

**BETWEEN A ROCK AND A HARD PLACE: A QUALITATIVE  
INVESTIGATION OF THE EXPERIENCE OF ACCESSING COUNSELLING**

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## ABSTRACT

Clients' experiences in attempting to access counselling help have rarely been studied. As such, a full and clear understanding of clients' experiences with accessing services, as well as identification of the barriers encountered by clients and clients' ideas about what would make accessing more comfortable, have eluded researchers. Typically, the research focus has been quantitative investigations of the no-show phenomenon, whereby clients fail to arrive at pre-booked counselling appointments. Such studies have left 24% of the variance in the unexplained "other" category. More recently, researchers have begun to question whether or not mental health stigma impacts counselling attendance. The present study sought to describe the experience of individuals who self-identified as having booked a counselling appointment within the previous 8-months and then had failed to attend. A basic interpretive qualitative research design (Merriam, 2002) was employed for the purpose of describing and understanding this phenomenon, with special emphasis given to identifying possible barriers to accessing counselling. Interviews with four middle class Caucasian adults aged 27-33; two of whom had accessed counselling previously and two of whom had not, were conducted. Transcripts were analyzed in terms of a shared meaning and descriptive categories (Kearney, 2001). Findings revealed that stigma, self-stigma, several fears, and some counselling practices functioned as barriers. However, participants also expressed positive emotions associated with reaching out and accessing counselling help and a desire for information about what to expect in counselling, whether they had accessed previously or not. The beginnings of a pattern associated with accessing counselling are discussed and implications for counselling practice and future research are described.

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To my parents and family: for your unconditional love and support, for raising me to be kind, caring and thoughtful, thank-you so very, very much. I am blessed to have you as my family.

## **DEDICATION**

This thesis is dedicated to my husband, Andrew, and to our children, Samantha, Bethany, Ryan and Thomas.

Thank-you Andrew and for all you give to me each and every day; for hanging in there with me throughout the process of completing my thesis; for sharing your life with me. I so look forward to moving together in chosen directions now that this process is completed!!

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## CHAPTER 1: INTRODUCTION

Once deemed “crazy” and considered “unacceptable,” those with mental health concerns were hidden away in institutions and publicly shunned. Mental health, or a lack thereof, was one of those things people “didn’t talk about.” The issue of mental health care was brought to public attention throughout the 1950’s and 60’s with the development of new medicines and the implementation of de-institutionalization (Baron & Byrne, 1997). This governmental recognition of the need for more comprehensive community mental health care meant that the community mental health center (CMHC), or counselling agency, became commonplace. Today, many such centers exist in our cities and towns, and some even advertise in print and radio media.

The need to consider both physical and mental health is widely recognized and accepted today as demonstrated by the explosions in both wholistic and alternate approaches to medicine and the booming focus on physical fitness practices which incorporate a mind-body connection such as yoga and tai chi. Yet while there appears to be public acceptance around the idea that mental and emotional health are legitimate concerns, requiring our care and attention, many individuals still struggle to access counselling when faced with mental and emotional health care challenges (Paolillo & Moore, 1984; Peeters & Bayer, 1999; Corrigan, 2004; Vogel, Wade & Hackler, 2007).

The experience of reaching out for help and booking an initial counselling appointment, then not showing up for it, is not at all uncommon. According to some estimates, only 11% of individuals experiencing a diagnosable problem seek psychological services, while fewer than 2% of those struggling with problems that do not meet diagnosable criteria seek help (Andrews, Issakidis, & Carter, 2001). Of those

that do seek help, some 30% to 75% fail to keep an initial appointment, while 20% to 60% do not arrive for follow-up appointments (Smoller, McLean, Otto, & Pollack, 1998; Westra, Boardman & Moran-Tynski, 2000). Within the human service industry, the term “no-show” has evolved in reference to the phenomenon in which a client books, then does not arrive for, a first, or consecutive, counselling appointment. While reliable rates have not yet been established, various studies report no-show rates at counselling and mental health care centers of between 11% to 50% (Allan, 1988; Lesaca 1995); 15% to 40% (Lowman, DeLange, Roberts, & Brady, 1984); 20% to 50% (Cheston 1991; and 13-45% (Pulaakos & Morrison, 1994). Hochstadt and Trybula (1980) quote rates of from 20% to 44% on average. In their study aimed at reducing missed initial appointments at a CMHC, they had no-show rates of 55% (for the non-intervention control group) and a steady no-show rate at the agency of 33%.

Costs to clients associated with this phenomenon include working days lost, lost opportunities for care, and continued suffering (Nolan & Badger, 2005). Peeters and Bayer (1999) reported findings that the presenting complaint remains present up to 15 months after the no-show incident for 78.7% of clients who book, but do not arrive for their appointments. Lowman et. al. (1984) reported an average time elapsed between initial awareness of a problem and seeking help of 4.2 years for both no-show and therapy clients over many studies; 82.5% of participants in their own study waited over a year before seeking help. That’s a long time to be suffering needlessly if something can be done about one’s concern. For humane reasons alone, it is important to learn why those in need of help do not show up and what can be done to reach them.

Beyond the humane reasons for better understanding clients’ difficulties in

accessing counselling is the fact that the no-show phenomenon represents a considerable problem for mental health care providers as well. There are costs associated with it. Counselling agencies often face shrinking resources and frequent budget cuts (Dubinsky, 1986; Pulakos & Morrison; 1994), while dealing with increasing caseloads and demand (Hochstadt & Trybula, 1980), resulting in the need to provide services while overburdened and understaffed (Paolillo & Moore, 1984). As such, frequent failure to access previously booked appointments represents a serious drain on often scarce resources as well as a misappropriation of mental health resources that could be spent more efficiently (Smoller et al., 1998). Therapists' time spent in preparing for and waiting for clients who do not arrive could be spent more advantageously in working with a present, comfortable and willing client.

