artist, writer, poet, and an Appalachian feminist. Brooks (1999) commented on Miles works of fiction which portrays the hardships of Appalachian women and their struggles between mountain culture, motherhood, and the search for self-identity.

To learn more about Appalachia Ohio, I perused the following Internet websites:

Ohio Department of Mental Health - Appalachian Behavioral Healthcare, Integrated Services of Appalachian Ohio, Ohio Valley Appalachia Regional Geriatric Education Center, Ohio Department of Development: Governor's Office of Appalachia, and Ohio Appalachian Center for Higher Education. The following universities offer graduate degrees in Appalachian Studies: Appalachian State University, Marshall University, East Tennessee State University, and Radford University.

Using OhioLINK, I typed in the words "Appalachian women" and dissertations and theses were found from universities in Ohio. I perused these writings for the context of Appalachia and rural Appalachia Ohio. The following dissertations were found and examined: Murphy (2005) studied rural Appalachian parents' expectancies and perceptions of barriers to mental health services for children; Dye (2008) investigated stereotypes and stigmas of rural Appalachian Ohio women and how these women develop identities; Reiter (2008) studied self-identity among females in rural Appalachia Ohio in relation to cervical cancer screening and risky sexual behaviors; and Deardorff (2009) investigated rural Appalachian Ohio health care in relation to a mobile clinic. The following theses were found and examined: Fagen (2005) interviewed 43 females from rural Appalachia Ohio who are survivors of domestic violence and findings showed a lack of community support and obstacles that perpetuate the cycle of violence; and Powell (2005) investigated stereotypes of single mothers in poverty in rural Appalachia.

Due to my previous experiences, frame of reference, and assumptions, I recognize researcher bias as an issue that can negatively impact the soundness of this present study. Maxwell (2005) states that a bias needs to be acknowledged and (Moustakas 1994)

require the researcher to suspend prior knowledge to investigate the phenomenon at a deeper level and to bracket out personal experiences. I paid attention to this bias.

Data Analysis

It is the responsibility of the researcher to select appropriate strategies for data collection and the means to manage, record, and analyze data (Patton, 2002). From the beginning of data collection, the researcher consistently analyzes the data (Rubin & Rubin, 2005). According to Miles and Huberman (1994), phenomenologists are cautious about condensing and I paid close attention to the collapsing of sub-themes. The researcher reads the transcripts over and over until meanings spark and promote understanding. In reference to data analysis of phenomenology, Wertz (2005) describes the concept of attitude whereas the researcher puts on “an attitude of wonder that is highly empathetic” (p. 172) and steps into the written (transcribed) stories of participants. The researcher reflects on meanings. In a sense, this process is similar to using empathic responsiveness by stepping into a client’s shoes and seeing the world as she/he sees it. Empathy is an important characteristic and skill for a counselor (Egan, 2007).

Data analysis involved the identification of patterns and themes from reading typed transcripts and becoming immersed in the collected information (i.e. field notes, summary sheets, memos, audit trail, participant feedback forms, and demographic questionnaire). The general sequence of data analysis included: data organization, identifying categories, theme development and interpretation, and report writing. However, a phenomenological research model employs unique ways of discovering the participants’ meaning and understanding of the phenomenon. Moustakas (1994) rejects the idea of generalizations and explanations and instead focuses on core meanings.

According to Creswell (2007) the researcher of phenomenology describes the commonalities of participants as they experienced and reported the phenomenon. In addition, Strauss and Corbin (1998) affirm, "Analysis is the interplay between researchers and data" and "it is the balance between science and creativity that we strive for in doing research" (p.13).

According to Polkinghorne (1989), the aim of phenomenological research "is to produce clear and accurate descriptions of a particular aspect of human experience" (p. 44). Data analysis is a process that requires time, diligence, reflection, reasoning, and critical thinking skills. Rereading transcripts and listening to the audio-tapes multiple times allows learning to slowly produce new learning by the formulation of new thoughts, ideas, perceptions, opinions, beliefs, insights, and new understandings.

Due to the amount of data, each phase of analysis involved data reduction (Marshall & Rossman, 2006) as the researcher organizes the meaning units into themes that allows the emergence of the common participant themes (Moustakas, 1994). Descriptive, topic, and analytic coding occurred (Richards & Morse, 2007). Descriptive coding organized the demographic information and the context of the setting. Topic coding, a form of analytic coding, created categories with consideration of other coded data. Analytic coding occurred next and was used to develop categories thematically. Some codes and the naming of categories emerged directly from the words of the five participants while other categories and themes were assigned by the researcher based on integration of data. A combination of Colaizzi's (1978, pp. 59-61) phenomenological method, Van Manen's (1984) phenomenological approach, and Moustakas' (1994) phenomenological research model was utilized for data analysis for this study.

Colaizzi's Approach

In the beginning of the data analysis process I utilized Colaizzi's approach in order to become familiar with phenomenological procedures. Streubert and Carpenter (2003) simplified Colaizzi's phenomenological approach and listed the following steps to the phenomenological research process.

1. Describe the phenomenon of interest.
2. Collect participants' description of phenomenon.
3. Read all participants' description of phenomenon.
4. Return to the original transcripts and extract significant statements which are phrases about the investigated phenomenon.
5. Explore and write the meaning of each significant statement.
6. Organize the meanings into clusters. Look for recurring themes. Themes are found in words and phrases called structural units of meaning.
7. Write an exhaustive description.
8. Return to the participants-for validation of the description.
9. Incorporate any new data into the exhaustive description. (Streubert & Carpenter, 2003, pp. 36-56).

I made use of Colaizzi's phenomenological approach in order to organize information, "meet" the data, and become comfortable in the analysis process. Next, I reflected on how to probe deeper into the data by applying the steps of the following two phenomenologists in order to garner varying perspectives on differing data analysis and to add in-depth richness to this current study.

Van Manen's Approach

The following 9 steps (Van Manen, 1984) were utilized by the researcher for phenomenological data analysis and are further explained:

1. Use personal experience as a starting point. Van Manen asserts that the starting place of examination begins with the researcher's own experience. I experienced counseling twice as a client, once before I became a therapist and once after. My perceptions of these experiences are recorded in this study. While these personal experiences were bracketed during the research process, they remain salient in my consciousness. When I interviewed clients (participants) in this study I came from the perspective of one who had been counseled. Although my own psychotherapeutic changes experienced during counseling as a client are not included in data analysis or in the results, I am the research instrument in this qualitative study. Therefore, my cognitive experiences were brought to the interview/transcription process for analysis. I am a female who was born and raised in rural Ohio Appalachia. I relocated and lived outside of rural Appalachia for 15 years. A few years ago I relocated back to my rural county of origin.
2. Trace etymological sources (explore the origins of words and phrases and the source). The word change has an interesting etymology and has evolved with different meanings depending on context. The word change goes back to the 13th century Latin where it meant cambīre or barter and a later form of the verb was cambiāre, which appeared outside currency-exchange shops. In English cambium was used for a "layer of plant tissue" in the 17th century and was developed from the idea that it "changes" into new layers. In relation to Old French "changier"

was a source of English change (Online Etymology Dictionary). The phrase “change of heart” is defined as a conversion to a different frame of mind (Oxford English Dictionary, 2004). The word change is both a noun and a verb and can be altered to the adjectives changeable and changeless. The Appalachian Mountains were named by Spanish explorers in the 16th Century. The word Appalachian was taken from an Indian village in northern Florida called Apalachee (Raitz & Ulack, 1984). According to Abramson and Haskell (2006) the word Appalachia is pronounced Ap-pa-LATCH-a in the mountain regions, but Ap-pa-LAY-cha in other regions.

3. Search for idiomatic phrases (slang, cultural phases, hidden meaning in statements). I explored the transcripts for any words or phrases used by people of Appalachian areas. For example, one of this study’s participants reported she grew up in a hollow. She pronounced it “holler.” She defined a hollow as a road “with one way in and one way out.” Hollow neighbors know each other and many are relatives.
4. Obtain participants’ experiential descriptions. Using the interview protocol (Appendix H) I reviewed each question and the participant’s answers and wrote their descriptions verbatim. Single words, phrases, and sentences were examined. The central research question was revisited.
5. Look for descriptions in the phenomenological literature and consult literature. I returned to the literature review of this present study to search for phenomenological descriptions. I perused OhioLINK Internet Library’s Electronic Dissertations and Thesis (EDT) Index and Worldwide EDT Index and typed in

Van Manen's name in the (EDT) section and read other dissertations, both nationally and internationally, that utilized his phenomenological approach to data analysis.

6. Use phenomenological reflection to conduct the thematic analysis by uncovering themes in the descriptions of participants. Themes were compared and contrasted in order to explore the research questions. In addition to common themes, attention was given to unique responses as a way to provide meaning to the individual's experience. Both common themes and unique responses were analyzed and discussed.
7. Isolate significant thematic statements. The isolation of thematic statements is accomplished by examining the transcribed data line by line (Van Manen, 1984). I conducted a line-by-line approach, in which every sentence was scrutinized for its relevance to the phenomenon (Van Manen, 1977) which in this study is the psychotherapeutic change experiences of rural Appalachian women. I revisited my summary sheets and field notes. Using my central research question and sub-questions, I extracted reoccurring patterns and themes from the transcripts.
8. Determine and select essential themes. Themes generated from each transcript were selected. The main themes were selected from the commonalities of all transcripts. Secondary themes were noted.
9. Write, edit, and rewrite paragraphs by combining themes with participants' words and experiences. Rewriting is a final process that allows the researcher to rethink the studied phenomenon. I allowed my cognitions to become immersed and saturated in the data and the participant stories.

I selected Van Manen's approach because it allocates creativity by allowing the researcher the opportunity of phenomenological reflection. The following outline was adapted and utilized in data gathering and the data analysis process.

Van Manen's (1984) Phenomenology Methodological Outline

A. Turn to the Nature of Lived Experience

1. orient the phenomenon
2. formulate phenomenal question
3. explicate assumptions & preunderstandings

B. Existential Investigation

4. explore the phenomenon
 - 4.1 use personal experience as starting point
 - 4.2 trace etymological source
 - 4.3 search idiomatic phrases
 - 4.4 obtain experiential descriptions from participants
 - 4.5 locate experiential descriptions in the literature
 - 4.6 consult phenomenological literature

C. Phenomenological Reflection

5. Conduct thematic analysis
 - 5.1 uncover thematic words & phases in descriptions
 - 5.2 isolate thematic statements
 - 5.3 compose linguistic transformations
 - 5.4 determine essential themes

D. Phenomenological Writing

6. attend to the speaking of language
7. use varying examples
8. write
9. rewrite

According to Van Manen (1997) a theme must “contain qualities that make a phenomenon what it is and without which could not be what it is” (p. 107). Participant responses gathered in the interviews were examined for commonalities pointing to themes for that particular individual. As the next transcribed interview was read, the responses were analyzed for comparative analysis. This process continued until the 5 interviews were analyzed and a list of themes emerged.

Moustakas’ Approach

I selected Moustakas’ approach because it allowed the context of the setting, rural Appalachian, to be integrated into the psychotherapeutic change experience and the understanding from the female Appalachian’s perception and viewpoint. It better enabled the researcher to describe the cultural aspects of the counseling experience.

The following steps are Moustakas’ (1994, pp.180-182, 190-192) research process that I utilized in data analysis:

1. Epoche-acknowledging and setting aside bias and prejudgment. The researcher brackets out her/his own experiences. I wrote in a reflection journal during the study and noted preconceived notions about my own counseling experiences as a client and turned to this journal during analysis. I also noted my experiences as a therapist as I have counseled many clients. Prior knowledge of the professional literature influenced the study design and the research questions. However, this knowledge was questioned when interpreting data to follow the technique of Epoche (Moustakas, 1994).
2. Phenomenological reduction-describing what you see internally and externally as the relationship between the phenomenon and self. The unique qualities of

each participant's experience are referred to as invariant constituents. I created three sheets for the process of reduction (Appendix K). I listened to the digital voice recorder of each interview simultaneously while reading the transcripts. The following questions were considered as I actively listened to the tapes. What words and phrases do participants use to describe change? What words match the key words used in the research questions? What words do participants use to talk about self-change? Next, I read each transcript several times. I also listened to the audiotape with my eyes closed. The summary sheet, consisting of my typed field notes, was read several times. The field notes contained my observations of participants during interviews. The following questions were considered. What was the participant's nonverbal body language (i.e., facial expressions, posture, and eye contact) as the phenomenon was discussed? Was voice tone, loud or soft? Did participants appear to be relaxed or uncomfortable? I read the transcript while reflecting on core meanings or meaning units. Next, the meaning units or invariant constituents were clustered into common categories or groups and themes were derived from the groups. Repetitive statements were removed. I applied this procedure to all transcripts. Utilizing intuition, I focused on the individual textual themes of the participants. The individual textural description explores the theme generated by the data of each participant.

3. Imaginative variation-this process consists of reflecting, tapping into intuition, and deriving structural themes. The researcher explores the phenomena from different viewpoints and opposite meanings. The individual structural

description integrates each individual description into a group by considering the context of how the phenomenon was experienced. I described the commonalities of participant experiences and the collective qualities of the phenomenon of psychotherapeutic change. In this study the context represents experiencing change in rural Appalachia. The researcher contemplates on the setting and context in which the phenomenon of study was experienced.

4. The essence or synthesis of composite textural and composite structural descriptions is the organizing and analyzing the data to develop descriptions, and make meaning of the data by ways of clustered themes by viewing the whole of participants' experiences. I integrated the composite textural and composite structural descriptions which are referred to as the essence and the synthesizing of the meanings of participants' experiences as a group (Moustakas, 1994). How did the group as a whole experience psychotherapeutic change? Were their cultural barriers and other factors familiar or diverse?

The following outline has been adapted from Moustakas' (1994) Phenomenology Methodological Outline and was utilized in the last phase of the data analysis process by writing a narrative format to present the textual and structural descriptions and essence for this present study.

A. Individual Textual Descriptions

1. Explores what the adult female participants experienced.
2. The participants experienced psychotherapeutic change in counseling.

B. Individual Structural Descriptions (Imaginative Variation)

3. Describe the context or setting of how the phenomenon was experienced.
4. Psychotherapeutic change experienced in the context of a rural Appalachian environment with cultural factors of gender, identity, access to office.

C. Essence - Integration of Individual Textual and Individual Structural Meanings

5. Meanings of the experience derived from invariant constituents & themes.
6. Unique experiences of Appalachia females and psychotherapeutic change.
7. Wrote a paragraph with descriptions and interpretations of researcher.

D. Composite Textual Descriptions

8. Invariant constituents of all participants portray the group experiences as a whole.
9. What (psychotherapeutic change commonalities) did the adult females in this study experience?
10. Composite textual themes are revealed from the analysis of the study.

E. Composite Structural Descriptions

11. How did the females in rural Appalachia understand their psychotherapeutic change? Integrate the context of the rural Appalachian Ohio setting and culture.
12. Composite structural themes are revealed from the analysis of the study.

F. Essence - Integration of Composite Textual and Composite Structural

13. Integrate for a synthesis of meanings and essences of the experience.
14. Describe the perception, experience, and understanding of psychotherapeutic change in counseling in the context of being a rural Appalachian female attending therapy in rural Appalachia Ohio. Elaborate when needed.

See *Figure 1*. Data analysis process on the following page as it depicts the phases and steps utilized for this present study.

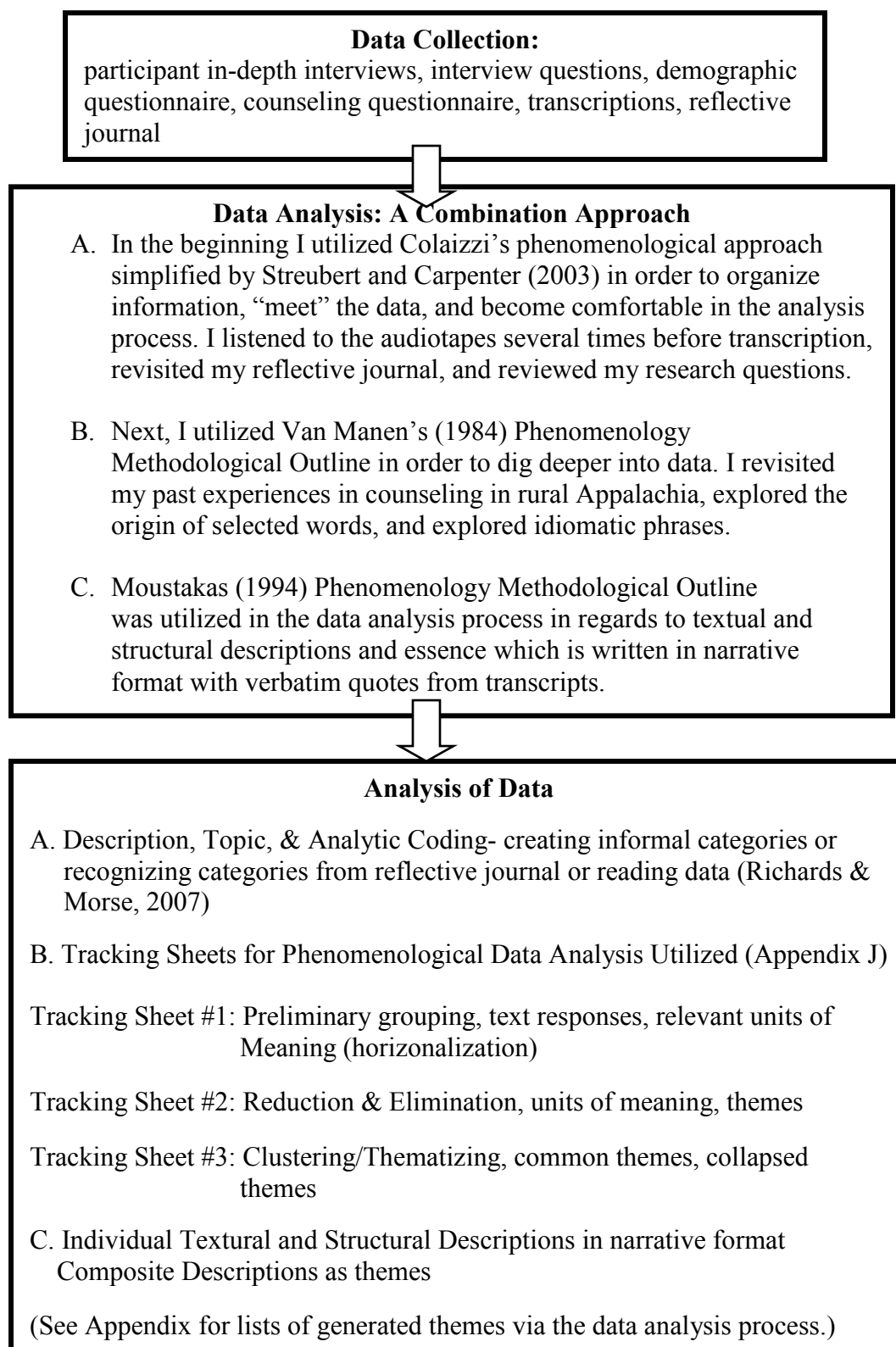


Figure 1. Data analysis process

Preliminary Pilot Interview

A pilot interview is a small-scale preparation to practice skills for the larger research project and can be useful in the initial steps of qualitative research (Patton, 2002). I conducted an initial pilot interview and a second follow-up meeting with one female participant. What else did I learn from this preliminary pilot interview? I learned to schedule private rooms in libraries in advance. In upcoming interviews, I asked the participants how much time was needed to be allotted in order to not infringe on their schedules. I was able to practice using the digital voice recorder and this eased my worry about accidentally deleting the recorded interview. I made a digital folder for each interview. I narrowed down the questions on the interview protocol concerning therapeutic change and I tweaked my questions on Appalachian cultural influences. The pilot participant suggested that I use a laptop to type notes during the interviews instead of pen and paper in order to save time however, I thought the laptop may be considered a personal barrier for the participants. I took notes instead. I learned to organize my data into folders. In future interviews, I provided bottled water for participants and for myself. Using a software program I copied the audio data from my IC digital recorder to my computer in order to abet the transcription process. Transcribing the interview was tedious and time-consuming work, therefore I learned to schedule large blocks of time for this procedure. I saved data on my computer hard drive and on two flash drives in case I lost one. I became familiar with the process of data analysis as I followed the phenomenological approaches outlined in this chapter. Units of meanings were derived from the participant's transcription and written paper and data was reduced. Multiple themes and subthemes emerged. I continued to reduce and collapse the themes. I

reviewed the themes. The preliminary preparation interview provided an opportunity to learn, reflect, and evaluate my research skills.

The following statement was presented at the beginning of each interview:

“Please describe for me your experiences about change in therapy, starting from the beginning and taking me through until the very end.” Information about access to mental health services for women in rural Appalachia, the challenges, and the barriers were solicited. Socioeconomic factors that affect mental health issues were discussed (e.g., poverty, housing, transportation, health insurance, lack of mental health services). Moreover, the participants’ point of entry into counseling was discussed. The semi-structured interview protocol included six questions pertaining to the cultural context of attending counseling in rural Appalachia Ohio.

During data analysis, the meaning units or invariant constituents (the distinctive qualities of each participant’s experience that stand out) were identified for each participant. Lists of the clustering or grouping of initial textural and structural themes were developed for the group as a whole as theme reduction, elimination, and combination was repeated. Each list was reviewed multiple times during this process. Initial lists and final lists are provided for the reader with identified themes, meaning units, and support quotes. Next, the initial and final lists of integrated themes are provided. The themes were then presented in narrative format utilizing the composite group textural and group structural descriptions or essence (See Appendix for initial and final lists of generated and reduced themes.).

Demographic Information of Participants

The five women participating in this inquiry were Caucasian women who ranged in age from their early twenties to sixty years of age. Specifically, they were 22, 34, 43, 45, and 60 years of age.

The five women were born and raised in rural Appalachia Ohio and resided in rural counties and considered themselves to be of Appalachian heritage. Both biological parents of each of the five women were born and raised in rural Appalachia. However one participant's father was born and raised in rural Appalachia Kentucky and his biological parents migrated to rural Appalachia Ohio where he was raised. The maternal and paternal grandparents of the five women reside or lived in rural Appalachia Ohio; however, several grandparents are deceased. Consequently, they were a generational part of the Appalachian culture milieu.

In terms of sexual identity four participants reported heterosexual identities while one participant identified as lesbian. Their marital status differed as well. Two participants were single and never married. Two participants were divorced once and not remarried; and one participant was married, divorced, remarried then recently widowed.

Parenthood varied amongst the participants. Three of the five women had biological children; one had a child under the age of 18. One participant had five adult children and another had one child. Two participants were childless.

Educational attainment varied as well. One participant received a high school diploma and attended but dropped out of beautician training. One participant was working toward a bachelor's of science degree in nursing. Two participants received master's degrees. One possessed a master's degree in teaching and another participant

possessed a master's degree in the sciences. The youngest participant was working toward a master's degree in Student Personnel. One participant considered whether to return to college for a doctoral degree in the field of education. The women with degrees graduated from universities in rural areas. Four of the five women had completed or were completing college degrees. Three of four college-educated women had completed or were in the process of completing a master's degree.

Socioeconomic status, employment, and financial resources varied. One participant was employed full-time as a teacher in the public school system, received child support, and lived alone in an apartment. One female was employed part-time but was looking for full-time employment. One woman received Social Security Income (SSI) due to a chronic mental disorder and resided with her mother, aunt, and sister. The youngest participant received a college stipend, worked part-time, and shared an apartment with a roommate. One resided with her mother and used financial aid (i.e., Pell grants and student loans) as a supplement while she worked toward her nursing degree. One reported adequate health insurance, one received health services from a campus clinic, one received a Medicaid card, and two participants did not have health insurance. None of the women currently own homes. However, two of the participants owned their own homes in the past when they were married. Both women moved into apartments when they divorced their husbands.

The women varied in religious/spiritual affiliations with two participants identifying as Christians who regularly attended church services, one identified Wicca, one identified agnostic, and one woman follows Eastern religion practices, mainly Buddhism.

The women also filled out a pre-interview questionnaire pertaining to counseling information. Health insurance varied as well. One had health insurance, attended a private practice for counseling, and was referred by her nurse practitioner. One attended a university counseling center which provided services through student health insurance. Three participants attended local community mental health services. Two women were referred by their nurse practitioner. Of the women who attended counseling at community mental health services, one used Medicaid while two participants utilized a sliding scale for service fees due to lack of health insurance. Four of the five women selected counseling services based on their payer sources.

The distance from their homes to the counseling locations ranged from 1/2 mile to 25 miles. Three of the five women had driver's licenses and one regained hers during the course of therapy. One participant did not have a driver's license and was transported to counseling by a family member.

The number of individual counseling sessions required as a criterion for this study was 10 or more and the number of sessions ranged from 10 to 24 sessions. All of the women received services from more than one counselor at various times over the years. One attended an initial evaluation with an individual who was different from her assigned counselor. Two women had attended group therapy and one woman's therapy group was for victims of domestic violence. One participant joined an on-line grief support group. Only one participant attended marital counseling; however it was only two sessions.

Four of the women knew their mental health diagnoses and one was unsure. Four of the participants were prescribed psychiatric medications by either a psychiatrist or a nurse practitioner; four were prescribed antidepressant medication for depressive

symptoms and two were also prescribed a temporary anti-anxiety medication for anxiety symptoms. One participant was prescribed a mood stabilizer and an antidepressant medication for Bipolar Disorder.

None of the parents of the women had ever received counseling services to their knowledge. Two participants believed their mothers and grandmothers had undiagnosed depression and/or anxiety. Two participants had fathers who abused alcohol.

The Demographic Form information and Counseling Form information are also presented in the following tables with the pseudonyms of the five participants.

Table 1

Demographic Form Information

Name	AGE	RACE	SEXUAL IDENTITY	MARITAL PARTNER STATUS CHILDREN	EDUCATION Work Status Financial resources	RELIGION
Corrie	22	Caucasian	lesbian	single no children	completing MA Student Personnel Counseling part-time work at university stipend student loans	agnostic
Lucy	60	Caucasian	heterosexual	widowed 5 adult children	master's degree in Sciences part-time work & seeking FT	Wicca
Rose	43	Caucasian	heterosexual	single No children	high school diploma SSI	Christian attends church
Hila	34	Caucasian	heterosexual	divorced 1 child	master's degree in teaching full-time teaching job child support	Eastern religions
Lydia	45	Caucasian	heterosexual	divorced 1 adult child	pursuing BS degree in nursing unemployed Pell Grant Student loans	Christian attends church services

Table 2

Counseling Form Information

Participant	Corrie	Lucy	Rose	Hila	Lydia
counseling agency	University health clinic	Community MH agency nonprofit	Community MH agency nonprofit	Private practice	Community MH agency nonprofit
Agency miles from home	½ mile	1 mile	25 miles	15 miles	20 miles
transportation	Own car	Friend	Mother or aunt	Own car	Own car
Payment used	No cost	Cash sliding scale fee	Medicaid	Health insurance	Cash sliding scale fee
Agency in same county where you live	yes	yes	Yes	yes	yes
Selection of agency	Due to no cost & close by	Due to no health insurance	Accepted Medicaid	Recommended by someone	Due to no health insurance
# of sessions attended	10	18 ongoing	20 ongoing	15	20
Medications	no	yes	Yes	yes	yes
Did you know your diagnoses?	Unsure Relationship Break-up	Panic Disorder Grief	Bipolar Disorder P.T.S.D.	Anxiety Disorder Panic Disorder Depression	Depression Domestic Violence

Summary

Chapter Three presented the methodology, qualitative research design, history of phenomenology, research questions, data collection and procedures, sampling strategy,

use of semi-structured interviews, trustworthiness, ethics and protection of human subjects, researcher as the instrument and researcher as self, and data analysis procedures.

The phenomenological focus of this study described what the research participants share universally with regard to the phenomenon of clients' experiences of psychotherapeutic change. "Within the client is a uniquely personal theory of change waiting for discovery" is declared by Duncan & Miller (2000, p. 180). How do clients change? How do clients perceive and understand change? This present study explored the central research question: What are the Appalachian Ohio female clients' experience, perception, and understanding of psychotherapeutic change? In an effort to explore the essence of these and other questions most appropriately, a phenomenological methodology was selected. The intent of qualitative research is to understand the meaning given to life experiences from the perspective of participants (Merriam, 1998). Participants were chosen for the study using a purposeful, criterion-based method of selection. Data were collected primarily through an interview format. Additional data were derived from a demographic questionnaire, counseling questionnaire, field notes, an optional reflection paper, and observations. After transcriptions, significant statements, sentences, phrases, words, and quotes were highlighted with colored markers. The process of highlighting statements in order to provide an understanding of how the participants experienced the phenomena is called horizontalization (Moustakas, 1994). Standards of credibility were served through member checks and standards of dependability were enhanced through an audit trail. To clarify clients' conceptualizations of change, the phenomenological methodology was utilized to elicit the universally shared meanings of psychotherapeutic change during therapy experiences of women in

rural Appalachia Ohio. The essence or shared meaning of psychotherapeutic change in the counseling experiences of clients was unearthed through the themes extracted from the data. The phenomenological methodologies selected allowed the researcher to construct meaning by employing imaginative variation and synthesizing the textural, structural, and thematic descriptions.

The following chapter introduces the stories of the Appalachia women. The voices of the participants are portrayed in the form of quotations describing the essence of the phenomenon. A cross-case analysis about Appalachian women; who they are, their strengths and uniqueness, and how the cultural context shaped them is provided. Additionally a summary, implications, suggestions, and conclusions are discussed in the last chapter.

CHAPTER FOUR: STORIES OF THE PARTICIPANTS

Meet the Appalachian Women

The following section depicts the stories and healing journeys of the five rural women in this study. Each woman encompasses individual qualities yet they also possess some of the same characteristics. This researcher sought to explicate each woman's narrative of what they experienced in relation to psychotherapeutic change during mental health counseling. Moreover, from their own voices we learn how their experience of psychotherapeutic change was bound by their cultural context in rural Appalachia Ohio. Each participant is introduced in the order in which she was interviewed.

Corrie's Story

Corrie was dressed in a casual outfit with shorts and a green tee-shirt. In the beginning of the interview she appeared somewhat apprehensive and cleared her throat several times. As I briefly read over the completed forms, I spied our common ground as she was working on a degree in Student Personnel. We chatted about our commonalities before I began audio-taping. Her body language relaxed. The ice was broken and the interview proceeded.

