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Mental Health Services in Appalachia

Miranda Renee Waters
Eastern Kentucky University

MENTAL HEALTH SERVICES IN APPALACHIA

By

Miranda Waters

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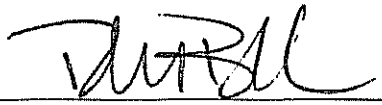

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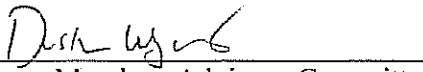

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By

Miranda Waters

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DEDICATION

This thesis is dedicated to all the hardworking and deserving Appalachian Americans.

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I would like to thank the Chair of my advisory committee, Dr. Jon Gore, for all of his patience and guidance through the revision process. I would also like to recognize Dr. Robert Brubaker and Dr. Dustin Wygant for their advice and encouragement.

Abstract

People from rural areas of the country, such as the Appalachian region of Kentucky, continue to struggle with inadequate mental health services. Past research has identified several barriers for mental health services in rural communities such as lack of mental health providers, lack of transportation, and lack of education. The purpose of this study was to examine the severity of a psychological problem and how it could influence Appalachian and non-Appalachians' preference for type of help. It was hypothesized that people from the Appalachian region would recommend seeing a mental health professional when a problem had reached its highest severity. Additionally, it was hypothesized that people from the Appalachian region would recommend, in this order, talking to no one, close others, a religious leader, and physician before talking to a mental health professional. On the other hand, it was believed that people from non-Appalachians areas would recommend, in this order, talking to no one and close others before talking to a mental health professional. Results showed that the first hypothesis was confirmed, and hypotheses two and three were partially confirmed. Findings suggested that Appalachians' tendency to recommend a mental health counselor was strongly linked to their perception of how severe the symptoms were. More Appalachian participants recommended talking with a religious leader compared to non-Appalachian participants. No significant differences were found between the groups when examining the percentage of recommendations for a physician.

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I. INTRODUCTION

The accessibility and affordability of mental health services has increased over the years in most parts of the world. However, people from rural areas, such as the Appalachian region of Kentucky, continue to struggle with inadequate mental health services. The Appalachian area is one of the poorest in the United States with 83 distressed counties (MDC, Inc., 2002). As the number of people in the Appalachian area grew, the economy did not. The area became highly dependent on industry, agriculture, and mining. However, a constant for the people who live in this region is strong family relationships. Rural families tend to be part of a collectivistic culture unlike most other American families, which tend to be very individualistic (Tighe, 2007). In addition to rural families being more collectivistic, most are also considered to be part of the low socioeconomic class (Tang & Russ, 2007). Factors such as accessibility to mental health services and low socioeconomic status have been linked with elevated levels of distress from a mental health problem in rural areas. To further analyze factors affecting mental health care in Appalachia, this study examined how the severity of a psychological problem could influence Appalachian's and non-Appalachian's preference for type of help. This was accomplished by having participants read scenarios that involved an individual who was experiencing some type of difficulty. Participants recommended the type of helper that would be helpful for the type of situation. Demographic information was collected from each participant.

Barriers to Mental Health Services

Several barriers can prevent people from seeking mental health services in rural areas. Availability of transportation, the existence of mental health services, and knowledge about mental health can determine if people receive care. Finding transportation to health care is a problem for many people, especially the ones who live in rural areas. Public transportation networks are often scarce and there is

generally less access to personal vehicles (Kihl, 1993; Gesler et al., 2001). Transportation provided from a family member, friend, or a public transportation source can increase the number of visits to a facility (Arcury, Gesler, Preisser, Sherman, Spencer, & Perin, 2005). Geographic and spatial behavior factors tend to play a major role in utilization of health care.

Unfortunately, there are also significant shortages of mental health providers in rural areas of the country. Trained professional helpers are in short supply where recent stressors (e.g. economic changes) have left many individuals in need of mental health assistance (Reed, 1992). This results in having to travel to larger urban centers to receive care, which decreases the number of overall visits to a mental health professional (Hausenstein et al., 2006). In addition to the shortage of facilities in rural areas, preexisting facilities struggle with recruiting and retaining staff. Graduate students' lack of specific training in dealing with rural populations can have negative consequences for both the professional and the community because they are not aware of the ideology and values of the people (Sullivan, Hasler, & Otis, 1993). A clinician's lack of training and cultural sensitivity can cause the client to perceive the clinician's behaviors as inappropriate or thoughtless.

A person's lack of knowledge about mental health is related to a general lack of education (Reed, 1992). Reed (1992) described a psychiatrist's observations while she was involved in the National Health Service Corps in rural Kentucky. The author reported that many clients at rural clinics have less than a high school education. A lack of formal education can also lead to illiteracy. People who reside in rural areas may continue to live in the same community their entire lives where employment opportunities may be restricted. Opportunities for social and economic mobility are restricted because of a lack of formal education and marketable work skills, combined with geographic isolation (Reed, 1992).

Alternative Services

Kermode, Bowen, Arole, Joag, and Jorm (2009) collected data from 240 random sampled community members and 60 predetermined sampled village health workers (VHW) to assess who people consult with during times of stress and crisis. The participants were presented with two scenarios that described people who were experiencing symptoms of mental disorders. The participants were asked to name the problems and to identify the treatments and people that were most likely to be helpful, and the outcomes that were likely to occur. Results showed that interventions sensitive to culture and socioeconomic status that were provided by family, friends and neighbors were considered to be very helpful to people residing in rural areas (Kermode et al., 2009). Voss (1996) found that 80 percent of people in rural areas who seek help for mental health problems first go to doctors, clergymen, friends, and other informal helpers in the community. It is believed that people from rural areas are likely to go to a mental health professional only after they talk to their friends and family. Without proper knowledge about mental health, many people in rural areas may not seek help until the problem has become a crisis.

Throughout time, the church has been the center of community service and outreach (Voss, 1996). Rural citizens are more likely to approach their religious leader with personal or family problems before going to a mental health professional or another helper (Reed, 1992). Only since the development of government social programs has the church stepped down from its role as a source of help for the needy. However, cuts in federal aid for rural mental health can be seen as an opportunity for the church to again be involved in meeting social needs (Voss, 1996). Churches can provide counseling to church members as well as education and prevention relevant to mental health. Nevertheless, rural church members may feel embarrassment from seeking help from their pastor and hesitate to go to them. They may feel they are lacking strength if they speak to their pastor about their problems (Thrasher, 1984).

Kermode et al. (2009) inquired about services from physicians and psychiatrists. Services provided by physicians were rated as favorable, however, the

services of psychiatrists were rated as disapproving. It was necessary to examine research literature from other parts of the world because of the lack of research for this topic. In rural areas of India, psychiatrists are viewed as being of a higher social status and more costly (Kermode et al., 2009). Psychiatrists are seen as unfriendly as well as relatively distant and unfamiliar. The majority of participants expected the services of physicians and hospitals to be helpful if they utilized them. Trust, accessibility, and recommendations by significant others can determine the choice of healthcare providers for people with mental disorders (Kermode et al., 2009). It appears that physicians are expected to provide a variety of services in rural areas.