To date, research on the no-show phenomenon has primarily been of two types: (a) that attempting to predict no-shows on the basis of client/patient demographics, such as age, sex, marital status, socio-economic status, type of referral (Allan, 1988; Cheston, 1991; Peeters & Bayer, 1999) and (b) that attempting to enhance client/patient attendance via delivery system manipulations, such as mailed or telephone reminders and no-show fees (e.g., Cheston, 1991; Hochstadt & Trybula, 1980; Lesaca, 1995; MacLean, Greenough, Jorgenson & Couldwell, 1989; Westra, Boardman & Moran-Tynski, 2000). Recently a third type of research has been added to the mix: exploring the manner(s) in which clinicians respond to clients who miss their appointments, i.e., whether, how, and when they contact clients who do not show up (Smoller et al., 1998). More recently still, researchers have begun to look at client perceptions, including stigma, around mental health to explain their difficulties in accessing counselling (Corrigan, 2004; Corrigan,

Watson & Barr, 2006; Yen, Cheng Fang, 2005 ; Kelly & Jorm, 2007; Rusch, Angermeyer & Corrigan, 2005; Vogel, Wade & Hackler, 2007).

While no conceptual framework has currently been forwarded in the literature to explain clients' difficulty in accessing counselling, including the no-show phenomenon, I speculated that Festinger's (1957) Cognitive Dissonance Theory or perhaps Blau's (1964) Social Exchange Theory may be illuminating in terms of framing the study's findings.

Cognitive dissonance is discord between behavior and belief. It is an unpleasant internal state that occurs when individuals discover inconsistencies between two of their attitudes or between their attitudes and their behavior. Based in social psychology, cognitive dissonance theory highlights individuals' drive to maintain concordance and minimize distress. It suggests that when individuals experience dissonance, they are motivated to reduce it through one of three mechanisms: (a) change attitudes or behavior so that these are more consistent with behavior (b) acquire new information that supports one's new attitude or behavior (c) trivialize the attitudes/behaviors in question, concluding that they are not important, thus minimizing distress (Festinger, 1957).

Cognitive dissonance theory may prove relevant to the research, especially if clients experience discrepancies between negatively held attitudes towards counselling (and/or those who access it) and their own behavioral attempts to enter the counselling realm. Research in the area of persuasion and attitude change, as they relate to cognitive dissonance theory, may be applicable to the no-show phenomenon if individual's attitudes or beliefs about counselling are problematic in terms of their seeking counselling.

Social exchange theory, like cognitive dissonance theory, comes from social psychology, and suggests that modification of social behavior (in this case following through on accessing counselling) may occur if perceived and expected reinforcements (benefits) are increased relative to expected costs (Blau, 1964). The theory suggests that reinforcements, or benefits, need only be perceived or expected, in order for motivation to be affected, and therefore behavior (Blau, 1964). This is important for first-time clients since many actual reinforcements will not be delivered until attendance occurs. While social exchange theory has not been researched in relation to accessing counselling or the no-show phenomenon, it may be applicable if individuals hold negative perceptions about the efficacy or experience of being involved in counselling therapy, especially as it suggests that expectations for a positive outcome can lead to increased willingness to access and greater follow-through with same.

A better understanding of the difficulties clients experience in attempting to access counselling will help us to know why people who are considered, by themselves or others, to suffer from a mental health problem do not keep a previously made appointment. Such knowledge, in turn, may lead to more effective ways of reaching those in need. Because the first appointment is a crucial step in the delivery of services to clients, it is important to understand clients' experiences in order to facilitate their arrival for that first appointment.

Finally, a deeper understanding of the no-show phenomenon may facilitate the determination and development of a reasonable standard of care in regard to the manner in which clinicians respond to no-shows. Toward all of this, however, a logical first step is to gain a better understanding of the no-show experience itself. Such an understanding

is, in fact, the goal of this study. We know that a sound therapeutic relationship promotes change. In fact, Miller, Duncan and Hubble (in press) inform us that a full 30% of the variance in successful treatment or change is due to the strength of the therapeutic relationship alone. Miller et al. (in press) cited findings from a large, landmark, methodologically sound comparative study of cognitive, interpersonal, and antidepressant therapies. Findings indicated that the strength of the therapeutic relationship was a better predictor of outcome than either the type of treatment received or the severity of the presenting problem. However, it is impossible to establish such a relationship in the absence of the client. Therefore, for those no-show clients whose problem continues (versus abates) beyond the date of their missed initial session, and for those who cannot bring themselves to book a first appointment, it is imperative that we discover how to help get them through the door; that we come to understand their experience in order to find ways to support their finding a soft spot between the rock and the hard place that accessing mental health services seems to represent to too many.

Untreated or poorly managed mental health concerns such as depression or anxiety have multiple consequences, which include suicide, high rates of sick leave, frequent job changes, lethargy, marital disharmony and poor physical health (Nolan & Badger, 2005). Yet very little research has been focused on exploring clients' experiences, whether positive or negative, of attempting to access mental health care, particularly from a qualitative perspective. While it has commonly been held that individuals with mental health concerns such as depression are discriminated against, Kelly and Jorm (2007) stated "No up-to-date research exists on discrimination experienced by people with mood disorders" (p.13). Peeters and Beyer (1999) declared

the first time no-show “a frequently encountered but rarely studied phenomenon” (p.323). Allan (1988) pointed out that it is vital to explore and understand specific interactions which may impede or facilitate successful referrals by self or other.

There is evidence to support the contention that people with mental health concerns can achieve success in treatment and return to work in relatively short periods of time if they develop collaborative relationships with health care professionals and receive quality information (Miller & Duncan, in press; Nolan & Badger, 2005). Given that depressive disorders are set to become the second most frequent cause of ill health worldwide by the year 2010 (Nolan & Badger, 2005), it is critical that we learn how to facilitate our clients’ comfort in fully accessing our services so that we can provide the care they need and desire.

### *Current Study*

The current study focused on the experience of individuals who had called to book a counselling appointment and then not arrived for that appointment. The study aimed to explore individual clients’ experiences with attempting to access counselling after previously booking and subsequently failing to arrive at a counselling appointment. The purpose of the study was to describe and understand the experience of individuals accessing counselling, with special attention given to participants’ thoughts and feelings about mental health care and those who access it, as well as to the intake experience and any specific interactions which may have impeded or facilitated participants’ successfully accessing the counselling help they desired. The hope is that this study illuminates both areas of difficulty and areas of promise, or comfort, for clients attempting to access counselling services.



A qualitative research design was most appropriate, given the study's exploratory nature (e.g., Morse & Richards, 2002) and focus on obtaining rich descriptive data (Merriam, 2002). The research question that guided this inquiry was: "What is the experience and meaning of attempting to access counselling help?"

