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Experiences of counselors who assist women in midlife who display depressive symptoms: a transcendental phenomenological study

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EXPERIENCES OF COUNSELORS WHO ASSIST WOMEN IN MIDLIFE WHO DISPLAY DEPRESSIVE SYMPTOMS: A TRANSCENDENTAL PHENOMENOLOGICAL STUDY

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Dedication

This dissertation is dedicated first to God and his angels because without them I would not have been able to continue, finish, or enjoy this challenging journey. Second, I dedicate this to myself for believing in myself even when I experienced challenging times. Third, to my special and supportive family and friends: my parents, Ana Maria Pestana and Cesar Tovar; my siblings, Ana Fasone, Mariano Tovar, and Chris Fasone; my nephew Guillermo Tovar; my nieces, Adelina and Emma Fasone; and my friends, Noemi Nandin, Patricia Ramirez, Cynthia Redhead, Rosa Maria Quevedo, and Pamela Portal. This dissertation would have not happened without all the people I love, their constant unconditional love, and their daily support. All of them have been by my side, encouraging me, supporting me, and motivating me throughout this long, challenging, and exciting journey. For these reasons, my dissertation is dedicated to them as a way to tell them that I love all of them and that I am eternally grateful.

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Abstract

EXPERIENCES OF COUNSELORS WHO ASSIST WOMEN IN MIDLIFE WHO DISPLAY DEPRESSIVE SYMPTOMS: A TRANSCENDENTAL PHENOMENOLOGICAL STUDY

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St. Mary's University, 2023

Dissertation Advisor: Melanie Harper, Ph.D.

In this dissertation, I present a transcendental phenomenological study conducted with 12 counselors who worked with women in midlife who displayed depressive symptoms. The purpose of this study was to understand the lived experiences, clinical and personal, of licensed professional counselors (LPCs) who worked with women in midlife who displayed depressive symptoms. Through the study, I sought to recognize the essence and themes that emerged from these LPCs who worked with this population. Moreover, this study was designed to obtain a better understanding of how these LPCs managed their feelings and thoughts, how they helped when working with these women, and what recommendations or suggestions they offered to other LPCs. Findings indicated the importance of the connection between counselors and women who had depressive symptoms. Counselors need to connect with their clients to understand their stories and to be able to offer them the best treatment plan. Recommendations are provided in the realms of counselor preparation (including education and supervision), counseling, and future research. Recommendations will help counseling students to help them recognize that when working with women in midlife who have depressive symptoms, whether they have a depressive diagnosis or not, it will take a significant amount of investigation of

their clients' lives to be of assistance to them. It will also take counselors to show empathy and compassion to their clients, be aware of themselves, and to create a safe environment for their clients. It may require that counselors have an extremely varied theoretical background to match the right treatment to their clients.

Keywords: counselors, women in midlife, depressive symptoms

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CHAPTER 1: Introduction

The purpose of this study was to understand the lived experiences, clinical and personal, of licensed professional counselors (LPCs) that worked with women in midlife who displayed depressive symptoms. The transcendental phenomenological approach (Moustakas, 1994) helped to obtain knowledge of LPCs' clinical and personal experiences related to their work with women who displayed depressive symptoms. This knowledge may help other LPCs to develop more awareness of themselves and to internalize knowledge and experience attained through this study.

The American Counseling Association (ACA) Code of Ethics (2014) states that when counselors have a better understanding of themselves, they are more aware of their own biases when working with clients. This awareness helps LPCs to process their own biases in their personal lives and allows LPCs to refrain from contaminating their relationships with their clients. When LPCs maintain healthy professional relationships with their clients, they work more effectively.

Having a better comprehension of LPCs' clinical and personal experiences when working with women in midlife who display depressive symptoms may help all LPCs by providing the additional knowledge and the experiences obtained from their peers. LPCs may develop more skills and have more resources for their work with clients. The new skills and resources may help LPCs to work more efficiently and effectively with clients.

Statement of the Problem

Researchers have conducted a variety of evidence-based studies concerning women in midlife who display depressive symptoms (Ghaemi, 2013; Harrington, 2019; Lafrance, 2009; Mackinnon, 2016; Mazure & Keita, 2006; Mcintyre, 2016; Ussher,

2011). Even though there are numerous evidence-based studies about women in midlife who present depressive symptoms, there are no evidence-based studies of the clinical and personal experiences of LPCs who assist women in midlife who display depressive symptoms. This gap in the literature has helped me to choose this topic of study.

Noonan (2016) demonstrated that women in midlife who display depressive symptoms, are sometimes unaware if these symptoms are based on biological, hormonal, emotional, psychological, or sociocultural causes. Noonan indicated that women who start counseling expect their counselors to discover the right course of action for them. A client expects counselors to explore the resources the client currently has, and those that the client may need, and then expects counselors to refer them to other health providers as needed (Noonan, 2016). If the clients need medications, clients expect counselors to help them with medication and treatment compliance (Noonan, 2016).

The Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016) has established standards for training counselors. These standards include assessment, diagnosis, and treatment in general, but do not state the degree of training that students should obtain in helping clients with a particular diagnosis, such as depression. These standards also do not give any guidelines to counselors on how to help their clients manage their frustrations when searching for an effective medication or treatment, or how to keep clients motivated toward treatment when progress is minimal or stalled.

Literature regarding evidence-based studies of the clinical and personal experiences of LPCs' who assist women in midlife who display depressive symptoms is lacking. Noonan (2016) stated that women anticipate their LPCs explore the symptoms

they display in therapy, and discover if these symptoms are based on biological, hormonal, emotional, psychological, or sociocultural causes. Women also expect that LPCs will offer them the best treatment plan for their symptoms (Noonan, 2016). Even though CACREP (2016) established standards for training counselors, they do not give any guidelines to LPCs on how to help their clients manage frustration and demotivation when searching for an effective treatment plan. The results of this study may provide LPCs increased knowledge and resources regarding how to help clients managing their emotions when seeking the best treatment for their symptoms.

Research Questions

The central research question for this qualitative study was: "What are the clinical and personal experiences of LPCs who assist women in midlife who report depressive symptoms?" The base interview questions asked of participants in this study were:

- "What are your feelings and thoughts when you assist women in midlife who display depressive symptoms?"
- "How do you manage the thoughts and feelings you experience when you assist women in midlife who display depressive symptoms?"
- "How do you help women in midlife who have depressive symptoms?"
- "What suggestions or recommendations do you have for LPCs to work more effectively and efficiently when they assist women in midlife who present depressive symptoms?"

Rationale and Justification for the Study

The purpose of this study was to understand the lived experiences, clinical and personal, of LPCs who worked with women in midlife who display depressive symptoms.

The transcendental phenomenological approach (Moustakas, 1994) helped in obtaining knowledge of LPCs' clinical and personal experiences related to their work with these women. LPCs will be able to learn what other LPCs do to help clients who display depressive symptoms; how LPCs deal with their own thoughts and feelings when they work with these clients; what LPCs recommend to others to help them work more effectively and efficiently with these clients; and to also help these clients to overcome suicidal ideation and avoid suicide itself.

Chandra et al. (2009) stated that women are more predisposed to depression and anxiety than men because of changes in the female reproductive system (hormonal changes). Mazure and Keita (2006) indicated that biological factors (hormonal changes), psychosocial factors such as managing different roles (wives, mothers, and professionals), and coping with work, family, and changes in society, cause more depression in women than in men. These factors are only present in women, and they increase directly and indirectly with regards to their reaction to stress (Mazure & Keita, 2006).

Manning (2020) indicated that depression is a mental state that increases the risk of suicide. In the modern world. Both professionals and lay people primarily treat suicide as a medical or a mental problem (Manning, 2020). Niederkrotenthaler and Stack (2017) demonstrated that globally, suicides account for 50% of all violent deaths among men and 71% of all violent deaths among women. Despite the availability of suicide prevention programs, therapy, and pharmacological treatments, the suicide rate is either expanding or lingering at an elevated rate around the world (Niederkrotenthaler & Stack, 2017).

Greden et al. (2011) found that clinical depression is the second most costly disorder in the United States population. Greden et al. stated that in the United States there are approximately 30,000 to 50,000 suicides each year. From these estimates, 80% to 90% are connected to clinical depression (Greden et al., 2011). The Centers for Disease Control and Prevention (2019) stated that suicide is the 10th leading cause of death in the United States.

Mackinnon (2016) indicated that major depressive disorder (MDD) is a major risk factor for disability globally. MDD is linked to a higher risk of medical illness (poorer prognosis), and it is the main predictor of suicide (Mackinnon, 2016). The risk of suicide in people who have severe MDD is hundreds of times greater than the risk for the general population (Mackinnon, 2016). More effective treatments for MDD might reduce the number of suicides and improve the health prognoses for women who have MDD (Mackinnon, 2016).

Harrington (2019) demonstrated that some studies recommend treating men with a serotonin-norepinephrine reuptake inhibitor (SNRIs) or tricycle antidepressants (TCAs) and treating women with selective serotonin reuptake inhibitors (SSRIs). Chandra et al. (2009) indicated that no specific doses are established for women when taking psychotropic medications. Thus, in general, work with women who have depressive symptoms can be challenging because of a lack of clear treatment methods. Even treatment of women who have been diagnosed medication for depression can be challenging due to the need to find an effective medication and establish an effective dosage for each individual.

Advantages and Limitations of the Study Design

Keegan (2009) indicated that qualitative research design focuses on the meaning of, and understanding how, individuals and groups think and behave, instead of measuring their experiences. This design explores questions such as what, why, and how, rather than how many or how much. Keegan noted that there may be some criticism about interviewing as a qualitative methodology because what people say they do, think, or feel, may not be true. These supposedly false interview responses may lead to distorted results, but through interviews, more in-depth information can be obtained, and information beyond what the researcher might expect to uncover (Creswell, 2013). Using a qualitative methodology with an interview format can allow a researcher to gain more useful knowledge about the research topic, even if a small portion of the information may not be completely accurate (Creswell, 2013).

Patton (2015) demonstrated that there are several benefits of using qualitative methods. Patton concluded that some of the benefits are that the researcher will be able to illuminate meaning, study how things work, and capture stories to understand people's perspectives and experiences. The researcher will also be able to explain how systems function and their consequences for people's lives, understand the context (how and why it matters), identify unanticipated consequences, and make case comparisons to discover important patterns and themes across cases (Patton, 2015).

Patton (2015) concluded that one of the key limitations of qualitative research involves the risk of researcher bias. Patton stated that the researcher should use some present-moment techniques such as body awareness and self-reflection to continue becoming more self-aware. Patton (2015) also indicated that another limitation of

qualitative research is the excessive amount of time that is required for the researcher to collect all the data from the narrative experiences and use this data effectively.

Definitions of Terms

There are several terms that are in my research question that needed to be defined. These terms are licensed professional counselors, women, women in midlife, and depressive symptoms. The following section describes these terms.

Licensed Professional Counselors

The ACA Code of Ethics (2011) defines licensed professional counselors (LPCs) as "licensed clinical professional counselors" or "licensed mental health counselors." LPCs provide mental health and substance abuse care to millions of Americans. LPCs are mental health service providers with a minimum of a master's level degree in the field, trained to work with individuals, families, and groups in treating mental, behavioral, and emotional problems and disorders.

Women

The American Psychological Association (2020) presented the difference between genderism and cisgenderism. Cisgenderism refers to the belief that being cisgender is normative, as indicated by the assumption that individuals are cisgender unless otherwise specified. The American Psychological Association defined cisgender women as "women whose sex assigned at birth aligns with their gender identity." For this study, women will refer to cisgender women.

Women in Midlife

Norman and Scaramella (1980) presented that midlife starts around the age of 40 and it ends around the age of 65. Degges-White and Myers (2006) reported that even

though this life transition is often considered an age of crisis, today's women in midlife are living lives full of activity and the entire midlife period is considered as a time of growth, development, movement, and challenge.

Depressive Symptoms

The diagnostic criteria for MDD is presented in the American Psychiatric Association's (2013) *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5). Although this study did not require LPCs to have diagnosed MDD in one or more women in midlife, the LPCs identified that they have worked with women who have identified one or more of the following symptoms detailed in the DSM-5: depressed mood, loss of interest or pleasure, significant weight loss when not dieting, weight gain, decrease or increase in appetite, insomnia, hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or excessive or inappropriate guilt, diminished ability to think or concentrate, indecisiveness, recurrent thoughts of death, or recurrent suicidal ideation. These symptoms must not be attributable to the effects of a substance, another medical condition, or certain specified psychological disorders.

CHAPTER 2: Literature Review

Chapter 2 contained the following sections – counseling, women in midlife, depressive symptoms, treatment for depressive symptoms, and theory based in research: cognitive-behavioral therapy (CBT). The counseling section described the roles of counselors and how counselors are trained to do work with clients. Counselors must be aware of themselves, have knowledge of CACREP Standards (2016), and have knowledge of the ACA Code of Ethics (2014) so that they can provide ethical and effective counseling to clients.

The women in midlife section provides information highlighting that the entire midlife period is considered as a time of growth, development, movement, and challenge (Degges-White & Myers, 2006). Miller (2010) found that the state of mind-body relationship determines what events and factors are more stressful to individuals during aging, and these perceptions determine quality and length of life. Furthermore, Miller stated that midlife individuals perceive Erikson's psychosocial development through generativity when they care for their own children and their parents.

The depressive symptoms section provides the history of depression, examines the biological, psychological, and sociocultural factors that cause depression and depressive symptoms, and addresses suicide in relation to depression. This section also examines the differences between men and women who experience depressive symptoms, family and health conditions related to depressive symptoms, diagnosis of depression, counseling treatments for depressive symptoms, and psychotropic medications for depression. Counselors must take all this information into consideration

when they diagnose and treat their clients who display depressive symptoms (Nydegger, 2008).

Finally, the theory based in research that the researcher is used for her study, is CBT. The researcher used this theory because Mazure and Keita (2006) identified that CBT is an effective treatment when treating depression in women. Moreover, Choate (2019) stated that CBT focuses on clients with depression and their current maladaptive behaviors, their dysfunctional cognitions, and their emotional dysregulation. Thus, CBT is a commonly used treatment modality for clients who have depression or depressive symptoms (Choate, 2019; Mazure & Keita, 2006).

Counseling

In the ACA Code of Ethics (2014), counseling is defined as "a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (p. 3). The values of the counseling profession are enhancing human development, honoring diversity, promoting social justice, safeguarding the integrity of the counselor-client relationship, and practicing in a competent and ethical manner (ACA, 2014). These values support the ethical principles of autonomy, nonmaleficence, beneficence, justice, fidelity, and veracity as the foundation for ethical behavior and decision making (ACA, 2014).

Joseph (2019) stated that when both psychiatrists and counselors work together, they provide a greater opportunity for their clients to obtain better treatment outcomes. Joseph noted that psychiatrists are responsible for finding the best psychotropic medications for their clients. Counselors are responsible for helping clients become aware of their psychiatry and counseling processes (Joseph, 2019). Counselors can work more

efficiently with some clients when psychotropic medications have provided clients with more mental clarity (Joseph, 2019).

Bentley (2010) concluded that when counselors ask their clients about their symptoms they need to explore as much as they can. Bentley stated that counselors can ask about initial symptoms, current symptoms, or current medications. In addition, counselors can collect dates, names, and addresses of any physicians whom clients have consulted for assessment, treatments, and medications (Bentley, 2010). Counselors also should inquire about any side effects that clients have experienced from previous treatments and medications (Bentley, 2010). Exploring this information will help counselors to be aware of a client's previous experience with various treatments and medications (Bentley, 2010).

Role of Counselors

Farmer and Chapman (2016) reported CBT is an action-oriented approach. Farmer and Chapman pointed out that CBT counselors assess clients' problem areas from a behavioral standpoint, and they acknowledge the uniqueness of the clients and their context. Farmer and Chapman stated that clients must be active participants and share responsibility with CBT counselors within the therapeutic process. CBT counselors must establish a collaborative therapeutic relationship and provide their clients with a realistic therapy timeline (Farmer & Chapman, 2016).

Farmer and Chapman (2016) noted that the collaborative relationship between a CBT counselor and the client is built by frequently asking questions of the client such as: "Do you have anything you would like to add?" Farmer and Chapman indicated that CBT counselors can also develop a collaborative relationship with their clients when they use

"we" statements, indicating that counselors and clients are a team working together toward the same goals (p. 25). When counselors provide these realistic goals for therapy with their clients it is important that they instill hope regarding its potential efficacy (Farmer & Chapman, 2016).

Bentley (2010) indicated that when clients feel more hopeful concerning their therapy goals, they are more compliant with their treatment and medication. Roe et al. (2009) stated that counselors assist clients to maintain medication and treatment compliance. Bentley pointed out that counselors help clients to maintain medication and treatment compliance, but sometimes this compliance does not occur. When clients are noncompliant and do not make progress, counselors may feel frustrated and hopeless (Bentley, 2010).

Counselors' Preparation

CACREP (2016) established standards for training counselors. These standards include assessment, diagnosis, and treatment in general, but do not state the degree of training students should obtain in helping clients with a particular diagnosis, such as: depression, helping clients to manage their frustrations when searching for effective medication or treatment, or keeping clients motivated towards treatment. In the United States, individual states set standards of training for licensing, and these state level standards often are less clear than CACREP's standards (CACREP, 2016). For example, a state may require a 3-credit hour course in diagnosis and a 3-credit hour course in assessment without providing further guidelines for the content of these courses.

The ACA Code of Ethics (2014) is a national standard. Even though some states have adopted the ACA Code of Ethics as part of their regulations and most schools

require students to learn and follow the ACA Code of Ethics, following these ethics is not required in many states (Friedman, 2017). Friedman (2017) stated that even though the ACA Code of Ethics specifies counselors in training participate in self-care activities to maintain and promote their own emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities, self-care is briefly mentioned in the ACA document.