When people from rural areas decide to seek help, they frequently go to their primary health care clinics and complain of physical symptoms. Unfortunately, primary healthcare staff generally lack the skills required to make an appropriate psychiatric diagnosis and to provide a reasonable standard of care (Patel & Oornman, 1999; Simon, Vonkorff, Piccinelli, Fullerton, & Ormel, 1999; Weiss, Isaac, Parkar, Chowdhury, & Raguram, 2001; WHO & WONCA, 2008). Patel et al. (1999) found convincing evidence of a relationship between depression and the effects of a co-existing, physical illness. In developing countries, most individuals with depression remain undiagnosed and untreated, or are treated with a range of symptomatic medications. Simon et al. (1999) collected data from the World Health Organization (WHO) collaborative study of psychological problems. The data were used to examine the somatic symptoms of depression in primary care settings. Represented were countries with a range of culture, economic development, and types of health care delivery. Standardized measures were used in 14 countries on 5 continents. Depression was assessed according to *the Diagnostic and Statistical Manual of Mental Disorder, Fourth Edition* (APA, 1994). Somatization was assessed according to the symptoms in the DSM-IV or the *International Classification of Diseases, Tenth Edition* as diagnostic criteria for somatoform disorders (WHO, 1992). At each primary care center, a physician decided if each symptom was medically explainable. Results showed that the depressive symptoms seemed to vary little from one country to another, however, the interactions between doctors and depressed patients varied

considerably (Simon et al., 1999). The study concluded that patients may believe that the reporting of somatic symptoms is a more appropriate route for seeking help.

Clients may not know if they are receiving the appropriate treatment because of a lack of knowledge about mental health care. This suggests that not only are rural citizens lacking knowledge about mental health, but physicians may be unclear when it is appropriate to refer their patient to a mental health professional. At times, it can be difficult to distinguish between symptoms of a medical condition and a psychological condition. Physicians should spend adequate amounts of time on ruling out diagnoses that are less obvious.

"Do it Yourself" Mentality

Rural citizens continue to possess a "do it yourself/fix it yourself" mentality. People from rural areas are more stoic and more self-reliant than people from non-Appalachian areas in dealing with problems of all kinds including mental health problems (Fuller, Edwards, Proctor, & Moss, 2000). Those who seek help are potentially viewed as being a weak character (Wrigley, Jackson, Judd, & Komiti, 2005). Human and Wasem (1991) examined federal programs in rural mental health care in the Departments of Health and Human Services, Agriculture, and Education, as well as selected congressional initiatives. The authors found that rural values, attitudes, and traditions, together will create a tendency to mistrust outsiders, and a lack of knowledge about mental health services, may prevent a family or individual from utilizing mental health services. Rural people may not utilize services even when they are available because there is a tradition of everyone handling their own problems (Human & Wasem, 1991). Lifetime help-seeking for a psychological problem or a mental health issue is positively associated with higher levels of distress and lower levels of stoicism (Judd et al., 2006).

The "do it yourself/fix it yourself" mentality seems to get passed down from one generation to the next. This mentality is reinforced because some parents residing in rural areas do not take their children to psychological treatment if they need it. As a

result, children may tend to grow up believing that they have to deal with their issues and outside, professional help is not an option. Even if adolescents consider outside help to be an option, they have additional obstacles to face such as access to a mental health facility (Boyd et al., 2006). Permission from parents is required when minors are being treated. Adolescents face all the barriers to mental health care that adults do, in addition to a break in confidentiality and feelings of embarrassment. To receive transportation to a mental health facility, children and adolescents have to reveal their problems to their guardians. If the adult does not see the problem as needing a solution, the child or adolescent may not receive transportation to the facility.

Preventive Measures

Boyd et al. (2008) wrote a response to an article written by Jackson et al. (2007) and reviewed their literature on mental health problems in rural contexts. The aim of Jackson et al. (2007) was to determine which sociodemographic, illness-related and psychological factors impacted a person's decision to seek help and the factors associated help-seeking attitudes in rural settings. Sociodemographic factors such as gender, age, and marital status; illness-related factors such as having a mental disorder, comorbidity, and psychological distress; and, to a much lesser extent, psychological/attitudinal factors, including stigma, stoicism, and self-efficacy were included. Twenty relevant studies were selected from a pool of 350 studies. The most relevant studies investigated factors that were associated with attitudes that involved help-seeking behaviors from a formal health care provider for mental health problems. The authors compared studies that were specific to rural settings to studies that were not specific to any setting. Jackson et al. (2007) discovered that most adolescents were preoccupied with how others perceived them. However, younger males who resided in rural areas showed lower levels of awareness about mental health and had negative attitudes towards help-seeking and social stigma. They were also less confident in dealing with mental health issues. The authors found that stigma

and social exclusion can result from gossip networks and social visibility within rural communities (Jackson et al., 2007).

Research indicates that adolescence is the first developmental stage in which most mental disorders first manifest (Patel, Flisher, Hetrick, & McGorry, 2007). Obsessive-compulsive symptoms, depression, anxiety, and psychoticism were found to be common symptoms reported on a first visit in a community mental health center (Carscaddon, George, & Wells, 1990). These authors studied consumer satisfaction in a rural community mental health center. They believed that clients who were least likely to change were those who had adapted to their condition. As a result, they suggested that early intervention might be useful in helping younger clients before they became accustomed to their symptoms.

Stigma and Discrimination

People with mental disorders and their families experience substantial stigma and discrimination. Not all people will be hindered by barriers such as lack of education and transportation, but a large number will be hindered by the stigma that is attached to seeking services from a mental health professional. People may be stoic due to the stigma they fear will get attached to them if they seek treatment. This influences their willingness to seek treatment, the quality of help they receive, and the likelihood that they will adhere to treatment (World Health Organization, 2001). Hoyt, Conger, Valde, and Weihs (1997) found that people living in rural regions expressed significantly greater concern about stigma than those in populated centers. Using data from a panel study of 1,487 adults, they created a model that predicted changes in depressive symptoms. They found that men who lived in rural villages of under 2,500 or in small towns of 2,500 to 9,999 people had significantly greater increases in depressive symptoms than men who lived in the country or in larger towns. The authors also found that people who lived in the most rural areas were more likely to hold negative attitudes toward mental health care. In the study by Hoyt et al. (1997), when participants were asked about the possible causes of depression

and schizophrenia, some answered “upbringing”, “stress”, “social/environmental”, “genetics”, “drug use”, “personality”, and “weakness of character.” Those who thought the cause was “biological” were more likely to have positive attitudes about mental health services. Those attitudes were strongly predictive of willingness to seek help. Stigma directed towards mental health care was associated with significantly less likelihood of willingness to seek formal help in the future (Hoyt et al., 1997).

An individual can feel inferior and vulnerable when they are stigmatized by others. When stigma is implemented by the more powerful over those who are relatively weak, the weak experience a downgrade in their social status (Link & Phelan, 2001). Status loss and discrimination are the main components to creating stigma within a group. People who are labeled are not just set apart but they are excluded from full and equal participation in society (Link & Phelan, 2001). Community members are permitted to limit their obligations to people with mental disorders in the community. As a result, the motivation to stigmatize the mentally ill is more prevalent in communities where access to formal mental health services is scarce.

Why does it seem that people who live so close to one another in non-Appalachian areas are not concerned with their neighbors’ personal lives, but people in rural areas who live miles from one another know more about their neighbors? Parr, Phil, and Burns (2001) examined rural communities in terms of social proximity and physical distance. They found that, in rural environments, community members may be separated by many miles yet they can be considered socially proximate in that they can have an intimate knowledge of each other’s lives. In non-Appalachian environments, the opposite sociospatial relationship usually exists whereby community members tend to be live closer together but they are more socially distant. Parr et al. (2001) referred to this as the “rural paradox of proximity and distance” and described the ways in which this sociospatial relationship is responsible for the silencing of mental health problems. The authors also thought this was responsible for the exclusion of people with mental illnesses in a way that is more pronounced than what occurs in non-Appalachian areas. Eventually, social withdrawal combines with

psychological distress and affects utilization of mental health services to the point where a poorer treatment outcome might be expected (Parr et al., 2001). Appalachians may become more concerned with the lack of privacy and news getting out about their problems (Hoyt et al., 1997). Gossiping about a neighbor can lead to serious and harmful consequences regarding their mental health.