### *Definitions*

The following terms are used throughout the thesis as defined below:

No-Show: The booking of a counselling appointment followed by failure to arrive at the appointment

Accessing: Either making contact with the Intake counsellor to book an appointment in the case of those participants who did not actually arrive at their appointments, but who *did* receive *some* validation and symptom relief via the intake counsellor as described by themselves OR arriving at one's pre-booked or walk-in counselling session for any one individual counselling concern at any one point in time.

Mental health concern: a diagnosable mental illness such as one might find in The Diagnostic and Statistical Manual of Mental Disorders or DSM-IV-TR (American Psychiatric Association [APA], 2000), e.g., dysthymia; depression; generalized anxiety disorder OR any concern of daily living NOT listed in the DSM-IV-TR (APA, 2000) that impacts one's overall mental health and happiness / daily functioning e.g., family communications and relations problems, debt worries, parent-teen conflict, marital problems, parenting/behavioral concerns.

## CHAPTER TWO: LITERATURE REVIEW

This chapter provides a review of the literature to date on client difficulties in accessing counselling as well as on client perceptions of mental health. First, research on failure to arrive at pre-booked appointments is described, including rates, reasons, attempts at change, and clinician management of this “no-show” phenomenon. Second, a review of recent research on stigma associated with mental health is delineated. Finally, two theories which may prove useful in explaining clients’ difficulties in accessing counselling, as well as in helping to positively change client perceptions of mental health (where these are negative) is described.

### *The No-Show Phenomenon: Rates, Reasons, and Attempts at Change*

No-show rates are important to community mental health centers and counselling agencies because the associated costs affect both the agency, especially when resources are in short supply, and its clients, who may not receive the care they both need and desire (Hochstadt & Trybula, 1980; Shih, 1997).

Beyond being an interesting mystery, the no-show phenomenon, because it represents a considerable problem for mental health care delivery systems, does so as well for the communities these systems serve (Cheston, 1991; Lesaca, 1995; Westra et al., 2000). When large numbers of clients don’t show up for their scheduled appointments the result may be counsellors wasting time preparing and waiting for them; interview rooms (which may be in short supply) being reserved and not used; and other prospective clients being placed on waiting lists unnecessarily because counsellor’s schedules are filled (MacLean et al., 1989; Shih, 1997). Funding may also be negatively affected by no-shows, especially when based on hours of direct client contact (Allan,

1988), as administrators are then asked to provide adequate staff coverage despite an uncertain and fluctuating client caseload (Lesaca, 1995).

The clinician-client relationship may be impaired by no-show behavior (Meyer, 2001; Smoller et al., 1998). In ongoing treatment, no-shows represent an interruption in continued care for the client and a loss in valuable treatment time for both clients and their therapists (as well as an increase in clerical costs due to the need for repetitive re-scheduling of appointments) (Lesaca, 1995). The frequent booking of a first-time appointment followed by a no-show may adversely affect clinician-client relations. Smoller et al. (1998) pointed out that clinicians are increasingly expected to adhere to a standard of care, which may at times be difficult to discern, and that failure to do so may have medical-legal consequences. In the absence of an established standard of care regarding follow-up of no-shows, the phenomena may be problematic due to the potential harm associated with delayed follow-up (e.g., suicide of a depressed client).

While reliable rates have not yet been established, various studies report no-show rates of between 11% to 50% (Allan, 1988; Lesaca 1995); 15% to 40% (Lowman et al., 1984); 20% to 50% (Cheston 1991) and 13-45% (Pulaakos & Morrison, 1994). Hochstadt and Trybula (1980) quoted rates of from 20% to 44% on average. Their study, which aimed to reduce missed initial appointments at a CMHC, found no-show rates of 55% for the non-intervention control group and a steady no-show rate of 33% at the agency.

Previous research in the area of the no-show phenomenon has been almost, if not entirely, of a quantitative nature. Three types of studies make up the core of this research: those seeking to predict no-shows on the basis of client demographics and

social factors; those seeking to reduce no-show rates through various service delivery manipulations; and those seeking to examine the format and ethical underpinnings of clinician response to no-shows.

### *Prediction Studies and Client Demographics*

Prediction studies have looked at such client demographics as age, gender, culture/race, socio-economic status, marital status, presence and ages of children, single parenthood, education, and employment (Allan, 1988; Cheston, 1991; Dubinsky, 1986; Lowman, et. al., 1984; Mooney & Johnson, 1992; Noonan, 1973; Orme & Boswell, 1991; Paolillo & Moore, 1984).

The research in this area yields conflicting findings. Mooney and Johnson (1992), in a study on rural mental health appointment adherence, found no significant relationship between no-show behavior and whether clients were individuals or couples, males or females. Allan (1988) found that no-show rates for women and younger clients (20-39 years) slightly exceeded those for men and older clients (60-79 years). Yet Cheston, (1991) building upon work by Raynes and Warren in 1971, found males were more likely to not show up. She reported findings that blacks, males, and those under 40 years were less likely to arrive at a previously booked intake appointment (Cheston, 1991). Orme and Boswell (1991) found that patient-therapist gender matches were related to the probability of children (but not adults) showing for intake interviews, with those scheduled to see an interviewer of the opposite gender being more likely to arrive.

Orme and Boswell (1991) found no significant relationship between age and no-show behavior. Paolillo and Moore (1984) found that non-compliant appointment clients tended to be younger, Caucasian, and unemployed, while appointment-compliant clients

tended to be older, non-Caucasian, employed full-time, and covered by insurance, while Cheston (1991) reported no correlation between clients not showing up for an appointment and levels of socio-economic status, occupation or education. Yet others have noted these as significant (Paillilo & Moore, 1984; Rusch, Angermeyer & Corrigan, 2005). Dubinsky (1986) reported that the unemployed are more likely not to show up than are the employed, though he found no significant relationship between no-show behavior and sex, age, marital status, years of schooling, or income. Weighill, Hodge and Peck (1983) reported that clients from a lower socio-economic status are less likely to keep a previously booked appointment. However, other researchers found no such relationship (Gaines, 1978; Gould, Paulson & Daniels-Epps, 1970; Noonan, 1973).

Lowman et al. (1984) in a study of clients seeking family therapy at a CMHC (N=2358) found that those who did not follow through with treatment tended to have children older than 8 years of age, to have more behavioral and fewer personality problems, to have demonstrated problems earlier than client groups, and to have parents who were slightly older. Orme and Boswell (1991) found no relationship between marital status, age, client gender, interviewer gender, or client-interviewer gender pairing and dropping out prior to an initial interview; though among adults seeking treatment for themselves, those with children were significantly more likely to show up than were those without children.