Friedman (2017) reported that counselors who do not participate in self-care activities are at risk of burnout. Friedman noted that when counselors experience burnout, they are not only harming themselves, but also their clients' wellness. Counselors must find ways to attend to their own needs for their own benefit and for their clients as well (Friedman, 2017).

Women in Midlife

Norman and Scaramella (1980) presented that midlife starts around the age of 40 and it ends around the age of 65. Even though this life transition it is often considered an age of crisis, Degges-White and Myers (2006) reported that today's women in midlife are living lives full of activity and the entire midlife period is considered as a time of growth, development, movement, and challenge. Degges-White and Myers concluded that women can no longer pretend that their midlife stages will follow the patterns of the women who preceded them. Counselors may encourage women in midlife to choose stages that are different from the previous generation and support these women in their choices (Degges-White & Myers, 2006).

Moustafa et al. (2020) indicated that throughout life there are major transitions such as giving birth, menopause, retirement, children leaving the family home, and

midlife crisis. Degges-White and Myers (2006) reported that the most common transitions for women in midlife were physical changes (perimenopause), psychological changes (increased inner focus), relationship issues (entered or ended committed relationship), vocational issues (returned to school), and family issues (loss of parents). Moustafa et al. noted that the various major transitions can be perceived by women as neutral, positive, or negative.

Moustafa et al. (2020) demonstrated it is possible that the different ways individuals perceive life transitions are related to which individuals develop depression. Sassarini (2016) indicated that women in midlife are at increased risk of low mood and depression. Sassarini noted that a history of depression seems to be the most important risk factor, but there are still several confounding factors such as comorbid medical conditions, education, and risky lifestyle choices.

Miller (2010) found that the state of the mind-body relationship determines what events are more stressful to individuals as aging occurs. Miller stated that how individuals respond and adapt physically, psychologically, emotionally, and socially to the changes of aging, helps to determine their quality and length of life. Faubion et al. (2018) stated that understanding the health and well-being of women in midlife is critical for providing individualized care to women as they age.

Miller (2010) concluded that Erikson's psychosocial development theory is a theory of ego development (Erikson, 1950, as cited in Miller 2010). When working with clients, this theory provides a roadmap of development and life transitions, what to expect, and where to intervene (Miller, 2010). Miller stated that successful transitions depend on how individuals adapt themselves within these changes, and how their

biological, psychological, emotional, and social factors interact to cope with their stresses to avoid developing disorders. Midlife individuals perceive this psychosocial development through generativity when they care for the life cycles of others, such as their own children and their parents (Miller, 2010).

Depressive Symptoms

This section includes the subsections: history of depressive symptoms, family history related to depressive symptoms, biological factors of depressive symptoms, psychological and sociocultural factors of depressive symptoms, suicide and depressive symptoms, differences of depressive symptoms in men and women, and diagnostic criteria of depressive disorders. When evaluating and diagnosing, counselors must include their clients' histories of depressive symptoms, if they are male or female, and whether they have any physical or mental conditions based on biological, psychological, sociocultural, or family factors (Bromberger et al., 2015). Manning (2020) indicated that counselors must accurately diagnose their clients' depressive symptoms because depression is a mental state that increases the risk of suicide and physical health issues.

Azizi et al. (2018) used 16 articles for their systematic review exploring depression symptoms and risk factors in women in midlife in the Middle East. Azizi et al. found Middle East results to be consistent with other zones in the world (Europe, Australia, USA, and South America). Women in midlife in the Middle East region are at higher risk for depression than men of the same region due to the presence of different factors (Azizi et al. 2018). The factors placing women in the Middle East at higher risk of depression are sociodemographic, menopausal symptoms, chronic medical conditions, and past psychological ill health (Azizi et al., 2018). Azizi et al. noted that the incidence

for depressive symptoms in perimenopausal women is higher than in premenopausal women.

While Azizi et al. (2018) reported that depression and menopause are connected, Chandra et al. (2009) indicated that they are not related. Both Chandra et al. (2009) and Azizi (2018) noted that depression and menopause can result in disturbed sleep, as well as psychosocial, socioeconomic, and physical distress in some areas of daily functioning. Sassarini (2016) stated that a history of depression seems to be the most important risk factor foe depression. Sassarini indicated that even though a history of depression appears to be the main risk factor, there are several confounding factors not limited to, but involving comorbid medical conditions, education, and risky lifestyle choices.

History of Depressive Symptoms

Maletic and Raison (2017) identified that depression is a recognized disease process, or vulnerability, that has been reported since antiquity. Maletic and Raison noted that, presumably, people have suffered with depression since the origin of the human species. Jackson (1986) stated that during the latter half of the nineteenth century the descriptive uses of depression to indicate affect became increasingly common, but the basic diagnostic term was still usually melancholia or melancholy (p. 6). Ussher (2011) stated that, at the beginning of the 20th century, the term depression was changed to the diagnostic term major depressive disorder "MDD" in manuals such as the DSM (p. 50).

Ghaemi (2013) defined depression as, "a clinical problem and that it is not the same thing as sadness" (p. 11). Ghaemi concluded that people who have depression are sad, but they also have problems with their sleep and are tired when they try to do simple

things. People suffering from depression also have difficulty focusing on daily tasks, they feel dumb and guilty, and sometimes suicide seems reasonable (Ghaemi, 2013).

Family History Related to Depressive Symptoms

Bromberger et al. (2016) conducted a longitudinal, quantitative study of 297 Black and White premenopausal women, aged 42 years to 52 years, who: had an intact uterus and at least one ovary; had experienced at least one menstrual period; had no use of reproductive hormones in the previous three months; were not pregnant; and were not breastfeeding. Bromberger et al. noted that these participants were enrolled at the study of Women's Health Across the Nation (SWAN) Pittsburgh site, across 13-years of follow up. Psychiatric interviews obtained information on lifetime psychiatric criterion and episodes of depression annually (Bromberger et al., 2016). Bromberger et al. provided information on the natural course of clinical depression disorders in women in midlife during a period of major endocrine, health, and psychosocial changes. Bomberger et al. stated that persistent and recurrent depression is common during midlife. Bromberger et al. concluded that personal and family histories, current sleep problems, and recent disturbing events, are strong factors for a destructive depressive course.

Using a quantitative method, Colvin et al. (2014) explored whether family history of depression predicts major depression in midlife women, independent of psychosocial and health problems at midlife. Colvin et al. noted the 303 participants were both Black and White women (42 years to 52 years at baseline), recruited into the Study of Women's Health Across the Nation (SWAN) and the Women's Mental Health Study (MHS) in Pittsburgh, Pennsylvania. Colvin et al. stated that family history of depression is an

essential predictor of major depression in women during midlife, but mostly in those with a lifetime history of depression prior to midlife.

Colvin et al. (2014) reported that family history of depression predicts major depression in women in midlife independently of psychosocial and health problems, The role of family history with incidents of recurrent depression in women in midlife is unknown (Colvin et al., 2014). The effects of family history were independent of lifetime history of depression, age, trait anxiety, chronic medical conditions, and stressful life events (Colvin et al., 2014).

Jones et al. (2020) used a longitudinal quantitative study to explore whether depression symptoms were associated with physical health problems in women in midlife. Jones et al. reported that the longitudinal data was obtained for 36 months from 264 women in midlife, of African American, White, and Latina descent, who began the study as vigorous, consistently menstruating, 40-year-old to 50-year-old women with 75 who transitioned to peri or post-menopause within the 36-month study. Jones et al. concluded that there is strong support for the correlation between chronic illness and risk of depression in women in midlife prior to the onset of menopause and during early menopausal transition. Jones et al. stated that depression and chronic diseases occur together, therefore, it is recommended to assess for comorbidity of depressive symptoms and chronic diseases. Clarifying which disease appears first may contribute to the improvement of mental and physical health of a considerable number of women in midlife (Jones et al., 2020).

Biological Factors of Depressive Symptoms

Chandra et al. (2009) noted that worldwide, biological reality is the same for all women, but the real difference is how women perceive their lives, and how they look at their body, aging, relationships, environments, health, and pain. Choate (2019) indicated that perimenopause is a natural life transition that occurs in all women and starts 10 years prior to menopause, usually between the ages of 40 years and 55 years. During this biological transition, women are more at risk of developing depression and depressive symptoms (Choate, 2019). Choate described menopause as a dramatic hormonal transition that occurs in all 51-year-old women. In this transition, women develop depressive symptoms that can last up to 10 years and vary depending on their biology, beliefs, attitudes, and cultural experiences (Choate, 2019).

Chandra et al. (2009) indicated that menopause and depression can result in disturbed sleep, as well as psychosocial, socioeconomic, and physical distress in some areas of daily functioning. Chandra et al. stated that even though researchers have found these similarities, they do not associate menopause with depression. Chandra et al. indicated that researchers should continue exploring the factors that differentiate between women who experience depressive symptoms and women who do not experience depressive symptoms during the transition to menopause.

Seaman and Eldridge (2009) demonstrated that there is a limited connection between reproductive transitions (menarche, menstruation, and menopause) and the onset of depression. Chandra et al. (2009) stated that reproductive life is a stressor for women because of pregnancy and having to take care of children. Chandra et al. indicated that this reproductive stressor has a negative effect on a women's careers because of the

challenges that women face balancing their different roles as mothers, wives, and professionals.

Psychological and Sociocultural Factors of Depressive Symptoms

Choate (2019) noted that midlife is associated with more stressful life events than other developmental transitional stages. Choate stated that some of these stressful life events include balancing family and work life, caregiving for aging parents, and dealing with the death of parents. Other challenging life events occur when individuals in midlife deal with issues related to their adult children and grandchildren and lose social and financial support because of children getting older (Choate, 2019). Additional traumatic experiences involve personal illness, divorce or separation, hormonal changes, and body image changes related to aging (Choate, 2019). Vijayalakshmi (2020) conducted a quantitative study to explore the connection between loneliness and mental illness. Vijayalakshmi stated that the investigator chose 40 men and 40 women for the study and that the sub-variables of this study were sex, type of job, age socio-economic status, and parental qualification. Vijayalakshmi reported that the objectives of this study were to assess the level of loneliness of the respondents and to ascertain if there is any significant difference in the degree of loneliness in terms of demographic variable. Loneliness causes dissatisfaction, unhappiness, and depression (Vijayalakshmi, 2020). Vijayalakshmi (2020) concluded that loneliness causes low dynamism, feeling inadequate to cope with problems, lower quality of life, and it is a predictor for functional decline and death.

Colvin et al. (2014) stated that individuals in midlife experience negative events, such as taking care of a family member or a friend who is sick or has a substance abuse

disorder. Colvin et al. indicated that an additional negative occurrence is when these individuals in midlife are experiencing problems with close relationships. Individuals encountering financial difficulties also experience this as a negative factor that affects their psychological being (Colvin et al., 2014).

Mazure and Keita (2006) reported that some stressors women deal with in their lives are: physical and sexual abuse, gender inequalities (the lower social status of women, poverty, and the more difficult climb up the economic ladder), and discrimination (sexual harassment). All these stressors are potential risk factors that can trigger depression in women (Mazure & Keita, 2006). Lafrance (2009) stated that some common and persistent themes in the experiences of women who have depression include stories of trauma, abuse, poverty, difficulties in relationships, and struggles and challenges in their everyday lives.

According to Chandra et al. (2009) some women have been exposed to major gender-related stressors at their jobs that have affected their physical and mental health. Plewes (2016) reported that women who experience sexual harassment in any of their environments have a reduction in their self-esteem and life satisfaction. Plewes indicated that the symptoms of depression, anxiety, and post-traumatic stress disorder (PTSD) that women experience are increased by sexual harassment.

Malila et al. (2014) noted that sexual harassment was a predictor of low self-esteem and low job satisfaction among 120 female nurses in-training from four teaching hospitals/medical institutes. Malila et al. stated that participants' lives were impacted by sexual harassment, and participants showed low self-esteem, feelings of isolation and helplessness, withdrawal, and fear of dismissal or loss of a job. The study results hold

considerable value for mental health and other professionals by encouraging the implementation of sexual harassment trainings, policies, and procedures to provide a safe environment for the nurses (Malila et al., 2014).

Suicide and Depressive Symptoms

Manning (2020) reported that depression is a mental state that increases the risk of suicide. In the modern world, both professionals and people in general treat suicide as a medical or a mental problem (Manning, 2020). Niederkrotenthaler and Stack (2017) stated that globally suicides account for 50% of all violent deaths among men, and 71% of all violent deaths among women. Despite the availability of suicide prevention programs, therapy, and pharmacological treatments, the current suicide rate is either expanding or lingering at an elevated level around the world (Niederkrotenthaler & Stack, 2017).

Greden et al. (2011) found that clinical depression is the second most costly disorder in the United States population. Greden et al. stated that in the United States there are approximately 30,000 to 50,000 suicides each year. From these estimates, 80% to 90% of suicides are associated with clinical depression (Greden et al., 2011). The Centers for Disease Control and Prevention (2019) stated that suicide is the 10th leading cause of death in the United States.

Mackinnon (2016) indicated that MDD is a major risk factor for disability on a global level. The World Health Association (2019) concluded that 322 million people (i.e., 4.4% of the global population) suffered from depression in 2015, making it the most important cause of disability worldwide. Ong et al. (2018) stated that symptoms of depression such as: loss of interest, psychomotor retardation, loss of energy, suicidal

thoughts, sleep disturbance during the night, and decreased weight, were meaningfully connected with larger disability in several functional areas. Ong et al. noted that depression is associated with a variety of unfavorable outcomes, such as functional disability, impaired quality of life, and suicidal behaviors.

MDD is linked to a higher risk of medical illness, and it is the main predictor of suicide (Ong et al., 2018). The risk of suicide in people who have severe MDD is hundreds of times greater than the risk for the general population (Ong et al., 2018). More effective treatments for MDD might reduce the number of suicides and improve health prognoses for women who have MDD (Ong et al., 2018).

Differences of Depressive Symptoms in Men and Women

Keitel and Kopala (2003) reported that research also consistently found that gender differences can factor into the prevalence of depression in the population. Nydegger (2008) indicated that depression itself is not different for men and women; it is the same disorder, but depression manifests itself differently in men and women and at different rates. Harrington (2019) reported that, according to some experts, women suffer from depression more than men. Chandra et al. (2009) concluded that women are more predisposed to depression and anxiety than men because of changes in the female reproductive system.

Mazure and Keita (2006) indicated that biological factors (genetic) and psychosocial factors cause depression to be more prevalent in women than in men. These two types of factors increase directly and indirectly in relation to a woman's reaction to stress (Mazure & Keita, 2006). Mazure and Keita concluded that genetic factors cause a greater biological stress reaction in women than in men. Women are twice as likely to

have an initial episode of depression, but they are also more likely to receive successful treatment and prevention (Mazure & Keita, 2006). Mazure and Keita noted that when both men and women have depression, they have recurrent episodes of similar duration.

Kravitz et al. (2014) stated that anxiety symptoms can be the primary indicators for developing depressive episodes during midlife. These anxiety symptoms often precede MDD, and they may increase the vulnerability of additional depressive episodes in women in midlife (Kravitz et al., 2014). Bromberger et al. (2015) noted that women in midlife without symptoms preceding MDD are at a lower risk for developing additional episodes of MDD than those with a previous history of MDD, and the risk profile for first onset differs from that of persistent MDD.

Mackinnon (2016) stated that women are about twice as likely as men to have MDD. Mackinnon presented that MDD affects between 5% and 20% of the general population. Chandra et al. (2009) reported that when comparing men's and women's mental health, the most constant and common symptoms were depressive symptoms in women. Chandra et al. noted that MDD is the most frequent disorder in women, and women are at twice the risk for recurrent MDD when compared to men.

Mazure and Keita (2006) indicated that stressors cause greater rates of depression in women than in men. Mazure and Keita stated that women experience stressors more often than men because of women's sociocultural status (social roles). Women have some personality or cognitive characteristics, such as rumination and biological challenges, that men do not have (Mazure & Keita, 2006).

Chandra et al. (2009) indicated that even though women and men have similar jobs, qualifications, and experience, women still earn less income than men due to sex

discrimination. Chandra et al. stated that women's mental health status is clearly connected to culture and how women respond to cultural messages and expectations. The differences between the roles of men and women in society are defined by the norms, values, and behaviors (Chandra et al., 2009). Chandra et al. reported that women are more exposed to burnout because of the multiple life roles (mothers, wives, and professionals) for which they take responsibility.

Mazure and Keita (2006) found that, worldwide, women are at greater risk than men to suffer from different forms of abuse, such as sexual and partner violence, because women do not have as much social power as men. The reduced social status of women can also cause chronic stress (Mazure & Keita, 2006). Chandra et al. (2009) reported that women are the primary victims of physical and sexual harassment (sexual violence) and that these victims have considerably more depression, anxiety, and somatizations than non-victims.

Chandra et al. (2009) stated that throughout the last 10 to 15 years, individuals have developed more awareness regarding violence because it is a significant public mental health problem, especially for women. Plewes (2016) noted that violence is not only associated with depression, but it also brings with it an increased risk of depression. Choate (2019) indicated that domestic violence, sexual violence, and gender-based violence are twice as likely to happen to women than men, and that all these different types of violence increase the risk of depression in women.

Choate (2019) reported that depression in women is influenced by biological, developmental, psychological, and sociocultural factors. Lafrance (2009) noted that the causes of depression involve social, biomedical, or psychological frameworks

(neurochemistry, genetic inheritance, cognitive coping style, interpersonal relationships, and negative live events). Lafrance (2009) concluded that researchers are still making efforts to identify the dominance of one or more of these frameworks. Ghaemi (2013) reported that even though several studies have demonstrated that people with MDD have recurrent depressive periods that involve a combination of genetic or biological and environmental factors, the primary causes of depression are genetics and early life environment.

Mazure and Keita (2006) indicated that gene-environment interactions are at the heart of the cause of depression. According to Mazure and Keita, the gene-environment continuum (GEC) analyzes when genes interact with environmental risk factors. This interaction produces the body-brain complex that has a unique causal role in depression (Mazure & Keita, 2006).