The Current Study

Past research has not thoroughly examined psychological barriers to mental health services specifically in the Appalachian region. Most research has focused on the lack of transportation, low socioeconomic status, and lack of mental health facilities in other rural parts of the world. However, no one has examined how the severity of a problem can influence who Appalachians consult with during difficult times. For this study, the way participants respond to scenarios, in which the severity continues to increase, will be examined. Participants will be able to recommend the person who is the most suitable to talk with from a list of helpers. They will also rate the severity of each scenario after it has been read.

Past research (Voss, 1996; Kermode et al., 2009; Reed, 1992) has suggested that people from rural areas prefer talking to close others (friends, family, and neighbors), religious leaders, and physicians during times of stress and crisis. It is predicted that Appalachian participants will recommend talking to no one and all the helpers previously mentioned before recommending a mental health professional. People from non-Appalachian areas are thought to be less affected by barriers that sometimes prevent people from Appalachian areas to seek help from mental health professionals. Non-Appalachian areas are more urbanized which increases public transportation to mental health facilities (Arcury et al., 2005). Trained professionals are more likely to locate in areas where mental health facilities are more abundant, therefore, increasing the chances that mental health professionals will be widely available in non-Appalachian areas. In addition, people from non-Appalachians areas are likely to have more than a high school education compared to people from

Appalachian areas, possibly increasing their knowledge about mental health (Reed, 1992). If non-Appalachians have adequate knowledge about mental health, they may be able to distinguish between problems that should be addressed by mental health professionals or by other helpers. As a result, non-Appalachian participants are expected to recommend no one and then close others only before recommending a mental health professional.

It is believed that a highly elevated level of severity is required before Appalachians will consider going to a mental health professional. The first hypothesis is that there will be a stronger correlation between severity and recommending a mental health professional among Appalachians than among non-Appalachians. The second hypothesis is that people from the Appalachian region will recommend, in this order, talking to no one, close others, a religious leader, and physician before recommending a mental health professional. The third hypothesis is that people from non-Appalachian areas will recommend, in this order, talking to no one and close others before recommending a mental health professional. For the purpose of this study, "close others" refers to family and friends.

II. METHOD

Participants

Participants consisted of 320 undergraduate volunteers at Eastern Kentucky University (EKU). 158 participants reported that they did not spend their childhood in an Appalachian area and 162 participants reported that they did spend most of their childhood in an Appalachian area. Students received course credit for participation. Participants were required to contribute to all parts of the study in order to receive full credit for their participation. Participants signed up using the online EKU SONA system to participate in the study. The SONA system is the university's web-based, human subject pool management software. Students are able to sign up for studies online, researchers can set up their studies online, and administrators can ensure students have completed all their requirements.

Materials

On the SONA system, 14 scenarios presented various situations in which the need for help ranged from ambiguous to clearly requiring help. The scenarios assessed whether help was necessary and if the person should seek help (Appendix A). In addition, participants were also presented with a demographic survey (Appendix B).

Scenarios. Scenarios and related questions were designed by the principle investigator, in collaboration with a colleague. Participants were instructed to read each scenario. For example, the first scenario stated, "Jan and her friend, Samantha, recently got into an argument and haven't been talking. Jan believes that Samantha was talking about her behind her back. Samantha also believes that Jan is talking about her behind her back." The order of the scenarios in Appendix A are listed as lowest severity to highest severity as rated by the participants.

Recommendation Level. The questions following the scenarios inquired about who the participant was willing to recommend for the individual in the scenario (friend,

psychologist, life coach, etc.) on a scale from 1 (*definitely not*) to 5 (*definitely should*), and who they would recommend the person in the scenario to talk to the most.

Perceived Severity. The scenarios were presented to the participants in random order. Participants rated the severity of the scenarios on a three point scale from 1 (*low*) to 3 (*high)* as they completed the survey.

Coding. Participants' mean severity levels were used to code scenarios 1 through 14.

Demographic Survey. The demographic survey was also designed by the principle investigator. Questions on the survey inquired about gender, hometown, age, race, year in college, and previous experiences with a therapist or psychologist. Not all of these additional factors were used for the purpose of this study.

Procedure

In order to participate, students signed up online through the EKU SONA system. The participants had the option of completing the study on a computer in any location. Participants were presented with a consent form that briefly described the procedure of the study. The participants were informed that they would receive credit for their introduction to psychology course immediately upon completion of the study. They were only identifiable to the researchers by a numeric ID code. They were also informed that participation would last approximately 50 minutes. It was stated that no risk of harm was expected from this study. The principle investigator's contact information was available to the participants if they had any questions after the study. During the study, participants were presented with 14 scenarios that described situations in which people were experiencing some type of difficulty. The participants read each scenario and answered three questions regarding what they read. The first question asked the participant how much they would recommend each helper. The second question asked which helper the participant would recommend the most. The third question asked the participant to rate the severity of the problem. The participants also completed a demographic survey. Lastly, they were presented with a debriefing form that explained the purpose and

hypotheses of the study. Citations of past research were listed for further reading if desired. The EKU Counseling Center's information was listed if the participants felt upset after completing the study.

III. RESULTS

Regression analyses were conducted to test the first hypothesis, which stated there would be a stronger correlation between severity and recommendation of seeing a mental health professional among Appalachians than among non-Appalachians. It is important to note that the results represent the participants' perceptions of severity rather than the principle investigator's perception of severity. The findings were marginally significant for recommending a mental health professional for Appalachians ($\beta = .12$, $p = .06$). A bivariate correlation revealed that recommending services from a mental health professional was positively correlated with severity for Appalachians (r=.451, p=.00) (see Figure 1). The findings from the regression analysis were nonsignificant for non-Appalachians, therefore confirming the first hypothesis.

Regression analyses were also conducted for the other available helpers in the study. The findings were significant for recommending close others for Appalachians ($\beta = .17$, $p < .05$). A bivariate correlation showed that recommending services from close others was positively correlated with severity for Appalachians (r=.357, p=.00) (see Figure 2). The findings from the regression analysis were nonsignificant for non-Appalachians. Findings for severity and recommendation of other helpers were nonsignificant.