As noted by several researchers themselves, and as demonstrated by the above findings, it appears that client demographic variables have demonstrated little consistent ability to predict no-show behavior (Cheston, 1991; Kluger & Karras, 1983; Orme & Boswell, 1991).

*Prediction Studies and Other Variables*

Other factors assessed to predict no-show behavior include referral source, presenting complaint / type of disorder, previous inpatient treatment, degree of impairment, length of time between initial contact and first appointment (wait time), fees or cost, lack of transportation, lack of child care, anxiety about the appointment / uncertainty of what to expect, location of agency, clarity of presenting issue /goal, vague motivation, magical expectations, forgetfulness, dissatisfaction with first call, dissatisfaction with application procedure, spontaneous resolution of presenting problem prior to initial appointment date, attainment of help elsewhere, and ‘other’ which indicates that none of the above explain a no-show event (Cheston, 1991; Folkins, Hersch & Dahlen, 1980; Gould et al., 1970; Lowman et al., 1984; Orme & Boswell, 1991; Noonan, 1973; Peeters & Bayer, 1999).

Several researchers have investigated the effect of referral source on no-show rates with the outcome that these have been shown to affect no-show rates by some researchers but not by others. Allan (1988) studied referral source impact on no-show rates using 8 referral source categories; self, family, medical doctor (MD), public health nurse (PHN), school, legal, agency, other. The highest no-show rate as a function of referral source was noted to be ‘other’ followed by PHN and MD, with the lowest no-show rates being from another agency, followed by school and self respectively (Allen, 1988). Gould (1970) noted a positive correlation between referral source and no-show activity, with the least number of no-show events taking place when the referral is from a ‘convincing source,’ that being a doctor, lawyer, or spouse. Yet other studies found no significant relationship between referral source and no-show behavior (Gaines, 1978;

Noonan, 1973; Raynes & Warrren, 1971).

Cheston (1991), in her book on making effective referrals, points out in a chapter on decreasing the probability of no-show referrals that certain problem areas tend to yield no-show activity. Citing Raynes and Warren (1971), Cheston noted that clients referred for counselling to work through grief and loss were less likely to show up for the first appointment than clients referred to counselling for other problems. Another presenting problem that Cheston described as 'resistant' to referral is what clients may refer to as 'having a nervous breakdown.' This, she feels is due to the likelihood that clients who indicate they are experiencing a nervous breakdown may actually be experiencing an episode of histrionic behavior, which typically subsides quickly, such that the presenting problem then, has 'spontaneously resolved' prior to the initial appointment time.

In a pilot study conducted at a mobile satellite CMHC in rural Hawaii, Allan (1988) examined no-show behavior in relation to presenting problem and referral source. Presenting problems were categorized generally into 8 groups: psychosis, depression, 'nerves' (possibly a local slang for anxiety?), family, school, legal and anti-social, drugs and alcohol, and other. While Cheston (1991) found that "nerves" as a presenting problem was 'resistant' to referral, Allan (1988) found that no-show rates were actually lowest among clients presenting with "nerves" and with family problems, while they were highest for clients with alcoholism and psychosis. Although Allan and Cheston's findings differ from each other, Allan's findings are congruent with both Dubinsky's (1986) and Paillilo and Moore's (1984) findings that alcoholism appears to predict appointment non-compliance.

Paolillo and Moore (1984) also examined various demographic and psychiatric

signs and symptoms in relation to the no-show phenomenon. All participants in their study had diagnoses of neuroses, personality disorder, alcoholism, or transient-situational disturbance according to the Diagnostic and Statistical Manual, Second Edition criteria. Participants had already attended an initial assessment appointment, with many of them receiving their diagnoses at that appointment. Findings indicated that the strongest influencing factors in appointment-compliant behavior were diagnoses of obsessive-compulsive disorder, anxiety and paranoia, while the strongest influencing factors in non-compliant appointment-keeping behavior were alcoholism and previous mental health care (Paolillo & Moore, 1984). Lowman et al. (1984) found that many of those who did not arrive for an initial, previously booked intake appointment had sought treatment elsewhere.

Carpenter, Morrow, del Gaudio, Andrew and Ritzler (1981) reported that clients previously treated for mental health concerns were more likely to show for initial appointments than were those not previously treated. However, Raynes and Warren, (1971) found no relationship between previous mental health care involvement and no-show activity. Dubinsky (1986) echoed this finding when reporting no significant relationship between no-show activity and prior treatment, type of treatment, diagnosis (apart from alcoholism), or fee.

Cheston (1991) indicated that clarity of presenting issue / goals are related to no-show activity. Citing Gould et al. (1970), she noted that those clients who have the most clearly defined reasons for seeking help tend to show up for the first appointment, while those with the vaguest reasons tend not to show.

Interestingly, Noonan (1973) noted that among clients indicating the reason for



their no-show event, all expressed anxiety about what to expect. They also all indicated that they were still considering accessing counselling. Participants in Noonan's study were 64-adult clients at a University-supported treatment clinic over a one-year period (15% of self-referrals for that year). His most frequent finding was that clients who did not show up had made a treatment contact without a minimal commitment to fulfill the responsibility that the contact implied, what he termed "vague motivation" (Noonan, 1973).

Overall and Aronson (1963) reported that clients with magical expectations of an initial interview could, following their first appointment, engage in no-show behavior if their expectations were not met. Mooney and Johnson (1992) found no significant differences between no-show behavior and initial or on-going contacts, i.e. the no-show rates were the same for both first-time clients and for continuing clients.

While fees, lack of transportation and lack of child care have been cited by clients as reasons for not showing up, none of these factors has been found to be significantly related to no-show behavior (Dubinsky 1986).

The most frequently cited significant finding in relation to no-show behavior was long wait-times (Allan, 1988; Cheston 1991; Folkins, Hersch, & Dahlen, 1980; Lesaca 1995; Hochstadt & Trybula, 1980; Orme & Boswell, 1991; Peeters and Bayer, 1999; Pulaakos & Morrison, 1994; Raynes & Warren, 1971; Westra, Boardman & Moran-Tynski, 2000). Yet Gaines (1978) in a cross-cultural setting, found no significant association between failure to show and either SES, wait-time, or referral source. Several other studies have had similar findings around wait-time, suggesting there is no relation to no-show behavior (Gould et al., 1970; Noonan, 1973; Shih, 1997).