Diagnostic Criteria of Depressive Disorders

The diagnostic criteria for MDD is presented in the American Psychiatric Association's (2013) *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5). Although this study did not require LPCs to have diagnosed MDD in one or more women in midlife, the LPCs worked with women who have identified one or more of the following depressive symptoms detailed in the *DSM-5* (American Psychiatric Association, 2013) under MDD criteria: depressed mood, loss of interest or pleasure, significant weight loss when not dieting, weight gain, decrease or increase in appetite, insomnia, hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or excessive or inappropriate guilt, diminished ability to think or concentrate, indecisiveness, recurrent thoughts of death, or recurrent suicidal ideation.

These symptoms must not be attributable to the effects of a substance, another medical condition, or certain specified psychological disorders (American Psychiatric Association, 2013).

Niederkrotenthaler and Stack (2017) stated that depression is a state of prolonged, persistent, and intense sadness or low mood. Niederkrotenthaler and Stack indicated that depression is linked to a lack of motivation, an inability to enjoy life, and low self-esteem. It is a panful state of mind that can lead to suicide for the sake of ending mental suffering (Niederkrotenthaler & Stack, 2017).

Nydegger (2008) concluded that depression is an equal opportunity disorder. It can affect anyone of any group, any background, any race, any gender, or any age (Nydegger, 2008). Nydegger reported that when people are suffering from depression, they regularly experience emotional, motivational, behavioral, cognitive, and physical symptoms. People who have depression have difficulty thinking positively about themselves or anything else and may constantly think of death or suicide (Nydegger, 2008).

Treatment for Depressive Symptoms

Noonan (2016) stated that clients who display depressive symptoms can start looking for a primary care provider (PCP) who will treat them right away or refer them to a mental health provider. Noonan reported that it may take a while to determine diagnoses for the health conditions of clients and to find the best health professionals for them. Van Geffen et al. (2009) noted that, occasionally, clients do not want to be referred to mental health professionals because they want to overcome their symptoms naturally without any medications.

Dog (2010) stated that pharmacological approaches, physiological modalities such as electroconvulsive therapy (ECT), and counseling are the major types of treatments aimed at lessening depressive symptoms. Nydegger (2008) stated that there are different aspects to treating depression, such as counseling, pharmacological, and the combination of both pharmacological and counseling. Dog indicated that counseling has different approaches, such as existential therapy, interpersonal psychotherapy (IPT), solution-focused brief therapy (SFBT), and cognitive-behavioral therapy (CBT).

Counseling

Nydegger (2008) reported that even though existential counseling has been helpful for some clients who had depressive symptoms, there is not much evidence that this counseling approach has been helpful in treating depressive symptoms. Guterman (2013) indicated that even though solution-focused brief therapy (SFBT) helps clients with depressive symptoms, SFBT counselors do not take that much time talking with their clients about their problems. This can cause clients to feel demotivated and hopeless (Guterman, 2013).

Richards and Perri (2010) concluded that interpersonal psychotherapy (IPT) not only helps clients with their depressive symptoms, but also focuses on their interpersonal issues, their interpersonal communication, and their social support. Richards and Perri stated that IPT is concentrated on the client's external interpersonal world and the relationships within it. Choate (2019) indicated that CBT is one of the most effective approaches to treat depression in women. Choate reported that, if the client does not respond to counseling alone after several weeks, both counselor and client can explore

alternative solutions that include a mixture of counseling and pharmacological treatments.

Counseling and Pharmacological Approaches

Several authors have stated that the most effective treatment for depressive symptoms is working with a multidisciplinary team (combination of pharmacological and counseling treatments) (Blenkiron, 2010; Choate, 2019; Ghaemi, 2013; Tolin, 2016). Antidepressant medications are recommended for moderate to severe depression in any population, but they are mainly suggested for women with previously severe symptoms and suicidal ideation (Roe et al., 2009). Counselors must help their clients to be aware of potential side effects of medication and help them to develop coping skills to properly handle these potential consequences (Roe et al., 2009). Roe et al. (2009) stated that counselors must have a healthy relationship with their clients. This healthy relationship will allow counselors to help their clients adequately comply with their counseling and pharmacological treatments (Roe et al., 2009).

Simpson and Moriarty (2014) concluded that people who have bipolar disorder and MDD need to learn symptom management and need to have a stable caretaker during times of suicidal ideation. Simpson and Moriarty reported that the multimodal treatment for MDD and bipolar disorder appear to be similar. A combination of pharmacological and psychotherapeutic approaches is the most seen treatment method for these disorders (Simpson & Moriarty, 2014).

Mcintyre (2016) reported that even though clinicians emphasize to their clients the importance of continuing with MDD treatment (antidepressants and counseling) for at least 6 to 9 months, a large portion of clients stop treatment after 2 or 3 months without

informing their prescribing clinicians. Mcintyre found that when these clients start to feel better, they think that they no longer need treatment. For these clients, it is important to monitor their symptoms and cognitive status, and to educate them regarding MDD (Mcintyre, 2016).

Greden et al. (2011) reported that when working with treatment resistant depression (TRD) it is important to explore a detailed family history. TRD is when MDD has not reacted yet to at least two courses of evidence-based antidepressant treatment of satisfactory dose and duration (Greden et al., 2011). Greden et al. (2011) noted that exploring the existence of psychiatric disorders in family members will help identify undiagnosed comorbid disorders in the clients with TRD.

Kern and Nicholson (2019) reported in their quantitative study of 3,207,684 pregnant women, 2.5% had peripartum depression. Of these pregnant women, half had incident depression during pregnancy. Of the women with peripartum depression, 5% developed TRD within one year of the depression (Kern & Nicholson, 2019). Kern and Nicholson concluded that TRD occurs in approximately 5% of women with peripartum depression. These researchers stated that the risk of TRD is higher in pregnant women with a history of depression (Kern & Nicholson, 2019). Women who had TRD had more psychiatric painful comorbidities than women who did not (Kern & Nicholson, 2019).

Psychotropic Medications

Joseph (2019) demonstrated that there are five types of psychotropic medications that mental health professionals prescribe for mental disorders. These types of psychotropic medications are antidepressants, antianxiety medications, antipsychotics, stimulants, and mood stabilizers (Joseph, 2019). Joseph stated that most of the time,

depressed mood and anxiety are reported by clients with all psychiatric disorders, except for clients with mania, hypomania, or psychotic features.

Harrington (2019) stated that by the 1940s, amphetamines were developed, and they helped patients to lift their mood and restore "their zest for life" (p. 188). Benzedrine was the first amphetamine developed to treat mild depression, and it became the center of the pill industry (Harrington, 2019). After 31exedrine31 went off patent, a new amphetamine named 31exedrine was developed (Harrington, 2019). In 1955, meprobamate was developed and it was a minor tranquilizer that only treated anxiety (Harrington, 2019). Dexamyl was also developed in 1955 and was used to treat the depression and anxiety of housewives (Harrington, 2019).

Harrington (2019) also described how, by the mid-1950s, *marsilid* or *"the psychic energizer"* was developed for endogenous depression, and it worked for the most deteriorated and regressed patients (p. 193). By the mid-1950s, companies selling the drugs chlorpromazine and reserpine were making a lot of money (Harrington, 2019). In 1957, the drug imipramine, which was known as a tricycle antidepressant because of its chemical structure, was developed to treat depression (Harrington, 2019). The tricycle antidepressant did not eliminate symptoms, but it did normalize them (Harrington, 2019).

Deegan (2005) reported that when clients were asked about their use of psychotropic medications, they also mentioned their personal medications. Deegan's study reported how clients with psychiatric disorders showed resilience when they were taking, or not, their psychotropic medications (Deegan, 2005). The 29 participants were adults, both men and women, all were from Kansas and had severe mental illnesses (Deegan, 2005). Researchers conducted individual semi-structured interviews asking

questions such as, how these clients came into mental health services, and what was their experience with psychiatric medications (Deegan, 2005). Deegan also used a focus group to collect data and describe activities that gave meaning and shared self-care strategies (Deegan, 2005). Deegan concluded that personal medicine gave life meaning, purpose, and it served to raise self-esteem, decrease symptoms, and avoid unwanted outcomes. Deegan indicated that people with psychiatric disorders demonstrated resilience taking non-pharmaceutical, personal medicine in the recovery process.

Side Effects of Psychotropic Medications

Joseph (2019) noted that psychotropic medications (antidepressants, antianxiety, and antipsychotics) have benefits and side effects. Joseph reported that the new generation of antidepressants, selective serotonin reuptake inhibitors (SSRIs) are venlafaxine, clomipramine, nefazodone, and bupropion. The new generation of antipsychotics are risperidone, olanzapine, and clozapine (Joseph, 2019). About 20 to 25 years ago, medications such as tricyclic monoamine oxidase inhibitors (MAOIs), tricyclic antidepressants (TCAs) were available, but they had serious side effects on the clients, which interfered with medication compliance (Joseph, 2019).

Bentley (2010) indicated that counselors help clients to be aware of themselves and their treatment process. Counselors help clients to focus on how they are managing their psychotropic medications, what side effects clients are experiencing, and how they are interpreting these side effects in their minds, bodies, emotions, and behaviors, and the importance of their social context (Bentley, 2010). Bentley noted that occasionally the side effects that clients are experiencing are not related to their psychotropic medications.

Bentley (2010) reported that empathy, accurate knowledge of mental illness and medication, and individualizing treatment were factors to take into consideration for better client outcomes. Bentley indicated how to understand the meaning and impact of taking psychotropic medications in clients with mental illness, who were in a residential program. Bentley recruited 21 volunteer adults, women and men, mostly White, who had experienced a history of severe mental illness that included being hospitalized. Most participants reported 8 to 20 hospitalizations and were currently taking multiple psychotropic medications (Bentley, 2010). Bentley interviewed participants two times face to face. In the first interview Bentley asked 21 questions regarding the effects and side effects of their medicines, the positive and negative experiences associated with taking these medicines, and their fears and hopes about their future. The second interview was a member check interview (Bentley, 2010). Bentley noted that participants indicated deep gratitude for more opportunities to be fully heard about both their positive and negative experiences with mental illness and medication. Bentley reported an eagerness of clients to fully participate in the design of programs and in individual decision-making about their care.

Antidepressant Medications

Harrington (2019) noted that antidepressants are a type of psychotropic medication. Some of these medications are amitriptyline (Elavil), bupropion (Wellbutrin), citalopram (Celexa), escitalopram (Lexapro), duloxetine (Cymbalta), fluoxetine (Prozac), fluvoxamine (Luvox), mirtazapine (Remeron), moclobemide (Aurorix, Manerix), paroxetine (Paxil), sertraline (Zoloft), and venlafaxine (Effexor) (Harrington, 2019). Harrington reported that some authors recommended treating men with a serotonin-

norepinephrine reuptake inhibitor (SNRIs) or tricycle antidepressants (TCAs) and treating women with selective serotonin reuptake inhibitors (SSRIs), but Chandra et al. (2009) had noted that no specific doses are established for women when taking psychotropic medications.

Mackinnon (2016) reported that the use of antidepressants for severe MDD has been proven successful for 60 years, but that the effectiveness for milder types of MDD has not been well established. Mackinnon noted that antidepressants help in 60% to 70% of cases, and symptoms are resolved completely. Ho et al. (2017) indicated that clients who have MDD need antidepressants and need to adhere to these psychotropic medications. Clients who do not take antidepressants, and do not adhere to their psychotropic medications have higher risk of relapse and recurrence, increases in hospitalizations and readmissions, and become an economic burden on the healthcare system (Ho et al., 2017).

van Geffen et al. (2009) stated that the side effects of antidepressants may arise instantly after starting to take these medicines. van Geffen et al. found that normally people who are taking these drugs will start experiencing some improvement of their symptoms after a few weeks of taking them. When this healing takes more than two weeks, people start to consider stopping taking their medications (van Geffen et al., 2009).

Anderson et al. (2015) reported in their qualitative study, that mental health providers must explore their clients' concerns before taking antidepressants. Their participants included 108 men and women, aged 22 years to 84 years, who had taken antidepressants for depression (Anderson et al., 2015). Anderson et al. stated that clients

expressed a variety of feelings, including being intimidated by taking antidepressants especially during the first few weeks of treatment. Anderson et al. indicated that clients had stigmas related to drug dependency and potential side effects.

Harrington (2019) indicated that the cost of newer antidepressants has increased over the past 25 years. It appears that these newer antidepressants work the same as the older ones (Harrington, 2019). If newer antidepressants cause fewer side effects, they will be easy to tolerate, they appear to increase the number of neurotransmitters, serotonin and/or norepinephrine, and possibly even dopamine (Harrington, 2019).

Medication Compliance and Adherence

Roe et al. (2009) noted that the therapeutic alliance relationships between health providers and clients with mental illness are important for improving medication adherence. Roe et al. stated that health care providers can improve medication adherence if they get a better understanding of their clients' beliefs, effectiveness, side effects, and attitudes regarding their psychotropic medications. When counselors understand the factors that influence clients to stop taking their psychotropic medications and their social-cultural environments, counselors have more clarity and are better able to create more effective treatments (Roe et al., 2009).

Roe et al. (2009) demonstrated the need and the importance of a healthy doctor-client relationship. Their study reported how and why clients with a severe mental illness decided to stop taking their medication. The Roe et al. study included seven adult volunteer participants, women and men who had a severe mental illness.

Roe et al. (2009) conducted individual, in-depth, semi structured interviews in which the researchers asked questions regarding the participants' perceptions about

taking psychotropic medications and feelings and thoughts when they stopped taking them (Roe et al., 2009). The researchers explained the five stages of the process of choosing not to take psychotropic medications: the person experiences major emotional crisis; the subjective experience of taking psychotropic medications and its consequences; the conflict of adherence; the gradual resolving of this conflict; and the development of a personal perspective on the use of psychotropic medications (Roe et al., 2009). Roe et al. concluded that participants struggled to develop a personal perspective, plan, and choice about medication use.

van Geffen et al. (2009) reported that medication noncompliance occurs when clients do not take medications as prescribed by their medical professionals. van Geffen et al. stated that some of these clients change their dosages or stop taking their medications. More than half of the clients who discontinue their medications think that they do not need them anymore and they do not inform their medical professionals (van Geffen et al., 2009).

van Geffen et al. (2009) noted that one of the reasons for medication noncompliance is that clients do not have an accurate understanding of the problem and its treatment, and clients prefer therapy over psychotropic medications. Additional reasons are that clients may change their minds after talking to others about taking these medications, these medications may start working after several weeks, clients' fear of side effects, and the fact that clients may not have health insurance and therefore, they may not have the money for the expensive treatments and medications (van Geffen et al., 2009).

Theory Based in Research: Cognitive-Behavioral Therapy (CBT)

Nooman (2016) stated that some primary care providers are experienced in treating early depression, but more severe types of depression may require a mental health provider. Noonan noted that there are several types of effective treatments for people who have depressive symptoms. Occasionally medication alone is sufficient; at times counseling alone is sufficient; sometimes a combination is needed (Noonan, 2016). Clients may have to try several medications or types of treatment before finding the one that is the most effective for their needs (Noonan, 2016).

Nydegger (2008) indicated that there are different aspects to treating depression such as counseling, pharmacology, and the combination of both pharmacology and counseling. Dog (2010) concluded that counseling has different approaches, such as existential therapy, IPT, SFBT, and CBT. Zhang et al. (2018) demonstrated that CBT is the most frequently used counseling treatment for mental disorders.

Tolin (2016) stated that CBT can be effective for several mental disorders including anxiety disorders, depressive disorders, mood disorders, compulsive disorders, substance use disorders, certain personality disorders, and even psychotic disorders. Keitel (2003) found that CBT has become more specialized to work with women who have PTSD, eating disorders, borderline personality disorder, and depressive disorders. Mazure and Keita (2006) noted that CBT is an effective treatment when treating depression in women. Mazure and Keita reported that CBT protects clients against relapse and recurrence after the treatment is completed.

Choate (2019) stated that CBT is a present-oriented and time-limited therapy that focuses on clients with depression and their current maladaptive behaviors, their

dysfunctional cognitions, and their emotional dysregulation. Venkataswami and Bittenahalli (2019) reported that CBT counselors have applied strategies in women with depressive symptoms to identify and restructure any dysfunctional cognitions, maladaptive behaviors, and emotional dysregulation. Venkataswami and Bittenahalli indicated that when these women improve their cognitions, behaviors, and emotions, they can also improve their sleep and quality of life.

Reddy and Omkarappa (2019) reported a quantitative study of 80 women from selected Primary Health Center (PHC) areas in Bengaluru, India. Reddy and Omkarappa findings showed that CBT interventions combining behavioral, cognitive, and educational strategies were effective in improving insomnia problems and quality of life among women with depressive symptoms. Reddy and Omkarappa stated that strategies that included identifying and restructuring any unhelpful thoughts, behavioral strategies, and psychological techniques helped participants to cope with their psychological distress.

Tolin (2016) noted that CBT is also a way of thinking and understanding why clients suffer (psychological problems), and how clients interact with their psychological problems. Tolin reported that these problems are caused and maintained by a variety of internal and external factors that include the client's emotions, thoughts, physiological sensations, behavioral contingencies, and skill deficits. Finding and developing effective solutions for these internal and external factors depend on having a greater understanding of how these factors interact to cause the problem (Tolin, 2016).

Farmer and Chapman (2016) indicated that cognitive-behavioral therapy (CBT) is an action-oriented approach in which both counselors and clients take responsibility

throughout the entire counseling process. Joiner et al. (2006) stated that CBT counselors have an active and directive role with their clients. Joiner et al. noted that when working with clients who have depressive symptoms, counselors help clients develop a better understanding of their symptoms and develop coping skills to deal with them.