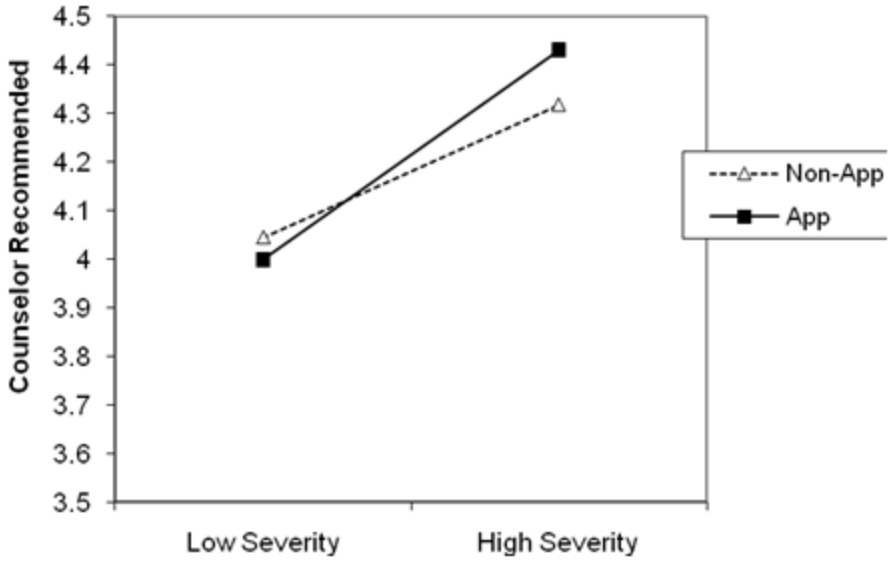

Figure 1. Recommendations for a Mental Health Professional

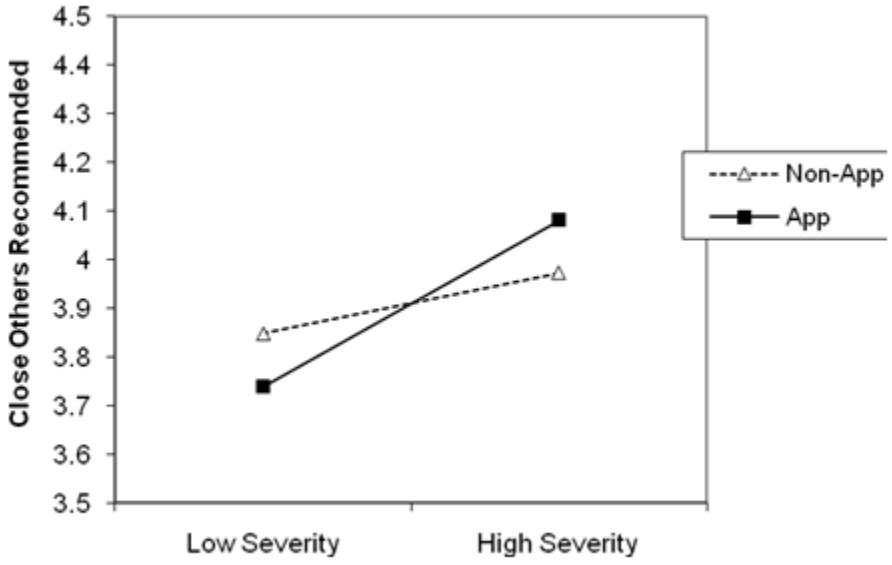

Figure 2. Recommendations for Close Others

A frequency analysis was completed in order to test hypotheses two and three (see Table 1). The second hypothesis stated that people from the Appalachian region would recommend, in this order, talking to no one, friends, family, a religious leader, and

physician before talking to a mental health professional. The third hypothesis stated that people from non-Appalachian areas would recommend, in this order, talking to no one, friends, and family before talking to a mental health professional. The results revealed the order of recommendations for Appalachian participants was; close others, religious leader, close others, mental health professional, close others, mental health professional, close others, then back to mental health professional. The order of recommendations for non-Appalachian participants was; close others, religious leader, close others, mental health professional, close others, mental health professional, close others, then back to mental health professional. Although the results did not completely support the hypotheses, most participants recommended talking to a close other for the first level of severity. Also, the non-Appalachian participants seemed to be more comfortable talking to family members at low levels of severity compared to Appalachian participants. Level 10 of severity appeared to be the "tipping point" for most participants, however, level 9 was the "tipping point" for non-Appalachians. The largest percentage of participants in both groups recommended talking to a mental health profession from levels 10 to 14.

Table 1. Recommendation Percentages for Non-Appalachians and Appalachians

Helpers	Severity Level													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Self	28	7	16	6	3	2	4	1	4	1	3	1	1	5
	25	6	18	4	4	2	2	1	4	2	2	1	1	5
Close Other	**51**	19	**39**	41	**47**	33	31	**53**	30	9	16	22	12	24
	62	11	**36**	22	**47**	22	28	**48**	**34**	9	12	18	9	23
Counselor	6	2	29	**53**	35	**52**	**55**	29	**34**	**82**	**55**	**69**	**73**	**50**
	8	5	29	**59**	40	**61**	**57**	32	31	**81**	**57**	**63**	**76**	**44**
Doctor	0	1	1	4	1	0	1	2	12	2	0	0	10	11
	0	1	2	4	1	1	1	2	13	1	2	2	9	13
Religious	4	**68**	9	4	3	9	7	4	4	1	17	6	3	4
Leader	2	**73**	11	9	2	8	7	3	4	2	18	14	2	7
Coach	0	0	0	1	7	0	0	0	2	0	0	0	0	1
	0	0	0	1	4	0	1	0	1	0	1	0	1	0
Life Coach	1	3	6	1	3	4	2	1	11	1	3	1	1	3
	2	1	4	1	1	4	3	4	11	1	2	1	1	5
Lawyer	0	0	0	1	1	1	1	1	3	4	7	0	0	0
	0	1	0	0	1	1	1	0	1	4	7	0	1	0
Professor	0	1	0	0	2	0	0	10	1	0	0	1	0	3
	0	1	0	0	1	1	0	10	0	0	0	0	1	1

Note: Non-Appalachian scores on top and Appalachians scores on bottom.

Follow-up ANOVA's (repeated measures) were performed to further examine how severity and region were related to recommending each type of person. Severity and region were the independent variables and recommendation of each type of person was the dependent variable. Results demonstrated that, as severity increased, Appalachian participants recommended the individuals in the scenarios talk with a religious leader more than non-Appalachian participants, $F(13,306)=1.538$, one-tailed $p=.05$. This further confirmed that Appalachians recommended a religious leader more than non-Appalachians at higher levels of severity (see Figure 3). When examining participants' recommendations for seeking services from all other helpers, results that not indicate that one group recommended a specific helper more than the other group.

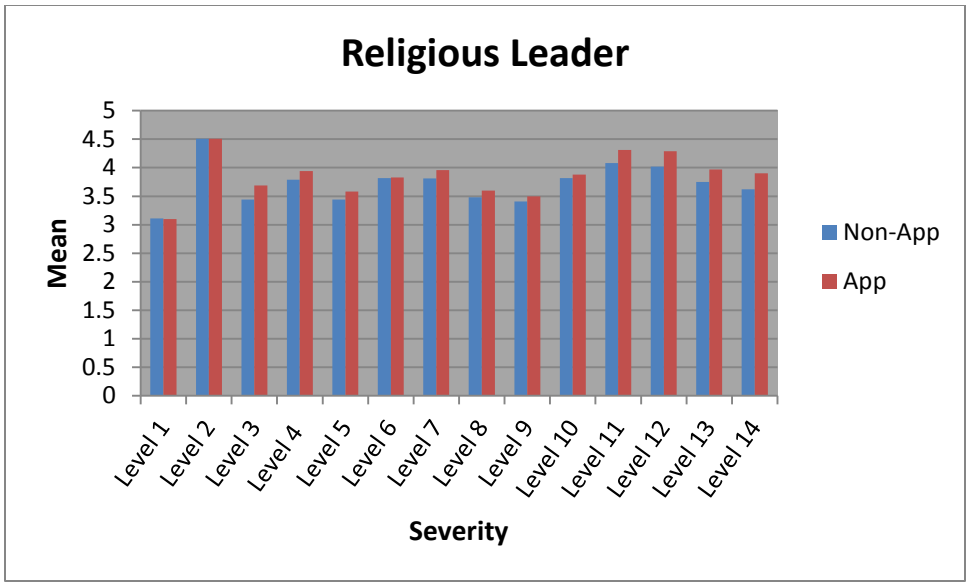

Figure 3. Mean Level of Recommendation for Religious Leader

The findings, illustrated that, as severity increased, Appalachian participants were more likely to recommend the individuals in the scenarios talk with a religious leader compared to non-Appalachian participants, but this was not found to be necessarily true for other helpers. It did not appear that Appalachian participants viewed services from a physician or a mental health professional as any less suitable compared to non-Appalachian participants.