Corrie is a 22-year-old single Caucasian female who was born and raised in Athens County in rural Appalachia Ohio. Her parents and maternal and paternal grandparents were born and raised in rural Appalachia Ohio where they continue to reside. Corrie is a full-time college student in a master's program, receives a graduate assistantship, and is employed part-time at a rural university. She is a first generation college student, the first and only lesbian in her family of origin, and the only agnostic as well. Her parents did not accept her sexual identity so she did not seek emotional support

from them during her tumultuous relationship problem discussed in her counseling sessions. Instead she walked in and made an appointment at the university counseling center.

During the literature research portion of this study and prior to the participant interviews, I did not consider exploring sexual orientation in regards to Appalachian women. Therefore, I did not conduct a literature review on the population of Appalachian females who define their sexuality as non-heterosexual.

Corrie's Counseling Experience: Seeking Relief

Corrie attended the most recent counseling experience due to debilitating emotional pain caused by a breakup with her partner. Emotional pain motivated her to seek help. Corrie disclosed symptoms of depression to her counselor, "I hit rock bottom." She experienced feelings of sadness, frustration, rejection, betrayal, and anger. Corrie wanted relief from her "emotional feelings" of overwhelming pain. She indicated "I was looking for anyway out for feeling like I was." Her symptoms affected her functioning in her personal life, college life, and at her workplace.

Corrie walked into the college counseling center and an intake appointment was scheduled for two weeks later. Carrie described her initial feeling after seeking counseling, "I was hopeful and I was glad I had something to look forward too." She felt some relief after meeting with the intake person, "It definitely felt good to talk...talking about everything helps. I hoped someone would come up with a solution for me." So, Carrie waited to go back to actually participating in counseling services in hopes that it would alter psychological and emotional distress.

Corrie was self-referred and her student health insurance offered a few counseling sessions at no cost at the university health center. She had attended one session of counseling one year prior to her most recent counseling experience at the same university health center. She attended ten counseling sessions at a university counseling center in rural Appalachia. Corrie resided near the campus and did not need transportation. Corrie denied any cultural barriers to counseling.

When she went for her first counseling session she stated the counselor was a different person than the intake person. When asked to describe her counselor, Corrie replied, “We clicked right away” and she ascribed the following traits to him: comfortable, conversational, outgoing. Corrie wanted a safe place where she could pour out her emotional distress. She appreciated a counselor who was nonjudgmental and not overly emotional. If the counselor had been discriminatory of her alternative lifestyle, she would have left. She wanted a counselor who would allow her to talk, listen to her own words, and find her own answers. Corrie’s counselor was goal-oriented and she wrote down her goals for counseling. They talked more about future goals and did not visit her past, “I don’t like looking back at things or dwelling on things.” Corrie expected to make changes in counseling and she believed that counseling would help.

During the first three sessions, she cried tears of emotional distress, “I needed an outlet. Yes, it got very bad.” Corrie experienced a change in perspective when her counselor accompanied her to a local hospital emergency room due to her suicidal thoughts. Corrie reported her suicidal ideation as an “ah ha” moment and her desperation scared her. She told herself, “You need to stop this. I didn’t want that [suicidal thoughts] to happen again. It was messy and a big deal.” Corrie decided she wanted to feel better

and make changes. While the literature on suicide or on women and suicidality is plentiful, no studies were found on female suicide in the Appalachian culture. Suicide research on the specific population in the Appalachian Ohio culture was lacking as well. I identified this as a gap in the literature. However, statistical suicide completions for the ten counties in this study are reported later in this chapter.

Corrie's counseling focused on learning to express, identify, and process her emotions, "I learned I could change my viewpoint, but I couldn't immediately change the way that I felt." This helped her to tolerate her emotions during the counseling process. "I moved from blaming other people for how I feel." She learned to take responsibility for her own emotional management. Corrie wrote down things to talk about for each session in between counseling sessions and this helped her to focus. She discussed obsessive thinking about her former partner and during the process of counseling these thoughts stopped.

Corrie: At Odds with Cultural Appalachia

The gender of the counselor was not important to Corrie, but being accepted as a Lesbian was crucial. Corrie revealed that she felt totally accepted by her male counselor. For Corrie, being accepted was essential because her parents and family disagreed with her sexual orientation. Being gay is often at odds with being Appalachian. When Corrie's gayness came out in adolescence, her parents sent her to a counselor "to be fixed." Since that time, Corrie has not discussed her sexual orientation with her family.

On demographic questionnaire Corrie indicated that she was agnostic. When I asked her if religion or spirituality was ever helpful to her, she stated, "I don't think so. I don't really consider myself a spiritual person. I can take it or leave it. It wasn't really

something that changed before or after.” Corrie’s religious beliefs and her sexual orientation were both at odds with the traditional Appalachian culture.

The holiday break away from the university and her former partner helped her and she was able to distance herself from problems and indicated that she found comfort in being home during the school break. Corrie, an Appalachian woman, loves and values her family; however, she knows they reject her sexual orientation and agnosticism. Therefore, she is torn between value systems; modern Appalachia and traditional Appalachia. These findings differ from the literature in this study (Purnell, 2003; Wagner, 2006). Traditional Appalachian religion is tied into families going to church together and worshipping the same deity.

When asked about change, she replied, “I don’t think anything is going to change until the person wants to change. If I wouldn’t have been willing to do it [change] then I don’t think it would have happened.” Corrie attributed 25% of change in counseling to her counselor, 50% to herself, and 25% to her support network of friends. She considers herself to be a self-changer. “Change is being motivated to fix something or alter something that’s not working.” Bohart and Tallman (1996) asserted, “...It is ultimately the active client who makes changes in the way he or she actually lives life” (p. 20). Clearly, Corrie saw herself as the agent of her own change (Bohart, 2000; Lambert & Bergin, 1994). In addition, Corrie experienced lasting change and this was one reason she participated in this study. Thomas (2006) reported findings that substantiate longer durations of change in clients who attribute change to their own diligence and determination. Furthermore, Manthei and Thomas (2006) stated that in-depth research on how the client maintains psychotherapeutic change is not present in the literature of the

counseling profession. O'Malley, Suh, and Strupp (1983) revealed that client-related factors have shown that outcomes are enhanced when clients develop a problem-solving attitude. Corrie possessed a problem-solving attitude, "Well, kind of talking about what my eventual goals were, like future school plans... And I think that helped because, in future sessions, we would relate my future goals into what was going on right now." She elaborated, "I'm better at pinpointing why I feel that way instead of just feeling and not having a solution." Notably, the literature reviewed in this present study focused on the general population of individuals who attended counseling. Any literature on the counseling change views of rural Appalachian females is scarce.

When asked how she knew she was getting better, Corrie confirmed, "The major indicator of getting better was that I felt better." Corrie elaborated:

It kind of goes back into how I can more identify my emotions. So, when I start feeling, like, anything, I feel more able to identify it and I'm better at dealing with it. I can talk to that friend and try and fix how I feel instead of just letting it bug me. It's easier for me to pinpoint why I feel like I feel. I go through steps to figure out why I feel like I feel. That was a revelation for me. I think it's a lot of mental work. There's no magic fix. You got to figure out why you feel how you feel.

That's probably the biggest thing, I guess.

There are counseling theories in the literature that posit the success of therapeutic change in clients is due to changes in clients' emotion and therapeutic interventions must address problematic emotions (Damasio, 1994; Greenberg, 1999; Lazarus, 1991). Corrie's understanding of therapeutic change is that learning to manage her emotions noticeably helped to improve her daily functioning.

Before counseling, Corrie stated she had “tunnel vision and I couldn’t think about anything else.” Her symptoms began to slowly decrease and that signaled a change for her. As a result of counseling, Corrie stated “I’m more self-aware.” She liked to talk in counseling and listen to what she was saying. Then she would figure out what she needed even when her counselor did not talk. She learned to use reasoning instead of acting on emotions only and she is more aware of her reactions to others. When asked what worked in counseling, Corrie stated, “Time was a big factor. Writing things down was what really helped me. I could see the problem on paper.” She learned to express and process her emotions. “Counseling was definitely a process.” It took a while, but it eventually went into more positive thoughts and future oriented thoughts.

When asked about change, Corrie stated:

I prefer stability to change...I don’t deal well with sudden change that I can’t control. Just that I don’t think it can be forced. And if somebody doesn’t want to change, then it’s probably not going to happen until they want to. I think that’s the biggest thing. And I think if you’re trying to force somebody, that’ll lead to them shutting down then you’re not going to get anywhere if they won’t open up.

Corrie feared change because for her it represented insecurity and unstableness. She is independent and assertive and does not want to be told what to do. Her counselor allowed her to direct the counseling sessions and this gave her a sense of control over making her own decisions and solving her own problems. For Corrie, the experience of therapeutic change was gradual. She perceived that time was a factor in her healing process.

Corrie's Resiliency: Bouncing Back

By the time I went on dates, I had kind of like figured out that I had changed my mindset on the past relationship. It really wasn't the best thing. Putting that in perspective, I didn't think about it a whole lot when I would go on other dates. But it definitely felt good that even though it was a rough time at least I wasn't in that relationship anymore. I guess it's good that I can now date other people and look for something better. I think I can look at it more objectively. I think I just don't make it (a romantic relationship) the sole focus of whatever I'm doing. Just to not let whatever relationship I am in, like, dictate everything I do. Instead of coming home from work and go and hang out with the person I'm dating every day, spend more time with my friends or do a variety of things instead of making the relationship the only thing I really care or think about, because I think that was the biggest problem. I was so involved in that relationship, that when it ended I didn't really have a lot to fall back on.

Corrie lost her own self-identity in her romantic relationship. She neglected her friendships and therefore she felt very alone when the relationship ended. Being a Lesbian in rural Appalachia without other friends with the same sexual orientation for support is lonely. Corrie missed her friends and she realized that her life needed to be balanced even when she has a partner. Counseling provided an environment where she could practice new ways of thinking, correct faulty beliefs, and practice new behaviors. She eventually began to date again and found more balance in her relationships.

... Making my friendship relationships a lot more important instead of just when it was convenient or when I needed them, just like making a better effort to be a

better friend. That was helpful. And now I have better friendships, so it all worked out well.

Corrie's friends embraced her when she was left broken and alone by her partner. She appreciated their emotional support during her counseling process. Corrie wanted her friends to see her as capable and not as depressed and this also motivated her to remain in counseling. She said her primary strength is that she is a loyal friend. Relationships with close friends appeared to be very important to Corrie. Marginalized groups often stick together and Corrie is a female, gay, and agnostic. Corrie's identified her strengths as "stubbornness" and being "driven" and these helped her to remain in counseling and not give up.

Corrie as an Appalachian Woman: Cultural Influences and Change

Corrie did not report any barriers or obstacles to counseling services that were due to the cultural context of Appalachia. Access to counseling services at her university was simple and she had health insurance. She did not share her most recent counseling experience with her family of origin who reside in rural Appalachian. Her parents have never attended counseling. Corrie elaborated:

As far as I know I'm the only person in my immediate family who has sought out counseling, but personally, I've also been pretty positive about counseling if you need it.

Corrie's view of seeking counseling in Appalachia differed from her family of origin. Although they sent Corrie to counseling when she was an adolescent, they are not supportive of counseling in general.

Corrie is at odds with her mother's cultural views on sexual orientation and religion. Corrie revealed to me that her mother has issues with her alternative lifestyle and she did not discuss the relationship breakup because her partner was a female. Corrie explained:

I mostly handled it here [in counseling] just because of the nature of the relationship. It was a girl, so my mom is not really open to talking about that. That wasn't really something that I had talked to her about.

She was silent about her counseling experiences with her family as she processed her emotional pain with her counselor. As she indicated in the interview, Corrie accepted herself as a gay woman and she no longer questioned her sexuality as she had during her adolescence. In reference to the cultural context of being a gay Appalachian female, Corrie's sexual orientation is at odds with the culture as well. However, going to college provided a safe haven where she could not only accept her sexuality but embrace it. We can understand Corrie's sexual orientation by reviewing the literature on Social Identity Theory. Group membership is part of an individual's identity and when the group social identity is undesirable, individuals will leave their group, join another group, or try to change their existing group (Tajfel & Turner, 1986).

Corrie: Reclaiming Empowerment

For Corrie, the counseling experience was perceived as positive and helpful. She believed therapeutic change occurred as she shared her problems and concerns in a safe environment and in a safe relationship. Corrie did not want to revisit her family of origin issues and instead she wanted to focus on the present and the future. She wanted help with developing goals so she could move forward by returning to her pre-crisis daily

activities without overwhelming feelings of loneliness, sadness, and loss. She felt stuck in the midst of her personal crisis due to the breakup of her relationship and she wanted to become unstuck. Corrie felt safe and comfortable enough with her counselor to reveal her suicidal thoughts. The counselor transported her to a local hospital emergency room where she was assessed for suicide, “ I was in counseling and I actually ended up being taken by my counselor to the emergency room...I could never have seen myself getting to that point. I didn't want that to happen again.” This was a turning point for Corrie as she could not believe she had considered suicide to be an option for ending her debilitating emotional pain. She did not share this experience with her rural Appalachian family members either and cited their lack of understanding with her sexual orientation as the reason. Because the ending of the relationship with her female partner was the impetus for her suicidal ideation, she chose not to talk about it with her parents. Corrie elaborated further:

I didn't go to counseling because I'm gay. I'd already accepted that, like feeling confused, like an outcast. And my family doesn't accept it so I don't talk to them about that kind of stuff. At college, I found people like me and I joined a group on campus... And that helped me a lot.

For Corrie, experiences at college promoted her self-awareness as she developed relationships with other gay Appalachian women like her. She felt accepted at the university she attended.

Corrie is a young Appalachian woman who sought out counseling at a university in rural Appalachia Ohio. As she indicated during the interview, Corrie was the first in her family to seek counseling. Family life in Appalachia is often closed to outsiders and

not open for public discussion. Consequently, Corrie's decision to seek counseling alters her experience as an Appalachian woman and goes against the general cultural practices of most women in Appalachia (Myers & Gill, 2004; Seiling, 2005).

In terms of outcomes of the counseling process, Corrie had lost her own identity in her relationship with her partner and she stopped spending any time with her friends.

In regards to her identity, she stated:

It definitely helped getting my identity back, because I was before and I am now still pretty high with self-esteem. I'm a little bit overconfident a lot of the time.

So, just having my identity changed so quickly, like that probably was the biggest hit to my self-esteem. But, finding it again and figuring out that, Oh, hey, I do have all those things, like the lists I would make. I have this career going for me and really great friends. So, that definitely helped to bring my self-esteem back up. I think if that had been my regular mindset, that I had low self-esteem, I don't think I would have been as able to get it up to a higher level, because at least I had that to go off of. I knew I had high self-esteem before, so I knew I could do it again.

For Corrie, returning to her former functioning was a relief. With her self-esteem intact, she once again became immersed in her friendships and educational activities.

Corrie's Purpose: Counseling & College & Career

Counseling helped Corrie recover what was lost and even improved her future outlook on life. She indicated that she is excited about her career and what life holds for her in the future. For Corrie, education and career goals provide meaning to her daily life and to her future. Corrie's counselor would often talk about her future career as a student

personnel counselor and he would say, "Well, if your student was in this position what would you tell them to do?" And I'm like, "I'd tell them to go to counseling." Corrie's educational and counseling experiences promoted empowerment and her future career goal is to be a college counselor.

Corrie possesses a Bachelor's degree and she is working towards a Master's degree. I posited the following question in Chapter Two: are higher education influences related to a rural woman's decision to seek out mental health counseling? Although Atwell (2005) spoke of how educational opportunities have helped Appalachian women over obstacles, the research is absent. However, Corrie's educational experience is quite different from what we already know about women in rural Appalachia (Shaw, DeYoun, & Redemacher, 2005). These authors reported that gender inequalities hinder education opportunities for females.

When asked what she would say to women in Appalachia concerning counseling support, Corrie replied: "Girls in Appalachia don't know how strong they are or can be until something happens, a crisis or something like that happens, and they work through it and get even stronger." Corrie possesses resiliency, an inner strength that allows individuals to bounce back from a crisis (Masten, Best, & Garmezy, 1990). Possibly growing up gay in rural Appalachia paved the road to her resiliency. Helton and Keller (2010) found that resiliency factors during adolescence determine adult strengths and resiliency in Appalachian females. Corrie has faced many personal challenges in rural Appalachia, but she stands resilient and true to herself. For Corrie, the therapeutic change process brought her into a healing journey of self-awareness and self-empowerment.

While Corrie was a young woman pursuing a graduate degree, the next Appalachian woman was more than twice her age and came to counseling for reasons related to loss as well.

Lucy's Story

Lucy's witty sense of humor impressed me from the introductions to the end of the interview. Her laughter was refreshing. Her short hair, dangling earrings, and flowery dress gave me the impression of a creative human being and a free-spirited woman. She told her story which encompassed life and death. She is a 60-year-old Caucasian female who was widowed one year ago. Lucy resides in Athens County and stated, "I am Appalachian. My family and friends are Appalachian. This is my home." Clearly, Lucy self identified as a proud Appalachian woman. Lucy has five adult children by her husband from her first marriage. She has a graduate degree and is employed part-time in the health field. Her second husband was born and raised in England. She relocated to his country temporarily but returned to rural Appalachian. For Lucy, rural Appalachia is where her home and heart reside. Her healing journey is one of despair turned into hope.

Lucy and Counseling: Seeking Comfort

Lucy was motivated to seek counseling because of grief and emotional pain due to the sudden and unexpected death of her spouse. "He died in my arms while I was giving him CPR." She was in crisis mode:

At first when I went I was literally in crisis... The inability to concentrate, focus, couldn't eat, couldn't sleep... Just want it [pain] to stop. I just wanted it to stop... I was just saying, Make it stop. You know, I basically was saying, Make this stop.

And she said, I can't, you know I can't. I'm sorry. But, I was just saying, No, it's got to quit. I can't do this. I can't focus. I can't. I'm going crazy.

Lucy's emotions included grief, despair, sadness, loss, fear, and depression. She was not able to function in her personal life and at work. Lucy revealed overwhelming emotional pain and she just wanted some relief from her symptoms. Undoubtedly, both Lucy is a strong rural woman, however this time she asked for help. Mahoney (1993) speaks of independence, self-reliance, and pride as Appalachian traits. Lucy possessed these same qualities, yet she sought help from outside of their families and friends.

When asked what type of change she was looking for, Lucy explained:

I think symptom relief and just basically how am I going to change my life. Help me figure out how I'm going to change my life now, because I know it's going to change and be different. So, help me figure out where I'm going from here. And so, she and I would sit and talk about where are you going from and here and what are you doing... Am I going to change things?

Unexpectedly, Lucy became a widow. She experienced shock and disbelief. She continued:

Still working on emotional. That takes a little longer. That little inner child is still screaming; I'm hurt, I'm hurt, I'm hurt. That it's going to take time. And between counseling sessions, I noticed that I was able to start once again doing rather than just being, if that makes sense. So, even though your emotions are still raw, you're working on them.

Lucy was immobilized from the emotional pain of her husband's death. The loss was overwhelming and in the initial stage of counseling she found comfort in being in the

presence of a compassionate counselor. Life without her soul mate would look, feel, and be different and she knew it. Her daily life was forever changed. While struggling with intense emotions, Lucy also projected her confusion onto her future. When some time had passed, she began to work on future goals. Her sorrow and grief became less intense over time.

Lucy experienced suicidal feelings. When her counselor assessed her for any suicidal thoughts, Lucy replied: "Doesn't everybody?... If you're asking me have I gathered a bunch of pills together or bought a shotgun or got rat poison, the answer is no." Although statistical data on suicide attempts and completions are available for Appalachia Ohio, the literature is lacking on suicidality issues for rural women.

As a result of her symptoms and responses to her husband's sudden death, Lucy was prescribed an antidepressant medication and an anti-anxiety medication by a female nurse practitioner who recommended a counselor. For Lucy, this was her first experience taking psychiatric medication, but her overwhelming emotional pain outweighed any cultural beliefs against psychopharmacological intervention. Any literature on the stigma of psychiatric medication in the rural Appalachian culture and women is absent.

Lucy accepted the nurse practitioner's recommendation and found a counselor. Obviously, this nurse believed that counseling would help this Appalachian woman who was overwhelmed with grief. Was this nurse an outsider or insider to rural Appalachia? The answer is unknown. Did the nurse feel comfortable making a referral due to grief over the loss of a loved one because in this situation counseling is acceptable and not stigmatized? The answer is unknown. The nurse's words were significant in the decision of Lucy to seek out a counselor.

Lucy did not think about counseling expectations prior to her first counseling session due to her emotional distress and severe panic attacks. Lucy disclosed a 12-year phobia of driving a vehicle due to a car accident where the other driver died. Her panic attacks returned in full force. Prior to her spouse's death, Lucy had no inclination or motivation to try counseling. She indicated that her Appalachian family, parents and grandparents, did not think highly of seeking help from counselors. Lucy indicated that her family holds the traditional Appalachian view that problems are not to be shared in a mental health center and this mindset is found in the literature on Appalachian attributes as well (Coyne, Demian-Popescu, & Friend, 2006). However, Lucy's adult daughters encouraged her to attend counseling.

Lucy: Feeling Safe

Lucy wanted a safe and caring environment where she could share her emotional pain with a safe person. But she also wanted an objective person. She did not want pity or sympathy, but someone who would provide feedback. She expressed a desire for a counselor who was not overly emotional. During the interviews, I found both Lucy to be a straightforward individual who said what she meant and meant what she said.

This was Lucy's only experience with counseling. When asked about the therapeutic relationship, Lucy shared that the counselor was easy to talk to, honest, straight-forward, listener, caring, nonjudgmental, encouraging, and supportive. She trusts her counselor and "tells her everything." She felt understood by her counselor. She had attended 20 individual sessions of counseling and was currently in counseling. For Lucy, the experience of therapeutic change was slow and gradual.

Lucy discussed the counselor's self-disclosure as helping her. Russ (2010) discussed self-disclosure as counselor traits that promote trust and loyalty in Appalachian clients. At the fourth session, Lucy felt safe with the counselor, "I don't trust people right away. I'm not saying that people are not trustworthy. But, when you get to be my age and you've been burned a few times and been around the track a few times and life is throwing you a few curves, you sit there and go, Hmm. A distrust of outsiders is prevalent in Appalachian society and is a part of the culture (Keefe, 2005), however Lucy indicated her distrust was also from past personal experiences. The counselor validated her thoughts and feelings.

Lucy expressed guilt to her counselor for smoking cigarettes again. The counselor gave Lucy permission to not feel guilty. "The thing I like about her [counselor] is that she has helped me to develop insights." Lucy was experiencing a crisis due to the sudden death of her spouse and that was her reason for seeking counseling. Her functioning in daily activities was impaired.

Lucy valued the therapeutic counseling relationship and the characteristics of her counselor. Lambert (1992) described four interrelated components that operate within common factors in reference to why counseling works: 1) 40% of change outcome belongs to the client (personal strengths, talents, resources, social supports, beliefs), 2) 30% belongs to the therapeutic relationship (based on empathy, acceptance, and warmth), 3) 15% belongs to the client's expectancy and hope (the client's expectations that change will happen), and 4) 15% belongs to techniques and interventions, and theories utilized. Lucy spoke to the trusting relationship with her counselor and their ongoing dialogue of mutual connection.

Lucy said she cried during every session for the first 2-3 months. Her counselor gave listening support and allowed her to cry. Lucy perceived her mood change and process of grief and loss to be slow and gradual. Lucy's reports of change agrees with the literature on Chaos theory, a model about gradual and turbulent change that explains what drives change and how order eventually follows chaotic circumstances and events (Bussolari & Goodell, 2009).

Eventually during counseling, Lucy began to attend an online grief support group which became a support network for her. She had allowed her driver's license to expire and an online support group fit into her lifestyle plus in the initial stages of counseling she isolated from others due to her anxiety, sadness, and depression. However, Lucy admitted she was apprehensive about sharing her grief with a group of strangers which is a typical response of Appalachian people (Jones, 1994). She also read self-help books about spirituality and the afterlife between sessions.

With the counselor's support, Lucy reapplied for her driver's license and started driving again. The counselor helped her to face the fear of driving and she was able to manage her panic attacks and symptoms of anxiety. Her depressive symptoms decreased as well. While Kazdin (2008) discussed symptom relief as a method of knowing when individual client in counseling is improving, Bohart and Tallman (1999) explained that the perception of change for many clients may be beyond a decrease in symptoms. This was certainly the case for Lucy. Change came about via other avenues as well and she elaborated, "Life is good...It's not great, but it's good...I go to plays. I go to movies. I have a friend who is gay. He and I do a lot of stuff together. I mow my own grass now."

She continued about her counseling process, “But, we are now mostly focused on the present and the future.”

Lucy discussed how she is processing the stages of grief and exploring life as a single person. She reports a strong support system of friends. Lucy reported that prior to her spouse’s death she practiced “thankfulness and gratitude” and she believes this currently helps her. Her sense of humor returned four months after her spouse’s death. She has changed her lifestyle to include healthy eating, walking, and yoga.

Lucy’s Spirituality: A Constant Companion

Lucy indicated that one of her major strengths is spirituality which promotes prayer and meditation activities. Lucy adheres to Wicca as her spiritual base and she does not share this with her family of origin due to their traditional and cultural religious beliefs. “I don’t consider myself religious. I do consider myself spiritual.” Lucy felt safe to talk to her counselor about her views of the afterlife. The majority of Appalachia is located in an area recognized as the Bible-Belt and the largest religious groups are Baptists, Catholics, and Methodists (Wagner, 2006). Christianity is the traditional religion of Appalachia. Lucy’s spirituality is at odds with Christian theology. However, Lucy journeyed outside the cultural box of religion to follow her own voice. The literature I reviewed did not address the Wicca philosophy in Appalachia and therefore the prevalence is unknown.

When asked about her own personal theory of change, Lucy again indicated that her spirituality helps her to accept the things she cannot change Lucy explained: “I am a Wiccan and I firmly believe that he [spouse] is in the summer lands, and he is waiting... I have hope that I will see him again in the afterlife. I have hope that one of these days I’ll

quit crying every time I think about it. I have hope.” Lucy believes she will see her husband in the afterlife and that gives her comfort and hope.

Lucy indicated that resiliency traits learned from her first divorce and from the death of her second husband sustains her through the painful experiences of life. Lucy elaborated on her resiliency: “I have always had purpose. I’ve always been kind of driven. But, it was a different purpose. It was more of a, okay, never been a widow before.” Helton and Keller (2010) explored resiliency in Appalachian women in a small study. Lucy certainly brought her resiliency with her to counseling.

When asked to further elaborate on the change process, Lucy stated that the counselor asked her questions, “What do you think?” She was able to use critical thinking processes. “She didn’t spoon feed me.” Lucy stated her counselor facilitates the process. Lucy attributed 50% of the change responsibility to herself and 50% to her counselor. “For me change is being able to have what is a normal life as a single person.” She attributed change to herself, her counselor, medication, and her support network of friends and her family. Lucy explained, “Well, I would say 50 percent my counselor and my nurse practitioner and then, probably 50 percent friends and family.” She also declared, “The medication has helped me to focus.” Her panic attacks stopped and she attributed this to the medication.

Lucy further elaborated on the meaning of change for her. “Well, for me, therapeutic change is being able to get my driver's license, go see a play, be able to have what is, oddly enough, termed a normal life as a single person.”

Lucy was able to talk about the memories of her spouse and marriage in the interview without crying. She continues to attend counseling one time per month, but will increase sessions during the first anniversary of her husband's death.

In regard to her counseling experience in the cultural context of the rural Appalachian, Lucy did not have health insurance due to working part-time; however, she has actively sought full-time employment. "I currently work part-time as a secretary because that's all I can find which is why I don't have any health insurance." She attended counseling at a local community health center where a sliding scale was used to assess fees for services. Without a sliding scale, she would not have been able to afford counseling services. Her barriers included lack of health care and lack of financial resources; however, she overcame these obstacles. Money or lack of health insurance was not considered a barrier to her even in a rural Appalachian county. She found the help she needed. Lucy is not eligible for Medicaid or food stamps due to her income. She will be eligible for Medicare at age 65 years. She expressed concern due to the economy and lack of full-time employment. She discussed her experiences with employment and ageism in Appalachia. "Lots of ageism. I have a Master's degree in health sciences." Lucy believes her age is preventing her from being hired in a professional employment position. In reference to her advanced college degree, Lucy does not fit into the norm when compared to other women in Appalachia. Furthermore, Lucy is 60 years old which means she obtained her degrees in an era when females rarely sought education in rural regions. Clearly, Lucy's educational experiences and achievements deviate from the literature review in regards to the findings of Shaw, DeYoun, and Redemacher, (2005).

Lucy recommended counseling for any female in rural Appalachia with mental health issues or problems. "I cannot emphasize enough how much the medication and the counseling has helped me to overcome an awful lot of the demons that I had from my husband passing away. It has helped tremendously."

The Appalachian community supported her decision to seek counseling to help her over her grief and claim a new life after the death of her husband. Consequently, maybe it was due to her husband's sudden death, but it appears that in Appalachia, people tend to support others seeking mental health support systems.

In regard to her Appalachian family's view of counseling, Lucy revealed:

Well, I used to think counseling was, well, honestly, I have to tell you I used to think counseling and antidepressants were for weak people. That's from my forbearers. You don't go do that. You just tough it out, you know? I think one of the stigmas of coming to counseling period, is that whole thing like my

grandfather. But now I can see the extreme benefit of it, and I can see that it's not.

Noticeably, Lucy's cultural worldview pertaining to the dismissal of counseling as viable has changed. Her words are powerful. The words of her grandfather's disapproving opinion of counseling no longer echoed in her ears. The literature is straightforward in postulating that many Appalachian families consider their problems to be private and not to be shared in the community (Coyne, Demian-Popescu, & Friend, 2006). Lucy spoke about her grandfather's negative view of counseling and she even believed it until the unexpected death of her spouse which caused severe emotional distress. Going to talk to a professional about your problems in Appalachia is often considered a weakness by the older generations. Coyne, Demian-Popescu, and Friend, (2006) found that family

problems are: (a) considered private and not to be shared in the community, (b) sometimes shared with extended relatives, and (c) sometimes shared with the church.

Lucy overcame this cultural notion and sought out counseling. Lucy further elaborated:

A friend of mine lives in (country deleted) and he is a counselor himself. He said, Depression is not because you are weak. Seeing a counselor is not because you are weak. It is because you have been strong for so long that you can't hold it up any longer and you need some help. So, I like that... Counselors are here for when you need help.

Lucy sought validation from another person about counseling. Her negative view of counseling had been deeply embedded in her upbringing. She continued:

If I had diabetes, I would go to a doctor and get insulin. If I had cancer, I would go to a doctor and get chemotherapy. I had a—have a mental health problem. I needed medicine and I needed a doctor, a counselor, just as much as those other two things.