Tolin (2016) indicated that CBT has three main principles: good therapy, good CBT conceptualization, and CBT techniques. Tolin stated that the principle of good therapy emphasizes that the counselor-client relationship is a solid relationship in which both the counselor and the client understand the client's suffering, cognition, emotions, and behaviors; and how all three of these aspects are interconnected and interactive. Tolin concluded that counselors carefully pay attention to and listen to, their clients' symptoms, what is meaningful for the client, how the client understands their quality of life, and how they interact with the counselor during sessions. Counselors can use these observations to facilitate positive expectations and hope (Tolin, 2016). Tolin reported that the principle of good CBT conceptualization is a good working model of why clients are suffering. When both counselor and client understand the reasons behind the suffering, they can piece together several different factors that facilitate this suffering (Tolin, 2016). The CBT techniques help a client to restructure cognitively and to engage in behavioral experiments to test out their thoughts (Tolin, 2016).

Blenkiron (2010) noted that there are six main steps to treat depressive disorders: the experience of depression; challenging negative thoughts (rumination) and keeping a daily record of activities and setting useful and measurable goals; doing more activities and reaching goals; removing the critical voice; practicing self-talk; and preparing for the future. Blenkiron stated that when CBT counselors work with clients who have

depressive symptoms and experience negative thoughts such as rumination, counselors can help them to identify that these thoughts are just thoughts. Blenkiron noted that when clients realize that these thoughts are just thoughts and not facts, this helps the clients to become more focused on positive thoughts, and practice activities and set goals that make them feel hopeful and happy. Blenkiron (2010) concluded that when clients focus on their positive thoughts and remove their critical voice, they can identify and change their negative thoughts at any moment. Once they can identify and change their negative thoughts, they learn how to be compassionate and kind to themselves (Blenkiron, 2010).

Nydegger (2008) indicated that there are three different aspects to treating depression: counseling, pharmacological, and the combination of both pharmacological and counseling. Dog (2010) concluded that CBT is one of the counseling approaches and that CBT is the most frequently used psychosocial treatment for mental disorders. Tolin (2016) noted that CBT has three main principles: good therapy, good CBT conceptualization, and CBT techniques. Blenkiron (2010) indicated that there are six main steps to treat depressive disorders: the experience of depression, rumination, and keeping a daily record of activities and setting useful and measurable goals, doing more activities, and reaching goals, removing the critical voice, practicing self-talk, and preparing for the future. Farmer and Chapman (2016) stated that cognitive-behavioral therapy (CBT) is an action-oriented approach in which both counselors and clients take responsibility throughout the entire counseling process. Counselors must be aware of themselves and their biases to avoid contaminating the relationship with their clients.

CHAPTER 3: Methodology

The purpose of this study was to understand the lived experiences, clinical and personal, of LPCs who work with women in midlife who display depressive symptoms. The transcendental phenomenological approach (Moustakas, 1994) helped the researcher obtain knowledge of LPCs' clinical and personal experiences related to their work with these women. This attained knowledge may help other counselors to develop more awareness of themselves, and to internalize and to apply knowledge and experience obtained from their peers. These counselors will be able to know what other LPCs do to help clients who display depressive symptoms, how LPCs deal with their own thoughts and feelings when they work with these clients, and what LPCs recommend others do to help them work more effectively with these clients and to help these clients overcome suicidal ideation and avoid suicide itself.

Research Design

The central research question for this qualitative study was: "What are the clinical and personal experiences of LPCs that assist women in midlife who report depressive symptoms?" The base interview questions the researcher asked the participants in this study were:

- "What are your feelings and thoughts when you assist women in middle who display depressive symptoms?"
- "How do you manage the thoughts and feelings you experience when you assist women in midlife who display depressive symptoms?"
- "How do you help women in midlife who have depressive symptoms?"

- "What suggestions or recommendations do you have for counselors to work more effectively and efficiently when they assist women in midlife who present depressive symptoms?"

Qualitative Method

Marshall and Rossman (2016) demonstrated that qualitative research is a broad approach to the study of social phenomena. Marshall and Rossman noted that qualitative research takes place in the natural world, and it focuses on context. Additionally, this research is emergent and essentially interpretive (Marshall & Rossman, 2016).

Abayomi (2017) stated that qualitative methodology provides investigators with the ability to improve and apply their interpersonal and subjective skills to their research process. Abayomi reported that the phenomenological approach offers the best opportunity for researchers to understand the personal reflection of the lived experiences of participants. Participants expressed themselves and the stories of their lived experiences in the ways that they see themselves fitting into their lives without any distortion (Abayomi, 2017).

Patton (2015) stated that qualitative research often asks questions about the stories of individuals to explore and understand their perspectives of themselves and the systems of which they are a part (social, family, political, religious, community, social, and economic). Patton concluded that qualitative researchers pay attention to the context of how these systems function. Context refers to what is happening between individuals and any of their systems of interest (Patton, 2015).

Creswell (2013) noted that one of the characteristics of qualitative research is that in the entire qualitative research process, the researchers learn the meaning that the

participants give to their problems. Creswell noted that another characteristic is that the qualitative research process is emergent and that all the stages of the process may change. An additional characteristic is that researchers try to develop a holistic image of the phenomenon under study (Creswell, 2013).

Phenomenological Transcendental Approach

Husserl (1931) was the principal founder of qualitative research approach known as phenomenology. He explored and understood the context of the lived experiences of people (research participants) and the meaning of their experiences (Husserl, 1931). Moustakas (1994) introduced the term transcendental (also known as psychological) phenomenology. Moustakas (1994) focused more on understanding and describing the lived experiences of research participants.

Husserl (1931) indicated that transcendental phenomenology is intimately connected to the concept of intentionality. Husserl noted that intentionality refers to the internal experience of being aware of something. Husserl (1931) employed intuition in his transcendental philosophy, and this intuition is essential in describing whatever discoveries present themselves.

Moustakas (1994) reported that the transcendental phenomenological approach is the first method of self-knowledge, because it starts with the things themselves. Moustakas stated that phenomenology eliminates any prejudices and reaches a high level of genuineness where individuals do not feel threatened by the customs and beliefs of the natural world. Eliminating prejudgment allows individuals to obtain knowledge based on real life experiences (Moustakas, 1994). Moustakas indicated that intuition, imagination,

and universal structures provide an understanding of how specific perceptions, feelings, and thoughts are created by awareness with reference to a particular experience.

Rationale for Design

This study was designed to help others understand the lived clinical and personal experiences of LPCs who worked with women in midlife who displayed depressive symptoms. A phenomenological approach was chosen for this study based on the philosophy of Husserl (1931), as the phenomenon being explored concentrates on the context of the lived experiences of people and the meaning of their experiences. The phenomenological approach selected for this study was transcendental based on the philosophy of Moustakas (1994).

This transcendental phenomenological approach (Moustakas, 1994) helped me to obtain knowledge of LPCs' clinical and personal experiences related to their work with women in midlife who displayed depressive symptoms. This attained knowledge is intended to help other counselors develop more awareness of themselves. Additionally, counselors should be able to internalize knowledge and experience obtained from their peers and apply this understanding to their clients.

Counselors will read about how other LPCs help clients who display depressive symptoms. Counselors will gain a better understanding of how LPCs deal with their own thoughts and feelings when they work with clients who experience depressive symptoms in midlife. In addition, they will be aware of what LPCs recommend others do to help them work more effectively with their midlife female clients who experience depressive symptoms.

Benefits and Limitations of Qualitative Methods

Patton (2015) indicated that there are several benefits of using qualitative methods. Krathwohl (2009) noted that qualitative research is mainly helpful when it provides the researcher the opportunity to obtain participants' insights that allow an understanding of participants' behaviors. Patton (2015) stated that some of the benefits are that the researcher is able to illuminate the meaning of the phenomenon under study, as well as capture and understand participants' stories. Patton reported that the researcher will also be able to clarify how systems function and their consequences in the participants' lives and make case comparisons to discover important patterns and themes across these participants.

Moustakas (1994) indicated that even though it is beneficial that a phenomenological approach for analyzing data provides a structured approach for novice researchers, it is also a limitation that some qualitative researchers may find this approach overly structured. Krathwohl (2009) noted that qualitative methods are extremely labor rigorous, and these methods require a proficient interpretation of the data by the researcher. Patton (2015) stated that another limitation of qualitative research is the extensive amount of time that the researcher must take to collect all the data from the narrative experiences and to be able use this data effectively.

Patton (2015) reported that another key limiting factor of qualitative research is that studies like this, with a single researcher, may have an increased risk of researcher's bias. Moustakas (1994) noted that researchers use the qualitative method of bracketing to address the problem of researcher's bias. Moustakas stated that bracketing is when the researcher sets aside any prejudgments regarding the phenomenon being investigated.

The researcher may use present-moment techniques, such as self-reflection, to continue using bracketing and to continue gaining more self-awareness (Moustakas, 1994). I have provided a short description on the self of the researcher to bracket my own research process.

Participants and Role of the Researcher

Patton (2015) indicated that qualitative investigation is personal. The researcher is the instrument of this investigation. The background, experience, training, skills, interpersonal competence, capacity for empathy, cross-cultural sensitivity, and how the researcher—as a human being and as a researcher—gets involved in the research, analysis, and credibility of findings, are key elements in qualitative investigation (Patton, 2015).

Creswell (2013) noted that Moustakas focused on one of Husserl's concepts, known as epoche, or bracketing (Moustakas, 1994, as cited in Creswell 2013). When researchers use this bracketing, they leave behind their experiences, as much as possible, to take a refreshing standpoint toward the phenomenon under examination (Creswell, 2013). Moustakas (1994) stated that researchers in a transcendental approach use disciplined and systematic forces to set aside prejudgments regarding the phenomenon being investigated.

Moustakas (1994) noted that bracketing requires that researchers have a fresh viewpoint when examining participants' experiences. Moreover, researchers following a transcendental approach are completely open when listening to these participants as they are describing their experiences relative to the phenomenon being studied (Moustakas, 1994). Creswell (2013) noted that some investigators describe their own experiences with

the phenomenon when they begin a project and bracket out their perspectives before proceeding with analyzing the experiences of the participants.

This study was an exploration of a phenomenon that I have experienced in my personal and professional life. I believe it was essential to disclose my personal and professional roles and interest in the research process. Sharing my awareness of my perspectives and experiences supported the foundation of genuineness with my audience and provided a description of my research journey that began with my personal identification with the focus of the study (Moustakas, 1994).

Being a counselor has given me the opportunity to work with many clients who had depressive symptoms; most of them were women. Some of them came to counseling thinking that I was going to tell them what to do and how to get rid of these depressive symptoms. Most of the time these clients had not been in counseling before, and they had no prior knowledge of what counseling involves. Other clients came to counseling asking me if they needed to see a psychiatrist, or if counseling would be enough to deal with their symptoms.

Most of the time, before I gave a response to all my clients' questions, I explained to them how I counsel. I also explained to them that our relationship is collaborative, that together we are going to determine the best treatment plan for them, and together we are going to frequently assess their progress. I emphasized to my clients that if we both believe that the treatment chosen is not the best, we will find the effective treatment.

I had clients who had depressive symptoms who told me they were not feeling that counseling was enough and that they wanted to also try medication. When working with these clients, the process of finding the correct medication was most of the time,

slow, frustrating, and painful. These clients were not only suffering from their depressive symptoms, but they also were suffering from the challenge of finding an effective medication.

Approximately four years ago, I talked to my own counselor about my own depressive symptoms. I told her that I was considering starting to also see a psychiatrist and take medication. It took me years to consider this option. If I made a guess about why it took me so long to contemplate this option and to do it, I would say that I was in denial, and that I was biased by the question, "How, if I am a counselor, will I take medication?"

At the beginning, when I started seeing my psychiatrist and taking medication, I was very hopeful, motivated, and excited. Then, when I started taking many different medications, and had side effects with many of them, I felt hopeless, frustrated, and sad. Both my psychiatrist and my counselor were supportive, patient, and hopeful; but I was feeling more tired, hopeless, and frustrated with them and with the medications.

I remember talking to my counselor and psychiatrist many times, in different sessions, about any medications working and that I was not sure what to think and feel. I remember behaving and feeling like a whiner and a complainer; and describing to them all my side effects. Both told me that we were going to get there, to be patient, and to trust them and the process, but I was still hopeless.

After many months of trying different medications, one day I felt that I was thinking more clearly, focusing more on my duties, feeling more motivated and hopeful, having more energy, and I was not having any side effects. When this day happened, I remember crying, but they were tears of happiness and thanking my counselor and

psychiatrist. Since that day I have been able to deal, in a healthy way, with my depressive symptoms; and being more focused, hopeful, motivated, productive, and happy.

I was happy and nervous about doing this study because I was not sure how I was going to feel while doing the interviews and listening to my participants. I felt nervous, because I remembered suffering myself while finding the most effective medications and listening to my participants' struggle with their clients' pain and frustration will bring out all this pain. I was aware of this nervousness, to process it, and to avoid contaminating my study.

I felt happy, because being able to do these interviews and listen to my participants' stories helped me confirm that this pain has helped me grow and be more empathic and compassionate to people who have had similar experiences as myself. I also felt happy to help my participants to be aware that they are not alone in this process of helping their clients, that they have an opportunity to process their own thoughts and feelings, and that they have more options to help clients to deal with their depression symptoms and their frustrations, especially when looking for the most effective medications.

This study not only helped my participants themselves, but it also provided information about what LPCs do to help clients who display depressive symptoms. It offered information about how LPCs deal with their own thoughts and feelings when working with clients who display depressive symptoms. Finally, the study provided some LPCs' recommendations to others to help them to work more effectively with these clients, and to also help these clients to overcome suicidal ideation and avoid suicide itself.

Purposeful Sampling Strategy

Creswell (2013) noted that purposeful sampling is used in qualitative studies. Creswell reported that the researchers choose specific participants for the study because they can purposefully give them an understanding of the research problem and central phenomenon of study. Patton (2015) concluded that purposeful sampling centers on selecting an information-rich case study that will explain the questions under investigation. The researcher of this study used purposeful sampling saturation (Patton, 2015) in which she analyzed patterns from the participants' experiences and continued to add to the sample any information gathered until nothing new was being learned.

Dukes (1994) stated that the process of phenomenological bracketing is a skill, and not an easy one to learn. There is always the risk of either seeing what the researcher wants to see rather than what is there to be seen (Dukes, 1994). For these studies, it is wise to include in the sample 3, 5, or possibly even 10 participants (Dukes, 1994). Based on Dukes (1994) information of sample size, 12 LPC participants who have worked with female clients in midlife who displayed depressive symptoms were recruited for this study. The researcher explored the information on LPCs from the National Board for Certified Counselors website (need to add the website here) and the Psychology Today web page (https://psychologytoday.com/us) to create a list of possible participants. The participants resided in a variety of cities and communities across Texas.

The researcher sent potential participants an invitation to participate in the study (Appendix A) and a link to a Qualtrics survey that included the consent information and the demographic questionnaire (Appendix B). The recruitment was completed when 12

participants from a variety of cities and communities across Texas were chosen and interviewed.

Consent and Privacy

The researcher invited licensed LPCs to participate in this study. Participants were invited to complete a demographic questionnaire through a Qualtrics link. In this questionnaire, the researcher introduced herself, summarized her study, asked demographic questions, and asked participants who wanted to volunteer for this study for their contact information. After participants agreed to be part of this study and sent their contact information, the researcher contacted 12 of them for the interviews. Before the interviews with each of the participants, the researcher explained the same information that was sent through Qualtrics, such as the informed consent, purpose, procedures, confidentiality, risks, and benefits of the study. Moreover, the researcher answered any questions that the participants had about the study. The researcher stated that no identifying information would be used and that only pseudonyms would be used in this study.

Cost and Risk to Participants

The sample for this study consisted of 12 LPCs who qualified for the investigation. The participants encountered no financial cost to their involvement and there was no compensation offered to any of the participants. The expense of time spent for the interviews was estimated to range from 45 to 60 minutes for the initial interview and 20 minutes for the follow-up interview (member checking).

After the initial interview was transcribed, the researcher sent a copy of the transcript to the participant and arranged for a follow-up interview to take place. This

meeting lasted approximately 20 minutes, and the researcher and participant discussed any information that needed clarification and any additional information the participant felt necessary. The time required for these interviews was included in the consent information form.

Data Collection Procedures

The central research question for this qualitative study was: "What are the clinical and personal experiences of LPCs that assist women in midlife who report depressive symptoms?" The base interview questions the researcher asked participants in this study were:

- "What are your feelings and thoughts when you assist women in midlife who display depressive symptoms?"
- "How do you manage the thoughts and feelings you experience when you assist women in midlife who display depressive symptoms?"
- "How do you help women in midlife who have depressive symptoms?"
- "What suggestions or recommendations do you have for LPCs to work more effectively and efficiently when they assist women in midlife who present depressive symptoms?"

Structured Interviews

The researcher met two times with participants—once for the interview and once for the revision (member checking) of the transcripts. Each initial structured interview lasted 45 to 60 minutes, and each interview for the revision of the transcript lasted approximately 20 minutes. The researcher utilized a secure recording device to save the interviews and transfer them to a computer via USB port. Interviews conducted through

the internet were directly recorded in a secure file. During the interviews, all participants were asked the same questions. After transcribing the recordings, transcripts were sent to the participants and were reviewed (member checking) to corroborate the information gathered for this study.

Demographic Questionnaire

The demographic questionnaire contained qualifying questions to determine if the volunteer was an LPC and if they had experience working with women in midlife (40 years to 65 years old) who displayed depressive symptoms. The demographic questionnaire contained additional questions that described the participants including: education level and degree; if their education programs were accredited through the Council for Accreditation of Counseling and Related Educational Programs (CACREP); number of years of experience as a LPC; primary practice environment (non-profit organization or a private practice); if their clients were able to afford to see health care providers and could afford their treatments; if their clients had health insurance; and if their health insurance covered their treatments (see Appendix B).