IV. DISCUSSION

The purpose of this study was to examine the severity of a psychological problem and how it could influence Appalachian and non-Appalachians' preference for type of help. Findings suggested that Appalachians' tendency to recommend a mental health professional and a close other were strongly linked to their perception of how severe the symptoms were. Consulting with a friend was the first choice for both groups. More Appalachian participants recommended talking with a religious leader compared to non-Appalachian participants. When the severity reached level ten, both groups began to recommend a mental health professional in each scenario, however, non-Appalachian participants began to recommend a mental health professional in scenario nine.

Implications

The findings from the current study helped to examine the preference for type of help for Appalachian and non-Appalachians when they need assistance for a mental health problem. Voss (1996) and Kermode et al. (2009) found that people in rural areas who seek help for mental health problems first go to doctors, clergymen, friends, and other helpers in the community. They stated that people from non-Appalachian areas were more likely to go directly to a mental health professional after they talked to their friends and family unlike people from rural areas. The data from the current study partially confirmed the findings from Voss (1996) and Kermode et al. (2009). As severity increased, there were positive correlations between severity and recommending close others and a mental health professional for Appalachian participants. Appalachians viewed the assistance of close others just as helpful as services from a mental health professional at higher levels of severity. Overall, Appalachians recommended the individuals in the scenarios talk to a variety of people such as friends, family, and mental health professionals at high levels of severity. This proposes that Appalachians do not want to burden others with their problems at

lower levels of severity. There was a significant difference between how much Appalachians recommended a religious leader at higher levels of severity compared to non-Appalachians. Recommending a religious leader was not correlated with severity for Appalachians, but Appalachians recommended a religious leader more than non-Appalachians did. A physician was recommended by a small percentage of participants in both groups, however, it was not the most popular choice in any scenario. One explanation is that there were no medical dilemmas or somatic symptoms included in any of the scenarios. In the next paragraph, it is explained that the majority of participants may have recommended consulting with a religious leader in scenario two because it involved a religious predicament. Previous research findings have indicated that when people from rural areas decide to seek help, they frequently go to their primary health care clinics and have somatic complaints or symptoms (Patel et al., 1999; Simon et al., 1999; Weiss et al., 2001; WHO & WONCA, 2008). It is difficult to disconfirm previous findings because the current study did not inquire about reasons for recommending a specific helper. However, it was clear that a physician was not frequently recommended by Appalachians or non-Appalachians.

Thrasher (1984) argued that rural church members hesitate to go to their pastor, or religious leader, because of the embarrassment they feel for lacking strength. The findings from the current study suggested that most participants recommended talking to a religious leader when the scenario was related to a religious problem. Scenario two described an individual who desired to tryout religious denominations other than her parents' choice of religious denomination. When she mentioned this to her parents, they became very upset about it. It is unclear why the participants recommended talking to the religious leader in scenario two and why they failed to recommend the religious leader in other scenarios due to the methodology in this study. However, this suggests that people may have alternative reasons for seeking other services for their psychological issues. Embarrassment felt for lacking strength may only be one explanation for failing to seek help from a religious leader. On this note, it is important for mental health professionals to consider cultural sensitivity to religion and dependency on faith when interacting with

clients in the therapeutic setting. This can be especially true when working with Appalachian clients.

Historically, the church has been the center of community service and outreach (Voss, 1996). The findings from this study imply that Appalachians look to religious leaders in times of crisis. Mental health professionals should take one of three approaches to this matter. The first approach is that mental health professionals could encourage clients to steer away from consulting with a religious leader when addressing psychological issues altogether. The second approach involves bringing together mental health professionals and religious leaders in order to work together. Religious leaders would be trained to recognize clinically significant symptoms and know when to refer the individual to a trained professional. The third approach is to train religious leaders in counseling and psychology. This would allow Appalachians to receive effective help from a religious leader if they felt more comfortable with seeking their services compared to services from a mental health professional. The second approach seems to be the most practical way of resolving this issue. The problems that Appalachians face may not be severe enough to warrant the services of a mental health professional. In addition, clients may not always be able to afford professional services, however, community mental health centers usually provide ways to accommodate payment issues. Training religious leaders in counseling and psychology would be the optimal resolution for this concern but it would not be realistic or practical. Many religious leaders have additional jobs or obligations in addition to their position in the church. Time and money restrictions could prevent this approach from being effective. Also, many religious leaders may see additional training as unnecessary and irrelevant to their calling or purpose in the church.

When examining the recommendations for scenarios one through nine, it seemed appropriate that most participants recommended other helpers besides a mental health professional. Consulting with close others seemed appropriate when the situation involved a relational matter or a situation involving stress and exhaustion (scenarios 1, 3, 5, 8, 9). In scenario four, it stated that "John" had been very upset and unable to concentrate after the September 11th terrorist attacks. A mental health professional was possibly recommended by most participants because the attacks occurred nearly a decade

ago, and it would not be considered normal to experience distress related to the attacks at this point. Some participants may have considered this as a symptom of Post-Traumatic Stress Disorder (PTSD). The principle investigator did not intend for this scenario to attract clinical attention, and it is believed that the participants assumed more was going on with the individual in this situation.

In scenario 5, most participants recommended "Whitney" seek help from close others. The results are surprising in that many participants did not believe the potential dangers of cyberbullying warranted clinical attention. In scenario 5, "Whitney" was attacked by three classmates on a social networking site. The classmates said rude and hurtful things to her, and it caused serious emotional consequences for her. She also quit the cheerleading team at school. Cyberbullying has become an acute issue in the past several years, especially in school-aged individuals. A large percentage of participants recommended talking to a close other, probably because cyberbullying has only received serious attention recently. If this study was conducted in 5 years from now, this type of situation would probably be viewed as a clinically significant problem, and talking with a mental health professional would perhaps be the most popular approach to this situation. Over time, cyberbullying will probably be a more recognizable topic and community-wide education will help to inform everyone of its consequences.

This study did not include ways to measure the participants' attitudes or thoughts, therefore, it is difficult to confirm or disconfirm past research that implied that stoicism and stigma influenced the recommendations of the Appalachian participants (Hoyt et al., 1997; Fuller et al., 2000; Human & Weiss, 1991). The perceived stigma may have been non-existent since the study was a self-report measure and the participants' believed their answers to be confidential. The consent form that was read at the beginning of the study informed the participants that they would be identifiable to researchers only by a numeric ID code. Also, the participants may have responded with a perspective of what other people should do when facing a problem, instead of what they would do if they were in the same situation.

It may be appropriate to suggest that children do not always grow up to believe that they have to deal with their own issues and reject outside help. Many young,

Appalachian adults recommended a mental health professional from level 9 to level 14, contradicting the findings by Boyd et al. (2006). However, the results from this study may be slightly biased in that all participants had more than a high school education. Reed (1992) stated that a person's lack of knowledge about mental health was related to a general lack of education. It appears that level of education may be correlated with knowledge about healthcare. This is a good indication for rural mental health as a whole. If our results truly reflect Appalachians' insights of mental health, children may grow up with a more positive insight for dealing with their psychological issues and this could predict better treatment compliance.