Lucy gained insight that her mental issues were just as important as any physical illness. She embraced a view that is opposite in the cultural context of how Appalachians view mental disorders. In the literature review (Saadallad, 2002) reported that females with mental issues and financial problems are apt to forgo mental health services. Clearly, Lucy does not fit into this category of rural women as she attended and thrived in a therapeutic milieu.

Lucy's Identity: Old Self and New Self

Lucy was trying to accept her new identity as a widow and understand an identity without her husband and without her marriage. Lucy talked about purpose with her counselor and stated:

I think she [counselor] gave validation. I had purpose before... but it was a different purpose. It was more of an okay, never been a widow before. What's this going to be like? And she said to me, I've never been a widow either. But I can tell you this. There are the changes that will probably occur as we go along.

Lucy struggled with the loss of a partner relationship and grappled with the loss of her identity which was connected to another person. The couples' category no longer applied. Lucy elaborated:

And she's been right so far... I feel like the pieces of me that were broken apart when this happened, through medication and counseling, I've been able to take the pieces of me that I like and leave behind the pieces of me that I didn't.

Throughout the counseling process Lucy learned how to reconnect with her independence, inner strength, and resiliency traits. Although Lucy is now single, she struggled with the identity of being a widow.

Lucy sought out a safe place for comfort and healing even though she grew up with the stigma that people in rural Appalachia do not share their hurts with counselors or those outside of the family. Lucy also spoke of becoming more aware of self:

I feel like the pieces of me that were broken apart when this happened... I've been able to take the pieces of me that I like and leave behind the pieces of me that I didn't and they're all super-glued together.

Although Lucy sought out counseling due to grief and emotional anguish, she also utilized the experience to address and discard disliked parts of herself. “So, now I've gathered together the shards of the glass that were prettiest and kind of put them back together and left the shards that weren't quite so pretty over here in this pile.”

When asked about counseling for females in rural Appalachian, Lucy replied:

First off, don't call me honey. Don't call me baby. Don't call me sweetie. Don't call me dearie. Don't minimize me. Just because I am of a certain age does not mean my gray matter is any less. Don't minimize your clients ever.

During the interview, I remember that Lucy made this statement with verbal force. This was the second time she alluded to ageism in Appalachia by making reference to her age. Lucy indicated she is being empowered in the counseling process. McInnis-Dittrich (1997) described the use of an empowerment-oriented model in a home-based mental health program for older women in the Appalachian region. For Lucy, counseling brought about empowerment by giving her permission to grieve and find her way back to daily living.

Whereas Lucy had come to counseling also seeking relief from sorrow, she found it. Moreover, what she found challenged her idea of what it means to be strong in the Appalachian community. Lucy now believes, contrary to her prior belief system, that seeking counseling means you are not weak but strong. Lucy's healing journey is still in the process.

Whereas Lucy came to counseling because her husband unexpectedly died, the next Appalachian woman, however, was seeking counseling for different reasons.

Rose's Story: A Lifelong Journey

Rose was waiting for me at her local public library. Her mother dropped her off and went to do some errands. Rose appeared somewhat shy and quiet in the beginning of the interview with limited direct eye contact. She was dressed in shorts and a brightly colored knit shirt. The library was one of her favorite places so she gave me a quick tour. She enjoyed socializing with both staff and patrons. Rose is a 43-year-old single Caucasian female who was born and raised in rural Appalachia in Meigs County. She lives with her mother, sister, and aunt. Her father is deceased. Her parents and maternal and paternal grandparents were born and raised in rural Appalachia Ohio. Rose is not employed and receives Social Security Income due to a mental illness and she has a Medicaid card. She graduated from high school. She had to drop out of beautician school due to her severe mood swings and anxiety from Bipolar Disorder. Her strengths are cutting and styling hair, playing with her cats, and gardening. She likes going to the library, playing bingo, going to church, listening to music, and paint-by-number sets. The most recent experience of therapeutic change for Rose set her free from a lifetime of guilt, shame, and blame.

Rose and Counseling: Seeking Wholeness

Rose had been acquainted with counseling services for a great deal of her life. It was, in some ways, not a traumatic event that caused her to seek counseling, but it was part of her lifelong journey. The experience of therapeutic change for Rose was a history of attending mental health counseling services at a community mental health center in rural Ohio Appalachia and being prescribed medications for a chronic mental health disorder. Her first counseling experience was at the age of 16 years. Rose attended

behavioral health services with multiple counselors over the course of 23 years. She had the same female counselor for the last year. Rose is required to attend counseling for medication maintenance. She currently attends an individual counseling session every two to three months and has attended approximately 24 sessions over the last two to three years. Rose prefers female counselors. When she experiences severe mood swings, she attends counseling sessions more often. Periodically, a mental health case manager visits her at home. Rose has accepted the permanency of her mental disorder and medication management.

Rose told me that she began acting out at around 14 years of age. Prior to displaying her anger, she was passive and quiet and did not want to draw attention to herself. A teacher at school who also went to the same church suggested counseling to Rose's mother. This was Rose's first counseling experience. It is interesting that a church member in an Appalachian country church recommended mental health counseling to Rose. Perhaps it was because the individual was a teacher who had attended college and questioned some of the traditional views.

Rose's Secret: Finding Safety to Tell It

Rose thrived in a safe therapy environment with a safe counselor and she stated, "I just felt safe with her, really safe." Rose appreciated a counselor who was caring, kind, and kept her sharing of session information confidential. She accepts her mental illness, is compliant with taking medication, and regularly attends her counseling appointments. She looks forward to visiting her current counselor. She feels hope for her future where before she felt depressed and out of control.

Rose needed a safe place and a safe counselor before she could talk about her problems. It is quite clear in the research that a positive counseling relationship is essential for change to occur (Horvath, & Bedi, 2002; Rogers, 1961; Sprenkle, Davis, & Lebow, 2009). Rose verbalized why she liked her counselor and spoke of the relationship as positive. Luborsky (1984) asserted the counselor must be viewed as supportive, empathic, helpful, as not seen as violating client values. It appeared that Rose's counselor embodied these traits.

Rose elaborated on the traumatic experience of incest she experienced in her rural Appalachian environment during childhood: "(counselor name deleted) said it wasn't my fault. I was so ashamed about all of it, and just so embarrassed." Research on incest and sexual abuse in general is plentiful but not in regards to rural Appalachia. One study was found on incest in Appalachia (Cantrell, 1994) and a paucity of studies on incest in Appalachia Ohio. Cantrell did address the stereotypical view of rampant incest in Appalachian families and she found that over one-third of women in her four projects compromised of females from high school, college, and young women reported at least one incestuous relationship. The abuse for Rose occurred from around ages 13 to age 16. While Rose's inner voice knew that incest was wrong, she struggled with the truth and turned her anger inward. Self-hatred visited and stayed until she purged the horrendous ordeal in the presence of a trusting and empathetic counselor who did not blame or shame her.

Rose stated she was afraid to tell her mother because "all the relatives would fall apart" and she did not want to bring shame and gossip to her family. All her family attended the same church. The close knit family ties of rural Appalachia, while

affirmative in some situations, can be harmful when abuse is hidden. Rose also talked about men having power women. She explained:

You just did what your daddy said to do. You didn't question it. I felt, like, confused all the time. It is right, wrong, or? Why would they do it to me if it was wrong? Dad and my uncles mostly told the women what to do and if they could go somewhere or not go somewhere. So, I thought that's what women do.

Rose spoke about her confusion with the teachings of her preacher and religious doctrine, "And then at church the preacher told us to always obey your parents so I thought I had to do whatever they said." Rose was taught not to question male authority figures and this is acceptable in a patriarchal society (King, 2001; Webster, 2007).

Rose grew up in a home, community, church, and culture that obeyed male authority and cultivated male dominance and inequality for females. In Chapter Two, I posited the following question: when rural women seek out counseling, do they bring their religious/spiritual beliefs as helps or hindrances? Rose remained in her childhood family church and Christianity. Although Rose is aware of gender oppression and male privilege in her family of origin and in her church, she continues to be involved in the cultural lifestyle. She indicated that her faith has helped her through the tough times in her life. Rose remains steadfast to Christianity, the major religion in Appalachia.

Rose's Counseling Experience: Speaking Her Truth

After years of counseling and many counselors due to her Bipolar Disorder, Rose revealed her painful secret to her most recent counselor. When asked to talk about the relationship with her counselor, Rose stated, "She didn't blame me for what my dad did." Rose trusts her counselor because "She doesn't tell my mom what we talk about... She

understands me.” Rose feels stronger since letting out the childhood sexual abuse secret.

“I’m just different... it feels strange... I feel free or something.” Rose was able to overcome the familial barriers of Appalachia. She felt safe and comfortable enough to talk to another female outside of her family about her greatest fears.

While Rose was finally free of living the shame of abuse, she still had other concerns. Rose expressed fear of living on her own and sometimes worries about the future when her mother and aunt pass away. However, at the same time, she longs for her own apartment and independence. Rose indicated that she longs for more self-sufficiency. She would like to get her own apartment and move closer to the city. Rose’s progress in counseling influenced her decision to try to become more independent from her family.

Rose does not have a driver’s license and according to Keefe (2005) the inability to drive is a major barrier for rural women. Rose did not share why she does not drive. Rose’s mother or aunt transports her to counseling sessions. She lives approximately 20 miles from the local community mental health agency; however this is common in rural regions. Rose discussed the cost of gasoline due to driving to the community mental health center and considers it a disadvantage. Access to mental healthcare can be influenced by lack of transportation, unpaved country roads, and greater travel distances to community mental health centers in rural regions (Rost, Fortney, Rischer, & Smith, 2002). When asked about barriers and obstacles, she acknowledged rural isolation and inability to drive. Rose indicated that her perception of isolation is due to residing in the country with few neighbors. When asked to define the word change, Rose stated:

Change is feeling free from shame and guilt. I don't hate myself now. It's when things get better and you feel better. It's when thoughts of hurting yourself go away. I finally felt free to be who I am... When [name deleted] told me it wasn't my fault then I let the guilt go. She said, You were a kid. You were a good kid and some bad things happened to you. You were not a bad kid. You're a good person. I cried because all this time I thought I was bad. And I deserved it all. So, I started seeing myself different.

Rose's view of herself began to change with the counselor's assurance that she is a valuable individual. Her self-esteem and self-concept improved. She started on a journey to empowerment. Rose talked about reading self-help books and this helped her:

(counselor name deleted) told me to read some books at the library because she knows I like it there. So, I read some things about abuse and it helped. I found stuff on the Internet. I realized other women were abused and got through it. So, I figured I could get through it too. And I felt better about myself. I stopped blaming myself... And I stopped being angry at myself. And (counselor name) helped me to look at all the stuff that happened and I just stopped hating myself.

For Rose, as for other victims of incest, she took the blame and shame upon herself. Self-hatred stunted her emotional growth. She experienced severe trauma during childhood, yet she found her inner adult strength and resilience; traits attributed to Appalachian women in the literature (Helton & Keller, 2010).

In regard to her counseling experience in the context of the rural Appalachian environment, Rose had incorporated treatment into her life script. Therapy was a permanent aspect of her life because of her Bipolar Disorder and the need for medication

as her disorder has no cure but is treatable. Individuals without a chronic mental illness attend counseling on a temporary basis.

When asked what she would say to a counselor who is providing services for an Appalachian female client, Rose replied:

Let her know that you really care about her. And let her cry it out. Don't talk down to her or like, don't make her feel worse by not believing her and she needs to feel safe in your office and not tell anyone else unless you want her too. She needs to be patient so the deep pain can come out... some families hide secrets when they all live in the country and down the road from each other.

Cultural barriers in rural Appalachia include geographic and social isolation. Rose spoke of these barriers as contributing to her experiences of incest. She lived in rural isolation in close proximity to relatives. They attended the same local church. Even as an adult, Rose has not disclosed the childhood incest to her mother.

When asked what she would say to another female in Appalachia who was considering therapy, Rose stated:

I would say go if you need it. Don't be ashamed. Do what you got to do to feel better. I would tell her to get the help she needs. Just do it... Don't be afraid. And I would tell her to get out of the house for awhile and go find someone to talk to... someone you can trust.

Whereas Rose had attended counseling with several counselors in seeking relief from her childhood secret of incest, she finally found it, but only after she found a safe place and a safe counselor.

She continues on in her healing journey. Rose now believes, contrary to her prior belief system, that she is not to blame for the childhood sexual abuse. The next Appalachian woman, however, was seeking counseling for different reasons than Rose.

Hila's Story: An Appalachian Traveler

Hila attended the interview as a friendly and talkative person. She shared her many unique experiences. She had taught English in a foreign country and had visited other countries outside of the United States. She was articulate and had a reservoir of interesting knowledge. She readily giggled when her life's story focused on funny incidents. Hila is a 31-year-old Caucasian female who was born and raised in rural Appalachia and resides in Athens County. Both sets of parents and maternal and paternal grandparents were born and raised in rural Appalachia where they resided. Hila is divorced and shares joint custody of her young son.

Hila: Education as a Journey

Hila is a first generation college graduate and is employed full-time. Hila perceives her strengths as "verbal and outgoing." She reported her "love of knowledge" and education as strengths. Hila is a teacher and is very proud of her educational achievements. Through the college experience of learning by way of course material, interactions with professors, mentors, and classmates, Hila applied this new knowledge to personal self-exploration and self-awareness and this played a pivotal role in her transformation to self-empowerment. Egan (1993) conducted a qualitative study on adult Appalachian women who were first generation college students. She interviewed 12 women and the findings revealed the influences of cultural norms, subtle family

messages, and communication from educators play a role in going to college. Hila elaborated on her fondness of learning:

I read books on astrophysics. It's hard for me to understand, but I get so much pleasure out of pushing myself to understand a concept, because I've done it before and I know that feeling. It's an amazing feeling when you finally get it, when you've had to put some work into it and then you get it. It's really a very pleasurable experience. So I feel that my love of knowledge puts me ahead because I appreciate life. I appreciate a lot of things that I look at, and I try not to be routine about things. When I walk outside, I really appreciate what's around me because maybe I know a little bit more about how it all works and how it's put together.

Hila alluded to the simple joy of being in nature. Jones (1994) listed love of place and a sense of beauty as a cultural value of Appalachian people.

Hila's Counseling: Seeking Solace

The catalyst that triggered her recent panic attacks was a work-related situation. Hila was motivated to attend counseling after several trips to the hospital emergency room due to symptoms of anxiety and severe panic attacks. She thought she was experiencing heart attacks. She found out she was experiencing severe “emotional pain” due to “pent up emotions.” “My therapist asked some questions that at first I thought were silly but later the questions helped me to make connections so I learned where my anxiety was coming from.” In regard to changes, she stated, “This time I felt like I was really ready to make changes.”

Her family showed concern over her three panic attacks and three trips to the hospital emergency room. She stated her spouse and mother were in favor of counseling because “they wanted me to be fixed... and they thought I was the problem.”

She sought out a safe place with an understanding person for counseling. “I felt safe from the very first session.” She appreciated a counselor who was nonjudgmental, genuine, open-minded, directive, and female. Her counselor presented as a “genuine person” who used “self-disclosure” to relate her [the counselor’s] past experiences with anxiety. Hila explained, “I recognized the imperfect person in her as well, which I really liked. I want to know that I’m talking to a human being. She was divorced. She’s on her second marriage.” Hila was able to identify with her counselor’s choice to divorce. She perceived self-disclosure as a form of egalitarianism. In the literature I reviewed, Berman (2001) found that counselor self-disclosure can strengthen the counseling relationship. Hila expressed a positive and trusting relationship with her counselor. She related that if the counselor was found to be judgmental, she would have sought another counselor elsewhere. Whereas the reviewed literature was silent on self-disclosure perceptions of Appalachian women, it makes sense that rural clients may desire a more personal counseling relationship.

Due to her prior counseling experiences, Hila felt comfortable driving to the private office and meeting her potential counselor. She was familiar with her town and did not experience anxiety connected with finding the counseling office or filling out the forms. Hila did not report any barriers or obstacles to seeking counseling. She did not lack financial resources or health care and she had adequate childcare and transportation.

She possessed a driver's license and her own vehicle. Hila and her son resided within the city limits in an apartment and she denied rural isolation.

She attended 15 sessions of individual counseling over a period of 7 months with a clinician in private practice in Athens County. She expected to make changes prior to her first counseling session and she expressed hopefulness that her symptoms would decrease and become manageable. Hila wanted to address her emotional pain and she wanted relief from overwhelming emotions.

Hila had attended counseling three different times over her lifespan and all sessions took place in Appalachia. For an Appalachian female, her extensive counseling experiences are not the norm.

Her first time in counseling was at age 15 years after she overdosed on pills. She stated, "I didn't want to commit suicide, it was a cry for help. It was an excuse to talk to someone. I had trouble dealing with my emotions." Hila indicated that she could not discuss her emotional distress with her parents, especially her father who had an alcohol addiction. As a teenager, she experienced symptoms of mental illness; however her parents ignored her until she attempted suicide. For Hila, the mental illness stigma of Appalachia was found in her own family.

She elaborated on her history of counseling experiences:

I felt that this time I was really ready to be open and to have the ability to follow their advice, because the second time was in college and I felt I wasn't in a very empowered moment in my life where I could handle the change. And the first time (first counseling experience) was in high school. I was very anxious and had very bad communication skills with my mother.

Hila reported her high school counseling experience as somewhat helpful. Her second counseling experience was during college due to anxiety and panic attacks. “I felt like I was at war with my body.” She learned to use meditation and biofeedback as a method to relax and reduce her symptoms of anxiety and panic attacks. She reported this experience as helpful.

In reference to her most recent counseling experience, Hila suffered with debilitating symptoms of anxiety and panic attacks. Her emotions were out of control and she experienced overwhelming stress and guilt, “I was a people pleaser. I wanted people to like me.” Hila talked about the emotions of frustration, anger, and guilt as she was contemplating a divorce and she needed a safe sounding board. As Hila previously stated she did not want to be judged for going against the cultural norms of marriage. She did not want a counselor to tell her the same things her mother and grandmother were saying about the evils of divorce. Hila was sensitive to any criticism about deviating from the cultural value system of her family, community, and church.

In regards to her counseling experience in the context of the rural Appalachian cultural environment, Hila was referred to counseling and a specific female counselor by her nurse practitioner. She had health insurance that covered mental health services. Prior to this she did not have health insurance as she was only working part-time and thus she did not seek out counseling when needed. At this time her lack of health care was considered a barrier to treatment. Hila had knowledge of the local community mental services and their sliding scale fee; however she chose not to seek out “less than desirable services.” The private counseling office was located in the same county where she resided. She had adequate transportation and the counseling office was approximately a

15 minute drive from her home. Hila was recommended to counseling by a female nurse practitioner.

Hila's Family Tree: Daughter and Mother Divide

Hila discussed how she learned about generational patterns of women and how she was becoming like her grandmothers and mother. She had tried to express her opposite cultural views to her mother and grandmother but they were so immersed in the rural Appalachian traditions and values that they blamed her for not being a good wife or mother. Hila felt alone, confused, and like a failure.

After the first couple of sessions, something I had been saying prompted her [counselor] to ask me, why is it so hard for you to be easy on yourself? And I thought, you know, I'm an educated person. I think a lot. I'm very introverted. So, not a lot of thoughts escape me, but that one has. I never asked myself that and then I cried on my way back home in the car and I thought, why? Why? Why am I so hard on myself?

Hila realized that like her female role models, she too, was trying to be so strong that she was actually becoming sad and depressed.

And then I started to become a little scared because I started thinking about my mother. And I started seeing, after that, more parallels in my family. I started noticing patterns in the behavior and character of each woman in our family, all the way through my grandmother and her sister, and my great-grandmother. And then I thought I'm in a cycle. I saw it and I thought, Oh, no. They've seen it in the family and unless you realize it and acknowledge it and try to change it, it's just going to keep happening.

In regards to generational abuse, Hila recalled:

My grandmother had a stepfather who abused her and whose mother didn't seem to care. And then my great-grandmother, she had seven children. She raised them all during the Great Depression. And she was also a tough woman, someone to look up to, like the perfect, strong country woman. So I started thinking, Oh, God. What if I'm like that with my children? And I was so happy when I had a boy. This was before I realized these things. I didn't want to have a daughter because I was so afraid that would happen again.... so I got angry inside, although I didn't tell them because I knew they're set in that role and there's nothing I can say to make them understand.

During counseling, Hila was able to determine patterns in regards to generational domestic violence and gender oppression. She further elaborated:

And that seems to be a kind of pattern in our family. The women have to be strong. The women usually carry the family... She [mother] was the breadwinner of the family. My father couldn't hold a steady job. But, their idea of happiness and my idea of happiness are two very different things.

Hila found herself in a quandary. While she viewed the women in her family as strong because they plowed through times of economic hardship and still provided for the children's physical needs, she perceived them as lacking in emotional strength. She perceived their silence on male aggression, gender oppression, and patriarchy as a weakness. She questioned the status quo of their female gender roles of inequality. Hila discussed how her husband's Middle Eastern culture resembled Appalachia.

It's very much like my ex-husband and the culture he comes from.

Happiness is just having a family, just having a house to have a family in and nice things for your family. That's it. Emotional and sexual needs and all of these things are superfluous. And I think that's kind of the same with my family.

They ignore their desires and they make themselves believe that all they want is deep religious spirituality and that's about it.

Hila became tired of suppressing her natural needs. She desired an egalitarian marriage but she knew it was futile.

Hila realized she could change herself but not her mother. She explained further:

And it means that I've also kind of divorced my family in a sense and I felt that was the only thing I could do because we'll never see eye to eye. And people say, All families fight. But, it's different because I realize and acknowledge that I can't fit in the role that they see me as. So, I've had to separate from them as well.

My son sees them and they get along with my ex-husband. I'm the enemy.

Hila decided to limit communication with her mother and grandmother.

I know they still love me and I still love them but I'm able to be more independent. I got myself back and I have a better idea of who I am and what I want out of life.

For Hila, self-awareness was meaningful for her. Although she was educated, well-traveled, and financially stable, she felt like a failure for seeking a divorce when it was opposed by her husband, mother, and grandmother as well as her society, community, and church.

Hila thought about the therapy conversations outside of therapy and would “make connections.” The counselor’s probing questions induced critical thinking which promoted intrinsic change in her belief system about her family of origin. The messages of “women need to be strong and take care of things” and “women need to stay married no matter what” were challenged. She was ready to address the childhood communication problems with her mother and “the generational patterns of accepting blame” and she learned “I was acting out the scapegoat as my family role.” She attributed the learning of new knowledge as a change factor. “She [counselor] asked me hard questions and guided me. She didn’t give me answers. She let me find my own answers.” She used self-help books recommended by her counselor between counseling sessions, “I read a book about changing your brain and some Buddhist readings.”

Hila: At the Intersection of Patriarchy and Religion

Hila and her spouse attended two marriage counseling sessions. She divorced her spouse after counseling ended and sought out other single/divorced mothers for support.

He’s from the Middle East and we have a lot of friends who are Middle Eastern families. Not extremely conservative but definitely conservative and he wanted me to wear the clothing and that kind of thing. I’m a skirt and dress person, but I would just give in and I would wear these outfits that I didn’t get to pick out, that I’d always been sent from his country. They made me feel fat and I just thought, This isn’t me. I feel like I’m pretending. And sometimes the way he said things, it makes me feel guilty even though it’s indirect... I started to realize that maybe I don’t recognize myself anymore. But, it took me longer to actually accept taking that big step and separating myself entirely.

She recognized that religion and patriarchy are not only about relationships but about the bigger picture of generational patterns of gender oppression. She wanted to “break this cycle of dysfunction.” She wavered between accommodating, resisting, and defying the gender inequality in her marriage. Hila stated, “I think it’s important for us [Appalachian women] to be respected... not pigeonholed.” Hila ultimately found a voice of egalitarianism after her marriage ended.

Hila balked at the intersection of patriarchy and religion in her life and she bowed out of the marriage and the church. Embedded in many religious doctrines, beliefs, and value systems are rigid views of the roles of females and males. Female oppression is legitimized through patriarchic systems of male privilege and certain religions.

In regards to attending counseling in Appalachia, Hila stated:

I feel that here, because a lot of life is kind of almost on the survival level, that, you know problems with the mind and emotions are considered ridiculous and a waste of time to talk about and to treat. And that the best medicine for anything is just to be stronger.

Because Hila’s father had an alcohol addiction and rarely worked, her family was often in survival mode. When a family struggles to put food on the table and pay utility bills, other things become lower priority, like mental illness or emotional problems. It is well documented in the literature that a major concern in Appalachia is poverty (Jones-Hazledine, McLean, & Hope, 2006) and it does impact mental health issues and prevents treatment (Belle & Doucet, 2003; Keefe, 2005).

Hila: Support Outside of Family

When asked about a support system other than her family, Hila answered:

I have other friends and coworkers. I have found other women who have divorced and who have become very successful. And it's not that I want a lot out of life.

Some of these women are extremely successful, but when they tell me that it was the right thing to do it just feels so much better just to hear that and to see that even though it's hard at first better times will come.

Hila sought out other Appalachian divorced women for validation. She went outside of her family and found a support system.

When asked whether change was gradual or sudden, Hila reported her change process was gradual and slow. When prompted, Hila stated in the beginning her counselor was responsible for 90% of the changes with her taking 10% of the responsibility for her changes, however, towards the end of counseling, Hila attributed 50% of the change process to herself and 50% to her counselor. In the initial stage of counseling, Hila allowed the counselor to lead but "Eventually I took charge."

When Hila was asked to describe her counseling experiences from the perspective of being an Appalachian woman she replied:

Women are expected to be strong in families. Appalachian women don't believe in divorce... you should stick with it no matter what... accepting blame... being overly responsible caretakers... being strong when the men don't provide... playing a role... being inhibited.

Hila's view on the cultural expectations of rural women to that they always must be strong. It is a dichotomy in Appalachia whereas females are viewed as the weaker sex by males, yet, they are expected to be strong by keeping the family together and by taking care of the children with cooking and cleaning.

When asked what she would say to another female in Appalachia who was considering counseling, Hila stated, "I would tell her it's not because they are a failure... we need help... we are not always aware of what's going on in our lives."

Hila: Finding Empowerment

Hila was searching for self-empowerment. She explained:

I was not empowered to handle change. I guess I was looking for someone who could help me get the power that I needed, that I felt that I had never had in my life. I guess empowerment.

When I asked Hila about her views of being an Appalachian woman, she stated:

I feel that, as an Appalachian woman, I have strengths because in Appalachian families, I feel that people are held more accountable for themselves and I feel we're raised to be more responsible and careful about our decisions, especially women... And I feel that because I've grown up in Appalachian, I feel that it's safer. It was a better childhood for me socially. There's a sense of community. I feel that I got a pretty good education and I never got into drugs except a little drinking in college like some people do. It's important for us to remember that we're individuals and we need to be respected for what we believe and how we feel about things... I think Appalachian women are really strong, but we're expected to fit into pigeonholed, religiously and socially and we're expected to

say this and that and otherwise you don't fit in. And I'd like to be a great example of how far you can go but still not be ashamed of your roots and to share it with other people.

Clearly, Hila identified as a strong Appalachian woman. She talked about the strengths of her upbringing and what facets she liked and embraced.

After counseling, Hila recalled, "I realized who I am as a person." When asked to describe change in her own words, she stated, "It starts with self-awareness...but change is a growth process." Her own personal theory of change includes "making connections" and developing "self-awareness and self-identity." Hila elaborated:

I guess I was looking for someone who could help me get the power that I needed, that I felt that I had never had in my life. So that brought me back to my therapy but, in a totally new way because I realized I was taking something that I had originally played with in my mind and in therapy and used in little ways and then saved my life through it, not just physically, getting away from the panic attacks but then also emotionally and mentally and even spiritually for myself. And amazingly, it just planted something deep inside that I thought had finished growing, I guess. It sounds funny but I thought I was done growing, but more change came. I was so amazed at my potential. I realized there was more there and it made me stronger.

Hila also discussed the positive aspects of being an Appalachian woman. She stated she was grateful for the sense of family and community and the family values she learned. She enjoys living in rural Appalachia and wants to raise her child in rural Appalachia.

While Hila shared the beliefs and communal aspects of Appalachian culture, she had also lived outside of it. She recalled:

Because you find a lot of similarities in other cultures. I've traveled the world and taught English in other countries and found other strong family structures, but the family structure in Appalachia is stronger than other places. There's a strong sense of community and family values, you need growing up, whether you like them or not and that's what builds character.

The literature addressed the family unit of Appalachia as characterized by close family ties (Beaver, 1988). Although in conflict with her mother, Hila holds deep sentiment for her country roots and she loves her family.

When asked to elaborate on her changes during counseling, she stated, "Counseling planted something deep inside... emotionally, spiritually, mentally...more change came... I got myself back." She used the phrases, "self-identity" and "self-empowerment" and "self-awareness" during this interview. For Hila, the healing journey included the search for self-empowerment, and ultimately, she found it in her own backyard. While Hila had traveled outside of Appalachia and overseas, she only found herself when she returned to her rural roots and sought out a safe place and a safe counselor for her journey of self-empowerment.

Hila's lived experience is similar to Lydia's story, the next participant. Both women grew up in homes with generational domestic violence, fathers who abused alcohol, and both women were at odds with their mothers. Both women are resilient Appalachians.

Lydia's Story: A Mission

Lydia seemed to be a more serious person and she wanted her voice to be heard so other women in Appalachia could benefit from her story. She was a woman on a mission. She was dressed in jeans and a shirt with a slogan about peace and justice. Her hair was pulled back in a clip. At times, her eye contact was intense.

Lydia is a 45-year-old Caucasian female who resides in rural Appalachia Ohio. She is divorced and lives with her widowed mother. Lydia was born and raised in a rural Scioto County. She resided in a hollow, an area lightly sprinkled with houses on a dirt road with one way in and one way out. Her paternal grandparents lived about ½ mile from her parents' home. Her grandfather's two brothers lived at the end of the hollow. Her maternal grandparents and relatives lived within a 10 - 20 mile range in the same area and county. Lydia graduated from a rural high school and attended classes at a rural community college. She met her husband at college and married at the age of 19. She became pregnant and dropped out of college. With her husband she relocated to his hometown, a rural Appalachian area in the state of West Virginia. Her husband's parents and siblings resided within a short distance. Lydia divorced her husband after five years of marriage due to domestic violence. She relocated back to her hometown and moved in with her parents in the same house where she was raised. Two years later, Lydia and her daughter moved into public housing in the same county. She raised her daughter as a single parent. When her daughter left home to attend college and after Lydia's father died, she and her mother made an arrangement that Lydia would help take care of her mother and the household in exchange for room and board. Lydia returned to the same

rural university to pursue a degree in nursing. However, what was once a community college had grown into Shawnee State University.