Trustworthiness: Credibility, Transferability, Dependability, and Confirmability

Krathwohl (2009) indicated that for researchers in a qualitative study to have a trustworthy study, they need to meet four standards: credibility, transferability, dependability, and confirmability. Krathwohl noted that the operational strategy that the researchers employ to meet credibility are to extend engagement in the field; triangulation; member checking; peer checking; time sampling; active search for discrepant data; and search for rival explanations for the phenomenon under investigation. Krathwohl (2009) reported that the operational strategy that investigators

employ to meet transferability is to offer a thick and detailed description of the phenomenon under study using purposeful sampling. Krathwohl noted that the strategies that the investigators use can include creating an audit trail; a code-recode approach; triangulation; peer examination; and extending engagement with the phenomenon of the study. Finally, the strategies that the researchers use to meet confirmability are triangulation, reflexivity, the use of participants' quotations, and audit trailing (Krathwohl, 2009).

In this study member checking and triangulation were used to meet the credibility standard, but Creswell (2013) stated that researchers are an instrument of the study under investigation, and this role can still affect the credibility of the study. The sample size of this study was 12 therefore transferability was not achieved, but nonetheless, thick descriptions of the 12 LPCs' lived experiences were obtained. An audit trail was created, and a code-recode strategy to meet the dependability standard was employed. Through reflexivity, participants' quotations were used to achieve confirmability.

Analysis

For this qualitative study, I used the software package MaxQDA. This software allowed me to create specific codes for sections of the data, collapse patterns, identify sub-themes, and themes. These analyses captured the overall perception and essence of the participants' experiences.

CHAPTER 4: Results

The purpose of this study was to understand the lived experiences, clinical and personal, of licensed professional counselors (LPCs) who worked with women in midlife who displayed depressive symptoms. The transcendental phenomenological approach (Moustakas, 1994) was used to obtain knowledge of LPCs' clinical and personal experiences related to their work with these women. This obtained knowledge may help other LPCs to develop more awareness of themselves and access knowledge and experience attained from their peers.

The central research question for this qualitative study was: "What are the clinical and personal experiences of LPCs who assist women in midlife who report depressive symptoms?" Interview questions that were asked of each of the 12 participants included:

- "What are your feelings and thoughts when you assist women in midlife who display depressive symptoms?"
- "How do you manage the thoughts and feelings you experience when you assist women in midlife who display depressive symptoms?"
- "How do you help women in midlife who have depressive symptoms?"
- "What suggestions or recommendations do you have for LPCs to work more effectively and efficiently when they assist women in midlife who present depressive symptoms?"

Description of Participants

Dukes (1984) recommended researchers conducting phenomenological research have between 3 to 10 participants. As such, 12 participants who met the inclusion criteria were included in this study. To be included in the study, participants had to hold a license

as a professional counselor and experience working with women in midlife who displayed symptoms of depression. Participants responded to a demographic questionnaire that inquired as to gender, age, racial/ethnic background, level of education, and how many years they have been LPCs. This information is summarized in Table 1. Pseudonyms are used for each of the participants to protect their identities.

Table 1

Participant Demographics

Participant	**Gender**	**Age**	**Racial/Ethnic Background**	**Level of Education**	**LPC Years**
Dan	Male	52	White	Master's*	3
Amy	Female	32	White	Master's*	4
Rose	Female	48	White	Master's*	4
Mia	Female	52	White	Master's* Doctorate*	9
Sun	Female	51	White	Master's*	1.5
Kate	Female	46	Asian	Master's* Doctorate*	4
Clark	Male	73	White	Master's Doctorate*	34
Tom	Male	52	White	Master's	6
Mark	Male	28	Latino	Master's*	0.5
Ann	Female	51	White	Master's*	14
Claire	Female	54	Latina	Master's*	2
Jose	Male	62	Latino, Mexican	Master's Doctorate*	25

Note: * indicates the degree was from a CACREP-accredited program.

The 12 participants were LPCs who have worked with women in midlife who had depressive symptoms. In summary, the participants' LPC years of experience ranged from 0.5 years to 34 years (M = 14 years). Participants' ages ranged from 28 years to 73 years (M = 51 years). Of the participants, seven were female (58.33%) and five were male (41.67%). Most of the participants were White (n = 8), with three Latinos/Latinas, and one Asian. Eight of the participants reported having a master's degree (66.67%), and four reported having a doctoral degree (33.33%). Ten of the participants' (83.33%) master's degrees were from programs accredited by CACREP, and three of the four participants who had doctoral degrees received those degrees from CACREP accredited programs.

Table 2

Participant Work Environments

Participant	**Theoretical Orientation**	**Workplace**	**Clients Can Access Other Health Providers**	**Clients Can Afford Treatment**	**Health Insurance Covers Treatment**
Dan	Mindfulness	Non-profit	Few	Few	Few
Amy	Humanistic	Private Practice	Most	All	Most/Few
Rose	Eclectic/CBT/ Existential	Private Practice	All	All	Most
Mia	CBT/Solution Focused	Private Practice	Few	Few	Most
Sun	Existential	Private Practice	Few	Few	Few
Kate	Relational Cultural Theory/ Existential	Other	Few	Few	Few

Participant	Theoretical Orientation	Workplace	Clients Can Access Other Health Providers	Clients Can Afford Treatment	Health Insurance Covers Treatment
Clark	CBT	Private Practice	All	All	Few
Tom	CBT/ Family Systems	Profit Agency	Few	Most	Most
Mark	Narrative	Private Practice	All	All	Most
Ann	Narrative/Body Focused	Private Practice	Most	Most	Most/Few
Claire	Client-Centered/ Trauma Informed	Private Practice	Most	Most	Few
Jose	Integral	Private Practice	Most	Most	Few

Theoretical orientations were mixed, and most participants indicated they used multiple theories. Four of the participants reported that their theoretical orientation was CBT, while other participants reported existential (n = 3), humanistic (n = 2), narrative (n = 2), and mindfulness (n = 1). One participant each indicated that they used eclectic, or that they worked with solution focused brief therapy, relational cultural theory, family systems, body focused, trauma informed, and an integral approach. Additionally, most of the participants (n = 10) reported in the interview that they were eclectic when working with their clients, but as these participants explained their approaches, an integrative approach may be a better description for their theoretical orientations because all talked about purposely choosing different approaches for their work with different clients.

Practice locations varied among the participants. Most of the participants indicated that they worked in a private practice (n = 9). Of the remaining participants,

one reported that they worked at a for-profit agency, one for a non-profit organization, and another did not clarify a practice location.

The participants described the resources of their clients as varied. Five participants reported that few of their clients had the ability to see other mental health providers, four participants indicated that most of their clients had the ability to see other providers, and three participants reported that that all their clients had the ability to see other providers. Furthermore, a third of the participants indicated that few of their clients were able to afford their treatments, another third reported that most of their clients were able to afford their treatments, and a third of participants reported that all their clients were able to afford their treatments. Half of the participants reported that few of their clients had health insurance, and the other half indicated that most of their clients had health insurance.

Dan

Dan described himself as a 52-year-old White male who has been an LPC for three years. He stated he has a master's degree from a program accredited by CACREP and that he is employed by a non-profit organization in which few of his clients have the resources to see other mental health providers and can afford their treatments. He reported that he works with women in midlife who have depressive symptoms and that few of his clients have health insurance that can cover their treatments. Throughout the interview, Dan appeared to show willingness to answer the researcher's questions.

Dan emphasized the importance of connecting with his clients from any population and the importance of being genuine when he is working with them. He also mentioned that he creates a safe place for his clients where he explores in-depth and the

totality of what is happening with his clients. Dan explained this by saying, “Probably the same thing that I would tell you if it was any other population. Start your connection with the client. Make sure that you are being genuine.” Dan uses psychoeducation to explain to his clients how he works. He is aware that he cannot be a counselor for everybody, just with the ones who connect with the way he does therapy. Dan described this by saying:

> Because the reality is I'm not for everyone and I don't want to be. I only want to be for those who connect with the way I do therapy because it’s the only way I know how to do it.

Dan said that he uses mindfulness when working with any population of clients, including when working with women in midlife who have depression. He emphasized that he does counseling with women in midlife with depression the same way as he works with other clients. Dan stated, “At the core of all of it is mindfulness; that's me being mindful of where the client’s at and trying to teach the client to be mindful of where they are at in all space.” He mentioned that knowing where his clients are at in their space helps him identify the approach of therapy needed and if he is the right counselor for these clients. When asked about his own feelings when he is working with these women, Dan said, “Minimal.” Thus, he seems to encourage mindfulness in his clients while staying more emotionally neutral from his clients’ feelings.

Amy

Amy described herself as a 32-year-old White female who has been an LPC for four years. She stated she has a master’s degree from a program accredited by CACREP and that she works in a private practice. Amy reported she works with women in midlife who have depressive symptoms, that most of her clients have the resources to see other

mental health providers, and all of them can afford their treatments. Amy stated that even though most of her clients have health insurance, just a few of them use insurance to cover their treatments. Amy seemed passionate during the interview.

Amy emphasized the importance of educating her clients that depression is caused biologically and that it is not caused because clients choose to experience these symptoms. Amy responded:

> I need people to understand that it's biological, but then … just because you have this doesn't mean you have no control over it. But understanding that it is something that some days you're going to have little control over, but we can still try to manage it.

Amy mentioned that she works with women in midlife who have depression who were coming out of domestic violence and sexual assault situations. She explained that she creates a safe place for these women. Amy also emphasized that she uses a humanistic approach, and this is because she believes that clients are the experts of their lives. She said she helps her clients to understand where they are and what they are experiencing in their lives. Amy said:

> When I first meet with a client, I tell them "I use humanistic theory. What this essentially means is you're an expert in you, and I am just here to help that make sense; I am here to clarify that," and then normally, I will always ask, "where do you want to start." Because with humanistic it's not my job to try to analyze what they're going through it's to help them understand what they're going through.

Amy reported that although she is working to understand what they are going through, that she compartmentalizes herself during and after sessions. She described this by saying:

> If I am in a situation where I can't deal with it, in that moment, if I am with a client and their story is really getting to me, I can't always have that feeling in that moment and tell myself: we'll take a deep breath and we're going to deal with that later.

Therefore, she seems to process her feelings after the sessions with her clients.

Rose

Rose described herself as a 48-year-old White female who has been an LPC for four years. She reported she has a master's degree from a program accredited by CACREP and that she works in a private practice in which all her clients have the resources to see other mental health providers, can afford their treatments, and most of her clients use insurance to cover their counseling costs. Rose stated she works with women in midlife who have depressive symptoms. Throughout the interview, Rose answered the questions enthusiastically.

Rose emphasized that she is a middle-aged woman. She remarked that she is "curious," "compassionate," and aware of her age and experiences so that she does not make assumptions when working with women in midlife who have depression. She also mentioned that she is very transparent with her clients and when she does not know if she is the right counselor for a client, she lets the client know this. She talks with the client about any triggers she might foresee and transfers the client if needed. Rose explained, "I have to constantly gate keep myself and make sure you know that I am not

overgeneralizing that I am not making … the assumption that they feel the same way about experiences I did."

Rose emphasized that she uses CBT, an existential approach, and that she can be eclectic. She mentioned that she uses an existential approach when working with women in midlife who have depression. Rose shared, "I have some clients who come in and they're not going to be receptive to CBT; it's too rigid, it's too clinical … And so, then we're going to look at it from the existential perspective." She also noted the importance of educating her clients about what depression is by saying, "… there's this psychoeducation, you know, kind of teaching the client about depression." Therefore, she seems to give an important role to psychoeducation for depression when working with women in midlife who experience depressive symptoms.

Mia

Mia described herself as a 52-year-old White female who has been an LPC for nine years. She stated she has a master's degree and a doctoral degree from programs accredited by CACREP. She reported that she works in a private practice and that few of her clients have the resources to see other mental health providers, and her clients can afford their treatments. She reported that most of her clients have health insurance that covers their treatment costs and that she works with women in midlife who have depressive symptoms. During the interview, Mia seemed passionate when she answered the questions.

Mia remarked that she is a middle-aged woman. She emphasized that she empathizes with her middle-aged clients and that she focuses on them, not on her own

feelings. She explained the importance of the role of compartmentalization as a counselor. Mia described this by saying:

> You have to learn how to compartmentalize and realize that this is the clients' time not your time. If you do have some strong emotions because of a client's circumstance, then it's up to you to go to your own therapist and speak to other colleagues to help you process through whatever you're going through.

She emphasized that it is very important to meet where her clients are in their lives. She described this by saying, "I would say, meet the client where they are and use techniques that they're willing to try." She mentioned that she focuses on a client's mind, body, and spirit, and uses an eclectic approach when working with these women. Mia explained this by saying, "Depends on where the client is, I use an eclectic approach, meaning whatever works, you know, sometimes CBT, RBT or DBT." Thus, she seems to first explore where her clients are in their lives, and then, to use an approach that she believes will work.

Sun

Sun described herself as a 51-year-old White female who has been an LPC for 1.5 years. She reported she has a master's degree from a program accredited by CACREP. She stated she works at a private practice in which few of her clients have the resources to see other mental health providers and can afford their treatments; few of her clients have health insurance. She reported she works with women in midlife who have depressive symptoms. During the interview, Sun appeared enthusiastic when she answered questions.

Sun emphasized that her whole focus when working with clients who are women is of not judging them and creating a safe place for them. She described this by saying:

> The main thing that I like to tell clients is, this is a place that you can come and there's no judgment; it's safe, so you can talk about the things and increase your own awareness of what might be going on for you.

She mentioned that applying theories and methods is an important part of being a counselor, but counselors must also prioritize their own healing. Sun explained this by saying, "Knowing the methods and the theories and how to apply them is one piece, but we must prioritize our healing." She stated that her approach is holistic and that if medication is helpful, it can be an option. She mentioned that every client is different and that she uses different tools when working with her clients. She remarked that she is eclectic and uses different approaches such as existential, CBT, narrative, trauma informed integrating eye movement desensitization and reprocessing (EMDR), and IFS. Sun described this by saying:

> You know, every client is different. Sometimes it's abstract. I utilize so many different tools; I would say it's an eclectic approach. Using what works with the client – sometimes it's imagery; sometimes its narrative. I prefer getting to know the client and figuring out what works. I'm so open to any method that resonates with the client. I don't like to put them in the box.

Therefore, Sun seems to be open to using different tools and approaches that can work with her clients.

Kate

Kate described herself as a 46-year-old Asian female who has been an LPC for four years. She has a master's degree and a doctoral degree from programs accredited by CACREP. Kate did not specify where she works but did report that a few of her clients have the resources to see other mental health providers and can afford their treatments, and few of her clients have health insurance that can cover their treatments. Kate reported she works with women in midlife who have depressive symptoms. Throughout the interview, Kate seemed willing to answer the questions.

Kate remarked that she is a middle-aged woman and that when she has a client her age, she empathizes with her without assuming what her client is feeling. She described this by saying, "I think whenever I have a client my age, I feel, I can empathize more, I can empathize easily, but at the same time, I try not to just assume what they're feeling." She emphasized that clients are unique, and counselors must avoid making assumptions. She mentioned that she helps women in midlife to hear their own voices and to use I-statements. Kate explained this by saying:

> Usually, at that age, they talk about other families, friends, and kids and then first step, I try to really listen to them and give them time to think about themselves. Instead of focusing on the other's story, I try to help them hear their own voices, their feelings, their emotions, and then I really encourage them to use the I-statement and help them redirect their statements.

Kate stated that she uses RCT and that this approach is the best for her clients. She remarked on the importance of being authentic when working with her clients. She

emphasized that even though she did not have specific training in RCT, she uses it to explore the meaning of her clients' lives. Kate described this by saying:

> RCT, according to the theory, authenticity and connection are foundation. In terms of the therapeutic relationship with the client, I try to be honest with them. I cannot say I have a specific training for the theory, I just learned that approach here and there and from the graduate school, so basically, I use the philosophy, the philosophical concept. I try to explore, understand the meaning of their actions and their life. I guess I use these kinds of questions: "How do I exist?" "What is the meaning of something" like words, actions, persons. I try to explore their meanings with their statements, their actions, their situations, and their feelings.

Hence, she seems to feel most confident using an RCT approach when working with her clients.

Clark

Clark described himself as a 73-year-old White male who has been an LPC for 34 years. He reported he has a doctoral degree, and his master's degree is from a program accredited by CACREP. Clark reported he works at a private practice in which all his clients have the resources to see other mental health providers and can afford their treatments. He stated that even though all his clients can see other mental health providers and cover their treatments, just a few of them have health insurance that can cover their counseling. Clark reported he works with women in midlife who have depressive symptoms. During the interview, Clark appeared very willing to answer questions.

Clark emphasized the importance of being optimistic and empathetic when working with women in midlife who have depression. He described this by saying, "Well, I will be extremely empathetic about her struggle and showing I understand how difficult this is." Clark mentioned that he acknowledges these women and their courage to come to counseling. He also noted the importance of the treatment plan to help these women to figure out how to manage their lives better. He described this by saying, "I'm thinking about a treatment plan and goals and how to help them to get out of their depression or manage their life better." He believes that CBT is the most effective approach for any client. He recommended to other counselors to get CBT training to help their clients. He explained this by saying, "They need to get training with David Burns in CBT and get certification, so they know how to do it because it is the most effective therapy out there." Thus, he seems to believe that CBT should be used by all counselors.

Tom

Tom described himself as a 52-year-old White male who has been an LPC for six years. He reported he has a master's degree from a program that was not accredited by CACREP. He stated he works at a for-profit agency in which only a few of his clients have the resources to see other mental health providers, but most of them can afford their treatments. He said most of his clients have health insurance that can cover their counseling. Tom stated he works with women in midlife who have depressive symptoms. During the interview, Tom appeared enthusiastic when he answered the questions.