An individual with a higher level of education may be able to better understand their rights to confidentiality when seeking help from a mental health professional. Hoyt et al. (1997) stated that Appalachians may be concerned with the lack of privacy and news getting out about their problems since these areas consist of smaller, more intimate communities. Community outreach programs need to spread the knowledge about mental health services and the clients' rights and privileges. A bottom-up approach rather than a top-down approach would be the best intervention for Appalachian communities. An approach that engages the entire community would be most effective at educating each individual and fighting social stigma. Mental health professionals should post flyers in churches and various office buildings explaining that the services they provide are private and confidential.

When clinicians are engaging in treatment with Appalachian clients, it may be helpful to explore how they perceive psychological issues. Our findings propose that recommending services from a mental health professional was positively correlated with severity for Appalachians. If Appalachians wait for the severity of a situation to reach increasingly high levels before they will consider consulting with a mental health professional, are they actually perceiving the severity accurately? It appears that this population recognizes some psychological symptoms as "normal" when compared to the way non-Appalachian populations recognize symptoms. Early education and prevention of psychological distress could help to teach Appalachians appropriate behaviors and symptoms.

Our findings suggested that as severity increased, Appalachians were more likely to recommend a mental health professional compared to non-Appalachians. Recommending services from a mental health professional was positively correlated with severity for Appalachians, but the correlation with these variables was weaker for non-Appalachians. Based on these findings, it appeared that the non-Appalachians' choice to recommend a mental health professional was correlated with a variable other than severity. We do not have the ability to determine what other variables played a role in the non-Appalachians' recommendations since the results of the bivariate correlations can only tell us the strength of the correlations.

It is important for mental health professionals to understand Appalachian culture. It may not be possible to build rapport and trust with clients if the clinician does not have the proper knowledge about their culture. Clinicians, especially the ones non-native born, need to be able to recognize their own cultural biases before they can determine what they need to do to conduct culturally sensitive practice with others. Attitudes or stereotypes that a clinician encompasses about a person or a population can impact the way they interact with clients. Cultural sensitivity and compassion can assist a clinician to effectively intervene to promote psychological wellness among the Appalachian population.

Limitations and Future Directions

The study involved a sample of college students only, limiting the variety of data. Most participants were enrolled in an introduction to psychology course and this could have further skewed the results. Participants who are in a psychology course could be more aware of psychological issues and outcomes than a person who is not enrolled in a psychology course. A replication of this study with a sample encompassing a variety of ages and occupations could help to further support the hypotheses for the purpose of generalization to a more diverse population.

The level of stigma felt by the participants could have been minimal in the study due to the wording of the questions, therefore, reducing the "do it yourself" mentality

often felt by Appalachians. If the questions had directly asked the participants what they would do in the situations, Appalachians may have felt more resistance when recommending a mental health professional. It is important to note that the scenarios were hypothetical situations created by the principle investigator. The participants may have responded with a perspective of what other people should do when facing a problem, instead of what they would do if they were in the same situation.

The scenarios covered many different content areas and problems. It was difficult to measure the scenarios in terms of severity. For future research, only one variable should change in the scenarios as severity increases. The same individual and setting should be presented in each scenario so there is a quantitative way to measure severity. If different content areas are implemented into the scenarios, results should focus on recommendations for each type of problem instead of a correlation between different variables.

Many participants in the study indicated that they felt part of the Appalachian culture even if they reported that they spent most of their childhood in a non-Appalachian region. This could have altered the data to make it appear that participants from both regions had similar preferences. Examining the cultural and regional identity of the participants may be a more effective means to support the hypotheses. If the sample was more diverse, including participants from different states and/or universities in the United States, the identity issue may be reduced or eliminated.

Conclusions

In addition to sociodemographic factors, socially influenced attitudes appear to be important when examining help-seeking behaviors in Appalachians. A comprehensive approach will help us to understand barriers to help-seeking and further explore factors such as social support, stoicism, self-efficacy, and stigma. There were indications of significant differences between the two samples, but slight methodical changes could produce more noteworthy findings. To help us better understand mental health services in Appalachian, subsequent studies may need to

inquire about the motives, instead of the frequencies, for recommending a service to solve a psychological issue. In conclusion, further research can help us to learn how to meet Appalachia's unique mental health needs.

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APPENDIX A:
Scenarios and Related Questions

Appendix A: Scenarios and Related Questions

Scenarios:

1. Jan and her friend, Samantha, recently got into an argument and haven't been talking. Jan believes that Samantha was talking about her behind her back. Samantha also believes that Jan is talking about her behind her back. **Would you recommend Jan**:

(1-*Definitely not* 2-*Not a good idea* 3-*Would not matter* 4-*A good idea* 5-*Definitely yes*)

Work it out on her own?	1	2	3	4	5
Talk to friends?	1	2	3	4	5
Talk to family?	1	2	3	4	5
Talk to counselor/psychologist?	1	2	3	4	5
Talk to medical doctor?	1	2	3	4	5
Talk to religious leader?	1	2	3	4	5
Talk to coach?	1	2	3	4	5
Talk to life coach?	1	2	3	4	5
Talk to legal professional?	1	2	3	4	5
Talk to college professor?	1	2	3	4	5

Which of the following would you recommend Jan talk to the most? (Please select one)

She should work this out on her own
Friends
Family
Counselor/Psychologist
Medical doctor
Religious leader
Athletic coach
Life coach
Legal professional
College professor

On a scale from 1 (low) to 3 (high), please rate the severity of this problem:

1	2	3
Low	Moderate	High

2. Amy has always attended the church that she grew up in. Lately, Amy has felt out of place in her church and would like to attend churches with different denominations. She has learned a few things about Catholic mass and would like to attend the next service at the Catholic Church that is close to her house. Amy mentioned this to her parents and they became very upset and told Amy that she should never attend a church of a different denomination. **Would you recommend Amy**:

(1-*Definitely not* 2-*Not a good idea* 3-*Would not matter* 4-*A good idea* 5-*Definitely yes*)

Work it out on her own?	1	2	3	4	5
Talk to friends?	1	2	3	4	5
Talk to family?	1	2	3	4	5
Talk to counselor/psychologist?	1	2	3	4	5
Talk to medical doctor?	1	2	3	4	5
Talk to religious leader?	1	2	3	4	5
Talk to coach?	1	2	3	4	5
Talk to life coach?	1	2	3	4	5
Talk to legal professional?	1	2	3	4	5
Talk to college professor?	1	2	3	4	5

Which of the following would you recommend Amy talk to the most? (Please select one)
She should work this out on her own
Friends
Family
Counselor/Psychologist
Medical doctor
Religious leader
Athletic coach
Life coach
Legal professional
College professor

On a scale from 1 (low) to 3 (high), please rate the severity of this problem:

1	2	3
Low	Moderate	High

3. Anthony recently got married. He and his wife are very happy. However, he recently noticed that since they moved in together they have begun to argue. **Would you recommend Anthony:**

(1-*Definitely not* 2-*Not a good idea* 3-*Would not matter* 4-*A good idea* 5-*Definitely yes*)

Work it out on his own?	1	2	3	4	5
Talk to friends?	1	2	3	4	5
Talk to family?	1	2	3	4	5
Talk to counselor/psychologist?	1	2	3	4	5
Talk to medical doctor?	1	2	3	4	5
Talk to religious leader?	1	2	3	4	5
Talk to coach?	1	2	3	4	5
Talk to life coach?	1	2	3	4	5
Talk to legal professional?	1	2	3	4	5
Talk to college professor?	1	2	3	4	5