Lydia: Don't Blame Me

Lydia sought out a safe counselor and a safe place with a female counselor because she did not want to be blamed for suffering from a multitude of abusive relationships with men. Lydia endured emotional, psychological, and some physical abuse from her first husband and boyfriends.

Lydia appreciated a counselor who was nonjudgmental, trusting, empathetic, caring, friendly, a good listener, understanding, and provided a safe environment. Lydia trusted her counselor and was willing to disclose personal information, "I could trust her... I told her my secrets." Lydia discussed her willingness to take risks, "I could try new things and not worry that she [counselor] would be mad at me if I failed... She [counselor] said, I'll be honest with you and you be honest with me." When asked about her counselor, she stated, "She didn't judge me, just listened to me. She seemed to really care about me... I felt like I could trust her... her office felt safe." Her counselor was supportive and encouraging. "She would ask me questions and I would think about it after I left her office." In reference to her own strengths, Lydia stated she is caring, compassionate, and a good mother.

Lydia's first counseling experience was at the age of 28 years at a rural community mental health center. In reference to how she selected the counseling location, Lydia stated:

My caseworker at the welfare office gave me a pamphlet about the local counseling services. She was helpful and not rude like my first caseworker and she said that my Medical card would pay for everything.

Counseling was financially feasible to Lydia due to her Medical card. "Several years later I tried counseling again. When I called for an appointment I was told about a sliding scale fee...so I went to the same counseling office." Financially, counseling was feasible for Lydia the second time due to help with the service fees. Lydia attended the same community mental health center. In the state of Ohio, nonprofit community mental health centers are funded by federal, state, and local tax levies.

Lydia elaborated on the stigma of attending counseling at the community mental health center that has a reputation for serving low-income residents.

The first time I was afraid I would be looked down on and judged because of being a divorced mom on welfare. I felt embarrassed, just really afraid I would run into someone I knew. I drove an old junker car that I got from my divorce... but it always had problems. I was living in an apartment at that time so I knew my parents wouldn't find out about the counseling or the welfare. In my family you worked hard... you didn't go on welfare.

Lydia indicated that she felt ashamed to be on public assistance. She withheld this information from her family because they made discriminating statements about individuals who received monthly checks from the government. Jones (1994) listed independence, self-reliance, and pride as cultural values for Appalachian people. Wagenfeld, Murray, Mohatt, & DeBruyn, (1994) discussed the stigma attached to mental illness in rural regions, however, the participants in this study overcame any fears,

embarrassment, or misgivings. Noticeably, these women differ from other Appalachian Ohio women according to existing research.

Pertaining to her first counseling experience, Lydia attended a few counseling sessions on and off for 2 months. “I was depressed and sad... drained. I was living off welfare... divorced... a failure.” She was diagnosed with depression. Her counselor asked her to make an appointment with the agency’s psychiatrist to be assessed for medication. Lydia followed through but declined to take the prescribed medications. “I felt like the counselor was pushing me to take pills and I just didn’t want to go there.” In hindsight she stated, “I guess maybe I just wasn’t ready to face some things.” For Lucy, her first counseling experience proved unsuccessful. The literature addressed the Transtheoretical Model which assesses client readiness and resistance to therapeutic change (DiClemente, 2003). Clearly, Lucy was not ready to tackle change in regard to her first counseling experience.

In regard to her second counseling experience in rural Appalachian cultural environment, Lydia self-referred to counseling. At age 40, Lydia quit employment as a nurse’s aide, returned to the local community mental health agency due to stress from the lifestyle changes of giving up her apartment and moving in with her mother, and returning to college. She stated she did not have health insurance and attended the local community mental health agency where a sliding scale was used for the cost. Lydia had knowledge of the agency due to her former counseling experience at the same location. She had a driver’s license and a vehicle. The agency was 20 minutes from her home. She denied any barriers counseling, however, she faced some obstacles but she found a way

to overcome them. Lydia could have given up before attending the first counseling session, but she chose not to.

She stated, “I felt emotionally drained, just felt hopeless. I started thinking about suicide and that scared me... I didn’t want to hurt myself.” Lydia was again diagnosed with depression and she began taking a prescribed antidepressant medication. She attended individual counseling with a female counselor for around 6 months. She attended group counseling for female victims of domestic violence for approximately 10 sessions at the same agency. She was motivated to make changes because “I wanted to feel different... to be different. I wanted more out of life. I didn’t like my life... I didn’t like me.” She expected counseling to help her to make the necessary changes. “A little bit of hope seeped in when I called to get an appointment.” Lydia wanted relief from her symptoms and emotional pain.

Lydia’s Process: Domestic Violence No More

Lydia began to question why she continued to be in relationships with abusive males. Lydia stated, “I was tired of dating men who later turned out to be controlling losers. I wanted to find out why I kept getting involved with men who were jealous and controlling. Why did I let men boss me around, you know?” She called the police when her last boyfriend became intoxicated, destroyed her furniture, and tried to choke her.

Growing up I thought men had the right to boss you around... be the head of the family... make most of the decisions. In counseling I learned that I can be a strong woman, independent... I can decide what is best for me. Before that I thought that all men tried to control their wives... I thought that’s just the way it is.

Lydia would tell another female in Appalachia who was considering counseling “to go for it... find a female counselor who doesn’t blame you for the abuse... understand generational domestic violence... it’s not your fault being hit.”

When asked about any “ah ha” moments in counseling, Lydia talked about learning about patterns of generational domestic violence.

I had seen my dad hit my mom a few times. He was insanely jealous and he controlled all the money. He wouldn’t let her work at a job or anything. My grandpa, my dad’s dad, was a mean old man. He bossed my granny around.

Granny was a sweet person who would do anything for anybody... I wanted to break that cycle. I didn’t want my daughter to settle for an abuser.

Lydia: At Odds With Mother

When Lydia shared her insights about generational domestic violence with her mother, she was disappointed because her mother refused to discuss anything from the past in regards to her deceased husband. Lydia spoke of being a witness to the abuse perpetrated on her mother by her father. Regardless, her mother remained in the marriage until her husband died. Per Lydia’s statements, her mother continues to deny intimate abuse as well as generational gender inequality in the family tree. Her mother grew up in an era when patriarchy and gender oppression were the norm. Through education and counseling, Lydia found self-empowerment and began the healing journey of throwing off the old traditional clothing of cultural gender issues.

Although Lydia loved and valued her mother, she was absent from Lydia’s support network. Lydia’s support network included her counselor, women in her support group, and new friends at college. At the suggestion of her counselor, she enrolled in a

self-defense class at the college, “I felt strong, I guess empowered. I stopped thinking about myself as a helpless victim.” Lydia wants to eventually volunteer at her local domestic violence shelter and help other abused women.

Lydia discussed the women in the domestic violence support group as being instrumental in many of her changes:

I felt like I wasn’t the only one. When some of the girls talked I felt like it was me... I felt relieved. I wasn’t crazy... I just cried when the women shared their stories... I found some hope for me. When I started writing poems the flood gates opened and I really cried a lot... I felt like I was getting rid of all of the old junk... like I was cleansing my heart, my soul.

Lydia: Reclaiming Her Faith

A group member invited her to church and she explained “I found my faith again... I stopped feeling worthless and guilty... I forgave myself for being so stupid.” She continues to attend this same church, attends a weekly Bible study with her friend, and prays daily. Lydia used the word “guilt” several times during the interview.

When asked to elaborate on the changes she made in counseling, she stated she learned to express and process her emotions without feeling guilty, “I learned to accept my emotions. My counselor said it was part of being human.” She learned to identify, express, and process her emotions, “I stopped living on the drama of feelings. I learned to calm myself before I erupted.”

Lucy discussed her counseling toolbox. Her counselor gave her weekly handouts and homework. She wrote positive statements on index cards and taped them to her mirror. She practiced saying these positive statements several times a day in the

beginning of counseling. She started “looking at what was good in my life instead of what was so bad.” Her counselor suggested “that I focus on the some of the solutions instead of all the problems.” Her counselor would often ask her, “What do you want your life to look like in five years?” Lydia read self-help books between counseling sessions. She read books her counselor recommended and other books she found at the college library.

When asked about who was responsible for the changes she made, Lydia gave 40% to herself, 40% to her counselor, and 20% to her support group members. When asked how she knew she was making changes in counseling Lydia replied, “I finally stopped crying... I didn’t dread waking up to face the day... I felt hopeful... I expected life, myself to be different.” She discussed a reduction in her depressive symptoms as being a signal of change. Her counselor would often ask her, “How do you know things are changing?” When asked to define change in her own words, Lydia stated:

Change is wanting the pain to go away... having some hope that things can get better... that things will be different. Change is hard, but it’s worth it. I change when I think about things... learn new things. I make changes when I pray or read books... or talk to others who’ve been through the same things as me. I wanted to change... I wanted to feel better... to understand why I did what I did and why I kept doing it over and over and over.

Clearly, Lydia was motivated to make changes in her second counseling experience.

When asked to address her counseling experiences from the perspective of being an Appalachian woman from a rural area, Lydia stated:

Make the girl feel safe... don't judge her, she'll feel worse... help her to understand why she keeps picking on abusive men... I would tell her it's not too late to make changes in your life.

For Lydia, counseling was a life-changing experience. She found a trustworthy female counselor who provided a safe haven. She unloaded years of guilt.

The reader met the five courageous Appalachian women in this study. Their stories of change were narrated. Their voices were heard. The following section further explores their likeness and dissimilarity.

Cross-Case Analysis

As an Appalachian woman myself, I wondered how the country and cultural context shaped the lives of the five resilient women in this present study. Our stories are similar and our stories are different. As the women spoke I listened to the sameness and at times during the interviews we nodded or smiled, both understanding our unique cultural background. Each healing journey is unique, yet each healing journey is diverse. We are definitely Appalachian women and this chapter discusses our uniqueness, our strengths, our resiliency, and how we face the problems and issues we encounter.

The women initially attended counseling because of overwhelming emotional distress. Multiple layers underlying issues related to cultural female identity and gender equality appeared hidden. During the process of counseling, these issues surfaced.

Corrie's lesbian partner broke her heart. Corrie could not share her pain with her family and especially with her mother. She challenged the cultural context of sexual orientation in her traditional Appalachian upbringing.

The unexpected death of Lucy's husband propelled her to counseling. Pain from grief held her hostage. Later in the counseling process, she spoke of her mother's view of marrying a man outside of rural Appalachia. She challenged the cultural context of marrying an outsider in the traditional Appalachian upbringing.

After much counseling, Rose finally revealed the secret of incest to a safe counselor in a safe space. She shared fears and tears. Rose began to question male dominance and control and she challenged the cultural context of female oppression and gender roles in her traditional Appalachian upbringing.

Severe panic attacks and anxiety catapulted Hila to counseling. She initially talked about a stressful situation at the workplace. However, she felt safe enough to question her patriarchal marriage. Then she started questioning gender roles in her family of origin, in her church, and in her community. She identified generational patterns of male privilege and female oppression. When she started patching her leaky roof she soon found a cracked foundation. Hila challenged the cultural context of gender identity and gender roles in her traditional Appalachian upbringing. She divorced her spouse and left her church.

Lydia sought out counseling for depression and suicidal thoughts. She examined her pattern of being in abusive relationships with men. Questioning generational patterns of domestic violence brought her face to face with her female ancestry. Lydia challenged the cultural context of gender identity and gender roles in her traditional Appalachian upbringing.

The women in this study revealed a range of similar and different characteristics and traits that influence rural Appalachian women's experience and understanding of

counseling and change. These women had different personal histories, cultural values of family and religion or spirituality, and their own understanding of gender inequality, class status, intimate abuse, childhood sexual abuse, social identity, and overall life experiences as females residing in a rural region.

The generated data from the five women in this study elicited both parallel and divergent information. Additionally, the cultural impact on the understanding of the counseling process and change is further examined.

Experiencing Therapeutic Change in a Safe Counseling Relationship

All five participants spoke of a safe place for the counseling and the process of change to occur. However, a safe place meant something different in the context of being rural Appalachian women. The women needed a space because they perceived their family of origins to be emotionally available. They believed they could not talk to their mothers or female family members because of differing cultural viewpoints and opinions.

A Safe Counseling Place for Relief of Emotional Distress

All five women spoke of overwhelming emotional pain and wanted relief. All participants stated the search for emotional relief catapulted them to counseling. Their emotional pain was a by-product of issues in family or partner relationships. Corrie's partner terminated their relationship abruptly. Lucy's husband died unexpectedly. Hila was considering a divorce. Lydia had a history of being involved in abuse relationships. Rose needed to heal from sexual abuse from her father. Additionally, the women were struggling in various degrees with relationships with their mothers.

The emotional pain of being incongruent in relationships between mothers and daughters due to differences in cultural values (i.e., divorce, religion, sexual orientation,

marrying outside of Appalachia, traditional gender roles, gender inequality, patriarchy) prompted participants to seek out a place to try on new ways of being after they expressed and processed intense feelings. All five women wanted something to change. They sought out a safe place to make changes in emotions, cognitions, and behaviors.

A Safe Counseling Place to Tell Secrets

All five women spoke of needing a safe counseling environment with a safe counselor to be able to comfortably share their secrets, problems, and issues. They spoke of not wanting to be judged because they wanted to discard certain cultural values and traditions in regards to female gender roles and male privilege. Rose was the only participant to reveal sexual abuse, yet she found a trustworthy counselor and began her journey to be empowered. Hila found a counselor who listened and did not judge her for considering a divorce and she felt empowered when she made her own decision about ending the marriage. Lydia found empowerment when she stopped the cycle of intimate abuse in male relationships. Corrie and Lucy reclaimed their empowerment as they processed loss of a romantic relationship.

A Safe Counseling Place to Explore Generational Roots

Participants wanted a safe place with a safe counselor to take apart their learned cultural values, cultural expectations, and generational roots. They wanted a safe space to examine gender identity, social identity, educational identity, and professional identity. The participants reconstructed a cultural and social self-identity through the change process of counseling in a safe environment with a nonjudgmental counselor. Three participants specifically sought out female counselors while the other two did not have a preference for gender. The women then used counseling to challenge cultural

expectations of gender roles and to try to make peace with their traditional Appalachian mothers. The counseling relationship was pivotal for change to occur.

Education as a Precursor to Experiencing Therapeutic Change

Education played a vital role in searching for answers and finding answers. All five participants traveled with educational experience as their companion. Education played a vital role in finding solutions. The women believed that educational experiences increased their knowledge of both personal and professional selves. All five women graduated from high school in rural Appalachia. Rose was the only female in her family with a high school diploma. For four of the participants, college educations gave them a career and employment identity. Corrie, Lucy, Hila, and Lydia are first generation college graduates. Lucy and Hila have a Master's degree while Corrie is completing hers. Lydia is completing her Bachelor's degree. Hila spoke of seeking a doctoral degree at some time in the future. In regards to college education, these women are atypical rural women. Educational experiences intersected with counseling experiences. The women viewed education as a precursor that catapulted them to seek out mental health counseling. The tenets of education exposed them to new information and knowledge that improved their insight into cultural differences. Educational experiences prompted an awakening to life outside of rural Appalachia.

Corrie, Lucy, and Hila acknowledged their family's support of a college education. Hila stated her mother and grandmother were proud of her educational accomplishments. Lydia's mother was helping her financially so she could complete her college degree. Rose's mother wanted her to graduate from high school. In regards to education, their mothers are supportive.

Corrie was attending counseling at her university health center and Hila had attended counseling at her university counseling center as well. They are the only members of their family to receive mental health counseling services. Rose, who lives the furthest from town, has a lifetime of attending counseling and a teacher from her high school recommended counseling. Lydia attended counseling when she returned to college to finish a nursing degree. Lucy attended counseling for the first time at 60 years of age.

Atwell (2005) posited that rural women have always faced obstacles, however many overcame obstacles because of the opportunities provided by education.

Experiencing Change as a Journey to Empowerment

For these Appalachian women, there was an unfolding story of how regaining control and power over their own lives was a catalyst for moving forward. This sense of empowerment was crucial for their changes. Empowerment came about as a process of change. They wanted freedom to choose to be one's own self, reclaim one's self, or create one's self. During the counseling process, they explored the self, gained awareness of the self, learned to understand the self, and learned to accept the self. They came to believe in their own abilities to make choices for themselves apart from cultural expectations of family, society, community, and church, and especially their mothers. Culture, most definitely, impacted the women's identity.

Religious/Spiritual Journey to Empowerment

Of the five participants, three left the traditional religions in Appalachia Ohio. Lydia left her mother's church to attend a more liberal church, however, she did not return to church until she returned to her most recent counseling experience. Rose continued to attend the church of her childhood where her family members attend as well.

Lucy and Corrie had left the traditional Christian church long before their most recent counseling experience. Hila left her church during her most recent counseling experience and before she divorced her spouse. During counseling, she began to explore Eastern religions. Making their own choices about leaving their traditional religions produced feelings of empowerment. Of the four participants, Corrie is the only one who is agnostic. They wanted freedom to choose. However, they wanted their families to understand their choices. They wanted their mothers to approve. However, that did not happen with Corrie and Hila. Lucy hid her choice of becoming Wiccan from her family and especially her mother. Four of the five participants indicated that their religious beliefs or facets of their chosen spirituality gave them meaning and inner strength.

For these women, their religious/spiritual identities intersected with unequal gender roles in the church. Unequal submission and female oppression is often legitimized through patriarchic systems of male privilege in some religions.

Resiliency and Empowerment

Clearly, all five women were resilient. They used the counseling process to bounce back from adversity, trauma, abuse, loss, and grief. The literature supports an individual's ability to adapt and change as a result of disaster, loss, and poverty (Rutter, 1987; Werner, 1992) and resilience is the ability to adapt despite challenging situations and events (Masten, Best, & Garmezy, 1990). Empowered women in Appalachia have the capacity to make choices based on knowledge, critical thinking skills, and problem-solving skills.

The women in this study reported increased access to social, cultural, educational, and economic resources. Being resilient rural women is consistent with research

conducted by Helton and Keller (2010). They described assets and cultural values that promoted resiliency in Appalachian women.

Experiencing Therapeutic Change as Modern Appalachian Daughters with Traditional Appalachian Mothers

Prior to attending counseling, the participants had begun the process of differentiating from their Appalachian culture and from their conventional mothers. Educational opportunities expanded their worldview and the gained knowledge propelled their journey of change.

At Odds with Appalachian Culture and Patriarchy

The Appalachian cultural context of gender inequality, oppression of women, and female cultural identity intersected with seeking counseling and desiring change for the five rural Appalachian females. Gender inequality and male domination perpetuated low self-image and lack of personal power and therefore influenced their symptomology of mental disorders. Hila and Lydia desired freedom of personal choice but were oppressed by their spouses. Hila's spouse wanted her to wear the traditional female clothing from his native country. Although he was not Appalachian, he possessed similar views of gender oppression. Lydia's spouse decided if her clothes were too tight or showed any breast cleavage. Corrie's partner was controlling and, as a result, she isolated herself from her friends and family and changed her lifestyle to accommodate her partner's demands, however, she did not leave the relationship. When her partner terminated the relationship, Corrie was devastated and her daily functioning was impaired. The women in this study described their turbulent romantic relationships and eventually these relationships ended.

Lucy described her second marriage as one based on equality, however, this husband came from England. Whether her first husband was Appalachian is unknown. All five women wanted to decide what was culturally right and what was culturally wrong for themselves in relationships. They spoke about not being judged for their opposing cultural views on female roles.

These women were struggling for gender equality and justice in a patriarchal society. They did not use the term patriarchy, but nonetheless they made reference to male privilege, male aggression, male domination, female gender roles, domestic and family violence, ageism, and discrimination of sexual orientation.

Something Old, Something New, Something Borrowed, Something Blue

What was very clear from the interviews is that all these women were at odds with their mother's cultural values, but in varying degrees. They wanted the power to choose what to believe, what values to keep, and what to discard. They wanted the right to define what being a female in rural Appalachia means to them. Yet, they also wanted their mothers' approval of their choices and this did not happen. When maternal approval was withheld, they experienced tension and incongruence. Daughters and mothers divided. On their healing expedition, Corrie, Lucy, Rose, Hila, and Lydia traveled through the process of trying to understand and make sense of their daughter-mother relationships, which proved to be important in moving towards positive change.

These women truly loved and valued their mothers, yet issues of gender inequality, patriarchy, and religion strained the mother-daughter relationship. Their mothers grew up in rural Appalachia during a different era. While the participants viewed their mothers as strong in the sense that when times were economically difficult, the

mothers found ways to feed and care the children, they questioned their mothers' strength because they stayed in abusive marriages or allowed men to keep control over them.

On this healing journey, they explored and transformed their cultural Appalachian identities as rural women. While Lydia's healing journey brought personal freedom and a reformed self-identity, it also put her at odds with her mother's traditional and cultural view of the roles of women. Corrie, Rose, Lydia, and Hila indicated they continue to struggle with their relationships with their mothers. Hila's mother accepted her foreign husband because his views of gender roles and patriarchy are similar to the views on females in rural Appalachia. After Lucy's spouse died, her mother again spoke harshly of her because she married a man from another country who was 12 years younger. However, counseling has made Lucy more tolerant and understanding of her mother's traditional and cultural views and values. Lucy also indicated that experiencing the death of her spouse has made her more appreciative and less critical of others. Lucy used the safe counseling place to come to terms with being a widow. Her self-identity was adjusted.

Daughters and Fathers at Odds

Four of the five women recounted strained relationships with their fathers. Corrie's father was emotionally unavailable. Rose's father was deceased but had sexually abused her during childhood. Hila's father was a chronic alcoholic and did not financially support his family nor interact with her during childhood. Lydia's father is deceased but she was afraid of him and did not interact with him much during her childhood. Although he did not physically abuse her, Lydia occasionally observed the

domestic violence in her home. Lucy's relationship with her father was consistently stable and differs in this aspect from the other participants.

In Love with Appalachian Culture

While the women possessed various roles (i.e., female, daughter, sister, mother, wife, partner, student, employee) they were bound by the cultural context of being a rural Appalachian woman. All participants identified themselves as Appalachian women. The women were born and raised in the rural region of Ohio and their desire was to stay in Appalachia because of their affection for place and devotion to family ties. Lucy and Hila were the most vocal about their love of the place called Appalachia Ohio. Hila and Lucy spoke of the beauty of nature. Rose recalled memories about working in the garden. Lydia spoke of country life in a hollow.

For these participants, the right to define their cultural identities, live these identities, and be proud of who they are as Appalachian females is crucial. They do not want to be ashamed, embarrassed, or treated like outcasts because they chose differently. Empowerment intersected with the accepting of their new cultural selves. Becoming emotionally and mentally healthy was a by-product of reconstructed cultural identities.

Mental Health Issues of the Study Participants

These women provided information on how specific cultural values affected their mental health, self-esteem, and self-identity. Women in Appalachia are confronted by various mental health issues. Some of the problems for which they seek assistance in mental health centers are domestic violence, a history of childhood sexual abuse, substance abuse, and suicide prevention and/or intervention. However, studies on mental health disorders and treatment outcomes in regards to women in rural Appalachian

regions and Ohio Appalachia were lacking. I identified this as a gap in the literature.

Therefore the following section presents statistical information and addresses the literature when available.

Domestic Violence in Rural Ohio Appalachia

Hila and Lydia revealed generational domestic violence issues in their families of origin. While Hila reported emotional abuse and male dominance in her own marriage, Lydia reported physical abuse in her marriage and other male relationships. Lydia did not utilize the county domestic violence shelters; however Lydia attended a therapy support group for victims/survivors. Corrie revealed dominance and control in her partner relationship but denied any physical abuse.

Few studies on domestic violence in rural Appalachia were found along with a dissertation and some Internet articles. However, Shoaf (2004) conducted a qualitative research study for the State of Ohio Office of Criminal Justice Services (OCJS) on what services are needed in the 29 Appalachia Ohio counties as perceived by adult female victims of domestic violence. As previously stated, Athens, Meigs, and Scioto Counties have domestic violence shelters and task forces.

Incest and Childhood Sexual Abuse in Rural Appalachia Ohio

Rose was the only participant who discussed sexual abuse and the abuse she suffered from was incest. Her father was deceased so she could not confront him as part of her healing process. Paucity on studies about incest in Appalachia and in Appalachia Ohio was found. When Cantrell (1994) investigated incest in Appalachia, she found that over one-third of women in her four projects reported at least one incestuous relationship

Substance Abuse in Rural Ohio Appalachia

None of the participants reported substance problems. However, both Hila and Lydia are adult children of alcoholics (ACOA). They stated their fathers had alcoholism. Neither Hila nor Lydia stated this issue was addressed in counseling. Rose talked about how her father and uncles drank alcohol and became intoxicated on Sundays when they went fishing.

Suicidality in Rural Ohio Appalachia

Corrie, Lucy, Hila, and Lydia discussed their suicidal thoughts during the interviews. While Corrie, Lucy, and Lydia's suicidal ideations presented during the initial stages of the counseling process, Hila recalled an attempt by overdosing on pills as an adolescent. For Corrie and Lucy, suicidal thoughts seemed to result from overwhelming emotional distress due to the loss of a relationship. Corrie's counselor transported her to an emergency room. For Lydia, suicidal thoughts manifested as a lifetime of being in abusive relationships. Four of the five participants in this study discussed suicidality.

Summary

Chapter Four presented the findings of this study in the context of Appalachian culture as experienced by the women in this study. Analysis and interpretation was provided by this researcher. The personal stories of five women in their own words were the substance of this chapter. The researcher provided a cross-case analyses in the transcribed stories. Whereas this chapter presented the reader with an understanding of whom the women are and their experiences in life and in counseling, the next chapter presents the three final themes garnered from an analysis of their experiences.

CHAPTER FIVE: THEMES

Introduction

This study identified the themes embedded within the overall meaning and essence of rural Appalachian women, counseling, and their perception and understanding of psychotherapeutic change experiences. This chapter illuminates the themes induced from the interviews of the participants in this study. The four themes that emerged from the participant's stories provide valuable information to the field of counseling and answered the central research question: *What are the Appalachian female client's experience, perception, and understanding of psychotherapeutic change?* Generated themes included: Experiencing Therapeutic Change in a Safe Counseling Relationship, Education as a Precursor to Experiencing Therapeutic Change, Experiencing Change as a Journey to Empowerment, and Experiencing Therapeutic Change as Modern Appalachian Daughters with Traditional Appalachian Mothers.

The qualitative data analysis utilized a combination of phenomenological approaches adapted and described by Colaizzi (1978), Van Manen (1990), and Moustakas (1994). As outlined previously, an in-depth interview was selected as the primary method for data collection and the interview transcripts were the foremost sources of data collection. Questions from the semi-structured interview protocol (Appendix H) were utilized in the face-to-face interviews as an informal guide.

Discussion of Themes

This section explicates how the generated themes from the research study can be understood within the existing literature. Themes represent the participants' perceptions and understandings of therapeutic change within the cultural context and setting of daily

life as a rural Appalachian woman with issues and problems. To understand the counseling stories within the context of rural Appalachia, Chapter Two examined the literature on the Appalachian region, attributes of Appalachians, physical and mental health of Appalachians, rural client care and rural mental health professionals, suicide in rural regions, religion, and education in Appalachia. As the participants in this study were adult females residing in Appalachia, the following factors were reviewed in the literature: depression, substance abuse, incest, domestic violence, resiliency, and self-identity. Studies specifically pertaining to women in rural Appalachia Ohio were reviewed. The relationship of the experiences of the women to the themes by the data analysis and interpretation is reviewed in light of the existing literature.

Experiencing Therapeutic Change in a Safe Counseling Relationship

A safe counseling place and a safe space with a safe counselor is the overarching theme of this study. The women sought out a trustworthy and nonjudgmental counselor and a secure place to make changes. They sought out counseling due to overwhelming emotional pain and they needed catharsis to express and process feelings before change occurred. Counseling was perceived as a lifeboat in a stormy life crisis. They wanted a quiet and secure shelter to rest and address their unbearable pain. They did not feel safe in sharing their emotional pain with their families of origin. Feeling safe and secure in a protected therapeutic relationship was essential. The emerging theme of a safe place with a safe counselor was true for all five women.

The women in this present study sought out a safe counseling place for a mixture of issues and problems. Corrie's partner ended their relationship and she was devastated with feelings of loss and loneliness. Lucy's husband died suddenly and unexpectedly and

she was devastated with feelings of grief and loss. Rose was in counseling for a chronic mental disorder and childhood incest. Hila sought out counseling because she wanted to divorce her husband and she was experiencing severe panic attacks and anxiety. Lydia sought out counseling due depression and a history of intimate abuse with males.

During counseling, the women experienced a safe haven where they could share their secrets and emotional pain and be understood by a nonjudgmental counselor throughout their therapeutic change process.

A safe relationship was essential because their Appalachian culture impacted whether a safe counselor would be judgmental or nonjudgmental in listening to their secret stories filled with disparities in traditional norms, values, and beliefs. The women sought out a safe place where they could cry and laugh and share their painful stories. Corrie worked through the emotional pain from her breakup and a year later she began to date again. She regained her self-esteem and former self-identity of being a strong and achievement-oriented female. Lucy worked through her grief over the death of her second husband and has to face the first anniversary of his death. She is accepting another identity as a widow, but a strong and capable widow. Rose worked through the painful trauma of childhood sexual abuse and is creating a new identity based on self-acceptance. Hila worked through debilitating panic attacks and anxiety, divorced her controlling husband, and created a new cultural identity of being emotionally and financially stable. Lydia went from being a victim of intimate abuse to becoming a survivor. She created a new cultural identity based on personal empowerment and gender equality. These women used counseling to reconstruct their contextual cultural identities.

Corrie's Safe Counseling Place

When asked to describe her counselor, Corrie ascribed the following traits to him: nonjudgmental, comfortable, conversational, and outgoing. Although secure in her sexual orientation, Corrie did not want to be judged for her lifestyle. Corrie wanted a safe counselor who would accept her and a safe place where she could cry. She found an outlet for her overwhelming feelings of rejection by her former female partner. Corrie could not share her distress with her parents and family because of their traditional and cultural views and beliefs about sexual orientation. Corrie turned to her gay and straight friends at college for emotional support.