Tom remarked that when working with women in midlife who have depressive symptoms, he asks himself if he will be helpful and how to be the most helpful to them. He explained this by saying, "My thoughts typically run to, 'Am I going to be able to be

helpful?' You know I'm always wondering, you know, 'Is this person at a level that you know, what would be most helpful?'" He mentioned the importance of meeting his clients where they are in their lives and validating their life experiences. Tom emphasized that he creates a safe place for these women and that his faith helps him to continue serving this population. Tom described this by saying:

> I will say that my faith is a big portion of that, for me, you know that my faith is a big part of keeping me able to continue to serve this population, because it can be draining at times.

He stated that he uses CBT and IFS with his clients. He shared that he has more success with his clients when he uses CBT. Tom described this by saying:

> I would say, you know – and I guess where you sit, is where you stand – I am primarily cognitive behavioral with sort of less family systems, so I tend to have more success with the cognitive behavioral than with the family systems.

Therefore, he seems to feel more confident using CBT than IFS because he has more success when working with CBT with his clients.

Mark

Mark described himself as a 28-year-old Hispanic, Latino who has been an LPC for half a year. He reported he has a master's degree from a program accredited by CACREP. Mark said he works at a private practice in which all his clients have the resources to see other mental health providers and can afford their treatments. He reported that most of his clients have health insurance that can cover their counseling and that he works with women in midlife who have depressive symptoms. Throughout the interview, Mark seemed passionate when he answered the questions.

Mark emphasized that when working with women in midlife who have depressive symptoms, he asks himself how he can help these women. He described this by saying, "I would have to say that my feelings and thoughts would be compassion, but also thoughts of how I can help this person? How can I help this individual? What can we do to make this situation better?" He also explained the role of compartmentalization in counseling, the importance of truly listening and being compassionate and empathetic with these women. He stated that counselors must avoid assumptions and not group clients into a box. He explained this by saying:

> Each woman within that age group that has depression, I would say yes there is a running theme, but they come from different backgrounds. Their depression comes from a different place … Have them tell you their story and truly actively listen and never assume; don't group them into a box.

Mark emphasized that he uses CBT and narrative approaches when working with women in midlife who have depressive symptoms. He remarked that he uses more narrative therapy than CBT. He stated that these women lean more towards the narrative approach. He described this by saying:

> With this population, they have a tendency to lean more towards the narrative approach, mainly because through our lives we start telling, we start forming a narrative about ourselves. "I'm not good enough," "I'm not worthy enough," "I'm not worthy enough to get this promotion or be a part of this family."

Hence, he seems to use a narrative approach when working with women in midlife who have depression because of his belief that this population seems to gravitate more towards an approach in which they can change their narrative.

Ann

Ann described herself as a 51-year-old White female who has been an LPC for 14 years. She reported she has a master's degree from a program accredited by CACREP and that she works at a private practice in which most of her clients have the resources to see other mental health providers and can afford their treatments. She reported that even though most of her clients have health insurance, just a few of them use their insurance to cover their treatments. She reported that she works with women in midlife who have depressive symptoms. During the interview, Ann appeared passionate as she answered the questions.

Ann said that when working with women in midlife who have depressive symptoms, she focuses on the value of their depression. She described this by saying, "For instance, let's look at if the depression was a coping skill that's not working anymore, what value does it have?" She stated that she creates a safe place for her clients where they can explore the value of their experiences. She emphasized the importance of giving her clients mercy and grace and the role of compartmentalization as a counselor. She explained this by saying:

> I'm trained in [Thought Field Therapy] TFT, so if they're too overwhelming, I will do tapping. I'll do crisis tapping for both of us or for myself. I'm also trained in doing it covertly so I can covertly tap myself. A lot of times I tend to just compartmentalize those pretty easily and go okay, I recognize and acknowledge that I might be experiencing some feelings and then I go okay, we'll deal with those after the session if they still are present. Rarely do they still present after we start kind of moving along in the session.

She mentioned that she uses a narrative approach and thought field therapy (TFT). She emphasized the importance of explaining to her clients each of these approaches and how they are going to work with them. First, she starts with the narrative approach and then moves to TFT body work. She described the narrative approach by saying, "So how I use narrative is, first, I explain that the problem is the problem; they are not the problem, and maybe how we have defined the problem has contributed to us feeling like a bigger problem." She explained the TFT body work by saying:

> As I'm explaining things, I'm watching their reactions and a lot of times, I will say … what I just saw … Where did you feel that in your body? on my chest, okay, so let's focus in on that chest. What do you think about that feeling in your chest? and tell me if the memory comes up or tell me what feelings are associated with that? Are they attached to a memory? Can you pull up a picture again? … Can you pull up a picture of the last time you had emotions that intense?

Therefore, she seems to prepare her clients with the narrative approach before she uses TFT.

Claire

Claire described herself as a 54-year-old Latina who has been an LPC for two years. She stated she has a master's degree from a program accredited by CACREP. Claire reported she works at a private practice in which most of her clients have the resources to see other mental health providers and can afford their treatments. She said that even though most of her clients can afford mental health providers and their treatments, just a few of her clients have health insurance that covers their counseling.

She reports that she works with women in midlife who have depressive symptoms. During the interview, Claire appeared enthusiastic when answering questions.

Claire emphasized that she could relate with women in midlife who have depressive symptoms because she is a middle-aged woman as well. She described this by saying, “I think my first thoughts are that I can relate right? Because I'm in midlife myself, and I know how what it is to have those kinds of symptoms.” She remarked that even though she is the same age as them that she avoids making assumptions about these women. She described the importance of being fully present and listening carefully to these clients. She explained this by saying:

> I really try to remain fully present when they're talking to me … I try to put my thoughts and feelings aside, even though I can understand and comprehend what they're going through. I also don't want to make assumptions just because I say well it's because of this or because I went through that experience. Life can be so totally different.

She emphasized that she is a client-centered counselor and depends on clients to indicate what they want from counseling. She stated that she uses a trauma informed approach and EMDR. She remarked that the approach that works the best when working with women in midlife who have depressive symptoms is EMDR. She explained this by saying, “What for me has worked the best for these women has been EMDR. That's why I use it, but because I am client-centered, it's about them … and how they want to proceed.” Thus, she seems to work with clients at their pace and respects how they want to proceed in their counseling sessions.

Jose

Jose described himself as a 62-year-old Latino, Mexican who has been an LPC for 25 years. He reported he has a doctoral degree from a program accredited by CACREP. Jose stated he works at a private practice in which most of his clients have the resources to see other mental health providers and can afford their treatments. He said that even though most of his clients can afford other mental health providers and their treatments, just a few of his clients have health insurance that covers their counseling. Jose reports he works with women in midlife who have depressive symptoms. During the interview, Jose seemed passionate when he answered the questions.

Jose emphasized that when working with women in midlife who have depressive symptoms, he asks himself if he can help these women. He described the importance of being fully present and listening carefully to his clients. He stated that he brackets his own assumptions when working with this population. He described this by saying:

> Initially, I become aware of what I'm feeling. I just allow it. Usually, I would move into the more cognitive level after … identifying what I'm feeling. I will move more into thoughts "I need to be present" and bracket my own assumptions and try to listen more than anything. So, when I do listen, I'm not thinking; I'm listening, receiving what the client is sharing with me.

He emphasized that he uses an integral approach. He stated the importance of focusing on body, soul, spirit, and their relationships among them. He also mentioned the importance of exploring the different dimensions of his clients' lives. He described this by saying:

> By integral I mean … the body, soul, and spirit in relationship with herself, with others, with culture to try to look at different dimensions of the human experience. So, I will ask about those different dimensions of human experiences.

Jose seems to work with his clients using a holistic approach in which he explores all his clients' dimensions and relationships.

Analysis of Data

Based on the transcendental phenomenology approach (Moustakas, 1994), I was aware of the importance of self-knowledge/awareness, self-reflection, and intuition when immersing myself in the personal and clinical experiences of the 1participants. Moreover, I was aware of bracketing out my own biases before proceeding with analyzing the participants' data. When I started immersing and bracketing out myself, I realized that bracketing out my biases was an ongoing process in the immersion of the data.

The first thing I did was to check my self-notes from all the interviews to bracket out any possible biases. Then, I watched all the recordings as many times as I needed to get a better understanding of who my participants were. After watching all these recordings, I started transcribing the interviews. I wrote self-notes during the interviews to compartmentalize myself because sometimes I felt that what my participant was telling me was affecting me. After each of my interviews, I checked myself and reviewed my self-notes to avoid contaminating my participants' data. I started bracketing out my biases, developing more self-awareness, and reflecting on myself when processing these self-notes.

After I transcribed all the interviews and performed member checking with each participant, I started processing all the interviews. I read all the transcripts as many times

as I needed. I highlighted and wrote many of the participants' quotations, and patterns of the data. Then, I summarized all the interviews, wrote memos, checked notes from all interviews, and wrote possible themes and sub-themes. I identified all the patterns and sub-themes I could from my participants' data until nothing new emerged. Saturation was obtained.

During this period of immersion, I practiced self-awareness, self-reflection, bracketing out my biases, and intuition to get a better sense of myself and my participants' data. After I analyzed all this data manually, I started using the qualitative analysis software package MaxQDA. This software allowed me to perform multiple analyses, create specific codes for large sections of the data, collapse patterns, identify sub-themes, and to capture the overall perceptions of the participants' experiences. While I was doing this analysis in MaxQDA, I was also comparing it to the information I had gathered manually from the data.

My intuition played an important role in the analysis of the data and helped me to identify the sub-themes, themes, and the essence of the participants' experiences. Participants shared their personal and clinical experiences. They shared their feelings and thoughts and how they managed them. The participants offered suggestions or recommendations for other LPCs to work more effectively and efficiently when assisting women in midlife who reported depressive symptoms.

The essence of this study was connection that emerged from the five major themes. The five major themes that were found from the data collection and the analysis process were (a) empathy and compassion, (b) curiosity, (c) managing the therapeutic process, (d) integrative model, and (e) creating a safe environment. The curiosity theme

had sub-themes of exploring clients' lives (8 participants) and exploring how to help clients. The managing the therapeutic process theme had sub-themes of countertransference, compartmentalization, and awareness. The integrative model had sub-themes of holistic evaluation, psychoeducation, unique treatment plan and transtheoretical. The creating a safe environment theme had sub-themes of avoiding making assumptions and avoiding judging clients and validating clients' experiences.

In chapter 3 in the Participants and Role of the Researcher section, I mentioned that I was both nervous and happy about conducting this study because I was not sure how I was going to feel interviewing my participants. I was afraid of feeling pain and that this pain was going to contaminate my study. I also felt happy because this pain was going to help me grow and be more empathic and compassionate with people who had similar experiences to myself. Even though in many of the interviews I felt nervous and I had to compartmentalize myself, I felt that I connected on a deep level with most of my participants. This connection made my participants and me grow as human beings and counselors. I also felt happy that I was able to be there for my participants, showing them that they are not alone in this process with their clients.

Themes

This study was designed to develop a better understanding of how LPCs manage their feelings and thoughts, how they provided help to middle aged women with depressive symptoms, and what recommendations or suggestions they offered to other LPCs. Review of collected data revealed the following:

Theme 1: Empathy and Compassion

Of 12 participants, eight of them reported empathy and compassion **w**hen the researcher asked the participants to share their feelings when they worked with women in midlife who had depressive symptoms. Some of the participants who answered empathy and compassion were Claire, Clark, and Jose. Claire responded:

I feel compassion, because I know that sometimes when you're feeling that way people want to put you in one category. It's just hormones, it's trauma, it's like there's all these things that it makes you feel so I understand how they feel. I guess what I'm saying is that I just think I have great compassion for that age range with those symptoms and where they're coming from, but I always want to know, "Could it be medical?" or "What has happened in their life?" to get them to where they are now.

Although Claire described empathy and labeled her feelings as compassion, Clark labeled his feelings as empathy when he said:

Well, I will be extremely empathetic about her struggle and show her I understand how difficult this is if she doesn't understand it. I would join her in her struggle. I would help her feel heard. That is, confusing difficult she doesn't even know why, and then I congratulate her for being so brave to come, even though she doesn't know what's going on.

Jose did not label his feelings as empathy or compassion, but he described these feelings by saying:

Listening, just trying to be present, hopefully, my eyes show care. I try to connect with their suffering and that you know, in a sense either say that they're not going to suffer alone, or nobody has to suffer alone, kind of hold it, with a sense of containing her.

Eight of the 12 participants made similar statements indicating that they experience empathy and compassion when working with women in midlife who are experiencing depressive symptoms.

Theme 2: Curiosity

Of 12 participants, 10 of them reported curiosity and a stance of not knowing when they were asked to share their thoughts on this research topic. The theme curiosity had two sub-themes: exploring clients' lives and exploring how to help clients. Tom and Claire gave responses integrating the main theme curiosity and its sub-themes of exploring clients' lives and exploring how to help clients. Dan, Sun, Ann, and Jose gave responses showing these two sub-themes. Tom said:

> I'm always wondering, is this person at a level that you know, "What would be most helpful?" I guess, it is another thought that I have, "Does this person just need an opportunity to tell their story?" or "Do they need some level of coping skills to develop those?" or "Do they possibly need to be encouraged to seek a medical referral?"

Although Tom and Claire are of different genders, both described curiosity when they were asked to share their thoughts. They emphasized the need to explore their clients' lives to learn how to help them. Claire responded:

> I think sometimes when you're in that age range people forget that you're going through menopause, pre-menopause, or post-menopause. Those things can also

> affect you, right? It's not just you, you got to look at everything. “Are they in a relationship?” or “Are they healthy?” My thoughts are always, I want to know more, I want to look at all aspects of their lives.

Even though Dan is a male and Sun is a female, both described in their own ways the sub-theme of exploring clients’ lives. Dan focused more on figuring out the core of the depression and its patterns by saying:

> Let's start digging in, let's find out, where the core of this is coming from. “Is this a repetitive thing?” or “Is this a neural pathway that is so ingrained that you can't pull that escape out of the groove and you just keep doing the same thing over and over again?”

Sun focused more on exploring what clients have been doing to deal with these symptoms by saying:

> Thoughts that come up, “Is that this person has gotten to a point where all the things that they've done to survive up into this time are no longer working?” And now they're at a point where the depression is so big and so hard that none of that works anymore and they're coming to seek help usually because they've run out of alternatives.

Although Ann and Jose are from a different gender, both described the sub-theme of exploring how to help clients. Ann focused more on looking for the value of the depression by saying:

> My first thought is to understand that my approach, instead of looking at depression and depressive symptoms as negative because that's where the brain

automatically goes, we start looking for the value of it. Also, my first thought is to approach it as it were a coping skill that had gone awry and what its value was.

Jose focused more on asking himself what dimensions of his clients' lives are connected to their depression by saying:

> Thoughts, I try to conceptualize them. Try to think, "How can I help this person?" "How can I help this woman?" I wonder if it's hormonal or biological. I wonder if there's depression in their family. I wonder if she has experienced trauma or abuse.

Ten of the 12 participants, both women and men, made similar statements indicating that they are curious about exploring their clients' lives and exploring how to help their clients who are women in midlife experiencing depressive symptoms.

Theme 3: Managing the Therapeutic Process

Of 12 participants, 11 of them reported managing the therapeutic process when asked to share how they managed their feelings and thoughts. The main theme managing the therapeutic process had three sub-themes: countertransference (5 participants reported this), compartmentalization (6 participants reported this), and awareness (11 participants reported this). Claire gave a response integrating the main theme and its sub-themes by saying:

> Let's say that if something triggers me, for some reason, I just take a moment to just breathe a little bit deeper, a little bit softer to just take a moment. Even something as simple as drinking a little bit of water and just taking that little moment. Even something as simple as wiggling your toes to just bring you to present moment.

Claire deals with countertransference triggers by compartmentalization through gaining a moment of distance and becoming more aware of her body. Rose and Tom both gave responses showing the sub-theme countertransference. Rose focused more on countertransference through compartmentalization by saying, “If I notice anything to myself, I check that at the door. As far as it's not about you, give me that quick reminder.” Tom focused more on how to address countertransference with his clients by saying:

> I think if there is anything that I feel like borders on transference or countertransference in those situations because of women that I know or had similar situations, I will tend to acknowledge that with the client to just make sure that the client knows that's happening.

Amy and Ann explained how they compartmentalized themselves when working with women in midlife who have depression. Amy responded by saying:

> It's okay to have that feeling, but not let it influence what I am about to do next. Giving yourself space and time to feel your feelings, even if it's about a client that you're trying to help. Mostly just that, compartmentalization and appropriate time in place processing.

Ann responded emphasizing that most of the time she only needed to compartmentalize herself during sessions by saying:

> I recognize and acknowledge that I might be experiencing some feelings and then I go okay, we'll deal with those after the session if they still are present. Rarely, they are still present after we start moving along in the session.

In order to deal appropriately with countertransference, many of the participants indicated a need for awareness and then compartmentalization. Although Jose and Mark responded in a similar way about the importance of being aware of what is happening to themselves and their clients in session, Jose focused more on paying attention of himself by saying:

> I try to pay attention to what I'm feeling and notice it and I try to see, "Am I being triggered?" or "Is this an intuition?" or "Is this transference and countertransference?" A little bit of more awareness and being present to what I'm going through, but at the same time be present to the person that is coming to talk to me and to see me. I would say awareness is the main thing and not dwelling on it too much.

Mark focused more on how he bracketed himself and separated it in session by saying:

> I bracket my own feelings and thoughts by being able to be aware of what's going on in my own life, or being able to recognize what has happened to me currently, or what's happened in the past and being able to recognize that and be conscious of what's going on. I would have been able to mentally separate that in session. If that's going on in session, I must be able to focus on my client.

Eleven of the 12 participants made similar statements indicating that managing the therapeutic process is a main factor when they deal with their thoughts and feelings when working with women in midlife who are experiencing depressive symptoms. Managing the therapeutic process involved identifying countertransference, compartmentalization, and self-awareness.