Interestingly, 24% of the variance in all prediction studies lies within the “other” category indicating that researchers, to date, have not yet captured the essence of clients’ difficulties in accessing counselling.

In summary, most of the variables investigated in relation to initial appointment failure have not been consistently found to be related to this phenomenon. Together with the conflicted findings just mentioned, this lack of clarity indicates a need for further study in order to learn exactly what clients struggle with in terms of accessing counselling. To date these “other” reasons or experiences remain unexplained.

#### *Reduction Studies*

Reduction studies have attempted to minimize no-show rates through service delivery system manipulations such as using reminder letters or postcards (Maclean, Greenough, Jorgenson, & Couldwell, 1989; Moser, 1994; Swenson & Pekarik, 1988), using phone reminders (Hochstadt & Trybula, 1980; Lowman et al., 1984), decreasing wait times (Folkins, Hersch, & Dahlen, 1980; Larsen, Nguyen, Green & Attkisson, 1983), enacting a penalty fee for no-shows (Bader, 1997; Lesaca, 1995; Wesch, Lutzker, Frisch & Dillon, 1987), providing pre-assessment information to clients through videotape, letter, brochure, or preparatory interviews / orientations (Larsen et al., 1983; Swenson & Pekarik, 1988), increasing client “buy-in” by having clients exert greater effort in obtaining appointments i.e., having clients fill out and return forms *or* supply a return phone-call prior to appointment setting (Larsen et al., 1983; James & Milne, 2003; MacLean et al., 1989; Palmer & Hampton, 1987; Pulakos & Morrison, 1994; Swenson & Pekarik, 1988; Westra, 2000).

Swenson and Pekarik (1988) examined the effectiveness of mailed reminder

letters and orientation letters in reducing missed initial appointments at a community mental health center. They did this by utilizing four experimental groups and sending letter prompts to their 150 participants either three days or one day prior to the scheduled appointment, or an orientation letter either three days prior or one day prior to the appointment. Letter prompts simply reminded clients about the appointment while orientation letters provided information about what clients could expect upon arrival in addition to reminding them about the appointment. Swenson and Pekarik (1988) found that clients receiving orientation letters one day prior to appointment had a significantly lower no-show rate (17%) than did the control group (43%). No-show rates for the other treatment groups were not significantly different than the control group. It appears that some orientation as to what clients can expect upon arrival at the counselling center may reduce misconceptions and /or anxiety, thus allowing for greater comfort around coming in.

Similarly, Moser (1994) measured the effectiveness of postcard reminders in addressing the no-show rate at a residency-based family practice center using a pre and post-test design. Moser found no significant change in patient arrivals, cancellations, or no-shows after the post-card reminders were implemented.

MacLean, Greenough, Jorgenson and Couldwell (1989) compared four types of reminder letters to each other and to a system whereby forms were required to be completed and returned prior to appointment setting at a provincially funded community mental health care center. The 106 participants were assigned to either a) a change-slip reminder group, requesting notification if appointment time needed to be changed via a returnable slip portion of the letter ; b) a warning reminder indicating the possibility of

losing their place on the wait list should two appointments be missed; c) a change-slip-warning reminder which combines both the previous interventions, or d) a usual reminder group which received the typical reminder letter used by the clinic. Of these participants, several were also assigned to a 'Forms Required' group (n=93) and were required to fill out a set of Family Information forms consisting of medical, school, and family history as well as information about treatment goals prior to appointment-setting. Findings indicated that use of the family forms was significantly better than use of other letters in reducing the no-show rate. The no-show rate for the 'forms required' participants in the experiment (those who also received letters) decreased to the point that no no-shows occurred in this group over the 4 months and 2 weeks of the study.

Hochstadt and Trybula (1980), in a study at a Chicago CMHC, assessed the efficacy of a telephone reminder in reducing the rate of no-show events (N = 88). Participants were assigned to one of four groups: a no intervention control group, a reminder letter 3 days pre-appointment group, a phone-call 3 days pre-appointment group, and a phone-call 1 day prior to appointment group. Results indicated that there was a significant reduction in the no-show rate for the group receiving the phone-call 1 day prior to appointment. This latter group had a no-show rate of 9% compared to 32% in the other experimental groups and 55% in the non-intervention control group.

The counselling agency of Family Service Saskatoon, this writer's graduate practicum site, performed a service delivery manipulation in 2000 in which service was offered either the day of, or day after, clients' intake calls. The agency fully expected to see a reduction in their no-show rate which sat at approximately 25% at that time, based upon research cited above. Very surprisingly for staff at FSS, no change was evidenced

in the no-show rate as a result of this strategy. While not overtly advertised, FSS occasionally provides child care and transportation via taxi or bus to needy clients. It is not clear at present whether or not this practice impacts no-show behavior.

Orme and Boswell (1991) studied adult individuals seeking individual counselling at an urban, Midwestern CMHC over a one-year period (N=721). They noted that while wait time was significant, the relationship between wait-time and possibility of showing up for a pre-booked initial intake interview was not directly inverse: a higher percentage of clients with appointments booked from 0 - 3 days away tended to show than did those with appointments booked from 4 - 6 days or from 7- 9 days away, but clients with appointments more than 10 days away showed up in more significant numbers than did those in any of the other wait-time categories, including 0 – 3 days away.

Wesch et al., (1987) assessed the implementation of a service fee on no-show rates at a large, urban, US student health center. In order to manage budget cuts at the university, administrators implemented a \$3.00 fee for all visits for health care. Results indicated that the \$3.00 administrative fee significantly reduced no-show rates at the student health center. Lesaca (1995) assessed the influence of a \$30.00 no-show fee on patient compliance at an urban out-patient mental health clinic in Pittsburgh, PA (N=69). Findings indicated that the no-show rate was decreased from 20% pre-intervention to 9.27% post-intervention. Bader (1997) noted cultural differences in acceptance of no-show fees. He spoke of a Norwegian colleague whose clients accepted such fees as a simple matter of course, seeing them as normal business practice. Bader (1997) highlighted and compared this cultural difference with his own experience that American

clients definitely minded such fees, perceiving them as undermining the therapeutic alliance of trust and goodwill.