Lucy's Safe Counseling Place

Lucy reported being in “crisis mode” for the first three months of counseling due to her husband's unexpected death. Lucy was experiencing overwhelming emotional pain, shock, and grief. She cried during the first 12 counseling sessions. She did not feel safe until the fourth counseling session, but she explained that is because she does not trust easily. Her feeling of distrust were linked to her cultural background. When she knew her counselor was trustworthy and safe, the counseling relationship began. When asked about the therapeutic relationship, Lucy stated the counselor was easy to talk to, honest, straight-forward, listener, caring, nonjudgmental, encouraging, and supportive. She trusted her counselor completely and stated she told her everything. She felt understood by her counselor.

Rose's Safe Counseling Place

Rose needed a safe place and a safe counselor who would listen to her heart-wrenching story of incest. Even though she had been in counseling for a good deal of her

life, she never felt safe enough to share her secret. Rose wanted confidentiality and a counselor who would keep her childhood secret of sexual abuse. Rose felt relieved when her counselor did not blame her for the sexual abuse. She felt accepted by the female counselor. Rose did not want her mother, sister, or relatives to know about the childhood incest because of the shame she thought it would bring to the family. She trusted her counselor to keep her secret.

Hila's Safe Counseling Place

Hila did not want a jury, judge, or executioner. She wanted a safe place with an understanding and nonjudgmental counselor. Hila wanted to spill out her emotional pain and confusion about her grandmothers and mother's generational values and views on divorce. Hila felt rejection from the female role models in her life and she did not want another woman to judge her as unworthy because she had different opinions on gender equality and marriage. The validation from the counselor gave Hila courage to examine the generational patterns of male oppression and domestic violence in her family tree.

Lydia's Safe Counseling Place

Lydia did not want to be blamed for the domestic violence perpetrated by her former husband and boyfriends. She wanted a safe place where she could talk about her past, present, and future experiences. She felt safe from the first meeting with her understanding and nonjudgmental counselor.

A Safe Counseling Place has a Safe Counselor

All five women expressed the need for a safe counselor in a safe place. The counseling relationship was the vehicle of safety for the women. The therapeutic alliance made it possible for the women to share their darkest secrets and deepest desires.

Corrie

We clicked right away. He was just really easy to talk to. He wasn't over professional, which, I guess, might make me feel like a guinea pig. So, he was very conversational and it was just very comfortable talking to him. Some of the other counselors I saw, like with the walk-ins, not that I was less comfortable, but it was just different talking to them. But, he was very outgoing, and I didn't feel like he was judgmental or anything like that.

Lucy

Now I will tell her just about anything. I've told her about some of the issues I've had with my children. I mean, I have no problem telling her that kind of stuff. She asked me what I missed about my husband, and I said sex. I miss sex and she sat there and went, "Well, I can understand that." ...And I told her, "Every time I come in here I cry" and she said, "That's okay. I have lots of Kleenex" and I said, "That's good."

Rose

I felt like I could trust her. I just felt safe with her, really safe. I needed to talk about what happened to me. I didn't tell anyone for a long time because I felt embarrassed about it.

Hila

I felt very safe from the first session. ...I thought, "If this person [counselor] isn't going to accept me the way I am, then I have to find someone else." ...I recognized the imperfect person in her as well, which I really liked. I want to

know that I'm talking to a human being. ...And you can tell, like some people they can put on a façade, but she was most obviously comfortable with her life. She was at ease. She was at peace. She had a very positive energy to her, very calming, and I admired that. And I knew that she's human. She's not perfect. She can be like this.

Lydia

She didn't judge me, just listened to me. She seemed to really care about me...I felt like I could trust her...her office felt safe.

The women found what they were seeking; a safe place with a safe counselor.

Feeling and being safe allowed confession and the revealing of secrets to occur.

Trust: A Safe Counseling Place Trait

The participants spoke about trust. A safe space needs a trustworthy counselor.

Lucy

I don't trust people right away. ...She cares. I could feel it.

Rose

I felt like I could trust her.

Lydia

She seemed liked a genuine person, not fake or phony. And I knew I could trust her after a few meetings. I let down my guard and just told her things.

Appalachian people are known for not trusting outsiders. The participants in this study deviated from this cultural norm. They trusted a person outside of their family.

Non-Judgmental: A Safe Counseling Place Trait

The women did not want to be judged by a counselor. They felt judged by their mothers for their differing cultural views.

Corrie

I didn't feel like he was judgmental or anything like that.

Lucy

I was thinking, yeah, she was going to judge me about the cigarettes, you know?

Hila

If this person [counselor] isn't going to accept me the way I am, then I have to find someone else.

Lydia

She didn't judge me, just listened to me. ...And make the girl feel safe. Don't judge her, she'll feel worse.

Guilt had accompanied the women into the counseling office. They needed a place to unload their guilt.

Revealing of Suicidality: A Safe Counseling Place Trait

Four of the five participants needed a safe place to reveal current suicidal thoughts.

Corrie

I had a really bad experience over the weekend. And I was in counseling and I actually ended up being taken by my counselor to the emergency room. So, that kind of kicked me into wanting to change, because I didn't want to find myself in

that position again [suicidal]. So, that definitely kicked me, like, and said, "You need to stop this or, like, figure out a way to change."

Lucy

She [counselor] said, "Have you ever had thoughts to suicide?" And I said, "Doesn't everybody?" And she said, "Have you done anything about it?"

And I said, "No, if you're asking me have I gathered a bunch of pills together or bought a shotgun or got rat poison, the answer is no." She says, "Good."

Lydia

After that I just felt worthless. I started thinking about suicide and that scared me ...I didn't want to hurt myself. Because I really wanted to feel different. I was just so tired of feeling sad. And I just want to be different. To have more out of life.

I didn't like my life...And I didn't like me.

The participants felt safe enough to reveal their fear, guilt, and thoughts of wanting to die to end emotional distress.

All five participants indicated that they are the only family members to attend mental health counseling. They are first generation counseling clients.

Corrie

I think people go to regular appointments for their physical health. I think people should go to regular appointments for their mental health too. I wouldn't say I was really looked down on in my family, but it's [counseling] just not something that was really, like, talked about.

Lucy

The one thing that I want to share is that I was like a lot of the folks around here, which is counseling is for if you're crazy or if you're weak and you can't do it on your own, or if you are you're touched in the head or if there's something wrong with you. No. Counselors are for you when you need help.

Rose

My mom always made sure I had a ride to counseling. She wanted me to go.

Mom came to some counseling appointments, but not Dad. I didn't want Dad to come to any. But I didn't tell about the abuse back then.

Hila

...That, you know problems with the mind and emotions are considered ridiculous and a waste of time to talk about and to treat. And that the best medicine for anything is just to be stronger. And just be responsible and be religious, go to church. If you've got problems, then you need make peace with God.

...I had gone to ER three times before then because I was so sure that what I was having were heart attacks because the symptoms are exactly the same. ... Oh, he was very supportive because he was very worried. Whenever I had the panic attacks, I looked like I was slipping out of this world, you know? And he was very supportive [of counseling] and he did his best, although he always slipped back into those patterns where we'd get into fights and it would just trigger them more. And that was a problem.

Lydia

My mom wasn't supportive of counseling for me, but she's from the old school where you don't tell your problems outside of the family.

The participants saw value in going to counseling. They went against the cultural norm.

The Process of Therapeutic Change in a Safe Counseling Environment

The women discussed being in a safe environment that allowed expression and reflection. A secure place provided an opportunity to make changes. They trusted their counselors; therefore they shared deep secrets and emotional pain. The women felt safe enough to discuss perceived taboo cultural issues. Their secrets were protected. They did not feel judged by their counselor. The women were motivated to attend counseling initially because they wanted relief from emotional pain and distress. The majority of the women described the changes they made as evidenced by simply feeling better.

The women spoke of needing a safe place with a safe counselor for the process of change to occur. The women perceived and understood the process of therapeutic change to belong to both client and counselor. They viewed the counseling alliance as collaboration between client and counselor. Relationships factors were important for all five women in this study which is consistent with the literature reviewed. The therapeutic relationship is the foundation of the change process. As Carl Rodgers (1961), the father of client-centered therapy noted, "change appears to come about through experience in a relationship" (p. 33). Participants placed meaning on the counseling alliance as the primary change promoting factor. Foremost, the client and counselor form a therapeutic relationship, which is necessary for psychotherapeutic change to occur (Horvath, & Bedi, 2002; Rogers, 1961; Sprenkle, Davis, & Lebow, 2009). The professional literature

confirms and demonstrates the importance of the relationship between therapist and client (Duan & Hill, 1996; Horvath, 2006; Norcross, 1993; Sexton & Whiston, 1994; Watson & Greenberg, 1994).

The information gained in this study contributes to an understanding of the role the therapeutic alliance plays in facilitating change when a safe environment is achieved. The significance of the counseling relationship can be more fully understood by reviewing the participants' perceptions and experiences obtained in this study.

The women in this study gave credit to both themselves and to the counselor in regards to who is responsible for change outcomes. The change process consists of both a counselor and a client; one cannot exist without the other. It is not all counselor nor all client. It is both. The existing literature conveyed the controversy about whether it is the counselor who brings about change or whether it is the client. From 1950 to 2000, the majority of theorists and researchers attributed the change task to the counselor (Bohart & Tallman, 1996; Hubble, Duncan, & Miller, 1999; Rennie, 1992); however, there is current research which attributes the capability of change almost entirely to the client (Duncan, Miller, Wampold, & Hubble, 2010). The women in this study gave credit to both themselves and their counselors. Therefore, the relationship is not only the foundation for change to occur but the counselor is given recognition for promoting, facilitating, encouraging, and helping change to manifest. However, the clients took responsibility for making change happen and accepted responsibility for making changes; were able to identify their strengths; and revealed their social support systems to be significant.

The women were able to verbalize positive counselor characteristics and identified the counseling relationship as foundational to the change process. They expected to make changes and hoped things would get better. They were able to articulate what techniques prompted change (i.e., challenging questions by counselor, feedback from counselor, helping client to set goals, allowing emotional catharsis, challenging faulty belief systems). Questioning by counselors was seen as particularly helpful as an intervention. Questions promoted cognitive processing of critical thinking, pondering, reflection, and problem-solving. The women reported they thought about these questions outside of the counseling office. Lambert (1992) suggested that models and techniques account for only 15% of improvements in therapy. However, questioning is a technique common to many theories. One woman utilized journaling and poetry as methods of working through her issues. Another liked informational handouts. Journaling, utilization of poetry, and handouts are techniques used across multiple counseling theories.

Counselor factors as important for change surfaced from the interviews and are consistent with the research in the field of counseling and psychology. The women used the following words and phases to describe their counselors: nonjudgmental, comfortable, conversational, outgoing, easy to talk to, honest, straight-forward, good listener, caring, encouraging, supportive, used self-disclosure, sense of humor, nice, confidential, open-minded, gentle, calming, honest, and genuine. By reviewing research on the personal attributes of therapists, flexibility, experience, honesty, respect, trustworthiness, confidence, interest, alertness, friendliness, warmth, and openness was found to be useful for the therapeutic alliance to flourish (Ackerman & Hilsenroth, 2003). Likewise, Hilsenroth and Cromer (2007) reviewed research and concluded that therapists who

convey warmth, understanding, appreciation, and a sense of trust are more likely to establish a stronger alliance with their clients. The participants trusted their counselors.

Self-disclosure of counselors was mentioned as valuable. Self-disclosure is the sharing of stories and hence the sharing of a dimension of the self with the client. A scarcity of literature exists on a client's perception of counselor self-disclosure as a therapeutic relationship enhancer, however a study by Barrett and Berman (2001) found that counselor self-disclosure can strengthen the counseling relationship. Lucy and Hila spoke of counselor self-disclosure as being helpful.

Lucy

I was thinking, yeah, she was going to judge me about the cigarettes, you know?

I figured that she would say, oh, now you've been in health. You know better than that. You know you're not supposed to smoke. But, you know what she told me? She went through a really bitter, nasty divorce. And she said first thing she said, I had quit for five years. She said, First thing I did was hello old friend.

That's a relief. She's human. She's not here. I'm not here, if that makes sense.

She's not way up here and I'm not way down here. We're more symbiotic. If that makes sense.

Hila

And she even shared stories about her own anxieties and her frustrations on the job when she was younger and less experienced and with older, more experienced colleagues.

These women found comfort in hearing similar stories about their own problematic experiences.

The premise of facing barriers reported from the interviews was found in the literature (Belle & Doucet, 2003; Keefe, 2005; Rost, Fortney, Rischer, & Smith, 2002); however, the women overcame these obstacles. Three women had health insurance and two did not. Hila had health insurance through the workplace; Corrie's insurance was through the university; and Rose received Medicaid. The two women without health insurance attended a local community mental health agency in their county of residence where a sliding fee scale based on income was used. The women found a way to seek out and find the help they needed. They talked of the stigma regarding counseling in the Appalachian community; however the participants made choices to attend anyway. Only one woman was socio-economically stable and this was due to a Master's degree in education and employment with health insurance and other benefits.

The women in this study expressed readiness for change prior to the first counseling session which is consistent with previous descriptions appearing in the literature. Weiner-Davis, de Shazer, and Gingerich (1987) studied pretreatment change in solution-focused therapy and found that 66% of clients reported experiencing change before their first session. The women in this study experienced change as a process. The Transtheoretical Model (TTM) developed by DiClemente, McConaughy, Norcross, and Prochaska (1986) includes stages of change and the process of change. There are three dimensions to the model: the processes of change indicate how change occurs, the stages of change indicate when change occurs, and the levels of change indicate the domain of the changing behaviors (Prochaska, 2003).

The women viewed change as a gradual process that happened in the counseling session with the counselor, outside the counseling session, and after counseling was

terminated. One woman divorced her spouse after counseling was terminated. Another participant volunteered at a domestic violence shelter. A few authors (Bohart, 2002; Bohart & Tallman, 1999; Manthei, 2006) studied what clients do between counseling sessions and found that client-initiated self-help efforts promote effective problem-solving and draw on insight to make changes in daily living.

The literature is limited in reference to clients' viewpoint on change results in their own words. This is one reason for this phenomenological study. The participants described what the result of change looks like to them. Participants described various types of change. The first and foremost type of change was a relief from painful emotions. Participants attributed symptoms reduction as a sign to feeling better. Catharsis for the release of emotions is well supported in the literature. Emotionally-focused therapists (Greenberg, 1999; Greenberg, Rice & Elliott, 1993) argue that therapeutic interventions must address problematic emotions and that therapy is considered successful by clients when emotions are processed (Damasio, 1994; Lazarus, 1991). Another type of change was in discovering awareness of self which included examining, critical thinking, reflecting, and understanding. The participants attended sessions, participated in therapeutic conversations, listened to the counselor's challenging questions, and tried to find answers by self-examination. They completed assigned homework, filled out handouts, read self-help books, used journaling and writing as expressive tools, wrote poetry, and made intrapersonal and interpersonal changes in their daily lives. Bohart and Tallman (1996) emphasized that "change is primarily a product of the active client, who makes therapy work; regardless of what therapy he or she is using" (p.17) and clients are "experts on themselves" (p. 23). These women experienced the

process of change throughout counseling as they began to integrate the former self with the newly developing self. The identity of self changed.

The premise that counseling change is a gradual process was reported by all five women in the study. All participants perceived change to be slow and none reported any sudden change such as that illustrated by quantum change theory (Miller & C'de Baca, 2001). Participants did report some “ah ha” moments during counseling; however, it was after questioning by the counselor followed by critical thinking, reflection, and feedback. “It has often been argued that it is the helping activity as the client understands, experiences, and later remembers it which results in the client’s change and growth” (Elliott, 1979b, p. 285). The conclusion drawn from this theme is that clients possess their own definitions of change and see themselves as doing the work to make change happen. There are research findings which found that clients who attribute change to their own efforts experience longer lasting change (Bohart, 2000; Lambert & Bergin, 1994) and Thomas (2006) reported findings that substantiate longer durations of change in clients who attribute change to their own diligence and determination. The women in this study were able to maintain the changes made in counseling. When asked the question during the interviews, do you consider yourself to be a self-changer, four of the women answered affirmatively and one was unsure. The next section provides an analysis of the second theme found in this inquiry.

Education as a Precursor to Experiencing Therapeutic Change

The second theme that emerged addressed how the participants’ educational experiences gave them the confidence to seek out counseling for the process of therapeutic change to occur. Both educational experiences and the counseling experience

produced empowerment. Past, current, and future educational experiences were discussed as important.

Education as Empowering

The women perceived former, current, and future education in the rural Appalachian region as inspirational in promoting personal and interpersonal changes before, during, and after counseling experiences. The women used their educational experiences as a source of power and strength to reformulate views of traditional gender roles, patriarchy, traditional religion, and sexual orientation during the counseling process. The findings of this study revealed an emerging theme that helps us to understand Appalachian women and how higher education influences and cultivates identity, social identity, cultural identity, professional identity, and overall self-identity. Education was a vehicle for empowerment. Education was an emerging theme in the shaping of their new identity. Higher education opportunities exposed the majority of the women to new knowledge, new information, and new ways of being. These women carried the changes in cognitions into the counseling session. Beliefs, ideas, and presuppositions influenced the ability to discard traditional values that did not fit and to try on modern values. There was a mixture of traditional with non-traditional ways. The process of counseling made this possible by providing a secure atmosphere where clients could talk, think, reflect, take risks, reveal deepest secrets, accept feedback, and try new behaviors. Moreover, counseling provided a venue for self-education and cultural change: an important concept for all of these women. Education was the catalyst for learning new things and thinking new thoughts.

Learning and Self-Help Books as Empowering

The women gained information from their counselors and outside factors such as books and/or the Internet. Four of the participants stated they read self-help books between sessions. Some books were recommended by counselors and some books were self-selected.

Lucy

I've read several books on grief... I bought one by George Anderson. It's called *Lessons from the Light*.

Rose

And then [counselor] told me to read some books at the library because she knows I like it there. So, I read some things about abuse and it helped. I found stuff on the Internet. I realized other women were abused and got through it. So, I figured I could get through it too. And I felt better about myself.

Hila

I read some self-help books. *Train Your Mind, Change Your Brain*. I think the author is Susan Begley, and she's a Buddhist, I think. It's something that my therapist had recommended and this woman had met with the Dalai Lama.

Lydia

That's when I learned about generational domestic violence. All then it all made more sense to me. I make changes when I read books.

The women wanted to learn more about the healing journey. They accessed other resources outside the counseling office.

All the women utilized computer technology. Rose talked about using the Internet at the library so it is unknown if she had access at her home.

Corrie's Experience of Education and Empowerment

Corrie graduated from high school, college, and is currently a full-time college student in a master's program. While pursuing her graduate degree, she receives a graduate assistantship, and is employed part-time at a rural university. She is a first generation college student.

Corrie discussed the stigma of attending counseling in Appalachia and she did not share her counseling experience with her family of origin who reside in a rural Appalachian county in Ohio. Corrie attended the counseling center at the university she attended. Consequently, it was due to her college experience that she had access to counseling. Corrie revealed to me that her mother has issues with her alternative lifestyle and she did not discuss the relationship breakup due to her partner being a female. She was silent about her counseling experiences with her family as she processed her emotional pain. Corrie believed that attending a university where gay students are accepted and respected is empowering. Leaving her small community and going to college allowed her to develop her own value system. Corrie credits both the college experience and counseling experience as helping her to become self-empowered.

Lucy's Experience of Education and Empowerment

Lucy graduated from high school, college, has a graduate degree, and is employed part-time in the health field. She is a first generation college student as well. Being 60 years of age, Lucy attended college during a time period when gender inequality was strongly alive and well. Lucy was encouraged by her parents to attend college and

without their financial support she would not have made it. Consequently, Lucy's parents differed from most Appalachian parents because they did not expect her to follow the traditional patterns of Appalachian females; they encouraged her to pursue a college education. Lucy is a spunky and assertive woman who speaks her mind. Although her values differ from her parents, she is grateful for them and for her college education.

Her career included a stable work history until a few years ago. She is actively seeking fulltime employment. Lucy credited her educational experiences as promoting her self-confidence as a female in a male-oriented workplace.

Rose's Experience of Education and Empowerment

Rose is the only female to graduate high school in her family. She is proud of this accomplishment. Her brothers and male cousins graduated from high school, but the girls usually dropped out to help take care of the younger siblings or to get married. Consequently, Rose as a high school graduate is not a stereotypical role of Appalachian women. Rose has not married and this is not the norm in her family or in rural Appalachia.

Rose was encouraged to attend counseling during high school by a teacher who also attended her church. This teacher talked to Rose's mother about it and as a result Rose was allowed to go to counseling. Rose wanted to attend counseling and the sexual abuse stopped immediately. Rose surmised the abuse stopped because her father was afraid she would tell. Rose was diagnosed with Bipolar Disorder and prescribed medication. After Rose graduated from high school, a teacher helped her to enroll in beauty school; however, she dropped out due to her symptoms of Bipolar Disorder. Rose was suffering from the trauma of the sexual abuse and she had not revealed the incest to

any of her counselors until she became an adult. After she admitted to being sexually abused and received counseling for Posttraumatic Stress Disorder, Rose thought about reenrolling in beauty school again. The self-education and empowerment she received from counseling left her hopeful and looking forward to her future.

Hila's Experience of Education and Empowerment

Hila is a first generation college graduate and is employed full-time. She reported her “love of knowledge” and education as strengths. Hila is extremely proud of her education and her degrees. Being a teacher is exciting for Hila. She has traveled to other countries to teach English. Education has been a vehicle to experience the world and expand her views about values, morals, and cultural traditions. Her goal is to someday return to graduate school and receive a doctoral degree. Education empowered her to become self-empowered. Hila stated it is paradoxical that her family is proud of her education and degrees on one hand, but on the other hand, they reject her divorce, religion, and her personal independence.

She attributed the acquisition of new knowledge as a change factor. “She [counselor] asked me hard questions and guided me. She didn’t give me answers. She let me find my own answers.” She used self-help books recommended by her counselor between counseling sessions, “I read a book about changing your brain and some Buddhist readings.” Thus, Hila’s formal education and informal education converged to provide her with the ability to reclaim her identity and empower her to make life choices.

Lydia's Experience of Education and Empowerment

Lydia graduated from a rural high school and attended classes at a rural community college. She met her husband at college and married at the age of 19. She

became pregnant and dropped out of college. After she divorced her husband, Lydia went to counseling to make changes in her life. She wanted to return to college but knew she first needed help due to domestic violence issues from her former marriage. With support and encouragement from her counselor, Lydia enrolled in college classes. Lydia stated she feels more self-confident now that she is in college. She believes she has a purpose and a passion for living. Being a nurse is her dream job. She attributed her self-empowerment to her education and her counseling experiences.

The literature on the educational experiences of rural Appalachian Ohio women is lacking. Therefore the following section discusses statistical information about education in the three counties where the participants reside. Corrie, Hila, and Lucy attended Ohio University in Athens County. Lydia is attending Shawnee State University in Scioto County. Rose graduated from high school in Meigs County.

All five participants shared how education experiences shaped their view of self. For the women, educational experiences were foundational for change to occur.

Corrie

Well, kind of talking about what my eventual goals were, like future school plans, stuff like that. And I think that helped because, in future sessions, we would relate my future goals into what was going on right now or right then... We did talk a lot about the future, and he related my goals as to work with students, so he would say things like, "Well, if your student was in this position, like what would you tell them to do?"... Like, I have this career going for me and really great friends. So, that definitely helped to bring my self-esteem back up.

Lucy

I have a Master's degree in Health Sciences in public health. I have worked in a lab. I have worked as an EMT [emergency medical technician]. I have worked in the ER [emergency room]. I have worked for a community college. I was a Program Chair for Medical Assisting at a community college.

Rose

I'm the only girl in my family to graduate from high school... I like to cut and fix hair. I learned some of it when I went to beauty school for awhile, but I cut everyone's hair way before that... And like I said before, I want to go back to beautician school but if I get a job I would lose my disability and Medical card and I need my medication. But I've been thinking about it a lot.

Hila

And she [counselor] recognized and she said that she can tell I'm very educated and I really do understand myself. I just need to learn to be honest with myself about how I really feel about things... My counselor asked me, Why is it so hard for you to be easy on yourself? And I thought, you know, I'm an educated person. I think a lot. I'm very introverted. So, not a lot of thoughts escape me, but that one has. I never asked myself that and then I cried on my way back home in the car. And I thought, why? Why? Why am I so hard on myself? I've always been a really big reader and I like to analyze things and be aware of things that are happening around me. So, that's helpful. Yeah, education is helpful because I'm a big reader. I feel that, because I've looked more into things and because I have talked with more people and been more places. I've seen a lot of things and I can

say for sure that I'm not an expert, but at least I have some evidence of, you know, life outside the family. And I'm the only woman in my family who has gone to college.

Lydia

Well, I'm back at college. That's a strength, I think, because I want to do something else with my life. And I'm older, an older student, but that's okay. I'm no longer drifting along. My life isn't depending on a man or waiting on a man. And I'm setting goals for school. And thinking about a job after I graduate. I have a purpose now.

Education in Appalachia Ohio

The Ohio Appalachian Center for Higher Education (OACHE) is a consortium of ten public colleges and universities in the 29 counties of Appalachian Ohio (Ohio Appalachian Center for Higher Education, 2012). The OACHE created the Educational Opportunity Center to aid first-generation, low-income adults who choose to enter or re-enter college in the 29-county region. The Appalachian Access and Success Study, a landmark study conducted by the Institute for Local Government Administration and Rural Development (ILGARD) at Ohio University (Athens County), examined the barriers to access in higher education in the 29-county area of Ohio Appalachia (Ohio Appalachian Center for Higher Education, 1992). The findings revealed that 80% of high school seniors want to attend college, but only 30% do.

Shaw, DeYoun, and Redemacher (2005) found that gender inequalities influence the educational differences that are greater between women and men in Appalachia. However, the women in this study deviated from the educational norms. Percentage of

the adult population who are college graduates is 18% in Appalachia and 24% in the United States (2000 Census and Appalachian Regional Commission, 2008). Four of the 5 participants in this study can be included in the 18% of Appalachian college graduates.

In Appalachia Ohio counties, the rate of adults with a college education or technical college education beyond high school is 20% below the state average (Appalachian Regional Commission, 2008).

The following section presents statistical information on education from the three studied counties of the participants.

Educational Attainment in Scioto County

Out of a population of 53,292 individuals living in Scioto County who are 25 years and older, 21,452 graduated from high school or possess the equivalency of a GED, while 10,029 did not graduate high school. In reference to a college education, 11,033 individuals reported some college, 4,115 reported an Associate's degree, 4,067 reported a Bachelor's degree, and 2,690 reported a graduate or professional degree (U.S. Census Bureau, 2010 Census). This information illustrates that Lydia is an atypical female in regards to education in her rural Appalachian county. Lydia, a first generation college student is seeking her degree at the only university in the same county where she resides; Shawnee State University in Portsmouth, Ohio.

Educational Attainment in Athens County

In regards to individuals who are 25 years and older (population of 33,523) who reside in Athens County, 11,156 graduated from high school or possess the GED equivalency while 4,310 did not graduate. In reference to college education, 5,944 reported some college, 2,576 reported an Associate's degree, 4,093 reported a Bachelor's

degree, and 5,444 reported a graduate or professional degree (U.S. Census Bureau, 2010 Census). Ohio University is located in Athens County, Ohio.

Corrie, Hila, and Lucy were able to overcome any barriers to a college education in Appalachia Ohio. These women are first generation college students. All three resided in Athens County and graduated from the only university in Athens, Ohio.

Educational Attainment in Meigs County

In regards to individuals who are 25 years and older (population of 16,408) 7,804 graduated from high school or possess the equivalency while 2,918 did not graduate. In reference to college education, 1,028 reported a Bachelor's degree, 2,840 reported some college, 1,487 reported an Associate's degree, and 668 reported a graduate or professional degree (U.S. Census Bureau, 2010 Census). Rose is the only female in her family to graduate from high school.

The educational experiences of these rural Appalachian women are not typical and the following section provides further examination.

Atypical Appalachian Women

Four of the five women in this study were considered atypical due to being college graduates. For Appalachian women, gender is connected to both poverty and lack of education attainment (Flournoy, 1982; Latimer & Oberhauser, 1995) and educational differences between women and men are greater in Appalachia than the remainder of the nation which is influenced by gender inequalities (Shaw, DeYoun, & Redemacher, 2005).

While Rose was the only female to graduate from high school in her family, Corrie, Lucy, and Hila obtained Bachelor's degree and Lydia returned to college to finish her 4-year degree. Both Lucy and Hila had completed their Master's degree and Corrie

was working towards hers. Hila stated she was considering a doctoral degree in education. Highly educated Appalachian women do not meet the cultural stereotypes that rural females are full-time housewives, mothers, and caretakers only. Lucy, Hila, and Lydia were divorced. Corrie, Hila, and Lydia reported differing of opinions on lifestyle, equality for women, and educational and career goals. These women defied the cultural deficit model of staying poor, staying depressed, staying uneducated, and staying married (Egan, 1993).

The theme of education as empowering emerged as the women described their journey of gaining new knowledge that prompted them to believe they could make lifestyle changes while still remaining in rural Appalachia. The women used their educational experiences as a source of personal power which allowed them to seek out counseling to explore their traditional gender roles and find new identities. Education taught the women that they had choices. They chose counseling to learn more about the self. The major universities in the three studied counties have counseling centers for students: Ohio University in Athens (Athens County), Rio Grande University (Meigs County), and Shawnee State University in Portsmouth (Scioto County).

Universities deserve a large portion of credit for promoting and encouraging education in this region. Knowledge is power and with personal power comes empowerment and choice—the belief that change is possible and obtainable. Change has been slow, but change is here.

The women valued themselves initially because of their educational experiences. The women began to integrate change as they moved toward new levels of personal growth.

Empowered women in rural Appalachia have the capacity to make choices and changes based on knowledge, critical thinking, and problem-solving skills and tools learned in counseling. The counseling process promoted the change experiences.

Experiencing Therapeutic Change as a Journey to Empowerment

The women embarked on a journey to find themselves. They wanted to be able to make choices. Hila wanted to choose what to wear and what not to wear. They sought out simple choices and complex choices. The women desired the freedom to choose.

Empowerment: Personal Power

The women learned to value their own decision-making processes of what to discard and what to keep during the counseling process. The ability to make their own choices produced personal power and this produced empowerment in other areas of their lives.

Corrie

It [counseling] just really worked, because I needed the outlet to talk about everything that was going on to try and figure it out... So, if I decide I want to do something, there is not a lot that's going get in my way, I guess.

Lucy

I think she's trying to force me to use my brain and come up for some solutions myself rather than totally depending on anyone... I feel like the pieces of me that were broken apart when this happened, through medication and counseling, I've been able to take the pieces of me that I like and leave behind the pieces of me that I didn't.