Theme 4: Integrative Approach

Even though the participants were more focused on particular counseling theories when they answered the Demographic Questionnaire, of the 12 participants, 10 of them reported using some sort of integrative approach when the researcher asked the participants to share how they helped women in midlife who had depressive symptoms. The main theme integrative approach had four sub-themes of holistic evaluation (7 participants reported this), psychoeducation (9 participants reported this), unique treatment plan (9 participants reported this), and transtheoretical (10 participants reported this). Rose and Jose gave responses showing the sub-theme of holistic. Rose and Jose gave individually their own explanation of holistic counseling. Rose focused more on exploring a client's history and life experiences by saying, "I am very thorough. I am going to ask for a complete history. I use a question lead interview. Curiosity of life experiences such as any past trauma, any history of mental illness, or any caretaking." Jose focused more on exploring all the different dimensions of the human experience by saying:

> By integral I mean the body, soul, and spirit in relationship with herself, with others, and with culture to try to look at different dimensions of the human experience. I will ask about those different dimensions of human experiences, as I understand.

Nine participants stressed the use of psychoeducation as part of their practice. Amy and Dan each gave their own descriptions of psychoeducation. Amy focused more on the importance of educating clients that depression is not a choice by saying:

> Psychoeducation is my best friend. I think a lot of people, specifically this population, are under the impression that they're doing everything wrong and that this is all their fault. Especially when it comes to depression, especially if it's clinical depression. There are so many studies that counselors have access to because we're in the field and we're like this is normal. This is not something you've done to yourself; this is not a choice you're making.

Dan focused more on educating clients about the counseling process. He said that he let clients know that each counselor has their own approaches to counseling by saying, "that psychoeducation piece about why we do what we do. Also, a lot of explanation around the understanding that this is what Dr. Therapist does. But if you went to [another] therapist, you'd get a different approach."

When Tom and Ann gave responses about how they helped this population, both emphasized that the treatment plan selected depended on the clients they had. Tom responded:

> It depends, obviously, on the client I have. I think that for those that have recurring depressive symptoms without a clear link to triggering events, then medication has been more helpful than talk therapy in isolation. I'd say that the combination certainly is warranted for those that have experienced depression, for a long time and again, have a clear link to a cause.

Ann focused more on the importance of the value of counseling, medications, and the combination of both by saying:

> I think all three have their value in different areas. I think … it really to me depends on the client. Some clients have just chemical stuff in it, once and done.

> Some people have very complex cases that need both. In some, they don't have the chemical imbalance necessarily and have more resiliency, so they can do with just counseling, but I think you have to monitor all. I think it's so individualized.

Thus, treatment plans need to be customized for each individual, and some treatment plans will include medication and counseling, and others will include just one of these interventions.

Sun and Mia, both labeled themselves as eclectics, but as these participants explained their approaches, integrative may be a better description for their theoretical orientations because they talked about intentionally choosing different approaches for their work with clients. Sun said:

> Every client is different. Sometimes it's abstract; I utilize so many different tools. I would say it's an eclectic approach, using what works with the client. Sometimes it's imagery, and sometimes its narrative. I prefer getting to know the client and figuring out what works. I'm so open to any method that resonates with the client; I don't like to put them in the box.

Mia described her approach by saying:

> Depending on where the client is I use an eclectic approach, meaning whatever works, works. Sometimes CBT, RBT, or DBT. It all depends on the receptiveness of the client. I found that CBT is very effective, just because it helps change the thought process to change the behavior.

Ten of the 12 participants expressed similar responses, indicating that they use an integrative approach when working with women in midlife who are experiencing depressive symptoms.

Theme 5: Creating a Safe Environment

Of 12 participants, eight of them reported creating a safe environment when the researcher asked the participants to share the recommendations and suggestions, they had for LPCs to work more effectively and efficiently. The main theme of creating a safe environment had two sub-themes, avoiding making assumptions and avoiding judging clients (5 participants reported this) and validating clients' experiences (7 participants reported this). Claire and Ann gave similar responses of the main theme creating a safe environment. Claire responded:

> I think it takes time to find out what in fact is going on. You have to be patient. You have to listen. You have to be gentle. I think you definitely have to create that safe place again because it's hard for people to tell you their feelings, and so to create this trust that you're not going to judge why they feel that way, no matter what reasons they have.

Ann shared, "One of the things that we talk about is making the environment safe, so that they can explore trying to hear the value to what they're experiencing." Safety seems to be at foundation of counseling with this population.

Kate's recommendations and suggestions for LPCs to work more effectively and efficiently was to avoid making assumptions and judging clients. Kate described this by saying:

> Do not assume clients' stories. Do not make assumptions. I think it is very important. Then, we cannot judge; they have different educations, cultural backgrounds, and family backgrounds. There are so many factors, so I try not to judge them.

For five participants, creating a safe space involved not judging clients. For seven participants, creating a safe space involved validating the clients' experiences. Jose and Dan's recommendations and suggestions for LPCs to work more effectively and efficiently was to validate clients' experiences. Jose described this by saying, "Make sure that you are in touch with the feelings and emotions of the clients and have them talk about that." Dan responded, "It's only going to be driven by how much they are willing to work outside of those 50 minutes on everything else, and to be accepting of that. That's their pace; that's where they're at."

Eight of the 12 participants made similar recommendations and suggestions indicating the importance of creating a safe environment when working with women in midlife who are experiencing depressive symptoms.

Summary

Five themes emerged from the participants' responses. The first theme was empathy and compassion. The second theme was curiosity, and its sub-themes were exploring clients' lives and exploring how to help clients. The third theme was managing the therapeutic process, and its sub-themes were countertransference, compartmentalization, and awareness. The fourth theme was integrative approach, and its sub-themes were holistic evaluation, psychoeducation, unique treatment plan, and integrative. The fifth theme was creating a safe environment, and its sub-themes were avoiding making assumptions and avoiding judging clients and validating clients' experiences. Connection was the essence that emerged from all these themes. Connection plays an important role when counselors are working with women in midlife who have depressive symptoms.

CHAPTER 5: Summary, Limitations, Implications, and Recommendations

Researchers have conducted a variety of evidence-based studies concerning women in midlife who display depressive symptoms (Ghaemi (2013), Harrington (2019), Lafrance (2009), Mackinnon (2016), Mazure and Keita (2006), Mcintyre (2016), and Ussher (2011). Even though there are numerous evidence-based studies about women in midlife who present depressive symptoms, there were no evidence-based studies of the clinical and personal experiences of LPCs who assist women in midlife who display depressive symptoms. The results of this study extend the knowledge in professional literature about this topic.

The purpose of this study was to understand the lived experiences, clinical and personal, of licensed professional counselors (LPCs) who worked with women in midlife who displayed depressive symptoms. The study sought to recognize the essence and themes that emerged from the responses of the LPCs who worked with this population. Moreover, this study was designed to obtain a better understanding of how these LPCs managed their feelings and thoughts, how they helped when working with these women, and what recommendations or suggestions they might offer to other LPCs.

A phenomenological transcendental approach was implemented to seek answers to the following research questions. The central research question was: What are the clinical and personal experiences of LPCs who assist women in midlife who report depressive symptoms? The base interview questions were:

- "What are your feelings and thoughts when you assist women in midlife who display depressive symptoms?"

- "How do you manage the thoughts and feelings you experience when you assist women in midlife who display depressive symptoms?"
- "How do you help women in midlife who have depressive symptoms?"
- "What suggestions or recommendations do you have for LPCs to work more effectively and efficiently when they assist women in midlife who present depressive symptoms?"

Participants consisted of 12 mental health practitioners who were LPCs who have worked with women in midlife who had depressive symptoms. Participants' LPCs years ranged from 0.5 to 34, and participants' ages ranged from 28 to 73. Seven of the participants were female (58.33%), and five were male (41.67%). Eight of the participants were White (66.67%), three were Latino/as (25%), and one was Asian (8.33%). Eight of the participants had a master's degree (66.67%), and four had a doctoral degree (33.33%). Most of the participants had many years of experience being an LPC, and all of them had a graduate degree.

The researcher met two times with each participant—once for the interview and once for the revision of the transcripts (member checking). Each initial structured interview lasted 45 to 60 minutes, and each interview for the revision of the transcript lasted approximately 20 minutes. Interviews were transcribed and analyzed to identify the essence, common themes, and subthemes supported by key statements expressed by participants.

The essence of this study was connection that emerged from the five major themes. The five major themes identified in the study were empathy and compassion, curiosity, managing the therapeutic process, integrative approach, and creating a safe

environment. These five themes answered the central research question and the four base interview questions of this study. The curiosity theme had subthemes of exploring clients' lives and exploring how to help clients. The managing the therapeutic process theme had sub-themes of countertransference, compartmentalization, and awareness. The integrative model had sub-themes of holistic evaluation, psychoeducation, unique treatment plan, and integrative approaches. The creating a safe environment theme had sub-themes of avoiding making assumptions and avoiding judging clients and validating clients' experiences. Conclusions were drawn from the findings within each theme.

The feelings that were expressed most frequently across participants were empathy and compassion. Eight of the 12 participants reported these feelings of empathy and compassion. One of the male participants emphasized that he had minimal of feelings when working with these women. When the researcher asked the participants what their thoughts were when working with this population, of 12 participants, 10 of them indicated curiosity. Most of the female and male participants had similar answers such as how they could help these women overcome depressive symptoms when they answered this question.

Of 12 participants, 11 of them reported that they managed their feelings and thoughts when working with women in midlife who had depressive symptoms by managing the therapeutic process (theme). Most of the participants emphasized the importance of countertransference, compartmentalization, and awareness (subthemes). Most of the participants explained how they compartmentalized themselves in sessions and the importance of working on themselves, their thoughts, and their emotions after these sessions.

Of 12 participants, 10 of them indicated that they helped women in midlife who had depressive symptoms by using an integrative approach. The majority of the participants emphasized the importance of a holistic evaluation, giving a unique treatment plan, using psychoeducation, and using multiple approaches when working with these women. Even though most of the participants answered in the demographic questionnaire that they practiced within a specific theoretical orientation when working with these women, in the interviews, most of them expressed that they used varied theories according to what they thought was the best for their clients.

Of 12 participants, eight of them recommended creating a safe environment when working with women in midlife who had depressive symptoms. Most of the participants emphasized the importance of avoiding making assumptions, avoiding judging clients, and constantly validating clients' experiences. Even though a pre-research notion was that a major recommendation was going to be self-care for counselors, only two participants gave this suggestion, which was not enough participants to develop a subtheme.

Limitations

Patton (2015) concluded that one of the key limitations of qualitative research involved the risk of researcher bias. Patton stated that the researcher should use some present-moment techniques such as body awareness and self-reflection to continue becoming more self-aware and to not interfere in the analysis of the results. Another limitation according to Dukes (1994) was that the process of phenomenological bracketing is a skill and not an easy one to learn. I practiced all these techniques throughout the interview and analysis processes. There is always the risk of either seeing

what the researcher wants to see rather than what was there is to be seen (Dukes, 1994). Patton described one more limitation of qualitative research is the excessive amount of time that is required for the researcher to collect all the data from the narrative experiences and use this data effectively. An additional limitation is that even though a thick description of the 12 LPCs' lived experiences was provided, transferability may not be achieved because the sample was too small to represent the full population of counselors who work with women in midlife who exhibit depressive symptoms. Although these limitations are substantial, I worked throughout the study to minimize these limitations.

Another limitation of this study is that I interviewed LPCs who worked with this population, but I did not ask questions that clarified their work as successful. Because most of these counselors have been practicing for many years, one might assume that they have had some success. This assumption, however, may not be valid. Thus, there may be other information that could be obtained from counselors who have demonstrated success reducing depressive symptoms in midlife women.

Implications

The current study adds findings that need to be considered when investigating counselors who assist women in midlife who display depressive symptoms. There is a gap in the literature regarding evidence-based studies of the clinical and personal experiences of LPCs who assist these women. These findings also confirm that the role of the researcher is key in a qualitative study. Patton (2015) indicated that qualitative investigation is personal. When working with women in midlife who have depressive symptoms, it is very important that counselors give their clients a safe place, show them

empathy, and compassion. These feelings of safety would be the first step to establish a relationship; therefore, a connection with their clients. It is also important that these counselors are curious enough about their client's stories and see them in an integral and holistic way to be able to fully understand what their clients are experiencing. Moreover, counselors must manage their therapeutic process to be fully present for their clients. Recommendations from the findings are provided in the realms of counselor preparation (including education and supervision), counseling, and future research.

Recommendations

The following recommendations are provided to counselor educators and current and future counselors. The counselor must recognize that when working with women in midlife who have depressive symptoms, a substantial amount of investigation of their clients' lives is necessary. Therefore, before helping a client, counselors must be curious and explore their clients' lives to have a clear understanding of what is happening in their clients' lives. Counselors must establish and be aware of the relationship with their clients, showing them empathy and compassion. Counselors must expect to spend much time managing the therapeutic process. An extremely flexible theoretical background may be necessary to match the right treatment with each client. Most of the success happens when counselors are knowledgeable enough about multiple theories and can adapt their theories to an individual's needs to help them progress in their lives. Therefore, counselors must be able to recognize when a theory is not working with a client and be able to change their theoretical perspective to match the best approach for the client's treatment.

Another recommendation might be that counselors must be grounded in the scholarship related to the problems faced by particular clients. Students in counselor training programs should explore varied client issues by reviewing scholarship during their clinical courses. This exploring of client issues should be done on a regular basis by licensed professionals. Moreover, psychoeducation is a strategy that might help when working with women in midlife who have depressive symptoms. Furthermore, taking a holistic approach with this population might help to assist these clients get medical evaluations, dietary consultations, and appropriate psychiatric treatment.

Counselor educators and supervisors should be knowledgeable of and skilled in a variety of theoretical frameworks and methods. Recognizing that counselors in the field are integrating many theories and methods in their work, counseling students and supervisees need guidance in how to conceptualize using a variety of theories and how to effectively select and apply a variety of interventions. Although some counselors may perform counseling solely through one theoretical lens, this may not be helpful to all clients, especially when some clients may not be comfortable with the techniques associated with that theory.

Future research should further explore the personal and clinical experiences of counselors who assist women in midlife who display depressive symptoms. Subsequent research should consider the influence of other demographic factors of the sample, such as age, gender, cultural background, and how many years of experience they have as a LPC. Similarly, subsequent research should focus on demographic considerations of the clients. For example, do clients of different cultural backgrounds, socioeconomic statuses, and education levels respond differently to different treatments? Lastly, future

research should clarify which clinical approaches have demonstrated success with women in midlife who have experienced depressive symptoms.

REFERENCES

Abayomi, A. (2017). The interpretation phenomenological analysis (IPA): A guide to a good qualitative research approach. *International Journal of Education & Literacy Studies, 5*(2), 9-19. https://doi.org/10.7575/aiac/ijels.v.5n.2p.9

American Counseling Association. (2014). *2014 ACA Code of Ethics.* Alexandria, VA: Author.

American Counseling Association. (2011). *Who are licensed professional counselors?*

American Psychiatric Association. (2013*). Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

American Psychological Association. (2020). *Publication Manual of the American Psychological Association* (7th ed.).

Anderson, C., Kirkpatrick, S., Ridge, D., Kokanovic, R., & Tanner, C. (2015). Starting antidepressant use: A qualitative synthesis of UK and Australian Data. *BMJ Open, 5,* e008636. https://doi.10.1136/bmjopen-2015-008636

Azizi, M., Fooladi, E., Masoumi, M., Orimi, T. G., Elyasi, F., & Davis, S. R. (2018). Depressive symptoms and their risk factors in midlife women in the Middle East: A systematic review. *Climacteric, 21*(1), 13-21. https://doi.org/10.1080/13697137.2017.1406908

Bentley, K. J. (2010). Psychiatric medications and meaning-making in a residential program for adults with serious mental illness. *Qualitative Social Work, 9*(4), 479-499. https://doi.org/10.1177/1473325010367822

Blenkiron, P. (2010). *Stories and analogies in cognitive behavior therapy.* Wiley.

Bromberger, J. T., Kravitz, H. M., Youk, A., Schott, L., & Joffe, H. (2016). Patterns of depressive disorders across 13 years and their determinants among midlife women: SWAN mental health system. *Journal of Affective Disorders, 206,* 31-40. https://dx.doi.org/10.1016/j.jad.2016.07.005

Bromberger, J. T., Schott, L., Kravitz, H. M., & Joffe, H. (2015). Risk factors for major depression during midlife among a community sample of women with and without prior major depression: Are they the same or different? *Psychological Medicine, 45*(8), 1653-1664. https://doi.org/1017/S0033291714002773

Centers for Disease Control and Prevention (2019). *Data & statistics fatal injury report*. Retrieved from https://afsp.org/suicide-statistics/

Chandra, P. S., Herrman, H., Fisher, J., Kastrup M., Niaz, U., Rondon, M.B., & Okasha, A. (2009). *Contemporary topics in women's mental health: Global perspectives in a changing society.* Wiley.

Choate, L. M. (2019). *Depression in girls and women across the lifespan: Treatment essentials for mental health professionals.* Routledge.

Colvin, A., Richardson, G. A., Cyranowski, J. M., Youk, A., & Bromberger, J. T. (2014). Does family history of depression predict major depression in midlife women? Study of Women's Health Across the Nation Mental Health Study (SWANMHS). *Archives of Women's Mental Health, 17,* 269-278. https://doi.org/10.1007/s00737-014-0433-8

Council for the Accreditation of Counseling and Related Educational Programs. (2016). *CACREP Standards.* Retrieved from https://www.cacrep.org/for-programs/2016-cacrep-standards/

Creswell, J. W. (2013). *Qualitative inquiry research design: Choosing among five approaches* (3rd ed.). SAGE Publications.

Degges-White, S., & Myers, J. E. (2006). Transitions, wellness, and life satisfaction: Implications for counseling midlife women. *Journal of Mental Health Counseling, 28*(2), 133-150.

Deegan, P. E. (2005). The importance of personal medicine: A qualitative study of resilience in people with psychiatric disabilities. *Scandinavian Journal of Public Health, 33*(66), 29-35. https://doi.org/10.1080/14034950510033345

Dog, T. (2010). *Integrative women's health.* Oxford University Press.