Swenson and Pekarik (1988), as mentioned above, have demonstrated the helpfulness of orientation information when given to clients prior to initial appointments. This practice can significantly reduce no-show rates in mental health settings. Larsen et al. (1983) conducted an innovative study in which they gave all callers an appointment within 4 days of contact and had the assigned therapist call the client to confirm the appointment. The intent was to both remind them of their appointment and to provide them with a direct verbal contact with the therapist prior to intake. Findings revealed that instituting shorter waiting periods and arranging for prompt verbal contact between prospective clients and therapists significantly increased the likelihood that clients would keep their appointments.

In sum, several researchers have demonstrated the efficacy of various interventions to reduce no-show rates. These include interventions such as increasing client “buy-in” by having clients complete forms prior to intake appointments and / or calling the agency to confirm interest in receiving services (Larsen et al., 1983; McLean, et. al. 1989; Pulakos & Morrison, 1994; Shih, 1997; Westra, 2000).

### ***Clinician Response to No-Show Behavior***

More recently Smoller and colleagues (1998) looked at how clinicians respond to no-shows. Clinicians, including psychologists, psychiatrists, social workers and internists (N=356), were asked whether or not they responded to clients who did not arrive for first appointments; under what circumstances they did so; at what point following failure to arrive did they do so; and how frequently or commonly they did so. The manner in

which the clinicians made contact (if they did so) was also noted. Findings suggested a wide range of variability in clinician response to no-shows. This is not surprising, given there is no stated “standard” of care around the no-show phenomenon. Smoller et al. (1998) found different approaches to no-shows based upon the area in which the clinician worked, as well as in the presenting problem. For example, when clients presented with a high degree of risk for suicide, for example, clinicians, no matter their area of practice (e.g., social work, psychiatry), were generally more likely to attempt contact with the client following a no-show event. Smoller et al. (1998) demonstrated that, in general, psychiatrists were initially less likely to take steps to contact non-high-risk patients who missed appointments than were non-physician therapists or internists. However high-risk patients provoked a different response; whereas only 19% of psychiatrists would call a low-risk psychopharmacology patient, 78% would call a high-risk patient. Overall 78% to 90% of clinicians from the three groups would initially call a high-risk patient who missed an appointment. Further findings indicated that the initial response to no-shows across all patient groups, in both high-risk and low-risk categories, and by all clinicians was either to call or to wait; very few clinicians in any of the four categories exercised the option of writing or contacting others, such as family members. (Smoller et. al., 1998).

In sum, the majority of clinicians appeared to demonstrate a high degree of ethical behavior, and genuine concern for clients. As demonstrated by Smoller et al.’s (1998) findings, clinicians generally made contact with high-risk clients following no-show events. That the same is not true for non-high-risk clients, however, may be problematic - particularly if these clients are not making appointments due to fears around what to expect in therapy and / or fear of the counsellor / clinician him or herself.

It is clear that instituting a standard of care following no-show events, and including same in clinicians' codes of ethics, would be a most helpful step both in terms of providing clinicians with greater structure and clinical direction in the area of no-shows, and in terms of better aiding the client to access the help he or she desires.

### ***Stigma Associated with Seeking Counselling***

Researchers have recently begun to look at whether or not the stigma associated with mental health care, and with those who access it, might help to explain the phenomenon of clients failing to arrive for pre-booked counselling appointments or, moreover, clients failing to seek counselling help at all when experiencing mental health difficulties, whether diagnosable or not (Corrigan, 2004; Rusch, Angermeyer & Corrigan, 2005; Vogel, Wade & Hackler, 2007).

Stigma is defined as a mark or flaw resulting from a personal or physical characteristic that is viewed as socially unacceptable (Blaine, 2000). The stigma associated with mental health sees people who seek psychological services is undesirable and socially unacceptable (Blaine, 2000; Vogel, Wade & Haake, 2006). Corrigan (2004) pointed out that, in general, the public seems to disapprove of persons with mental illness significantly more than they disapprove of persons with physical illnesses. This is, largely because persons with mental illness are perceived to be in control of their illness and responsible for causing it, where those with physical illness are not. While it has long been held that those with severe mental illness suffered public stigma the recognition that those with less severe mental health concerns (e.g., depression, anxiety, family, or relational concerns) were also stigmatized is a recent viewpoint. Even more recent is the notion that such stigma might impact peoples' attitudes toward counselling,



and their willingness to access same (Corrigan, 2004; Dorrigan & Penn, 1999; Rusch, Angermeyer & Corrigan, 2005; Vogel, Wade & Hackler, 2007).

Two models of stigma are described in the literature: Corrigan (2004) identified three core cognitive and behavioral features associated with stigma: 1) stereotypes - negative beliefs about a group, such as incompetence, character weakness, dangerousness; 2) prejudice - agreement with the belief and associated negative emotional reactions such as anger or fear; and 3) discrimination - behavioral responses to prejudice such as avoidance by employers, landlords, general public in offering help. Self-stigma is the internalization of public stigma, which according to Corrigan (2004) involves the same three features except that the focus of the stereotype, prejudice, and discrimination is on the self versus the “other.” According to this model, a person who internalizes the public stigma associated with those who have mental health issues and / or who access counselling services, would (a) apply the stereotypic belief that he or she is “weak” or “lacking character” to him or herself (e.g., all people with mental illness are incompetent); (b) self-prejudice by agreeing with this negative belief and displaying the associated negative emotional reactions of anger, fear, anxiety, low self-esteem and low self-efficacy (e.g., I have a mental illness so I must be incompetent); and (c) self-discriminate by avoiding opportunities (e.g., Why should I even try to get a job, I’m an incompetent mental patient) (Corrigan, 2004; Vogel, Wade & Hackler, 2007). Corrigan (2004) asserts that in order to avoid the label and escape the stigma and the harm that it can bring, individuals deny their concerns and avoid accessing treatment.