Rose

When [counselor] told me it wasn't my fault, I just stared at her. Then I cried.

And something lifted off of me. Well, the more I talked about it, I just felt better.

It felt like something was stuck in me... I stopped blaming myself. And I stopped being angry at myself.

Hila

I guess I was looking for someone who could help me get the power that I needed, that I felt that I had never had in my life. I guess empowerment.

Lydia

I was looking for something. And I didn't know I was looking for me. I didn't know what I liked or what I didn't like. I felt like a person with no identity.

These women felt respected and valued by their counselor and this produced the valuing of self. The inner process of personal power produced empowerment. Their changes began on the inside with awareness of self and exploration of self and worked its way to the outside. Through understanding of self and acceptance of self, they were able to reconstruct or reclaim their Appalachian cultural identities as females and remain in the rural region they appreciated and cherished. For these women, personal empowerment was found by self-exploration, self-understanding, and self-acceptance.

Empowerment: Social Support

The participants found empowerment in the relationships they built with new friends with the same problems and issues that propelled the women to counseling or surfaced during the therapy process.

Lucy

I belong to an online grief support group. The nice thing about the online grief support is, number one, they very strongly advocate for counseling. They say even if you only need it briefly, you need it. They're very strong advocates, plus I can go to this online grief support and talk to other people who have been through this.

And they know exactly what I'm going through and what I'm feeling.

Rose

And she [counselor] told me about sexual abuse and how women deal with it.

... And now she wants me to go to group counseling to hear how other women deal with sexual abuse. So, I'm thinking about going.

Hila

I have run into and found women who have divorced and who have become very successful. And it's not that I want a lot out of life. Some of these women are extremely successful. But, when they tell me that it was the right thing to do, you know it just feels so much better just to hear that and to see that, even though it's hard at first better times will come.

Lydia

When some of the girls [from her support group] talked I felt like it was me... I felt relieved. I wasn't crazy... I just cried when the women shared their stories... I found some hope for me.

The women found social support outside their families of origin. Corrie returned to her previous friends and reinforced these relationships by spending time with them and by not taking them for granted.

The women participants valued their families (Coyne, Demian-Popescu, & Friend, 2006); however, they expressed satisfaction when they found their own identities, which included gender empowerment in regards to marriage/partner equality. Appalachia is a collectivistic culture; however, three of the five women in this study struggled with autonomous individualism. Hila distanced herself physically from her mother and grandmother when they continued to blame her for the divorce. Lydia was temporarily living with her mother while she attended college distanced herself emotionally because her mother denied generational domestic violence. Her relationship with her mother stayed the same before, during, and after counseling. According to the literature, the Appalachian family structure is viewed as a strength when members seek physical, financial, social, and emotional support from within; however it can be seen as a barrier when it prevents necessary mental health treatment and services (Beaver, 1988).

All the women identified a strong attachment to their rural region. Appalachia is their home. Not one interviewee spoke of relocating outside of Appalachia. The theme love of place (Jones, 1994) that emerged from the interviews is consistent with the literature. Three of the women in this study embraced certain characteristics of their group identity of being Appalachian; however, that, too, was a process. They learned to honor the positive characteristics of being Appalachian females.

The last theme illuminated how the women were different from their mothers' generation.

Experiencing Therapeutic Change As Modern Appalachian Daughters with Traditional Appalachian Mothers

What was very clear from the interviews is that these women were at odds with their mothers' generational and cultural values, beliefs, and views in regard to gender roles, marriage and relationships, religion/spirituality, and sexuality. All participants in various degrees seemed torn between the dichotomies of two cultural identities; the traditional Appalachian woman and the modern Appalachian woman. The biological mothers of the five participants were born and raised in rural Appalachia.

The women in this study initially came to counseling to address typical women issues such as abuse, divorce, grief, guilt, shame, and loss. However, through the process they realized they needed to discard some traditional beliefs and adopt some modern beliefs. Through the process of counseling these values changed. Their changes were similar and their changes were different.

Even though the participants are adult women, they felt rejection from their mothers because they were choosing to question many of the cultural norms and their mothers did not understand why. Counseling provided a safe environment where they could reconstruct their self-identities and chose what cultural traits to keep and what cultural characteristics to throw away. Rose, Hila, and Lydia chose female counselors and they felt validated by another female who lived and worked in an Appalachian region. Lucy did not consider the counselor's gender and Corrie was scheduled a male counselor and she also reported feeling validated.

My Mother's Education – Not My Education

Educational empowerment was a theme that surfaced from the data analysis. The emergence of education as central to the lives of these women stood out. Clearly, they value education and the empowering aspects it brings. The women found new information and knowledge during the time spent in higher education. They learned about gender equality. This knowledge gave them the courage to seek out counseling to further explore their problems and find solutions. The women used their educational experiences as a source of power to reformulate traditional gender roles into a new cultural identity. The women spoke of education as pivotal in achieving their goals to be or become self-sufficient. They wanted a career, not just a job. The finding of this study found that women do change as they make the higher education journey. The participants gained knowledge and started to question why they believe what they believe. Self-confidence improved. Social skills improved. More change occurred. Self-empowerment was evidenced as they realized the potential for financial self-sufficiency and stability. Bauer, Katras, Seiling, and Ovel (2007) addressed empowerment and financial security in the literature and Bates (1989) stated, "Self-knowledge is empowering" (p. 5). Empowerment came when the women found their ability to choose what to keep and what to discard and to be able to cope with the cultural rejection from family, church, community, but mostly from their mothers.

My Mother's Gender Role – Not My Gender Role

Through the process of social learning, the daughters modeled social roles, social identity, and gender identity from their mothers. After Hila and Lydia left home and

attended college, and prior to their counseling experiences, they began to question their mothers and family female role models for not questioning gender inequality and patriarchy.

Hila's Voice

My grandmother had a stepfather who abused her and whose mother didn't seem to care. Then my great-grandmother, my grandfather's mother, she had seven children. She raised them all during the Great Depression and she was also a tough woman, someone to look up to, like the perfect, strong country woman. So, I started getting scared, thinking, "What if I'm like that with my children?" I was so happy when I had a boy. This was before I realized these things. I didn't want to have a daughter because I was so afraid that would happen again.

Hila revealed her fears of motherhood if she had a daughter. She wanted to stop the cycle of male dominance, abuse, and generational inequality that may have been passed on to a daughter. She further explained:

I feel like the men are coddled a little bit more and they're just expected to be rascals and they're expected to run into some trouble here and there. But, the women they're expected to be more.

Lydia's Voice

Growing up I thought men had the right to boss you around; be the head of the family; make most of the decisions. In counseling I learned that I can be a strong woman, independent and I can decide what is best for me. Before that I thought that all men tried to control their wives. I thought that's just the way it is.

My Mother's Marriage – Not My Marriage

Hila and Lucy discussed three generations (maternal grandmother, mother, and themselves) as experiencing levels of emotional, social, financial, and/or physical abuse in marriage. The multigenerational message of women as being submissive and dominated was transmitted across generations. The women experienced incongruence between their mothers' expectations and self-expectations. These women had recreated their mothers' patriarchal marriage. Their mothers refused to see male dominance and male aggression as reasons for divorce. Both Hila and Lydia divorced their abusive husbands. However, Lydia continued to be involved in abusive male relationships and through the process of counseling she gained awareness and insight. She vowed to no longer date abusive males.

Hila

I started to become a little scared because I started thinking about my mother and I started seeing more parallels in my family. I started noticing patterns in the behavior and the character of each woman in our family, all the way through my grandmother and her sister and my great-grandmother... They [mother and grandmother] are just saying something automatically because they've said it all the time and their mothers said it all the time and I've got to break the cycle.

Lydia

When I learned that I was living what I learned from my family and all about generational domestic violence. I mean that I believed women were lesser.

When I saw the truth of the matter, I changed how I think about things.

I don't believe in men dominating women in any culture or society.

Men should not hit or push or do anything violent to any woman or girl.

It's not right. It's just not right. Just because you live in the country or in parts of Appalachian does not mean its okay to abuse your wife and kids.

DeKeseredy and Joseph's (2006) qualitative study on abused women in Ohio Appalachia found that the victims' relatives rarely intervened in domestic disputes. The women in this study spoke about the impact of generational domestic violence on their overall mental health, and as adults they began to recognize the patterns of abusive relationships. They desired something different. They wanted to be different and live differently. Intimate abuse was shunned and discarded. These two women (Hila, Lydia) requested female counselors because they did not think a male would be understanding and empathetic.

In the context of cultural Appalachia, divorce symbolizes failure, specifically failure by the wife (Keefe, 2005). However, two women viewed divorce as a way to gain personal freedom and independence from male dominance. They recognized the lack of gender equality in their marriages and partners and associated it with factors related to control of women in Appalachian culture and traditional religious beliefs. Incongruence was felt.

Hila and Lucy stepped outside of Appalachia and married men from other countries. While Hila's mother accepted her spouse because of similar views on gender roles in marriage and family life, Lucy's mother rejected her husband, especially when they relocated to England for a short time.

Lucy

But, to me, through my counseling with her, she [counselor] has helped me to develop these insights. One of them is my mother, who said, oh, well, she should never have gone to England with him and she had a good job and he just took her away and duh, duh, duh, duh.

Mothers Viewed as Strong - Mothers Viewed as Weak

The participants praised their mothers for taking care of the children and family when the men failed to provide the basic needs such as shelter, food, clothing; however the participants viewed their mothers as weak for being silent and allowing their spouses, fathers, and grandfathers to perpetuate cultural male privilege.

Rose

The women in my family are strong, mothers, aunts, grandmothers, and definitely my great-grandmothers. They did everything, like cooking and cleaning.

And they made sure the kids ate, took baths, and went to church, things like that.

And when the men went hunting or fishing and sometimes drinking, the women still stayed home with the kids.

My Mother's Religion – Not My Religion

Three of the women (Corrie, Lucy, Hila) acknowledged that their spiritual beliefs are at odds with the traditional and cultural Appalachian religion of Christianity. Even though many of the participants were at odds with their mother's religious views, they indicated their religious or spiritual beliefs to be sources of inner strength and comfort.

Both Hila and Lucy challenged Christianity and left their family's religion in search of other ways to worship. Hila was quick to point out the difference between

religion and spirituality. Corrie also left her family's church, but she explained that she is agnostic.

Corrie

I'm agnostic.

Hila

I feel that here, because a lot of life is kind of almost on the survival level.

You know problems with the mind and emotions are considered ridiculous and a waste of time to talk about and to treat. And that the best medicine for anything is just to be stronger. And just be responsible and be religious, go to church. If you've got problems, then you need make peace with God.

And I felt myself going back to the church not for myself but to satisfy my family and to put their mind at ease about me.

Lucy's family adheres to the Christian religion and she has not disclosed that she is Wiccan. Lucy is very aware that her spirituality is at odds with Appalachian traditional values.

Lucy

There's religious discrimination too. When he [husband] came over here from England he brought a cross with Gaelic... and I said that's beautiful but I'm not a Christian. And he said that's okay. It's Celtic. A Celtic cross. I am Wiccan.

And I firmly believe that he [deceased spouse] is in the summer lands and he's waiting. But, I don't share this with my family.

Lydia and Rose's choices were different from the other three participants. Although Lydia identified intimate abuse, male privilege, and gender oppression in her family tree,

she did not speak of the inequalities found in religious doctrines of many traditional churches in Appalachia. During the interview, Lydia did reveal that she had left her family's church and religion, but returned to Christianity during the end stages of counseling.

Lucy

Well, I went to church with my family growing up, but I didn't go back after I left home. I felt like the women were second class citizens cause they had to wear dresses to every service. They couldn't be in the pulpit except to sing and they couldn't drive the church van and so on and so on. And the girls were always cooking or cleaning up after church dinners. And the men just stood around and talked. So I quit church until recently when a woman in my group asked me to go with her to church. So I went a few times with her and I liked the preacher and his wife. Long story short so I found my faith again. And I started going to a new church with my friend. The people were kind there. And I felt like I belonged. They didn't judge me. So, I was relieved. And I didn't have to explain about being divorced or anything like that. And guess what? Women can wear pants so that's what I do. And there's a women's dinner every year where the men cook the dinner and then serve it to the women at tables. And the men clean the kitchen too. They refill the glasses with iced tea and the women just laugh.

Lydia did not return to her mother's church but began to attend another Christian church with a friend from the support group for victims of domestic violence. I wondered when Lydia would begin to question the female subservient roles in the church as she continued on in her journey of self-empowerment and female equality. I wondered how Lydia, a

budding feminist in rural Appalachia, would navigate through any institution or religious organization that either allowed or ignored intimate abuse and inequalities against women. Lydia had become an advocate of herself.

Three women believed they could not seek support from family, specific friends, and church members from the traditional organized Christian churches due to pursuing other religions: Agnostic, Wicca, and Buddhist. Two of the women adhere to Christianity and attend church services. One woman attends the church of her youth while another attends a more contemporary church. For these two women, religion is an integral part of their self-identity and they chose Christianity because it is compatible with being an Appalachian woman.

My Mother's Sexuality – Not My Sexuality

Corrie's sexual orientation differed from the other participants. Corrie is an Appalachian female who is a lesbian and lesbians are often shunned in rural areas with fewer social supports (Rural Women's Work Group of the Rural Task Force of the American Psychological Association, 2002).

Corrie

I didn't go to counseling because I'm gay. I'd already accepted that and dealt with those feelings, like feeling confused, like an outcast. My family doesn't accept it so I don't talk to them about that kind of stuff. At college, I found people like me and I joined a group on campus. And that helped me a lot.

Hila

As far as, you know, emotional and sexual needs and all of these things are concerned all those are superfluous... They ignore their desires and they make themselves believe that all they want is deep religious spirituality.

Hila expressed her view that sexual needs were ignored by the women in the family tree and replaced by religious beliefs.

Daughters and Mothers Divide

Hila, Lydia, and Rose reported their relationships and communication with their mothers became more strained during and after counseling. Hila distanced herself from her mother and grandmother. Lydia stopped discussing the generational domestic violence in their family tree and Rose decided not to disclose her childhood sexual abuse to her mother. Lydia and Rose lived with their mothers at the time of the interviews.

Rose

I probably won't tell them. It's over. My guilt is gone and I don't want to dwell on it. And I can't blame them now. They didn't know. My mom didn't know about the abuse. And I didn't tell her... I love my family but I have to get away for awhile so mom drops me off at the library for a few hours when I need to.

Hila

But, it's different because I realize, acknowledge that I can't fit in the role that they see me as. I can't. So, I've had to separate from them as well. My son sees them. And they get along with my ex. They're crazy about him because, well, you know, the man. He didn't want to divorce. He's the one who wanted to save the marriage. I'm the enemy. I know that they still love me and I still love them.

But, I've always been a person who is able to be more independent.

How can I say it? I got myself back in the deal, and at the same time, I have a better idea of who I am and what I want out of life.

Lydia

The past is not changeable and my mother's opinion is not changeable.

But, we don't have to talk about the past. It's over and Dad passed away.

Corrie, Hila, Lydia, and Lucy sought out friends for emotional support during and after the counseling process. The premise of substituting friends for family members that emerged from the interviews is not consistent with the literature. Appalachian families are known for collectivism, kinship, and closeness (Jones, 1994); however, the participants in this study sought out others who supported their changing viewpoints on traditional lifestyles. The women sought out other relationships when their mothers did not support their decision for a divorce and blamed them for rebelling against the traditional views of marriage. The women looked elsewhere for emotional and personal support and viewed friends and coworkers as confidantes, sources of comfort, and givers of advice. Friends and coworkers were viewed as significant before, during, and after counseling. A premise for the women was the necessity of a social support network. The women valued relationships and when they did not receive comfort from their mothers, grandmothers, or family members, they sought out friends, and/or coworkers. Two women attended support groups; one for victims of domestic violence and one was an online grief support group.

Research supports the premise that a client's support network influences improvement (Lambert & Anderson, 1996; Lambert & Asay, 1984) and the women in

this study went outside of their Appalachian families to find emotional support and encouragement. The women sought out new friendships.

Old and New Collide

Through the change process, the women explored mother and daughter relationships and reformulated their own cultural self-identities as rural Appalachian females. The women felt safe and therefore were able to challenge traditional gender roles, gender inequality, and gender oppression. All five women reported spending time with their mothers and grandmothers during childhood and adolescence; however, the relationships changed for Corrie, Hila, and Lydia after they attended college. The college atmosphere provided a new way of thinking about old ways. These three ladies embraced the opportunity to disagree with their perceived views of several negative cultural traits of Appalachia which included their opposition to male oppression, belief in equality in marriage or partner relationships, and the ability to make their own choices about lifestyle and religion. However, these women felt stuck between the traditional and the modern. They wanted to decide what the best of both worlds was and to feel comfortable with their choices. They wanted their mothers to understand and accept their choices, but that was not happening.

Through the therapy process, the women became aware of negative generational patterns and how these patterns were carried out in the client's own relationships and life. They became aware of differences in cultural value systems.

A Safe Counseling Place to Talk About Their Mothers

Counseling provided a place where they could express their emotions concerning views of their mother's lives, opinions on generational domestic violence, and patriarchal

dominance. Finding a safe place was crucial for these Appalachian women to feel comfortable enough to talk about how their views differed from their families of origin, especially from their mothers. Corrie, Lucy, Hila, and Lydia loved their mothers but experienced incongruence because they wanted a different lifestyle while remaining in their Appalachian environment. Rose wanted to move closer to the city to attend and experience more activities. She longed for independence and her own apartment. While she loved the place of rural Appalachian, she was not tied to the land like her ancestors.

The women reconstructed their social identity within their cultural identity and understood how community norms influenced view of self and thus increased symptoms of depression and anxiety which prompted the seeking of counseling and change. They felt incongruent with their cultural identity prior to counseling.

By attending counseling, the women took action to change their situations and ultimately their lives. Corrie, Lucy, Hila, and Lydia created new cultural self-identities and Rose was still in the transitional stage of finding her own identity. Rose's family did not relocate closer to town and they did not want her to find an apartment. Corrie's family did not accept her sexual orientation or her agnostic beliefs. Hila's family did not accept her decision to divorce or her Eastern religion. Lydia's mother denied generational domestic violence. Both Hila and Lydia accepted that their mothers and grandmothers would not be changing any of their cultural beliefs about gender oppression, patriarchy, and divorce.

My Mother/My Self: The Daughter's Search for Identity is a book by Nancy Friday (1997). Through interviews, she investigated the generational legacy and unique interactions of daughters and mothers and why daughters become like their mothers.

However, in this present study the daughters rejected and discarded some of their mothers' traditional and Appalachian cultural values and beliefs. They found the process of developing a new self-identity while still keeping other beloved cultural values to be a painful journey. However, it was a personal expedition that they had to take. Education was the pathway and they traveled it undauntedly. They found the world was bigger than their own background of rural Appalachia. They struggled for female empowerment and through counseling they found their destination of self-empowerment. They left home to find home. These courageous women love their mothers and grandmothers but they realized they needed to cross the old covered bridge to learn to explore, understand, change, accept, and love themselves.

Understanding Their Appalachian Mothers

Toward the end of their counseling experiences, the participants were gaining insight and trying to understand their mother's choices in the contextual and cultural place of Appalachia. Their mothers had not attended college and did not have educational experiences to draw upon. Their mothers were not exposed to different ideas, other cultures, and opportunities outside of rural Appalachia.

Lucy

Through my counseling with her, she has helped me to develop these insights.

One of them is my mother, who said, "Oh, well, she should never have gone to England with him. And she had a good job and he just took her away." And so, I told her about this and I thought about it. And she [counselor] goes, "Well, what do you think?" I said, "I think what it is, is I am her daughter and she cannot comfort me in this, and so she's angry. And she cannot make this better."

Hila

They're not aware of what they're saying. They're just saying something automatically because they've said it all the time, because their mothers said it all the time and their mothers have said it all the time. And I've got to break the cycle.

Lydia

But since counseling I understand her [mother] more. She couldn't go to a safe shelter or counseling or even talk about it [the abuse] to her mother because her mother experienced abuse too. And there were no shelters back then. The police wouldn't get involved back then either.

The women were beginning to see their Appalachian mothers in light of gender roles in a patriarchal society. As was previously discussed in Chapter Three, Brooks (1999) titled her article, *Coming Home: Finding My Appalachian Mothers Through Emma Bell Miles*. She writes, "Growing up in a culture that frequently denigrates the very women that it relies upon, I had a difficult time finding models for womanhood among the women of my Appalachia" (p. 157). Brooks further declared, "I abandoned the Appalachian women of my past in search of a future with the new womanhood I saw in the academy" (p. 157). However, through her own personal life journey Brooks concluded,

Through discovery of the writings of one of Appalachia's earliest feminists, Emma Bell Miles, I found the value of the culture I had left behind, as well as my own ability to create space for myself within that culture on my own terms (p. 157).

The women in this study perceived and understood therapeutic change in the gradual process of self-exploration, self-awareness, self discovery, self-understanding, and self-acceptance in the formation of self-identity in the cultural context of rural Appalachian women. They became educated and empowered women of Appalachia, yet they stayed in Appalachia. The women focused on the results of change in the form of self and the aspects of awareness, understanding, identity, and acceptance. Change occurred in the women in the valuing of self; a mixture of new facets with some of the old cultural facets. They became more independent women and believed they could take care of themselves. Brooks (1999) ends her article by asserting:

... we need to help our daughter understand that they are more than the dress on the ironing board, that they and their Appalachian mothers have a legacy of worth. That legacy gives us the right to be whoever we want, whenever we want, and remind us that wherever we go, we are always home if we are at home in our hearts (p. 171).

The five women in this study wanted the right to choose this very same thing as Brooks. For these women, counseling through the therapeutic change process made it possible.

Counseling changed not only how they viewed themselves, but how they interacted with their families as well. Corrie separates her sexuality from family gathering and holidays. Because of her husband's death, Lucy realized the immortality of life and she is more tolerant of her mother's views. Rose worked through her feelings about why her mother did not protect her during the sexual abuse. Hila no longer discusses her changes with the women in her family and this frustrates her. Lydia is still

trying to understand why her mother denies the generational abuse of females. The counseling compass pointed these women in the direction of healing, but their journeys continue.

The defiance of cultural norms that these women valued increased symptoms of anxiety and depression and further detached them from their mothers. In terms of their familial relationships, their mothers adhered to the traditional values of Appalachian while the women sought to incorporate new traditions comprised of changes in thoughts, emotions, and behaviors. The identity construction or reconstruction of these women intersected with familial, educational, professional, and religious spheres of cultural influence along with the geographical region, state, county, township, community, and addresses they call home.

Through this study, the women wanted their self-empowered Appalachian voices to be heard. They wanted other rural women to know that change is a choice and it is a choice worth making. These women considered the counseling experience to be the vehicle that drove the therapeutic change process. The clients were in the driver seat and the counselors were in the passenger seat. The therapeutic alliance was constructed from a foundation of safety.

Participant's Theory of Change

The participants perceived and understood the process of therapeutic change to belong to both client and counselor. During the interviews, I drew a circle and asked the participants to use 100% to allot change to self, counselor, and others in regard to who was responsible for therapeutic changes. Corrie attributed 50% of change to herself, 25% to counselor, and 25% to social support system. Corrie and Rose attributed 50% of

change to herself and 50% to counselor. Hila attributed 90% of change to her counselor in the beginning; however, toward the ending of counseling she attributed 50% to self and 50% to counselor. Lydia attributed 40% of change to self, 40% to counselor, and 20% to social support system. The following chart represents the change percentages allotted to self, therapist, and others by the participants.

Table 3:

Client Counselor Percentage

% given to self		% given to counselor	% given to others
P1	Corrie 50%	25%	25%
P2	Lucy 50%	50%	0%
P3	Rose 50%	50%	0%
P4	Hila 50%	50%	0%
P5	Lydia 40%	40%	20%

The clients talked, listened to feedback, completed homework, and actively embraced the change process. The clients were active participants and not passive. The clients learned and practiced new coping skills and new skills. P1 stated, “I was willing to work to get better.” The participants discussed personal factors which prompted and motivated them to seek out counseling in order to make changes or to think, feel, or act differently. They reported readiness prior to the first counseling session. P1 stated she gained some relief after scheduling the first appointment with the receptionist, “I knew I had something to look forward to... this gave me some hope.” Clients were willing to disclose personal and painful information and share secrets in order to alleviate emotional distress. Clients brought their expectation of feeling better into the counseling office.

They had degrees of hope that something would change or be different. Participants were able to identify their personal strengths and talents as change promoting factors. P2 is creative and she used this talent to work on projects during her healing process. P3 used her talent for cutting and styling hair with her family members, neighbors, relatives, and friends. P4's strengths included her love for learning and she transferred this to learning about herself during counseling. P5's strengths included educational goal-setting and returning to college. She wrote out a plan for short and long-term goals. The clients were determined and committed to attending counseling sessions until relief manifested and something changed. The participants expressed a readiness for change prior to calling for their first counseling appointment. Participants were self-referred and attended counseling voluntarily. The expectations that counseling could help prompted attendance as well as the hope that things could get better over time. Some participants expressed feeling some relief and/or hope after making their first appointment. The participants had expectations that something would be different when they attended counseling. They spoke of hope and expectations of finding relief. They used the word hope during the interviews. One participant stated, "A little hope seeped in." Another participant stated, "I had some hope because I didn't think things could get worse at the time." They expected that something would change. Some participants talked about future goals in counseling sessions instead of dwelling in the past and some participants wanted to understand their past and generational dysfunction. Participants wanted to find solutions to their problems. Four participants discussed overwhelming emotional pain as a motivator for seeking counseling. They wanted to change how they were feeling. Participants wanted to learn how to express, process, and manage emotions. Two participants stated they were

experiencing an emotional crisis; both from lost relationships. One romantic relationship ended with a breakup and the other relationship ended due to death. Participants experienced emotional catharsis and worked through their intense emotional pain and distress and afterward they were able to explore cognitive and behavioral changes. All participants spoke of loss and the ensuing confusion, instability, and emotional chaos. Change happened in degrees before, during, and after counseling. The participants believed change occurred as a result of counseling.

Hubble, Duncan, and Miller (2003) postulated that “Within the client is a theory of change waiting for discovery” (p. 431) and theories of counseling are developed to facilitate change in the client (Bergin & Garfield, 1994; Blow, Sprenkle, & Davis, 2007; Overholser, 2005). But is the client solely responsible for the therapeutic change process? The Appalachian participants in this study gave credit to both themselves and the counselor.

Schlossberg, Waters, and Goodman (1995) penned the book, *Counseling Adults in Transition* and Schlossberg (1984) is developer of the Transition Model which posits four major influences in regard to how clients in counseling cope with transitions. The 4S’s are Situation, Self, Support, and Strategies. They discussed the Transition Process and explained, “Reactions to any change over time depending on whether one is *moving in, through, or out of* the transition” (p. 26). Does a change framework or model benefit a client attending counseling or is it more beneficial for the counselor? We need to ask the client. The following are responses to the statement: Describe the word *change* in your own words:

Corrie

I prefer stability to change. I don't deal well with sudden change that I can't control. I'm still kind of a control freak. The biggest indicator was just that I felt better and I was more able to do things, I was making better changes and thinking in different ways. I could do life. I could eat and sleep and go to work without feeling like I had this big cloud over me. I think it's a lot of mental work... it's not a magic fix... It kind of goes back into how I can more identify my emotions.

Lucy

For me change is being able to have what is a normal life as a single person... I'm not as critical of self or others. I tend to accept people's foibles a lot more readily. I cannot emphasize enough how much the medication and counseling helped me to overcome as awful lot of the demons that I had from my husband passing away. It has helped tremendously.

Rose

It's when things get better and you feel better. It's when thoughts of hurting yourself go away.

Hila

It starts with awareness, but change is a growth process... parts can happen right away... but it can become more.

Lydia

Change is wanting the pain to go away... having some hope that things can get better... that things will be different. Change is hard, but it's worth it. I change

when I think about things... learn new things. I make changes when I pray or read books... or talk to others who've been through the same things as me.

The five participants expressed gratitude to their counselors for being a facilitator of the change process. Hila stated, "I needed her to guide me... to show me how to do it... to give me hope that I could change things." Lucy stated, "She was there in my crisis... I did nothing but cry for several weeks... She handed me tissues.

In the experiences of these rural Appalachian women, I could hear both the tragedy and the triumph in their voices as they shared stories of trauma and travesties. They worked hard and long to expunge their demons and find peace and contentment in a reformulated cultural self-identity. They embraced change. Yes, it was difficulty and painful, but they transformed from victims to survivors. These Appalachian women were proud to share their stories with me. I think that being a part of this study validated their changes and the therapeutic change process.

Summary

In this chapter we heard the collective voices of change for Appalachian women through the counseling process. Four themes were generated: Experiencing Therapeutic Change in a Safe Counseling Relationship, Education as a Precursor to Experiencing Therapeutic Change, Experiencing Change as a Journey to Empowerment, and Experiencing Therapeutic Change as Modern Appalachian Daughters with Traditional Appalachian Mothers. They wanted the right to define what being a female in rural Appalachian means to them. They wanted to believe it, embrace it, live it, and be proud of it. They found a sense of self. They heard their own voices. What can we learn from

these women and how can it change our understanding and counseling practices for rural Appalachian women? This question is answered in the last chapter.

CHAPTER SIX: SUMMARY AND LEARNINGS

FROM RURAL APPALACHIAN WOMEN

This study focused on exploring the perception, experience, and understanding of psychotherapeutic change during the mental health counseling process by women residing in rural Appalachia Ohio. A qualitative methodology framed by a phenomenological inquiry was selected with the purpose of better understanding how these women make sense of their counseling experiences; specifically, the phenomenon of therapeutic change. The focus of phenomenology is on “descriptions of what people experience and how it is that they experience what they experience” (Patton, 2002, p. 107). A combination of Colaizzi’s (1978, pp. 59-61) phenomenological method, Van Manen’s (1984) phenomenological approach, and Moustakas’ (1994) phenomenological research model was utilized for data analysis.

Chapter Six is divided into the following sections: addressing the research questions, implications for the counseling profession as well as contributions of the findings of this study, future recommendations for research, and summary.

The Research Questions

This study explored counseling and therapeutic change in the context of life as a rural Appalachian woman and how culture influenced the meanings that participants of this study placed on their experiences. What did these rural Appalachian women tell us that we did not know before? The central research question that guided this study was: *What are the Appalachian female clients’ experience, perception, and understanding of therapeutic change?* Generated themes included: Experiencing Therapeutic Change in a Safe Counseling Relationship, Education as a Precursor to Experiencing Therapeutic

Change, Experiencing Change as a Journey to Empowerment, and Experiencing Therapeutic Change as Modern Appalachian Daughters with Traditional Appalachian Mothers. Four themes emerged.