Which of the following would you recommend Anthony talk to the most? (Please select one)
He should work this out on his own
Friends
Family
Counselor/Psychologist
Medical doctor
Religious leader
Athletic coach
Life coach
Legal professional
College professor

On a scale from 1 (low) to 3 (high), please rate the severity of this problem:

1	2	3
Low	Moderate	High

4. After the September 11th attacks, John has been very upset and unable to concentrate.
Would you recommend John:

(1-*Definitely not* 2-*Not a good idea* 3-*Would not matter* 4-*A good idea* 5-*Definitely yes*)

Work it out on his own?	1	2	3	4	5
Talk to friends?	1	2	3	4	5

Talk to family?	1	2	3	4	5
Talk to counselor/psychologist?	1	2	3	4	5
Talk to medical doctor?	1	2	3	4	5
Talk to religious leader?	1	2	3	4	5
Talk to coach?	1	2	3	4	5
Talk to life coach?	1	2	3	4	5
Talk to legal professional?	1	2	3	4	5
Talk to college professor?	1	2	3	4	5

Which of the following would you recommend John talk to the most? (Please select one)
He should work this out on his own
Friends
Family
Counselor/Psychologist
Medical doctor
Religious leader
Athletic coach
Life coach
Legal professional
College professor

On a scale from 1 (low) to 3 (high), please rate the severity of this problem:

1	2	3
Low	Moderate	High

5. Whitney recently broke up with her boyfriend. They decided to be friends and everything seemed to be working out. One night when Whitney came home from cheerleading practice, she found several messages on Facebook from 3 girls who attend the same school. They were saying rude and hurtful things to Whitney such as, "You didn't deserve your boyfriend anyways because you are so ugly" and "we wish you did not go to our school!" After Whitney's mother showed this to the school principle, the 3 girls received detention in school and their Facebook accounts were deleted. However, Whitney has been very sad and does not talk to anyone during the day. She also quit the cheerleading team. **Would you recommend Whitney:**

(1-*Definitely not* 2-*Not a good idea* 3-*Would not matter* 4-*A good idea* 5-*Definitely yes*)

Work it out on her own?	1	2	3	4	5
Talk to friends?	1	2	3	4	5
Talk to family?	1	2	3	4	5
Talk to counselor/psychologist?	1	2	3	4	5
Talk to medical doctor?	1	2	3	4	5
Talk to religious leader?	1	2	3	4	5
Talk to coach?	1	2	3	4	5
Talk to life coach?	1	2	3	4	5
Talk to legal professional?	1	2	3	4	5
Talk to college professor?	1	2	3	4	5

Which of the following would you recommend Whitney talk to the most? (Please select one)
She should work this out on her own
Friends
Family
Counselor/Psychologist
Medical doctor

Religious leader
Athletic coach
Life coach
Legal professional
College professor

On a scale from 1 (low) to 3 (high), please rate the severity of this problem:

1	2	3
Low	Moderate	High

6. Marie recently went through a divorce with her husband. She has been devastated since they separately. The main reason for the divorce is Marie had an extramarital affair with a co-worker. The couple tried to work out their problems but Marie's husband said that he could not ever trust her again. Marie feels very lonely and needs to talk to someone about her pain. **Would you recommend Marie**:

(1-*Definitely not* 2-*Not a good idea* 3-*Would not matter* 4-*A good idea* 5-*Definitely yes*)

Work it out on her own?	1	2	3	4	5
Talk to friends?	1	2	3	4	5
Talk to family?	1	2	3	4	5
Talk to counselor/psychologist?	1	2	3	4	5
Talk to medical doctor?	1	2	3	4	5
Talk to religious leader?	1	2	3	4	5
Talk to coach?	1	2	3	4	5
Talk to life coach?	1	2	3	4	5
Talk to legal professional?	1	2	3	4	5
Talk to college professor?	1	2	3	4	5

Which of the following would you recommend Marie talk to the most? (Please select one)
She should work this out on her own
Friends
Family
Counselor/Psychologist
Medical doctor
Religious leader
Athletic coach
Life coach
Legal professional
College professor

On a scale from 1 (low) to 3 (high), please rate the severity of this problem:

1	2	3
Low	Moderate	High

7. Tim has recently gone through a divorce with his wife. He has been devastated since they separately. The main reason for the divorce is his wife had an extramarital affair with a co-worker. The couple tried to work out their problems but Tim said that he could not ever trust her again. Tim feels very lonely and needs to talk to someone about his pain. **Would you recommend Tim**:

(1-*Definitely not* 2-*Not a good idea* 3-*Would not matter* 4-*A good idea* 5-*Definitely yes*)

Work it out on his own?	1	2	3	4	5
Talk to friends?	1	2	3	4	5
Talk to family?	1	2	3	4	5

Talk to counselor/psychologist?	1	2	3	4	5
Talk to medical doctor?	1	2	3	4	5
Talk to religious leader?	1	2	3	4	5
Talk to coach?	1	2	3	4	5
Talk to life coach?	1	2	3	4	5
Talk to legal professional?	1	2	3	4	5
Talk to college professor?	1	2	3	4	5

Which of the following would you recommend Tim talk to the most? (Please select one)
He should work this out on his own
Friends
Family
Counselor/Psychologist
Medical doctor
Religious leader
Athletic coach
Life coach
Legal professional
College professor

On a scale from 1 (low) to 3 (high), please rate the severity of this problem:

1	2	3
Low	Moderate	High

8. Lucy is a graduate student taking 12 hours in school this semester. She is experiencing difficulty with balancing homework, her job, and her thesis. She feels stress most days and cries frequently. She has been overeating, having difficulty concentrating, and getting little sleep each night. Her other classmates say that they are stressed also but they seem to happier than her.

Would you recommend Lucy:

(1-*Definitely not* 2-*Not a good idea* 3-*Would not matter* 4-*A good idea* 5-*Definitely yes*)

Work it out on her own?	1	2	3	4	5
Talk to friends?	1	2	3	4	5
Talk to family?	1	2	3	4	5
Talk to counselor/psychologist?	1	2	3	4	5
Talk to medical doctor?	1	2	3	4	5
Talk to religious leader?	1	2	3	4	5
Talk to coach?	1	2	3	4	5
Talk to life coach?	1	2	3	4	5
Talk to legal professional?	1	2	3	4	5
Talk to college professor?	1	2	3	4	5

Which of the following would you recommend Lucy talk to the most? (Please select one)
She should work this out on her own
Friends
Family
Counselor/Psychologist
Medical doctor
Religious leader
Athletic coach
Life coach
Legal professional

College professor

On a scale from 1 (low) to 3 (high), please rate the severity of this problem:

1	2	3
Low	Moderate	High

9. Ted has been laid off from his job for 3 weeks. Since then, he has experienced difficulty sleeping. He is only getting 3-4 hours of sleep a night. He feels very fatigued through the day and he does not feel like exercising, spending time with friends, or looking for another job. Before losing his job, he exercised at least 4 times a week and spent time with his friends every Friday or Saturday. **Would you recommend Ted:**

(1-*Definitely not* 2-*Not a good idea* 3-*Would not matter* 4-*A good idea* 5-*Definitely yes*)

Work it out on his own?	1	2	3	4	5
Talk to friends?	1	2	3	4	5
Talk to family?	1	2	3	4	5
Talk to counselor/psychologist?	1	2	3	4	5
Talk to medical doctor?	1	2	3	4	5
Talk to religious leader?	1	2	3	4	5
Talk to coach?	1	2	3	4	5
Talk to life coach?	1	2	3	4	5
Talk to legal professional?	1	2	3	4	5
Talk to college professor?	1	2	3	4	5