Dukes, S. (1984). Phenomenological methodology in the human sciences. *Journal of Religion and Health, 23*, 197-203.

Farmer, R. F., & Chapman, A. L. (2016). *Behavioral interventions in cognitive behavior therapy: Practical guidance for putting theory into action* (2nd ed.). American Psychological Association.

Faubion, S. S., Kapoor, E., Kling., J. M., Kuhle, C. L., Sood, R., Rullo, J. E., Thielen, J. M., Shuster, L. T., Rocca, W. A., Hilsaca, K. S. F., Mara, K. C., Schroeder, D. R., & Miller, V. M. (2018). Data registry on experience of aging, menopause, and sexuality (DREAMS): A cohort profile. *Maturitas, 107,* 44-49. http://dx.doi.org/10.1016/j.maturitas.2017.09.013

Friedman, K. (2017). Counselor self-care and mindfulness. *Contemporary Buddhism, 18*(2), 321-330. https://doi.org/10.1080/14639947.2017.1373437

Ghaemi, N. (2013). *On depression: Drugs, diagnosis, and despair in the modern world.* The Johns Hopkins University Press.

Greden, J. F., Riba, M. B., & McInnis, M. G. (2011). *Treatment resistant depression: A roadmap for effective care.* American Psychiatric Association.

Gutterman, J. T. (2013). *Mastering the art of solution-focused counseling* (2nd ed.). Wiley.

Harrington, A. (2019). *Mind fixers: Psychiatry's troubled search for the biology of mental illness.* Norton & Company.

Ho, S. C., Jacob, S. A., & Tangiisuran, B. (2017). Barriers and facilitators of adherence to antidepressants among outpatients with MDD: A qualitative study. *PLOS ONE, 12*(6), Article e0179290. https://doi.org/10.1371/journal.pone.0179290

Husserl, E. (1931). *Ideas: General introduction to pure phenomenology*. HUMANITIES PRESS.

Jackson, S. W. (1986). *Melancholia and depression: From Hippocratic times to modern times.* Yale University Press.

Joiner, T. E., Brown, J. S., & Kistner, J. (2006). *The interpersonal, cognitive, and social nature of depression.* Lawrence Erlbaum Associates.

Jones, H. J., Minarick, P. A., Gillis, C. L., & Lee, K. A. (2020). Depressive symptoms associated with physical problems in midlife women: A longitudinal study. *Journal of Affective Disorders, 263,* 301-309. https://doi.org/10.1016/j.jad.2019.11.166

Joseph, S. (2019). *Personality disorders: New symptom-focused drug therapy*. Routledge

Keegan, S. (2009). *Qualitative research: Good decision making through understanding people, cultures, and markets.* Kogan Page.

Keitel, M. A., & Kopala, M. (2003). *Handbook of counseling women.* SAGE Publications.

Kern, D. M., & Nicholson, S. (2019) Treatment resistant depression in women with peripartum depression. *BMC Pregnancy and Childbirth, 9*(323), 1-7. https://doi.org/10.1186/s12884-019-2462-9

Krathwohl, R. K. (2009). *Methods of educational and social science research: The logic of methods* (3rd ed.). Waveland Press.

Kravitz, H. M., Schott, L. L., Joffe, H., Cyranowski, J. M., & Bromberger, J. T. (2014). Do anxiety symptoms predict MDD in midlife women? The Study of Women's Health Across the Nation (SWAN) Mental Health Study (MHS). *Psychological Medicine, 44*(12), 2593-2602. https://doi.org/10/1017/S0033291714000075

Lafrance, M. N. (2009). *Women and depression: Recovery and resistance.* Routledge.

Mackinnon, D. F. (2016). *Still down: What to do when antidepressants fail.* The Johns Hopkins University Press.

Maletic, V., & Raison, C. (2017). *The new mind-body science of depression.* Norton & Company.

Malila, N. I., Malik, S., Qureshi, N., & Atta, M. (2014). Sexual harassment as a predictor of low self-esteem and job satisfaction among in-training nurses. *FWU Journal of Sciences, 8*(2), 107-116.

Manning, J. (2020). *Suicide: The social cause of self-destruction.* University of Virginia Press.

Marshall, C., & Rossman, G. B. (2016). *Designing qualitative research* (6th ed.). SAGE Publications.

Mazure, C. M., & Keita, G. P. (2006). *Understanding depression in women: Applying empirical research to practice and policy.* American Psychological Association.

Mcintyre, R. S. (2016). *Cognitive impairment in MDD: Clinical relevance, biological substrates, and treatment opportunities.* Cambridge University Press.

Miller, T. W. (2010). *Handbook of stressful transitions across lifespan.* Springer. https://doi.org/10.1007/978-1-4419-0748-6

Moustafa, A. A., Crouse, J. J., Herzallah, M. M., Salama, M., & Mohamed, W. (2020). Depression following major life transitions in women: A review and theory. *Psychological Reports, 123*(5), 1501-1517. https://doi.org/10.1177/0033294119872209

Moustakas, C. (1994). *Phenomenological research methods.* SAGE Publications.

Niederkrotenthaler, T., & Stack, S. (2017). *Media and suicide: International perspectives on research, theory, and policy.* Routledge.

Noonan, S. J. (2016). *When someone you know has depression: Words to say and things to do.* Johns Hopkins University Press

Norman, W. H., & Scaramella, T. J. (1980). *Mid-life: Developmental and clinical issues.* Bruner & Mazel.

Nydegger, R. (2008). *Understanding and treating depression: Ways to find hope and help.* Praeger.

Ong, W.J., Abdin, E., Chua, B. Y., Sambasivam, R., Shafie, S., Vaingankar, J., Chong, S. A., & Subramaniam, M. (2018). Symptom severity of MDD: Associations with functional disability, and prevalence of co-morbid illnesses. *ASEA Journal of Psychiatry 19*(2), 2231-7805.

Patton, M. Q. (2015). *Qualitative research & evaluation methods* (4th ed.). SAGE Publications.

Plewes, T. (2016). *Improving the health of women in the United States: Workshop summary.* The National Academies Press.

Reddy, N. V., & Omkarappa, D. B. (2019). Cognitive-behavioral therapy for depression among menopausal women: A randomized controlled trial. *Journal of Family Medicine and Primary Care*, 8, 1002-1006. https://doi.10.4103/jfmpc.jfmpc_396_18

Richards, C. S., & Perri, M. G. (2010). *Relapse prevention for depression.* American Psychological Association.

Roe, D., Goldblatt, H., Baloush-Klienman, V., Swarbrick, M., & Davidson, L. (2009). Why and how people decide to stop taking prescribed psychiatric medication: Exploring the subjective process of choice. *Psychiatric Rehabilitation Journal, 33*(1), 38-46. https://doi.org/10.2975/33.1.2009.38.46

Sassarini, J. (2016). Depression in midlife women. *Maturitas, 94,*149-154. https://dx.doi.org/10.1016/j.maturitas.2016.09.004

Seaman, B., & Eldridge, L. (2009). *The no-nonsense guide to menopause: A comprehensive resource with simple, unbiased advice on managing this important life stage.* Simon & Schuster Paperbacks.

Simpson, J. M., & Moriarty, G. L. (2014). *Multimodal treatment of acute psychiatric illness: A guide for hospital diversion.* Columbia University Press.

Tolin, D. F. (2016). *Doing CBT: A comprehensive guide to worship with behaviors, thoughts, and emotions.* The Guilford Press.

Ussher, J. M. (2011). *The madness of women: Myth and experience.* Psychology Press.

van Geffen, E. CG., Gardarsdottir, H., van Hulten, R., van Dijk, L., Egberts, A. C. G., & Heerdink, E. R. (2009). Initiation of antidepressant therapy: Do patients follow the GP's prescription? *British Journal of General Practice, 59,* 81-88. https://doi.org/10.3399/bjgp09x395067

Venkataswami, N., & Bittenahalli, D. (2019). Cognitive-behavioral therapy for depression among menopausal women: A randomized controlled trial. *Journal of Family Medicine and Primary Care, 8*(3), 1002-1006. https://doi.org/10.4103/jfmpc.jfmpc_396_18

Vijayalakshmi, N. (2020). Loneliness and its aftermath. *Shanlax International Journal of Education, 8*(2), 50-54. https://doi.org/10.34293/education.v8i2.2300

World Health Organization. (2019). *International statistical classification of disease and related health problems* (11th ed.). https://icd.who.int/

Zhang, Z., Zhang, L., Zhang, G., Jin, J., & Zheng, Z. (2018). The effect of CBT and its modifications for relapse prevention in MDD: A systematic review and meta-analysis. *BMC Psychiatry,* 1-14. https://doi.org/10.1186/s12888-018-1610

APPENDIX A:

Invitation Letter Soliciting Participants

I would like to ask for your help by participating in a research study involving interviews with approximately 12 licensed professional counselors (LPCs) in Texas that work with women in midlife (40 to 65 years old) who display depressive symptoms. The purpose of this study is to understand the lived experiences, clinical and personal, of LPCs that work with women in midlife who display depressive symptoms.

You will be asked to complete a short demographic questionnaire to determine if you meet the participant criteria for this study and to gather some information about you. The questionnaire will take approximately 10 minutes. This questionnaire will be conducted using an online survey. If you meet the participant criteria and you are selected to participate in this study, the researcher will contact you through email or phone, and provide days and times for a possible interview. The researcher will meet with each participant two times, once for the interview and the second time for clarification of some responses. The first interview will last between 45 to 60 minutes, and the second interview will last approximately 20 minutes. Both interviews will be audio recorded.

Participation in this research study is completely voluntary. There are minimal risks for participation in this study. Participants may feel emotional discomfort during the interviews. You may choose not to answer any questions, and you may withdraw your consent and discontinue your participation at any time. Any information you provide will be kept confidential.

You may not receive a direct benefit from participating. However, it is hoped that through your participation, the information the researcher will be able to provide to other counselors will help those counselors be more successful in their counseling work and will be more capable of managing their personal responses to their clients.

All data obtained from participants will be kept confidential and will be reported using pseudonyms that disguise participant identity. Participants will be asked not to provide any information that could identify their clients. The recordings and transcripts will be kept on a computer using a strong password.

You will be provided consent information on the first page of the online survey. If you have any questions about participation in this research, please contact the researcher at 210-317-5280 or ctovar5@stmarytx.edu.

If you have any questions or concerns about the nature of this study, please contact St. Mary's University Institutional Review Board-Human Subjects (210-436-3736 or IRBCommitteeChair@stmarytx.edu).

ALL RESEARCH PROJECTS THAT ARE CARRIED OUT BY INVESTIGATORS AT ST. MARY'S UNIVERSITY ARE GOVERNED BY THE REQUIREMENTS OF THE UNIVERSITY AND THE FEDERAL GOVERNMENT.

Please, click the following link to complete the 10-minute online survey that will determine your eligibility.

https://stmarys.az1.qualtrics.com/surveys/SV_5BAxiiwXDpgcrfU/edit?SurveyID=SV_5BAxiiwXDpgcrfU

Thank you for your consideration in helping with this research.

Sincerely,

Carla Tovar, M.A., LPC

Invitation Letter Soliciting Participation on Psychology Today's Website

I would like to ask for your help by participating in a research study involving interviews with approximately 12 LPCs in Texas who work with women in midlife (40 to 65 years old) who display depressive symptoms. The purpose of this study is to understand the lived experiences, clinical and personal, of LPCs who work with women in midlife who display depressive symptoms.

All data obtained from participants will be kept confidential and will be reported using pseudonyms that disguise participant identity. Participants will be asked not to provide any information that could identify their clients. The recordings and transcripts will be kept on a computer using a strong password.

Please contact the researcher at 210-317-5280 or ctovar5@stmarytx.edu, if you have any questions.

Please, click the following link to complete the brief online questionnaire that will help the researcher determine your eligibility:

https://stmarys.az1.qualtrics.com/jfe/form/SV_5BAxiiwXDpgcrfU

Thank you,

Carla Tovar, M.A., LPC

Invitation Letter Soliciting Participants on the National Board for Certified Counselors' Website

Thank you for the professionalism you demonstrate by being board certified in counseling. It is this level of professionalism that I am seeking for my dissertation research study on counselors who work with women in midlife (40 to 65 years old) who display depressive symptoms. Would you be willing to help me by participating in an interview so that I can learn about your lived experiences, both clinical and personal, with this population?

The purpose of this study is to understand the lived experiences, clinical and personal, of LPCs who work with women in midlife who display depressive symptoms. All data obtained from participants will be kept confidential and will be reported using pseudonyms that disguise participant identity. Participants will be asked not to provide any information that could identify their clients. The recordings and transcripts will be kept on a computer using a strong password.

Please contact the researcher at 210-317-5280 or ctovar5@stmarytx.edu, if you have any questions.

Please, click the following link to complete the brief online questionnaire that will help the researcher determine your eligibility:

https://stmarys.az1.qualtrics.com/jfe/form/SV_5BAxiiwXDpgcrfU

Thank you,

Carla Tovar, M.A., LPC

APPENDIX B:

Qualtrics Survey: Information About the Study and Demographic Questionnaire

INFORMATION ABOUT THE STUDY

This study involves research based on information gathered from approximately 12 licensed professional counselors (LPCs) in Texas who work with women in midlife (40 to 65 years old) who display depressive symptoms. The purpose of this study is to understand the lived experiences, clinical and personal of LPCs who work with women in midlife who display depressive symptoms. This attained knowledge may help other LPCs to develop more awareness of themselves and to internalize knowledge and experience attained from their peers.

Duration and Procedures

You will be asked to complete a short demographic questionnaire to determine if you meet the participant criteria for this study and to gather some information about you. The questionnaire will take approximately 10 minutes. This questionnaire will be conducted using an online survey. If you meet the participant criteria and you are selected to participate in this study, the researcher will contact you through email or phone and provide days and times for a possible interview. The researcher will meet with each participant two times, once for the interview and the other time for clarification of some responses. The first interview will last between 45 to 60 minutes, and the second interview will last approximately 20 minutes. Both interviews will be audio recorded.

Risks and Discomforts

There are minimal risks for participation in this study. Participants may feel emotional discomfort during the interviews. You may choose not to answer any questions, and you may withdraw your

consent and discontinue your participation at any time. Any information you provide will be kept confidential.

Benefits

You may not receive a direct benefit from participating. However, it is hoped that through your participation, the researcher will learn more about LPCs' experiences when working with women in midlife with depression and will be able to share this information with other mental health providers.

Confidentiality

All data obtained from participants will be kept confidential and will be reported using pseudonyms that disguise participant identity. The recordings and transcripts will be kept on a computer using a strong password.

Compensation

There is no compensation for this study.

Participation

Participation in this research study is completely voluntary. You have the right to decline to respond to items and/or withdraw at any time without consequence. If you desire to withdraw your participation after submitting your survey responses, or at any time before, during, or after an interview, please notify the researcher using the contact information below.

Questions about the Research

If you have any questions or concerns about the nature of this study, please contact the researcher

Carla Tovar Pestana, 210-317-5280, ctovar5@stmarytx.edu or dissertation chairperson Melanie Harper 210-438-6400, mharper@stmarytx.edu.

IRB Contact Information for Questions about your Rights as a Research Participant

If you have any questions about your rights as a research subject or concerns about this research study, please contact the Chair, Institutional Review Board, St. Mary's University at 210-436-3736 or email at IRBCommitteeChair@stmarytx.edu.

ALL RESEARCH PROJECTS THAT ARECARRIED OUT BY INVESTIGATORS AT ST. MARY'S UNIVERSITY ARE GOVERNED BY THEREQUIREMENTS OF THE UNIVERSITY AND THE FEDERAL GOVERNMENT.

(If you would like a copy of this document, you can copy and paste it into a file on your computer.)

I have read, understood, and been given an opportunity to print a copy of the above consent form, and desire of my own free will to participate in this study.

- ○ Yes
- ○ No

Q2 DEMOGRAPHIC QUESTIONNAIRE

Are you a Licensed Professional Counselor (LPC), not an LPC Associate?

- ○ Yes
- ○ No

Q3 Have you counseled women in midlife (40 to 65 years old) who have or had depression symptoms?

- ○ Yes
- ○ No

Q4 How do you want to participate in this study? (The researcher who will conduct the interviews is fully vaccinated against Covid-19.)

- ○ In-person
- ○ Internet

Q5 How do you want to be contacted by the researcher for the first interview?

- ☐ Phone number: _____
- ☐ Email address: _____
- ☐ Preferred day/time to be contacted: _____

Q6 What is your gender?

- ○ Male
- ○ Female
- ○ Non-binary / third gender

Q7 How old are you?

_____

Q8 What is your racial/ethnic background?

_____

Q9

What is your highest level of education?

- Master's
- Doctorate

Q10 Do you have a Master's and/or Doctoral degree from a Program Accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP)?

- Yes, a Master's
- Yes, a Doctorate
- Yes, Master's and Doctorate
- None

Q11 Which is your theoretical orientation?

_____

Q12 How many years have you been an LPC?

_____

Q13 Where do you work?

- ○ For-Profit Agency
- ○ Non-Profit Organization
- ○ Employee Assistant Program
- ○ Private Practice
- ○ Substance Abuse Facility
- ○ Inpatient Facility (other than substance abuse)
- ○ Other

Q14 Can your clients afford to see other mental health providers and afford their treatments?

	A few of my clients	Most of my clients	All of my clients
Afford to see other mental health providers	○	○	○
Afford their treatments	○	○	○

Q15 Do your clients have health insurance, and does it cover their treatments?

	A few of my clients	Most of my clients	All of my clients
Have health insurance	○	○	○
Health insurance covers their treatments	○	○	○

Q16 If selected, I will contact you within a week to schedule; if you would like to contact me sooner, feel free to email me at ctovar5@stmarytx.edu.

This now completes your survey.

Thank you.