What made it safe for these rural women to address the painful process of change? The counselor made it safe. The therapeutic relationship made it safe. The women felt accepted and valued. The counselor had to show a nonjudgmental attitude toward Appalachian women who differ from the cultural expectations of females. The women sought out a safe space to challenge their traditional cultural beliefs. These women had opposing wants, needs, opinions, desires, and life lifestyle goals in comparison with their Appalachian mothers. During the counseling process, the women felt safe enough to challenge traditional gender roles in their homes, workplaces, communities, and places of worship.

How were the women empowered during counseling by the process of therapeutic change? The counselors listened to their stories and allowed them to talk about their cultural disparities. The women were able to explore traditional values, rules, and to question why they believe what they believe. The women were able to create new identities of self by discarding some old and finding some new and they merged these two together to embrace the wholeness of self.

How did empowerment intersect with education? Because of educational experiences, the women compared their own cultural beliefs with the views of others in classes, in books, and they exposed themselves to other worldviews. Knowledge is power and it increases self-confidence. Education was an entry point to open their Appalachian minds. They learned where to go for resources. Interestingly, the participants conveyed

that their mothers supported their educational achievements. Education is an essential tool in combating social inequality (Flournoy, 1982). Educational experiences empowered these women to be able to explore their own backyard in a safe space with a nonjudgmental counselor. Education promoted personal empowerment which cascaded into exploration of social empowerment. For these women, change was an empowering process and change came about as a process of therapeutic change.

One of the most significant results of this study is that the participants were at odds with their Appalachian mothers before, during, and after counseling in varying degrees due to different beliefs in cultural gender roles and female oppression. They wanted autonomy and independence from their families of origin, yet they wanted acceptance and respect for their differing views. They wanted change, but they feared change at the same time. Their stories received validation from their counselors.

The three generated themes interconnected and intersected with one another. When gender in the cultural context intersected with education, the women triumphed with high school diplomas and higher education degrees. Their mothers supported their educational experiences. However, Corrie's mother rejected her sexual orientation; Lucy's mother rejected her marriage to a man from a country outside of Appalachia; Rose's mother rejected her blooming independence and longing for her own apartment; Hila's mother rejected her decision to divorce; and Lydia's mother rejected her new-fangled feminist views. Being female in a patriarchal society, they sought out a safe counseling place to disclose their differing views and to try on new cultural identities. They became empowered through this change process as the counselor provided a

nonjudgmental space. The women tried on new cultural clothes and discarded some of the old garments.

The sub-questions follow: *What are clients' beliefs concerning change during their course of therapy?*

The woman understood therapeutic change to be slow and gradual. They believed change occurred when they understood their family of origin issues that were related to the attributes and traits of Appalachian people. The women strove toward self-acceptance and found it. They gained self-awareness. All five women understood counseling not just to be helpful but to be a life-changing experience. They embraced counseling as an avenue for self-exploration, self-awareness, self-acceptance, and self-identity. They explored their thoughts, feelings, and behaviors.

How do participants describe/make meaning of changes that occurred before, during, and/or after therapy?

The women sought out counseling voluntarily. They wanted to make changes and that prompted the seeking of counseling. They were ready to make changes. They were initially motivated to attend counseling for relief from emotional pain. The women wanted to understand their losses and make sense of their lives. The women thought about the questions asked by therapists between counseling sessions and the readings from self-help literature and this prompted reflection and self-awareness.

What do participants attribute change to: themselves, therapists, or others?

The women attributed change to themselves, their therapists, and their support systems. Relationship was the vehicle for change to occur. Relationship with self,

counselor and others. The women viewed counseling as a collaborative process between client and counselor.

What suggestions would the women like to make to clinicians about the psychotherapeutic change process?

Hila and Lydia would like counselors to understand domestic violence and to help clients understand generational intimate abuse in Appalachia. The women want counselors to treat them as independent thinking women and to facilitate the change process. They wanted to be involved in the counseling process. Rose saw several counselors before she revealed her childhood sexual abuse and she wanted counselors to make sure clients feel comfortable enough to share secrets. She wanted counselors to understand how living in a rural area with family and relatives can isolate the victim geographically, socially, and emotionally.

Implications for Clinical Practice

The qualitative design of this study begins to fill the gap in the existing literature as presented in Chapter Two. The use of qualitative, specifically phenomenology research methods, in this study allowed detailed and meaningful data to be gathered and analyzed. The female participants provided their perspectives and understanding of therapeutic change in their own words as they told their counseling stories. Moreover, the data presented in this study identified the distinctive factors with the hope of bridging the gap that exists in the current literature regarding this population. The information gathered in this study may serve as an impetus to further study rural Appalachian females in relation to counseling and their psychotherapeutic change experiences.

Counselors/Clinicians in Rural Appalachia

One benefit of this study is to bring awareness to clinicians in rural regions. The final question asked in the semi-structured interview was: *What would you say to a counselor who is providing services for an Appalachian female client?*

All female participants spoke of emotional relief from painful and overwhelming feelings. They gauged change by a reduction and termination of symptoms and by simply feeling better. They learned to identify, process, and express emotions. Counselor educators may consider offering coursework or weekend seminars on Dialectic Behavioral Therapy and Emotion-Focused Therapy in order to give future counselors tools in emotional processing.

The information gained in this study contributes an understanding of the role the counseling relationship has in facilitating client change. It both supports and supplements the exiting literature. The significance of the therapeutic alliance can be understood more fully by assessing clients' perceptions and experiences of this mutual relationship in this study. As discussed previously, the therapeutic relationship is the foundation for change in counseling. Therefore it may behoove practitioners to become more aware of the building and maintaining of the therapeutic alliance. Soliciting the client's perception of the counseling relationship during the session periodically for feedback could increase understanding and further strengthen the therapeutic bond. The conclusion drawn is that first and foremost, the relationship between client and counselor is essential for the counseling process, the change process, and the outcome/result. The five women of this study indicated they developed a relationship with their counselor and this was fundamental in their ability to make changes.

The findings from the current study provide an avenue for future research in relation to women and counseling in rural Appalachia and how cultural factors and barriers need to be assessed. This study implies that it is important for counselors to include Appalachian clients' perceptions and understanding of therapeutic change in the initial assessment and evaluation, in the treatment plan, during and after each counseling session, and during termination. The women wanted to be included in the change process as active and not passive clients.

In order to meet the mental health needs of rural Appalachian women, helping professionals need to view each woman within her cultural context including her beliefs, her relationships, her barriers, and her resources. Three of the five women emphasized how listening as their counselor gave an example of a similar problematic experience helped to strengthen the client-counselor bond. Russ (2010) recommended using general self-disclosure with Appalachian clients to build trust into the relationship. A facet of the Appalachian culture centers on the sharing of stories and perhaps the clients became more comfortable with this mutual sharing. He discussed egalitarianism and self-disclosure as counselor traits that promote trust and loyalty in Appalachian clients. Counselors need to present themselves as authentic people without "airs" and without an attitude of an all-knowing expert. Counselors can utilize narrative therapy to encourage story-telling and can reciprocate with limited self-disclosure stories. One participant spoke ardently about wanting to be treated as an equal and she felt valued when the counselor talked about some of her own life experiences. Likewise, another participant said "I recognized the imperfect person in her as well, which I really liked. I want to know that I'm talking to a human being." In regards to self-disclosure she appreciated it

when her counselor shared a similar work problem and how she solved it, “She even shared stories about her own anxieties and her frustrations on the job.” Listening worked.

Counselor Training, Supervision, and Counselor Educators in Rural Appalachia

This study provides insight into the unique perspectives that rural Appalachian women have regarding their counseling experiences. Learning to better understand the culture of rural Appalachian women can assist practitioners in better understanding underserved groups (Arredondo, 2002; Keefe, 2005), cultural identity, gender (Hansen, Gama, & Harkins, 2002), heritage, generational influences, spirituality (Fukuyama & Sevig, 2002), and cultural empathy (Ridley & Udiipi, 2002). This study may be helpful for counseling programs that would like to include Appalachian culture and counseling within their multicultural courses. Counseling programs at universities in rural Appalachian regions can begin to include discussions and courses that focus more specifically on the Appalachian cultural competence of counselors to better serve this diverse clientele. This study can serve as a resource for additional research in this area.

Lessons were learned from these Appalachian women and counselors in training need to listen and heed how to ensure a safe place. The three women (Rose, Hila, Lydia) with abusive fathers sought out female counselors and would not have accepted a male counselor. The women’s need for safety illuminates the counseling experience and change in the Appalachian context. Hila and Lydia spoke of generational domestic abuse experienced by their grandmothers, mothers, and themselves. Helping professionals need to understand multigenerational issues and apply this understanding to rural Appalachian clients. The women in this study represented different generations of rural women and it would behoove counselors to consider the changing cultural aspects in Appalachian

families. Rose revealed her traumatic experiences of adolescence incest. While stereotypical views of Appalachian families as being incestual need to be dispelled, research, both quantitative and qualitative, is necessary for the training of counselors in rural regions. Research that focuses on counseling female victims of incest using a culturally sensitive model is needed.

Another aspect that needs to be explored is the Appalachian female's cultural identity, social identity, and self-identity in the 21st century. Hila alluded to "a newer version of the Appalachian woman." Counselors need to be aware of what happens in the space between the traditional identity of the Appalachian woman and the emerging identity of future generations. Cultural and social identities of the Appalachian female client may need further exploration in the process of therapeutic change. It may behoove clinicians to study aspects of feminist theory and how to apply it with specific female clients residing in Appalachia. How does the modern day female client in rural Appalachia understand therapeutic change? How do they think change will affect their family relationships? How do old views and new views coincide? Are the counseling experiences of younger Appalachian women different from older generations of Appalachian women? I would suggest that counselors-in-training read the book, *Women, Development, and Communities for Empowerment in Appalachia* by Virginia Seitz (1995). This book is a qualitative study of life history interviews and participant observations that is grounded in feminist theory and examines gender and social change in rural Appalachia. Would the modern version of a rural Appalachian client be comfortable with feminist theory which promotes female empowerment by exploring gender roles and egalitarian relationships?

Counseling did not improve the mother-daughter relationships with any of the women. While the women gained intrapersonal understanding about their own gender roles and found their own identities, they verbalized that their mothers would probably not change their traditional views. Perhaps clinicians could offer the option of inviting the mother to a family session in order to strengthen communication skills and understandings between daughters and mothers or the women could be helped to individuate. Research on Appalachian daughter/mother communication and interaction was not found.

The women in this study presented as cross-cultural with both individualistic and collectivistic outlooks and lifestyles. These women sought independence, self-identity, and the way to self-sufficiency; however, they continued to desire kinship and belongingness with their Appalachian families of origin. Does the rural Appalachian woman have to be one or the other? Counseling provided a safe and comfortable place for these clients to explore both individualism and collectivism. By learning to be ones' self, these women found a sense of self.

Religious preferences and practices are factors viewed as cultural in rural Appalachia. Corrie, Lucy, and Hila veered from the traditional religion of Christianity. Corrie is agnostic; Hila spoke to the difference between religion and spirituality and she was exploring Eastern religions; and Lucy practiced Wicca. These three women did not share their spiritual beliefs with their parents or relatives. Rose and Lydia identified themselves as Christians and both attended regular church services. The majority of Appalachia is located in an area known as the Bible Belt with Christianity believed to be the dominant religion. The largest religious groups are, respectively, Baptists, Catholics,

and Methodists (Wagner, 2006). Three of the women's experience with alternative religions illustrated a departure from the literature that focused on traditional religious practices in Appalachia. Counselors need not assume that all clients in rural Appalachia practice the same religion. Clients may fear judgment by counselors for adhering to other religions or to no religion at all. In addition, counselors need to consider the intersection of gender and religion in rural regions and how it affects clients.

Geographic location, traditional culture, and regional identity have impacted the lives of the rural Appalachian women in this study in various personal and professional degrees. The women in this study embraced these three elements, yet were not satisfied with the status quo. This study adds a rural Appalachian component to a growing body of qualitative research that allows women to have a voice. It emphasized the need for increased understanding of how change is influenced by the regional contextual culture of female clients.

Counselor educators may want to consider offering a separate course on the therapeutic change process. The book, *The Heart and Soul of Change: Delivering What Works in Therapy* by Duncan, Miller, Wampold, and Hubble (2010) may be used as the class textbook. A university master's degree program in Central Ohio has a similar course where this same book is utilized. Learning how to be more intentional with the process of change would help counseling students to apply information with future clients. The findings of this study support the existing literature indicating that common factors among various therapies contribute to counseling outcome and results. Common factors shared by the majority of therapies include the counseling relationship (i.e., providing a safe environment, alliance is foundation for change to occur); client factors

(i.e., expectations, hope, readiness for change, active participation); counselor characteristics (i.e., trusting, empathetic, caring, honesty, being genuine); and the use of techniques and tools (i.e., using questions, giving feedback, teaching skills). It is noted that these factors were described by the five women in this study. The information is this study contributes an understanding of the role the counseling relationship has in facilitating client change. It both supports and supplements the exiting literature. The conclusion drawn is that first and foremost the relationship between the client and counselor is essential for the counseling process, the change process, and the outcome. The women in this study indicated they developed a relationship with their counselors and this was fundamental in their ability to make changes.

Future Directions for Research

Research studies that explored the experiences, perceptions, and understandings of female clients in the rural Appalachian Region of Ohio, who reported psychotherapeutic change as a result of mental health counseling, were not found in the literature. The women in this study were considered atypical due their educational backgrounds. Highly educated Appalachian women do not meet the cultural stereotype that considers rural females to be in the role of full-time housewives, mothers, and caretakers. While being a mother and housewife is an honorable role, the problem is choice. Is this the only role that Appalachian women want? Do they want other choices? The women in this study learned to believe in their own ability to make choices for themselves apart from cultural expectations. Because the literature tends to view rural women from a deficit-based perspective (Atwell, 2005), it is necessary to explore a strength-based approach for rural women who seek out mental health counseling in a

culture that often shuns outside interventions. All participants graduated from high school. Four of the five women in this study had college degrees. Are educated women in rural Appalachia more apt to seek out counseling and to make therapeutic changes? A study needs to be conducted with non-degreed female clients in remote rural Appalachia to understand their experiences with therapeutic change in counseling. Would they attribute change to themselves or to other factors? Are their social identities different from women with college degrees? Are they less empowered? Are they less prone to seek out counseling? Do they have increased barriers to counseling (i.e., problems with health insurance, transportation, daycare, poverty issues)? Having a better understanding of rural Appalachian women and barriers to counseling will give counselors information about offering services to potential clients and identification of obstacles.

The participants in this study were all female. In order to broaden the scope of this study, future researchers could include adult males in rural Appalachian areas who have attended counseling and how they understand and experience the therapeutic change process.

One participant was of a different sexual orientation. How does sexual orientation of a female in rural Appalachia influence the process of therapeutic change? How does the cultural view of alternative lifestyles affect mental health in Appalachia? What do practitioners need to learn from this population of clients? Further research is warranted.

Three participants adhered to religious philosophies other than the traditional religion of rural Appalachian. How does this difference impact the change process? What do practitioners need to learn from this population of clients? Further research is warranted.

This study is a significant contribution to the literature because it is the only qualitative study that explored the views of Appalachian Ohio women and their meaning-making on the process of change in mental health counseling. It is the hope of the researcher that these results will stimulate further discussion and research. Some questions were answered while other questions were raised. In addition to the data obtained, a more in depth understanding regarding the lived experience of rural Appalachian women, counseling, and therapeutic change is needed.

Conclusion

The purpose of this qualitative study was to explore the experiences, perceptions, and understandings of female clients in the rural Appalachian Region of Ohio who reported psychotherapeutic change as a result of mental health counseling. Personal stories gathered during face-to-face interviews were explored from a phenomenological framework in order to allow the women to fully describe their understanding of the change process that occurred during the counseling process. The women's descriptions answered the research questions. The themes that emerged from the participant's stories answered the central research question: *What are the Appalachian female client's experience, perception, and understanding of psychotherapeutic change?* Generated themes included: Experiencing Therapeutic Change in a Safe Counseling Relationship, Education as a Precursor to Experiencing Therapeutic Change, Experiencing Change as a Journey to Empowerment, and Experiencing Therapeutic Change as Modern Appalachian Daughters with Traditional Appalachian Mothers.

Researcher Reflection

The professional researcher intersects with the personal researcher and the two overlap and become one as I reflect upon my own learning journey during the process of my study. In the beginning, I was only the researcher; yet, qualitative educators asserted I was the instrument. This study was not about me, yet, I shared commonalities with the rural Appalachian women and at times when I gazed into their mirror, I glimpsed myself and the women in my family tree. Did they glimpse any of me in their Appalachian mirrors? Separating researcher from self was, at times, confusing, but necessary for the sake of authenticity of the study. *Change*, a six-letter word, is packed full of diverse meanings and individual interpretations.

I, too, have been empowered by and continue to be empowered by educational opportunities and I was surprised to learn how pivotal education was in the therapeutic change process for the five courageous and resilient participants who volunteered to share their stories of tragedy and triumph with a stranger. Education births knowledge and choice. Knowledge is power and with personal power comes self-empowerment and the belief that changes are possible and obtainable. Knowledge begets an awakening that births wisdom. Speak Appalachian women. Let my pen be your voice.

If you want to know me then you must know my story, for my story defines who I am and if I want to know myself, to gain insight into the meaning of my own life, then I, too, must come to know my own story (McAdams, 1993, p. 11).

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APPENDIX A: OHIO UNIVERSITY INSTITUTIONAL REVIEW BOARD (IRB)

LETTER OF APPROVAL



OHIO
UNIVERSITY

Office of the Vice President
for Research

11F015

Office of Research Compliance
Research and Technology
Center 117
Athens OH 45701-2979

T: 740.593.0664
F: 740.593.9838
www.research.ohiou.edu

The following research study has been approved by the Institutional Review Board at Ohio University for the period listed below.

Project: Female Client Perception, Experience, and Understanding of Psychotherapeutic Change in Rural Ohio Appalachia

Researcher(s): Melissa C. Martin

Advisor: Tracy Leinbaugh
(if applicable)

Department: Counselor Education


Jeff Vancouver, Ph.D., Chair
Institutional Review Board

04/22/11
Approval Date

04/17/12
Expiration Date

This approval is valid until expiration date listed above. If you wish to continue beyond expiration date, you must submit a periodic review application and obtain approval prior to continuation.

The approval remains in effect provided the study is conducted exactly as described in your application for review. Any additions or modifications to the project must be approved by the IRB (as an amendment) prior to implementation.

Adverse events must be reported to the IRB promptly, within 5 working days of the occurrence.

APPENDIX B: OHIO UNIVERSITY CONSENT FORM FOR PARTICIPANTS

• This study has been approved by the Institutional Review Board for the Protection of Human Subjects at the Ohio University, Athens, Ohio

• Federal and university regulations require signed consent for participation in research involving human subjects. After reading the statements below, please indicate your agreement.

■ Researcher: Melissa Martin, MA, LPCC-S

■ Title of Research: *Female Client Perception, Experience, & Understanding of Psychotherapeutic Change in Ohio Appalachia: A Qualitative-Phenomenological Study*

➤ You are being asked to participate in research. For you to decide whether you want to participate in this project, you should understand what the project is about, as well as the possible risk and benefits in order to make an informed decision. This process is known as informed consent. This form describes the purpose, procedures, possible benefits, and risks. It also explains how your personal information will be used and protected. Once you have read this form and your questions about the study are answered, you will be asked to sign it. This will allow your participation in this study. You should receive a copy of this document to take with you.

➤ **Explanation of Study:**

This study explores the counseling experiences of adult females in Appalachia. This study will explore your understanding of the change process and the changes you made during your therapy. As a participant in this study, you will be: (1) asked to complete a demographic questionnaire and a counseling information questionnaire, (2) participate in a 90 -120 minute interview that is audiotaped, and (3) attend a second meeting lasting 30 - 60 minutes to clarify my interpretations and your quotes.

➤ **Risks and Discomforts:**

Discussing personal issues may contribute to some mild feelings of discomfort in some individuals and may illicit memories of past emotional situations in others. Should this occur, you will be given a list of local resources at the time of the interview. Your participation is confidential and voluntary and you may discontinue your participation at any time without penalty.

➤ **Benefits:**

As a result of your participation, you may gain personal insight or clarification about therapeutic change and your counseling experiences. Your participation in this study may benefit future counselor trainees, therapists, and counselor educators. However, there may be no direct benefit to you from this study.

➤ **Confidentiality and Records:**

Your responses will remain confidential. You will not be asked to put your name on any forms and instead a pseudonym will be used during this study. All questionnaires, tape recordings, and transcripts will be securely stored in a locked filing cabinet owned by the

researcher. The tape recordings with coded pseudonyms will be accessible only to the researcher. The transcriptions will be accessible to the research team only after any possible identifying information has been deleted or altered. Participants will not be individually identified in any publication or presentations of the research results. The recordings and master list will be destroyed after interview transcription (August 2011). The transcription will be destroyed June 2016.

Additionally, while every effort will be made to keep your study-related information confidential, there may be circumstances where this information must be shared with: Federal agencies, for example the Office of Human Research Protections, whose responsibility is to protect human subjects in research; Representatives of Ohio University, including the Institutional Review Board, a committee that oversees the research at Ohio University.

➤Compensation:

No compensation for participation will be provided. Participants will receive a book with the estimated cash value of \$12.08. Participants will receive an Ohio University mug with the estimated cash value of \$5.99.

➤Contact Information:

If you have questions regarding this study, please contact:

Researcher: Melissa Martin at (xxx) xxx-xxxx or melissamartincounselor@live.com

Advisor: Dr. Tracy Leinbaugh at Ohio University (740) 593-0846 or email:

leinbaug@ohio.edu

◆If you have any questions regarding your rights as a research participant, please contact JoEllen Sherow, Director of Research Compliance, Ohio University, (740) 593-0664.

→By signing below, you are agreeing that:

- you have read this consent form (or it has been read to you) and you have been given the opportunity to ask questions
- known risks to you have been explained to your satisfaction
- you understand Ohio University has no policy or plan to pay for any injuries you might receive as a result of participating in this research protocol
- you are 18 years of age or older
- your participation in this research is given voluntarily
- you may change your mind and stop participation at any time without penalty or loss of any benefits to which you may otherwise be entitled

➤Request for Permission to Audiotape:

I understand that the interview session involving myself and the researcher will be audiotaped, and the taped interview will be transcribed without identifying information. I also understand that following the transcription the tape recordings will be destroyed. I voluntarily agree to allow audiotaping of my interview.

Participant Signature

Date

Printed Name_____

APPENDIX C: RECRUITMENT LETTER FOR DIRECTORS AND COUNSELORS

Date:

Dear Director, Clinical Director, Counselor, or Psychotherapist:

I am a doctoral student at Ohio University, Athens, Ohio, who is working on a dissertation entitled, *Female Client Perception, Experience, & Understanding of Psychotherapeutic Change in Rural Ohio Appalachia: A Qualitative-Phenomenological Study*.

I am selecting 5-10 participants from ten Appalachian counties in rural Appalachia Ohio. I would like to invite your former or current clients to participate in this qualitative research study. The participants would need to meet the following criteria:

- female clients over 18 years of age
- raised in rural Ohio Appalachian and reside in an rural Appalachian county in Ohio
- completed 10 or more sessions of individual counseling at an agency or office in an Ohio county of Scioto, Lawrence, Adams, Pike, Gallia, Athens, Meigs, Jackson, Vinton, Highland or clients who are currently attending counseling
- have voluntarily attended and completed counseling by mutual termination with therapist
- report or reported psychotherapeutic change during the counseling experience
- be willing to fill out a demographic and counseling information questionnaire
- be able to participate in one 90 -120 minute audiotaped semi-structured interview
- be willing to complete a member check in the data analysis process at a 30 – 60 minute follow-up meeting

Each interview will last 90 - 120 minutes and will be audiotaped, however, strict confidentiality will be maintained and the tapes will be destroyed after transcription. Client names will not appear on any forms or documents.

Please contact me to further discuss this research study. I will provide you with a postage paid letter that can be mailed to a client who may consider participating in this study. Enclosed please find a copy of the Institutional Review Board of Ohio University's approval of the proposed research study. After this dissertation is completed, you will be emailed a copy for your agency.

Thank you for your time and consideration,

Melissa Martin, MA, LPCC-S

Licensed Professional Clinical Counselor

Phone: (xxx) xxx-xxxx email: melissamartincounselor@live.com

Dissertation Advisor at Ohio University, Athens, Ohio

Dr. Tracy Leinbaugh, Ph.D. Counseling and Higher Education, Counselor Education

Office Phone (740) 593-0846 email: leinbaug@ohio.edu

APPENDIX D: LETTER OF RECRUITMENT FOR PARTICIPANTS

Date:

Dear Potential Participant:

Would you consider volunteering to participant in a confidential research study where you would share your story about the changes you made during your counseling experience? Your participation in this study would be greatly appreciated.

If you are:

- a woman over 18 years of age
- raised in rural Ohio Appalachian and reside in an rural Appalachian county in Ohio
- voluntarily completed 10 or more sessions of individual counseling at an agency or office in an Ohio county of Scioto, Lawrence, Adams, Pike, Gallia, Athens, Meigs, Jackson, Vinton, Highland or you are currently attending counseling
- believed you made changes as a result of attending counseling & be willing to talk about changes

I am doctoral student in the Dept. of Counseling and Higher Education at Ohio University and this is a research study for a dissertation. This is not therapy; it is an opportunity to share your counseling experiences about change and to contribute to the knowledge base for counselors and therapists. I hope that the study results can be used to aid in understanding how clients experience change.

Identities of participants will remain confidential and your name will not be put on any forms or documents. You will be asked to sign a consent form for participation in this study and you will receive a copy. The interview will last approximately 90 - 120 minute and will take place at a convenient time and place for you. I will be audiotaping one 90 - 120 minute interview; however, the tape will be destroyed after transcription. You will be asked to attend a second meeting lasting 30 – 60 minutes in order to clarify interpretations and your quotes. You will also be asked to fill out a confidential form about background information and former counseling experiences. Any information about participation in this study will not be shared with your former therapist or counseling agency at any time. All information will remain confidential.

When this research study is completed, you will receive a copy via email or postal service with your permission. Your name or any identifying information will not be included in the dissertation.

Your participation is strictly voluntary and you may withdraw at any time. To learn more about this study or to volunteer to participate, please call Melissa Martin and leave a confidential voice mail message at (xxx) xxx-xxxx so that I may return your call. You do not have to leave your full name and you do not have to provide any information until

you agree to participate. If you are not home when your call is returned, I will only leave my name and phone number. Due to confidentiality, I will not leave a message.

This project has been reviewed and approved by The Ohio University Institutional Review Board. If you have any questions regarding your rights as a research participant, please contact JoEllen Sherow, Director of Research Compliance, Ohio University, (740) 593-0664.

Thank you for considering being a volunteer participant in this research study.

Melissa Martin, MA, LPCC-S

Ohio Licensed Professional Clinical Counselor

Phone: (xxx) xxx-xxxx email: melissamartincounselor@live.com

APPENDIX E: RECRUITMENT FLYER FOR PARTICIPANTS

Women

Study Participants Wanted to Share Stories of Change during Counseling

Women Volunteers Wanted for a Research Study

◆ Help counselors and therapists gain a better understanding of the counseling and change experiences of female clients in rural Appalachia.

Title of Study:

"Female Client Perception, Experience, and Understanding of Psychotherapeutic Change in Rural Ohio Appalachia"

Eligibility:

- a woman over 18 years of age
- raised in rural Appalachia Ohio & residing in a county in rural Ohio Appalachia
- voluntarily completed 10 or more sessions of individual counseling at an agency or office in an Ohio county of Scioto, Lawrence, Adams, Pike, Gallia, Athens, Meigs, Jackson, Vinton, Highland or you are currently attending counseling
- believe you made changes as a result of attending counseling & be willing to talk about your counseling experiences & changes

☛ Participants will receive a book and Ohio University mug.

⇒ To learn more about this research & to see if you qualify contact researcher, Melissa Martin, Ohio University Doctoral Student at (xxx) xxx - xxxx or melissamartincounselor@live.com

APPENDIX F: DEMOGRAPHICS QUESTIONNAIRE FOR PARTICIPANTS

Please complete the following information as it pertains to you. You are guaranteed complete anonymity and this information will only be used to describe general information of those who participate in the study in the final dissertation. Please use the back of this paper if you need more space. Thank you for participating.

1. What is your age? _____
 2. What is your marital status? ____ single ____ married ____ partnered ____ divorced
____ widowed
 3. What is your ethnicity? ____ Caucasian ____ African American ____ Hispanic
____ Native American ____ Asian ____ Other _____
- Do you consider yourself Appalachian? ____ yes ____ no ____ unsure
4. What county do you reside in? _____ rent or ____ own home
other: _____
 5. Where were you born? _____
 5. A. Where were you raised? _____
 6. What is the highest grade level of education you have completed?
____ High school 1 2 3 4 ____ GED ____ College 1 2 3 4 ____ Graduate school
Other: _____
 7. Your financial resources: ____ employment ____ public assistance ____ disability
____ unemployment benefits ____ worker's compensation ____ child support
____ food stamps ____ retirement pension ____ student loans
other _____
 8. Do your parents/guardians reside in Appalachia? Explain:

 9. Do your grandparents reside in Appalachia? Explain:

 10. What is your religious background?

APPENDIX G: COUNSELING QUESTIONNAIRE FOR PARTICIPANTS

Please complete the following information as it pertains to you. This information is confidential. Your answers will be used to help with my research project. Please use the back of this paper if you need more space. Thank you for participating.

1. Where did you attend counseling? _____
2. How far was the counseling agency from your home? _____
 - 2A. How did you travel to counseling? _____ my car _____ transported by family or friend
 _____ bus _____ walked _____ other
3. Payment used: _____ health insurance _____ Medicaid _____ cash
 Other: _____
4. How did you select your counseling agency? _____
5. Was the counseling agency in the same county where you resided? _____
6. How many sessions did you attend? _____
 Start date of therapy: _____ End date of therapy: _____
7. How many different times have you attended counseling? _____
7. A. How many different counselors have you seen? _____
8. Did you see the psychiatrist or nurse practitioner for medications? _____ yes _____ no
9. What medications were prescribed for you? _____
10. Do you know your diagnoses? _____ yes _____ no _____ unsure
 Diagnosis: _____
11. Have you attended group therapy? _____ yes _____ no
12. Have you attended marriage/couple/partner counseling? _____ yes _____ no
13. Have any of your children attended therapy? _____ yes _____ no
14. What helped you to stay in counseling? _____

APPENDIX H: SEMI-STRUCTURED INTERVIEW PROTOCOL

Although a semi-structured informal interviewing process is being utilized, the researcher will remain flexible and allow the conversation to flow and expand. Participants will further be able to clarify their stories in a written reflection paper and more content may appear. The researcher will utilize the following statement in the beginning of the interviews: “Please describe for me your experiences about change in therapy, starting from the beginning and taking me through your experiences until the very end.” The participants will be invited to elaborate.