As defined by Link and Phelan (2001), “stigma exists when elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that

allows these processes to unfold” (p. 63). Link and Phelan (2001) wrote from a sociological perspective thus stressing two societal aspects of stigma. First, as a pre-condition of stigma, differences between persons or groups must be noticed, regarded as relevant, and labeled accordingly. Second, for stigma to unfold its deleterious consequences, the stigmatizing group must be in a more powerful position than the stigmatized group (e.g., jokes about powerful politicians may be stereotyping but do not normally lead to discrimination and therefore are not ‘stigmatizing’ in the strict sense of the word). However, by virtue of being seen as “less than” or “incompetent” the counselling client is automatically on a lower rung of the power ladder than the non-counselling client; thus, the ‘power’ requirement for harm being done by stigma is fulfilled simply by virtue of one’s desiring counselling, which itself is perceived as indication of the existence of a mental health concern! In this view, it’s no wonder individuals struggle with accessing counselling help. This stigmatized viewpoint really does place individuals between a rock and a hard place. They cannot access help for concerns that may be as simple as communication skill development, relationship concerns, parenting concerns, or family functioning concerns without simultaneously accepting membership within the ranks of a stigmatized group.

Vogel, Wade and Hackler (2007) found that perceptions of public stigma contributed significantly to the experience of self-stigma, which, in turn, significantly influenced help-seeking attitudes and eventually help-seeking willingness. Vogel et al. (2007) echoed Corrigan’s (2004) viewpoint that self-stigma is the application of stereotype, prejudice and discrimination by individuals belonging to a stigmatized group *to themselves*. That is, individuals with self-stigma agree with the stereotype, *I’m weak*

*and unable to care for myself*, apply self-prejudice that leads to negative emotional reactions of low self-esteem and low self-efficacy; and self-discriminate, which leads to behavioral responses to prejudice such as failing to pursue work or housing opportunities or failing to seek help (Rusch, Angermeyer, & Corrigan, 2005). Yen (2005), in a study aimed at both assessing self-stigma in outpatients with depressive disorders and examining the factors related to self-stigma, found that clients with higher levels of depression and lower levels of education had higher levels of self-stigma. It may be that the greater the severity of a person's concerns, the greater the levels of self-stigma, though this has not been fully assessed.

In practical terms, researchers have found that people tend to report more public stigma surrounding counselling clients than non-clients (Corrigan & Penn, 1999). In scenario-based research, individuals described as seeking assistance for depression were rated as more emotionally unstable, less interesting, and less confident than those described as seeking help for back pain or those described as not seeking help for depression (Kelly & Jorm, 2007), and people labeled as having used counselling services have been rated less favorably and treated more negatively than those who were not labeled as having used counselling services (Sibicky & Dovidio, 1986; Ben-Porath, 2002).

Corrigan (2004) stated that many people who would benefit from mental health services opt not to pursue them, or fail to fully participate once they have begun.

Corrigan (2004) makes clear that one of the reasons for this disconnect is that people want to avoid the label of mental illness and the harm that it brings, so they decide not to seek, or fully participate in care in order to accomplish this label avoidance. Corrigan's findings are well supported by other studies that cite stigma as a reason why people do

not seek counselling and other mental health care services (e.g., Rusch et al., 2005; Vogel, et al., 2007; Yen, 2005). Vogel et al. (2007) indicated that self-stigma is a significant factor in both attitudes toward counselling and in willingness to seek counselling help for psychological and interpersonal concerns. They noted that it is important to communicate to the public that mental health problems do not need to be internalized as personal incompetence or as something shameful. Research suggests that people with concealable stigmas (e.g., non-heterosexual orientation, faith-based minorities) decide to avoid this harm by hiding their stigma or, alternatively, denying their group status and avoiding the institutions that mark them (i.e., mental health care) (Corrigan 2004). Label avoidance is cited as the most significant way in which stigma impedes care seeking (Corrigan, 2004).

In sum, stigma, both public and internalized, appears to represent a significant stumbling block for those seeking counselling help. This appears to be the case in terms of both individuals' attitudes toward counselling and in terms of individuals' willingness to seek help for their own mental health and interpersonal concerns.

#### *Consequences of Stigma*

Stigma has various consequences. Rusch et al. (2005) identified two deleterious consequences of stigma: 1) everyday life discrimination in interpersonal interactions and in stereotyping and negative images of mental illness in the media, and 2) structural discrimination such as private and public institutions that intentionally or unintentionally restrict opportunities of persons with mental health concerns. Corrigan (2004) saw the harm associated with stigma as diminishing self-esteem and robbing individuals of social opportunities. This view fits with Yen et al's (2005) finding that those with higher levels

of depression are frequently socially isolated by others, such that perceived higher levels of stigma are based on accurate perceptions of stigmatizing events and not due to cognitive distortion.

Corrigan (2004) pointed out that people with mental illness such as depression or anxiety are frequently unable to obtain good jobs or find suitable housing because of the prejudice of key members in their communities: e.g., employers and landlords. In addition, the criminalizing of mental health clients occurs when, for example police, rather than the mental health system, respond to mental health crises, thus contributing to the climbing prevalence of people with mental illness in jails (Corrigan, 2004). Furthermore, Corrigan (2004) argued that those labeled mentally ill are less likely to benefit from the depth and breadth of available physical health care services than people without mental illnesses. Combined, these examples suggest that public identification as an individual who is “mentally ill” can yield significant harm.

In addition, the indication that stigma prevents and / or prolongs individuals’ from seeking mental health care is itself a form of harm in that individuals’ suffering is prolonged or unending (Corrigan, 2004; Rusch et al., 2005; Vogel et al., 2007; Yen, 2005). Finally, because individuals do not live their lives in a vacuum, it follows that families, schools, and communities suffer as a result of this help-seeking avoidance as well.

#### *Attempts at Diminishing Stigma Associated with Mental Health*

There has been little research on the topic of diminishing the stigma associated with mental health care. Corrigan and Penn (1999) suggested that advocacy, government, and public service groups rely on three types of strategies to decrease the effects of

stigma. These include 1) protest (media watch kits, protesting examples of stigma against the mentally ill); 2) education (movies such as “As Good as it Gets”, “Nell”); and 3) promoting contact between those labeled ‘mentally ill’ and others without this label. An example of protest is seen in the 1995 protest by an advocacy group for the mentally ill of the release of a Paramount Pictures film entitled “Crazy People;” the name of the movie was changed due to pressure from the protest group (Corrigan & Penn, 1999).