Which of the following would you recommend Ted talk to the most? (Please select one)

He should work this out on his own
Friends
Family
Counselor/Psychologist
Medical doctor
Religious leader
Athletic coach
Life coach
Legal professional
College professor

On a scale from 1 (low) to 3 (high), please rate the severity of this problem:

1	2	3
Low	Moderate	High

10. Max has noticed that he struggles with all of his romantic relationships. He becomes very confused and anxious when the relationship becomes more intimate. Max believes that his problems come from the physical and sexual abuse he received from his father when he was a child. Max has never told anyone about his abuse, however his mother was aware of the abuse when it was happening. **Would you recommend Max**:

(1-*Definitely not* 2-*Not a good idea* 3-*Would not matter* 4-*A good idea* 5-*Definitely yes*)

Work it out on his own?	1	2	3	4	5
Talk to friends?	1	2	3	4	5
Talk to family?	1	2	3	4	5
Talk to counselor/psychologist?	1	2	3	4	5
Talk to medical doctor?	1	2	3	4	5
Talk to religious leader?	1	2	3	4	5
Talk to coach?	1	2	3	4	5

Talk to life coach?	1	2	3	4	5
Talk to legal professional?	1	2	3	4	5
Talk to college professor?	1	2	3	4	5

Which of the following would you recommend Max talk to the most? (Please select one)
He should work this out on his own
Friends
Family
Counselor/Psychologist
Medical doctor
Religious leader
Athletic coach
Life coach
Legal professional
College professor

On a scale from 1 (low) to 3 (high), please rate the severity of this problem:

1	2	3
Low	Moderate	High

11. Ally was driving home one night after a party at her friend's house and was involved in a car accident. She hit another car and it instantly killed the other driver. Ally's blood alcohol level was over the legal limit at the time of the crash. Ally was sentenced to 50 years in prison. Since the wreck, Ally has had a really hard time dealing with the fact that she killed another person and regrets her decision to drive while intoxicated. **Would you recommend Ally**:

(1-*Definitely not* 2-*Not a good idea* 3-*Would not matter* 4-*A good idea* 5-*Definitely yes*)

Work it out on her own?	1	2	3	4	5
Talk to friends?	1	2	3	4	5
Talk to family?	1	2	3	4	5
Talk to counselor/psychologist?	1	2	3	4	5
Talk to medical doctor?	1	2	3	4	5
Talk to religious leader?	1	2	3	4	5
Talk to coach?	1	2	3	4	5
Talk to life coach?	1	2	3	4	5
Talk to legal professional?	1	2	3	4	5
Talk to college professor?	1	2	3	4	5

Which of the following would you recommend Amy talk to the most? (Please select one)
She should work this out on her own
Friends
Family
Counselor/Psychologist
Medical doctor
Religious leader
Athletic coach
Life coach
Legal professional
College professor

On a scale from 1 (low) to 3 (high), please rate the severity of this problem:

1	2	3
Low	Moderate	High

12. Leo recently lost his mother due to a car accident. Leo and his mother were very close and they spoke on the telephone almost everyday. Since the car accident, Leo has refused to accept his mother's death. Also, Leo will no longer drive or ride in a car. **Would you recommend Leo:**

(1-*Definitely not* 2-*Not a good idea* 3-*Would not matter* 4-*A good idea* 5-*Definitely yes*)

Work it out on his own?	1	2	3	4	5
Talk to friends?	1	2	3	4	5
Talk to family?	1	2	3	4	5
Talk to counselor/psychologist?	1	2	3	4	5
Talk to medical doctor?	1	2	3	4	5
Talk to religious leader?	1	2	3	4	5
Talk to coach?	1	2	3	4	5
Talk to life coach?	1	2	3	4	5
Talk to legal professional?	1	2	3	4	5
Talk to college professor?	1	2	3	4	5

Which of the following would you recommend Leo talk to the most? (Please select one)

He should work this out on his own
Friends
Family
Counselor/Psychologist
Medical doctor
Religious leader
Athletic coach
Life coach
Legal professional
College professor

On a scale from 1 (low) to 3 (high), please rate the severity of this problem:

1	2	3
Low	Moderate	High

13. David is an Iraqi War veteran. He served in the Army for a total of 10 years. He is very happy to be home from Iraq so he can spend time with his wife and children. However, David seems to be jumpy most days and on guard all the time. His wife has noticed that he yells in his sleep and says things like, "Put down your gun!" and "Run!" When David got back to the United States, he took a job as a Recruiter for the Army. His co-workers are making comments that he seems to be staying to himself most of the time and does not make conversation often. **Would you recommend David**:

(1-*Definitely not* 2-*Not a good idea* 3-*Would not matter* 4-*A good idea* 5-*Definitely yes*)

Work it out on his own?	1	2	3	4	5
Talk to friends?	1	2	3	4	5
Talk to family?	1	2	3	4	5
Talk to counselor/psychologist?	1	2	3	4	5
Talk to medical doctor?	1	2	3	4	5
Talk to religious leader?	1	2	3	4	5
Talk to coach?	1	2	3	4	5
Talk to life coach?	1	2	3	4	5
Talk to legal professional?	1	2	3	4	5
Talk to college professor?	1	2	3	4	5

Which of the following would you recommend David talk to the most? (Please select one)
He should work this out on his own
Friends
Family
Counselor/Psychologist
Medical doctor
Religious leader
Athletic coach
Life coach
Legal professional
College professor

On a scale from 1 (low) to 3 (high), please rate the severity of this problem:

1	2	3
Low	Moderate	High

14. Jay is a 23-year-old student at EKU. Lately, he has been smoking marijuana and drinking approximately 10 beers a day because he says that it helps to "calm his nerves." Jay is starting to do poorly in his classes. He is also starting to worry about where to get his marijuana because the guy he used to buy it from is moving to California. **Would you recommend Jay:**

(1-*Definitely not* 2-*Not a good idea* 3-*Would not matter* 4-*A good idea* 5-*Definitely yes*)

Work it out on his own?	1	2	3	4	5
Talk to friends?	1	2	3	4	5
Talk to family?	1	2	3	4	5
Talk to counselor/psychologist?	1	2	3	4	5
Talk to medical doctor?	1	2	3	4	5
Talk to religious leader?	1	2	3	4	5
Talk to coach?	1	2	3	4	5
Talk to life coach?	1	2	3	4	5
Talk to legal professional?	1	2	3	4	5
Talk to college professor?	1	2	3	4	5

Which of the following would you recommend Jay talk to the most? (Please select one)
She should work this out on her own
Friends
Family
Counselor/Psychologist
Medical doctor
Religious leader
Athletic coach
Life coach
Legal professional
College professor

On a scale from 1 (low) to 3 (high), please rate the severity of this problem:

1	2	3
Low	Moderate	High

APPENDIX B:
Demographic Survey

Appendix B: Demographic Survey

1. What is your gender? Male Female
2. In which county did you spend most of your childhood (example: Madison, KY)?
_____
3. How much do you identify with the Appalachian culture?

1	2	3	4	5
None	Little	Somewhat	Much	A great deal

4. What is your age? _____
5. What is your race? Caucasian African-American Latino Asian Other
6. What year are you in school? Freshmen Sophomore Junior Senior Graduate
7. Have you ever had an experience (ex. therapy session) with a mental health professional (therapist, counselor, psychologist)? YES NO
8. Has someone you know ever had an experience (ex. therapy session) with a mental health professional (therapist, counselor, psychologist)? YES NO