Prompting Questions for Interviews

Counseling Experiences and Change

1. Talk about what motivated you to want to make changes.
2. Did you expect to make changes before you attended your first session? Explain.
3. What type of change were you searching for in counseling?
4. Could you share some “ah ha” moments about change?
5. Did your change come about in small increments or was it sudden change?
(process of change)
6. Did you change from the inside out or the outside in? Explain.
7. What strengths do you possess that helped you to make changes?
8. Please describe how you maintained your changes made in therapy?
9. What changes occurred between counseling sessions?
10. What beliefs changed during counseling?
11. How did you tolerate the discomfort of change during counseling?
12. What was changeable and what was not changeable?

13. Could you talk about who was responsible for the changes you made?
14. How was your therapist involved in your change process?
15. How were your family members or friends involved in your change process?
16. Do you consider yourself to be a self-changer? Explain.
17. Describe your life before you made your changes in counseling.
18. Describe your life after you made changes.
19. Describe the word 'change' in your own words.
20. How exactly do you think your changes happened? (personal theory of change)

Counseling in Appalachia for Females

1. How did you select the counseling place? (access to counseling)
2. What, if any, obstacles did you encounter before coming to counseling due to residing in Appalachia? (rural isolation, lack of financial resources, lack of transportation, lack of healthcare, lack of childcare, lack of family/friend support, other barriers)
3. Talk about your counseling experiences from perspective of being an Appalachian woman. (How would you describe the influence of being a rural Appalachian woman on your experience with counseling and change?)
4. Could you talk about your Appalachian culture and how it helped or hindered your changes? (stigmas of counseling)
5. What would you say to another female in Appalachia who was considering therapy?
6. What would you say to a counselor who is providing services for an Appalachian female client

APPENDIX I: FOLLOW-UP FORM FOR PARTICIPANTS

➤Follow-Up Meeting:

During the follow-up meeting, participants will be asked to read the interpretations by the researcher based on the former face-to-face interviews and the transcriptions. Participants will be asked to read their quotes for accuracy. Participants may discuss the findings and ask questions.

➤Risks:

Reading the interpretations of the researcher and reading your quotes may contribute to mild feelings of discomfort in some individuals and may illicit memories of past emotional situations in others. Should this occur, you will be given a list of local resources at the time of the interview. Your participation is confidential and voluntary and you may discontinue your participation at any time without penalty.

➤Participation:

Your participation is confidential and voluntary and you may discontinue your participation. You may request your data to be withdrawn and not used.

➤Confidentiality and Records:

Your responses will remain confidential. You will not be asked to put your name on any forms and instead a pseudonym will be used during this study. All questionnaires, tape recordings, and transcripts will be securely stored in a locked filing cabinet owned by the researcher. The tape recordings with coded pseudonyms will be accessible only to the researcher. The transcriptions will be accessible to the research team only after any possible identifying information has been deleted or altered. Participants will not be individually identified in any publication or presentations of the research results. The recordings and master list will be destroyed after interview transcription (August 2011). The transcription will be destroyed June 2016.

➤Contact Information:

If you have questions regarding this study, please contact:

Researcher: Melissa Martin, MA, LPCC-S
at (xxx) xxx-xxxx or email: melissamartincounselor@live.com

Advisor: Dr. Tracy Leinbaugh at Ohio University
(740) 593-0846 or email: leinbaug@ohio.edu

Participant

significant quotes & statements highlighted from text responses from transcription (horizontalization)	units of meaning or (invariant constituents)
--	--

Step 2: Reduction & Elimination Participant _____
CRQ: What are the Appalachian female client’s experience, perception, and understanding of psychotherapeutic change?

units of meaning	clusters or themes	collapsed themes

Step 3: Themes

Participant _____

CRQ: What are the Appalachian female client’s experience, perception, and understanding of psychotherapeutic change?

clusters or themes	common themes	collapsed themes

APPENDIX K: GENERATING THEMES THROUGH DATA ANALYSIS

What are the Appalachian female client's experience, perception, and understanding of psychotherapeutic change? This central research guided this present study along with the following sub-questions:

- What are clients' beliefs concerning change during their course of therapy?
- How do participants describe/make meaning of changes that occurred before, during, and/or after therapy?
- What do participants attribute change to: themselves, therapists, or others?
- What suggestions would the participants like to make to clinicians about their understanding of the psychotherapeutic change process?

The following statement was presented at the beginning of each interview:

“Please describe for me your experiences about change in therapy, starting from the beginning and taking me through until the very end.” Information about access to mental health services for women in rural Appalachia, the challenges, and the barriers were solicited. Socioeconomic factors that affect mental health issues were discussed (e.g., poverty, housing, transportation, health insurance, lack of mental health services). Moreover, the participants' point of entry into counseling was discussed. The semi-structured interview protocol included six questions pertaining to the cultural context of attending counseling in rural Ohio Appalachia.

During data analysis, the meaning units or invariant constituents (the distinctive qualities of each participant's experience that stand out) were identified for each participant. Lists of the clustering or grouping of initial textural and structural themes were developed for the group as a whole as theme reduction, elimination, and

combination was repeated. Initial lists and final lists are provided for the reader with identified themes, meaning units, and support quotes. Next, the initial and final lists of integrated themes are provided. The themes were then presented in narrative format utilizing the composite group textural and group structural descriptions or essence.

Group Textural Themes – female client’s perception, experience, and understanding of psychotherapeutic change.

Theme #1: Safety-clients wanted an emotionally safe place, a nonjudgmental, genuine, and safe counselor, and an emotionally safe and trusting relationship before the change process could begin in counseling.

Meaning units:

- felt safe
- office felt safe [place]
- nonjudgmental represented safe
- genuine and not a fake
- honest represented trustworthiness
- felt comfortable
- confidential
- supportive
- encouraging
- calming
- listener, easy to talk to
- permission to cry

Participant’s supportive quotes:

- Her office felt safe.
- I felt safe from the very first session.
- We just clicked right away.
- I could talk about my feelings.
- I tell her everything.
- I told her my secrets... she said I wasn’t crazy.
- She didn’t tell my mom what I told her.
- He didn’t judge me.
- She really seemed to care about me.
- She just listened to me.
- She was a genuine person.
- He was outgoing.
- She smiled a lot.
- She’s not a fluffy bunny.
- I was a mess.
- I felt comfortable.
- She didn’t judge me.
- I was hitting rock bottom.

- It felt good to talk.
- And I told her, “Every time I come in here I cry.”

And she said, “That’s okay. I have lots of Kleenex.”

Group Textural Themes – female client's perception, experience, and understanding of psychotherapeutic change.

Theme #2: Clients sought out counseling due to overwhelming emotional pain and they needed catharsis to express and process feelings before change occurred.

Meaning units:

- motivated for relief from painful feelings
- felt hopeless
- wanted to understand loss
- grieving from pain
- inability to function in daily life

Participant's supportive quotes:

- I was a mess.
- I was tired of hiding it [sexual abuse].
- I was looking for anyway out for feeling like I was...I hit rock bottom.
- I felt emotionally drained and hopeless.
- I needed help.
- I was having pent up emotions.
- He died in my arms.
- I couldn't function.
- I didn't want that [suicide thoughts] to happen again.
- Something had to give.

Group Textural Themes – female client's perception, experience, and understanding of psychotherapeutic change

Theme #3: Clients had hope and expectations that things would get better.

Meaning units:

- hope
- wanted change

Participant's supportive quotes:

- ... hope that I could change things.
- ... hoped seeped in.
- I wanted to feel different.
- I knew I had to do something.
- I wanted to stop being mad...
- ... God wasn't mad at me.
- Well, I have hope in the very basic level, I have hope that I will see him again in the afterlife. I have hope that one of these days I'll quit crying every time I think about it.

Group Textural Themes – female client's perception, experience, and understanding of psychotherapeutic change

Theme #4 Change is a slow and gradual process.

Meaning units:

- change was slow
- change was gradual
- change is a process
- clients continue to change after counseling ends

Participant's supportive quotes:

- Over time I felt better... It took awhile.
- ... there was a time factor.
- I'm still not done changing.
- She [counselor] let me find my own answers.
- My change came in small steps, not sudden.
- ... but change is a growth process.
- I think it's a lot of mental work. There is no magic fix.
- I kept learning stuff about myself... oh, that's why.

Group Textural Themes – female client's perception, experience, and understanding of psychotherapeutic change

Theme #5: Change via self-exploration, self-awareness, self-understanding, and self-acceptance

Meaning units:

- self-exploration
- self-awareness
- self-understanding
- self-acceptance

Participant's supportive quotes:

- I'm more self-aware
- I guess I became more aware of why I do things...I saw the patterns.
- I didn't feel stupid.
- It starts with awareness.
- I was not empowered to handle my problems.
- I learned to like me.
- I realized who I am as a person.
- I understand why I dated men like my father.
- I had to look inside of me... I found me.
- Something was different about me.
- I found out it wasn't my fault. I wasn't crazy... just abused.

Group Textural Themes – female client's perception, experience, and understanding of psychotherapeutic change

Theme #6: Clients as Active and Motivated Participants and Self-Changers.

Meaning units:

- motivated for relief from pain
- wanted to understand loss
- ready for change
- determined to make changes

Participant's supportive quotes:

- I felt emotionally drained and hopeless... needed help.
- Why did it happen?
- This time I felt like I was ready to make changes.
- I knew I had to do something.
- I don't think anything is going to change until the person wants to change.
- She didn't give me answers. She let me find my own answers.
- I got my driver's license back... and started driving again.
- I read a book about changing your brain and some Buddhist readings.
- Writing down things was what really helped me.
- I read books on the afterlife.
- I knew it was up to me to decide to make the changes. She [counselor] couldn't make me change if I didn't want to.

Group Textural Themes – female client's perception, experience, and understanding of psychotherapeutic change

Theme #7: Both Client and Counselor Cultivate Change

Meaning units:

- Client was an active participant in the process.
- The counseling relationship was foundational for change to occur.

Participant's supportive quotes:

- ... She [counselor] asked hard questions.
- I thought about what she [counselor] said during the week.
- I read a book she [counselor] recommended on grief.
- I don't go for loser men anymore.
- The crying stopped.
- ... God wasn't mad at me.
- My self-talk changed... no more me bashing.
- She [counselor] told me how she handled a similar situation.
- She [counselor] didn't give me answers. She let me find my own answers.
- She [counselor] was handing me the stick and I was ready to run on my own.

I was ready to go. I was just waiting for her to give me that go.

- Through my counseling with her, she has helped me develop these insights.

Group Textural Themes – female client’s perception, experience, and understanding of psychotherapeutic change

Theme #8: Clients found education to be a vehicle for personal self-empowerment.

Meaning units:

- Education was a forerunner in gaining courage to attend counseling.
- Education helped to produce self-empowerment,

Participant’s supportive quotes:

- I just wanted to do something with my life... I was tired of drifting. I quit my job so I could go back to college. That’s why I live with my mother right now.

I’m taking nursing classes. (P5)

- I’m the only girl in my family to graduate high school. (P3)
- I learned some of it when I went to beauty school for awhile... And like I said before, I want to go back to beautician school but if I get a job I would lose my disability and Medical card and I need my medication. But I’ve been thinking about it a lot. (P3)

- I have health insurance now. (P4)

- We talked about what my eventual goals were, like future school plans and I think that helped because in future session, I related my future goals into what was going on right now or right then and that helped. (P1)

- I appreciate educating myself just for fun. I’ve always been a really big reader and I like to analyze things and be aware of things that are happening around me.

Education is helpful. I’m the only woman in my family who has gone to college. I

have some evidence of life outside the family. I am proud of what I've accomplished. (P4)

Group Textural Themes

Theme #1: Safety-clients wanted an emotionally safe place, a nonjudgmental, genuine, and safe counselor, and an emotionally safe and trusting relationship before the change process could begin in counseling

Theme #2: Clients sought out counseling due to overwhelming emotional pain and they needed catharsis to express and process feelings before change occurred. Client experiences with loss and resulting painful emotions catapulted them to counseling.

Theme #3: Clients had hope and expectations that things would get better.

Theme #4: Change is a slow and gradual process.

Theme #5: Change via self-exploration, self-awareness, self-understanding, and self-acceptance

Theme #6: Clients as Active and Motivated Participants and Self-Changers.

Theme #7: Both Client and Counselor Cultivate Change

Theme #8: Clients found Education to be a Vehicle for Personal Self-Empowerment.

The researcher considered the themes, meaning units, and participant's quotes and then the 7 initial group textural themes were reduced and collapsed into the final 3 group textual themes.

Group Textural Themes

Theme #1: Safety-clients wanted an emotionally safe place, a nonjudgmental, genuine, and safe counselor, and an emotionally safe and trusting relationship before the change process could begin in counseling

Theme #2: Client's Perceptions of Change Factors

Theme #3: Both Client and Counselor Cultivate Change

Theme #4: Education was considered a Vehicle for Personal Self-Empowerment.

The following section contains the list of initial themes from group descriptions which is called the group structural themes which placed the counseling experiences of rural female clients within the setting of rural Ohio Appalachia.

Group Structural Themes – therapeutic change experiences of rural female clients in the cultural context of setting and place which is the rural Appalachian environment.

Theme #1: Generational Roots and Influences of Generational Appalachian Female

Views as Influencing Clients' Overall Problems: Seeking Counseling to Understand and Make Changes by Discarding Some Traditional and Adopting some Modern

Meaning units:

- Clients became aware of negative generational patterns and how these patterns were carried out in the client's own relationships and life.
- Clients became aware of differences in cultural value systems.

Participant's supportive quotes:

- I started to become a little scared because I started thinking about my mother and I started seeing more parallels in my family. I started noticing patterns in the behavior and the character of each woman in our family, all the way through my grandmother and her sister and my great-grandmother. (P4)
- They [mother and grandmother] are just saying something automatically because they've said it all the time and their mothers said it all the time and I've got to break the cycle. (P4)
- I mostly handled it here just because of the nature of the relationship. It was a girl, so my mom is not really open to talking about that. (P1)
- There's religious discrimination too. When he [husband] came over here from England he brought a cross with Gaelic... and I said "That's beautiful but I'm not a Christian." And he said, "That's okay. It's Celtic. A Celtic cross." I am Wiccan. And I firmly believe that he [deceased spouse] is in the summer lands and he's

waiting. And I pray and meditate every night. But, I don't share this with my family. (P2)

- I don't really consider myself a spiritual person. I can take it or leave it. So, it wasn't something that changed before or after. I'm agnostic. (P1)

- My mom didn't know about the abuse. And I didn't tell her... I don't know if sexual abuse happened to the other women in my family. (P3)

- But now that I'm thinking about getting an apartment or doing more stuff, she's like, "What is that counselor telling you?" And I say, "Nothing, it's my business." (P3)

- Growing up I thought men had the right to boss you around... be the head of the family... make most of the decisions. In counseling I learned that I can be a strong woman, independent... I can decide what is best for me. Before that I thought that all men tried to control their wives... I thought that's just the way it is. (P5)

Group Structural Themes – therapeutic change experiences in the cultural context of setting and place which is the rural Appalachian environment.

Theme #2: Overcoming Barriers to Access Counseling Services in Rural Ohio

Appalachia in order to understand and make Changes in the Counseling Process

Meaning units:

- Lack of health insurance
- Financial difficulties
- Unemployed or part-time employment
- Transportation issues

Participant's supportive quotes:

- As far as I know, I'm the only person in my immediate family who's sought out counseling. (P1)
- ... I only work part-time so I don't have health benefits. I make just enough to keep me from getting a Medicaid card. I can't find a full-time job in this area... men get the high paying jobs. (P2)
- I paid [for counseling services] on a sliding scale. (P2) (P5)
- My mom drives me to appointments. (P3)
- My counselor helped me get my driver's license back. (P2)
- We were on Medicaid before because of my son. And I was getting desperate because he would lose his Medicaid insurance, eventually because we were making just enough money, just above like 20 bucks. But, it's still 20 bucks above. Then I started to panic and I talked to my boss about the possibility of changing my status so that I can get employee benefits. (P4)

Group Structural Themes – therapeutic change experiences in the cultural context of setting and place which is the rural Appalachian environment.

Theme #3: Appalachian Daughters and Appalachian Mothers: Differences in Gender Identity, Beliefs on Patriarchy and Male Dominance and Expressing and Processing Cognitions and Emotions during the Counseling Process to Make Changes.

Meaning units:

- Clients wanted generational abuse to end.
- Clients kept information from mothers if it would bring judgment.
- Clients were at odds with their mothers due to cultural norms and gender roles.

Participant's supportive quotes:

- I mostly handled it here, just because of the nature of the relationship.

It was a girl, so my mom is not really open to talking about that.

That wasn't really something that I talked to her about. (P1)

- One of them is my mother, who said, "Oh, well, she should never have gone to England with him. And she had a good job and he just took her away." (P2)

- And my grandmother had a stepfather who abused her and whose mother didn't seem to care, although she cried and said that she misses her mother and she wishes she could still talk to her, that kind of things, and just accepting blame and just allowing themselves to be emotionally abused. (P4)

- The first time I was afraid I would be looked down on and judged because of being a single mom on welfare. I felt embarrassed, afraid I would run into someone I knew. I was living in an apartment at that time so I knew my parents

wouldn't find out about the counseling or the welfare. In my family you worked hard... you didn't go on welfare... I'd seen my dad hit my mom a few times. He was insanely jealous and controlled all the money. He wouldn't let her work at a job or anything. My grandpa, my dad's dad was a mean old man. He bossed my granny around. Granny was a sweet person who would do anything for anybody... I wanted to break that cycle. I didn't want my daughter to settle for an abusive loser. (5)

- I stopped dating abusive men... It [domestic violence] was passed on to me by my grandma and mom... Male dominance bothers me. (P5)

Group Structural Themes – therapeutic change experiences in the cultural context of setting and place which is the rural Appalachian environment.

Theme #4: Appalachian Community: Reconstructing Social Identity within Cultural Identity and Understanding how Community Norms Influenced View of Self and thus Increased Symptoms of Depression and Anxiety which Prompted the Seeking of Counseling and Change

Meaning units:

- Cultural identity
- Social Identity
- Identity of being single, married, divorced, or widowed
- Incongruent cultural identity increases symptoms of depression and anxiety

Participant's supportive quotes:

- I feel that here, because a lot of life is kind of almost on the survival level.

That, you know problems with the mind and emotions are considered ridiculous and a waste of time to talk about and to treat. And that the best medicine for anything is just to be stronger. And just be responsible and be religious, go to church. If you've got problems, then you need make peace with God.

And I felt myself going back to the church not for myself but to satisfy my family and to put their mind at ease about me. (P4)

- (counselor's name deleted) said incest is hidden and passed down in some families. She said it was generational sexual abuse. So, I don't know if my dad or his brothers or sisters were abused or not. I just know what it did to me and how it made me depressed and scared. And it made me so angry. So, I'm still working on

some of that anger. Dads dead so I can't tell him how I feel about it. (uncle's name deleted) is dead too, so I have to work out my anger about it. (P3)

- It was more of a, okay, never been a widow before. What's this going to be like?"... Actually, my counselor and I had been talking about my life as a single person now. (P2)

- I didn't go to counseling because I'm gay. I'd already accepted that and dealt with those feelings, like feeling confused, like an outcast. My family doesn't accept it so I don't talk to them about that kind of stuff. At college, I found people like me and I joined a group on campus. And that helped me a lot. (P1)

Group Structural Themes – therapeutic change experiences in the cultural context of setting and place which is the rural Appalachian environment.

Theme #5: Self - Reestablishing Personal Self-identity or Creating Personal Self-identity during the Process of Counseling: During the Process of Counseling Seeking and Finding a Congruent Cultural Self-Identity by Combining Traditional with Modern and Understanding the Change

Meaning units:

- Change came through the valuing of self
- Integrated old cultural ways with new ways

Participant's supportive quotes:

- I wanted my own identity... not his.
- I saw the patterns.
- I learned to like me.
- I'm still not done changing.
- I was not empowered to handle my problems.
- I realized who I am as a person.
- And that's when I started to realize that maybe I don't recognize myself anymore. At first I was just going to stick with it, have my own life, but I was two people. And I think that's really what part of the anxiety for me was that I was constantly splitting into two people, the wife and the woman that I am.
- I am a new version of an Appalachian woman.

Group Structural Themes – therapeutic change experiences in the cultural context of setting and place which is the rural Appalachian environment.

Theme #6: Education as Key to Overcoming: Educational Identity and Professional Identity as an Important Factor within Cultural Identity of Women: Putting the Identity Puzzle Pieces Together during the Process and Counseling to understand how to make Changes

Meaning units:

- All participants graduated from high school
- Education as opportunity for first generation college students
- Education boosted self-esteem
- Education as a way to get a better job to support family
- Education plus a job provides health insurance

Participant's supportive quotes:

- I just wanted to do something with my life... I was tired of drifting. I quit my job so I could go back to college. That's why I live with my mother right now. I'm taking nursing classes. (P5)
- I'm the only girl in my family to graduate high school. (P3)
- I learned some of it when I went to beauty school for awhile... And like I said before, I want to go back to beautician school but if I get a job I would lose my disability and Medical card and I need my medication. But I've been thinking about it a lot. (P3)
- I have health insurance now. (P4)

- We talked about what my eventual goals were, like future school plans and I think that helped because in future session, I related my future goals into what was going on right now or right then and that helped. (P1)
- I appreciate educating myself just for fun. I've always been a really big reader and I like to analyze things and be aware of things that are happening around me. Education is helpful. I'm the only woman in my family who has gone to college. I have some evidence of life outside the family. I am proud of what I've accomplished. (P4)
- Lots of ageism. I have a master's degree in health sciences, which is public health. I have worked in a lab. I have worked as an EMT. I have worked in the ER. I have worked for a community college. I currently work part-time as a secretary because that's all I can find which is why I don't have any health insurance. I just think they're very ageist. That's my opinion. (P2)

Group Structural Themes – therapeutic change experiences in the cultural context of setting and place which is the rural Appalachian environment.

Theme #7: Seeking Non-Family Support during and after counseling because of Differing Cultural Viewpoints and Generational Differences

Meaning units:

- Turned to supportive friends instead of family members
- New friends as support
- Women outside the family as a support network

Participant's supportive quotes:

- I spent more time with friends than my family. (P4)
- My best friend listened to me... that helped. (P1)
- I ran into and found other women who divorced. (P4)
- It helped to talk to some of my friends at work. (P4)
- I made some new friends at college. (P1)
- I talked to women at my church. (P3)
- I connected with the women in the therapy group. They got me. (P5)
- I joined an online grief support group. (P4)

Group Structural Themes – therapeutic change experiences in the cultural context of setting and place which is the rural Appalachian environment.

Theme #8: Appalachian Women as Resilient with Inner Strength: Rediscovering or Finding Resiliency during the Process of Counseling

Meaning units:

- Women are strong and take charge.
- Women have inner strength.
- Women are caretakers.
- Generational resiliency passed down from mother to daughter

Participant's supportive quotes:

- I feel that as an Appalachian woman I have strength... Women have to step up when the men don't have jobs... My grandmother and mother worked hard to feed us. (P4)
- Girls in Appalachia don't know how strong they are or can be until something happens, a crisis or something like that happens, and they work through it and get even stronger... And you have to be willing to, like, go through it and not just want a magic fix, I guess. Like, it takes time to work... I have this career going for me and really great friends, so, that definitely helped to bring my self-esteem back up. (P1)
- I have enough to pay my bills. I have enough to get my food. I have enough to keep a roof over my head. (P2)

- So, now I've gathered together the shards of the glass that were prettiest and kind of put them back together, and left the shards that weren't quite so pretty over here in this pile... Life is good. It's not great, but it's good. (P2)
- The women in my family are strong, mothers, aunts, grandmothers, and definitely my great-grandmothers. They did everything, like cooking and cleaning. And they made sure the kids ate, took baths, and went to church, things like that. And when the men went hunting or fishing and sometimes drinking, the women still stayed home with the kids. (P3)
- She [mother] made sure the bills got paid... She worked so hard then came home and cooked dinner and washed clothes. And picked stuff out of the garden. And my dad just came home and set down in front of the TV and mom and me and my sisters were expected to wait on him and my brothers, hand and foot... And the same thing went on at my grandma's house. All the men ate first, you know meals, then the women and kids ate, then we had to wash the dishes and clean up. So I just knew you had plow through it until things got better. (P5)

Group Structural Themes:

Theme #1: Generational Roots and Influences of Generational Appalachian Female Views as Influencing Clients' Overall Problems: Seeking Counseling to Understand and Make Changes by Discarding Some Traditional and Adopting some Modern

Theme #2: Overcoming Cultural Barriers to Access Counseling Services in Rural Ohio Appalachia in order to understand and make Changes in the Counseling Process

Theme #3: Appalachian Daughters and Appalachian Mothers: Differences in Gender Identity and Expressing and Processing Cognitions and Emotions during Counseling Process to Make Changes.

Theme #4: Appalachian Community: Reconstructing Social Identity within Cultural Identity and Understanding how Community Norms Influenced View of Self and thus Increased Symptoms of Depression and Anxiety which Prompted the Seeking of Counseling and Change

Theme #5: Self-Reestablishing Personal Self-identity or Creating Personal Self-identity during the Process of Counseling; Seeking and Finding a Congruent Cultural Self-Identity by Combining Traditional with Modern and Understanding the Change; Something Old and Something New

Theme #6: Education as Key to Overcoming: Educational Identity and Professional Identity as an Important Factor within Cultural Identity of Women: Putting the Identity Puzzle Pieces Together during the Process and Counseling to understand how to make Changes

Theme #7: Seeking Non-Family Support during and after counseling because of Differing Cultural Viewpoints

Theme #8: Appalachian Women as Resilient with Inner Strength: Rediscovering or Finding Resiliency during the Process of Counseling; Finding what was not Lost

The researcher considered the 8 initial group structural themes and reduced and collapsed them into 4 group structural themes.

Group Structural Themes:

Theme #1. Understanding Therapeutic Change via Generational Roots

Theme #2. Understanding Therapeutic Change via Components of Cultural Self-Identify

Theme #3. Understanding Therapeutic Change via Educational Experiences and
Opportunities in Rural Appalachia

Theme #4. Understanding Therapeutic Change via Rural Resiliency

Group Textural Themes:

Theme #1: Safety-clients wanted an emotionally safe place, a nonjudgmental, genuine, and safe counselor, and an emotionally safe and trusting relationship before the change process could begin in counseling

Theme #2: Client's Perceptions of Change Factors

Theme #3: Both Client and Counselor Cultivate Change

Group Structural Themes:

Theme #1. Understanding Therapeutic Change via Generational Roots

Theme #2. Understanding Therapeutic Change via Components of Cultural Self-Identify

Theme #3. Understanding Therapeutic Change via Educational Experiences and Opportunities in Rural Appalachia

Theme #4. Understanding Therapeutic Change via Rural Resiliency

The final 3 group textural themes and final 4 group structural themes were combined and integrated into the initial list of 6 themes on the following page.

Initial List

The final 3 group textural themes and final 4 group structural themes were integrated into the following initial list of 6 themes:

Theme #1: Participants wanted a safe place with a safe counselor to take apart their taught cultural values, cultural expectations and views and generational roots on gender identity, social identity, educational identity, professional identity in order reconstruct a new identity which meant keeping some old and adding some new; traditional women vs. modern woman. The participants created a new cultural and social self-identity through the change process of counseling.

Theme #2: Emotional pain of feeling and being incongruent in relationships between mothers and daughters due to differences in cultural values (i.e., divorce, religion, sexual orientation, marrying outside of Appalachia, traditional gender roles, gender inequality, patriarchy) prompted clients to seek out a place to try on new ways of being. Women used counseling to challenge cultural expectations of gender roles.

Theme #3: Resiliency traits of rural Appalachian women before, during, and after counseling experience allow changes in cultural belief system to occur.

Theme #4: Clients experienced and understood change in the slow and gradual process of self-exploration, self-awareness, self discovery, self-understanding, and self-acceptance.

Theme #5: High school education and higher education in this atypical group of rural Appalachian women as a change catalyst in their view of male dominion, patriarchy, and gender inequality.

Theme #6: Clients perceived and understood themselves to be self-changers and counselors as change facilitators: Six themes reduced on following page.

Second Reduced and Collapsed List

Theme #1: Perceived and Understood Therapeutic Changes via a Safe Place and a Safe Counselor to Explore Roots

Theme #2: Perceived and Understood Therapeutic Changes via Self-Identity Factors

Theme #3: Perceived and Understood Therapeutic Changes via Educational Empowerment

Theme #4: Perceived and Understood Therapeutic Changes in the Gradual Process of self-exploration, self-awareness, self discovery, self-understanding, and self-acceptance in the Formation of Self-identity in the Cultural Context of Rural Appalachian Women

Theme #5: Perceived and Understood the Process of Therapeutic Change as shared by both Client and Counselor

These 5 themes were reduced and collapsed into the final list which appears on the following page.

Collapsed List of Themes

CRQ: What are the Appalachian female client's experience, perception, and understanding of psychotherapeutic change?

Theme #1: Perceived and Understood Therapeutic Changes via a Safe Place and a Safe Counselor to Explore Roots

Theme #2: Perceived and Understood Therapeutic Changes via Educational Empowerment

Theme #3: Perceived and Understood Therapeutic Changes in the Gradual Process of Self-exploration, Self-awareness, Self-discovery, Self-understanding, and Self-Acceptance in the Formation of Self-identity in the Cultural Context of Rural Appalachian Women

Theme#4: Perceived and Understood the Process and Outcome of Therapeutic Change as shared by both Client and Counselor

Final List of Themes

CRQ: What are the Appalachian female client's experience, perception, and understanding of psychotherapeutic change?

Theme #1: Experiencing Therapeutic Change in a Safe Counseling Relationship

Theme #2: Education as a Precursor to Experiencing Therapeutic Change

Theme #3: Experiencing Therapeutic Change as a Journey to Empowerment

Theme #4: Experiencing Therapeutic Change as Modern Appalachian Daughters with Traditional Appalachian Mothers



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