Rusch et al. (2005) noted that in Germany, the United States of America (U.S.A.), and many other countries, consumer groups have actively targeted stigma in order to improve the lives of persons with mental illness. In the U.S.A., the National Alliance of the Mentally Ill, a group of family members and persons with mental illness, has been educating the public in order to diminish stigmatizing conditions. For example, they have pressed for better legal protection for persons with mental illness in the areas of housing and work. This group has successfully been used to protest against media representations of stigma in all 50 states (Rusch et al, 2005).

Corrigan and Penn (1999), in a paper devoted to utilizing research findings from the field of social psychology in attempts to decrease public stigma associated with mental illness, suggested that attempts in the areas of protest, education and promoting contact should be informed by social psychological research on minority groups. Specifically, people should not be asked to suppress their stereotypes as this tends to strengthen the stereotype as well as to take up mental energy that could otherwise be used to accept new information, which might help to diminish the stereotype. Corrigan and Penn (1999) also suggested that educational efforts should recognize that many stereotypes are resistant to change and that they are most pronounced when persons are

asked to consider whether minority groups members' traits, rather than their behaviors, are consistent with a stereotype (e.g., focusing change attempts on the behavioral aspects of stereotypes of mental illness are likely to be more successful than change efforts focused on the traits associated with the stereotype). Finally, Corrigan and Penn (1999) recommended that efforts involving contact could be enhanced by including equal status (e.g., persons with mental illness being introduced as 'just another person attending an event'), cooperative interaction (e.g., working together on a success-based project) and institutional support. (e.g., a school principal openly accepting and supporting a child with a mental illness).

As seen earlier, research to date indicates that the stigma associated with mental health can be applied to the self as self-stigma, and that in addition to the public stigma associated with mental health, self-stigma can lead to clients who avoid accessing counselling. Research on stigma has, to date, focused on understanding and defining these stigmas as well as on finding ways to diminish the public stigma associated with mental health. However, there has been no investigation of individual clients' experiences of accessing counselling, nor research that focuses on diminishing the self-stigma, versus the public stigma, associated with mental health. In fact, Kelly and Jorm (2007), in a study aimed at updating readers about current research on stigmatizing attitudes towards people suffering from mood disorders and on describing recent interventions in that area, stated that "no up-to-date research exists on discrimination experienced by people with mood disorders and very little research exists on interventions designed to decrease stigmatizing attitudes towards them." (p.13).. The present study aimed to explore individual clients' experiences with attempting to access

counselling after previously booking and subsequently failing to arrive at a counselling appointment. The hope was that this study would illuminate areas of difficulty for clients attempting to access counselling services.

***Theories That May Impact or Explain Client's Difficulties in Accessing Counselling***

*Cognitive Dissonance Theory*

Prior to beginning the research, two theories presented themselves as pertinent to the phenomenon under study: Cognitive Dissonance Theory (Festinger, 1957) and Social Exchange Theory (Blau, 1964). Both theories were considered in understanding the findings. Festinger's (1957) Cognitive Dissonance Theory is based on discord between behavior and belief. It describes an unpleasant internal state that occurs when individuals discover inconsistencies between two of their attitudes or between their attitudes and their behavior. Based in social psychology, cognitive dissonance theory highlights individuals' drive to maintain concordance and minimize distress. It suggests that when individuals experience dissonance, they are motivated to reduce it through one of three mechanisms: (a) changing their attitudes or beliefs so that these are more consistent with their behavior (b) acquiring new information that supports the attitude or behavior, or (c) trivializing the attitudes/behaviors in question and concluding that they are not important, thus minimizing distress (as in Aesop's "sour grapes" fable) (Festinger, 1957).

I anticipated that Cognitive Dissonance Theory might be relevant to this study especially if clients experienced discrepancies between negatively held attitudes towards counselling (and/or those who access it) and their own behavioral attempts to enter the counselling realm. Research in the area of persuasion and attitude change, as they relate to cognitive dissonance theory, could be applicable to the no-show phenomenon if



individual's attitudes or beliefs about counselling are problematic in terms of their seeking counselling.

### *Social Exchange Theory*

Social exchange theory, like cognitive dissonance theory, comes from the world of social psychology, and suggests that modification of social behavior (in this case following through on accessing counselling) may occur if perceived and expected reinforcements (benefits) are increased relative to expected costs (Blau, 1964). The theory suggests that reinforcements need only be perceived or expected in order for motivation, and therefore behavior, to be affected. This is important for first-time clients since many actual reinforcements will not be delivered until attendance occurs. While social exchange theory has not been researched in relation to accessing counselling or the no-show phenomenon, it may be applicable if individuals hold negative perceptions about the efficacy or experience of being involved in counselling therapy and subsequently, if these perceptions can be positively changed.

## CHAPTER 3: RESEARCH METHODOLOGY

### *Qualitative Inquiry*

Qualitative inquiry is an approach to research that includes methodologies such as ethnography, phenomenology, case studies, life histories, narrative inquiries and grounded theory research methods (Schwandt, 1997). Qualitative researchers set out to understand and make sense of phenomena as experienced by participants. They do not start with a hypothesis; rather they use inductive strategies, gathering data through the use of field notes, interviews, conversations, photographs, recordings, and their own research journals (Merriam, 2002; Denzin & Lincoln, 2000). Merriam (2002) wrote: “all qualitative research is characterized by the search for meaning and understanding with the researcher as the primary instrument of data collection and analysis.” (p. 6). Qualitative inquiry produces a richly descriptive end product (Merriam, 2002), which was well suited to the present study that sought to examine something that could not be quantified, calibrated, or otherwise concretely “measured.”

Merriam (2002) delineated several characteristics of the major constituents of the qualitative inquiry paradigm. First, she pointed out that qualitative researchers share the constructivist theoretical assumption that reality is not fixed or measurable, but is instead composed of multiple constructions and interpretations that fluctuate over time. That is, they believe meaning is socially constructed through individuals’ interactions with their world. In diametric opposition to a quantitative research paradigm, qualitative researchers view the world and its realities not as fixed, single, agreed upon, or measurable, but as having multiple constructions and interpretations, which are in a constant state of flux throughout time and space. Researchers working within this

qualitative paradigm are interested in understanding what those interpretations are at particular points in time and in particular contexts (Merriam, 2002). Second, as mentioned briefly above, the researcher in a qualitative inquiry is him or herself the primary data collection instrument and analyst, whereas devices of measurement such as rulers and beakers might be used in quantitative inquiry. The qualitative researcher processes data immediately upon its gain, clarifies and summarizes gathered material, performs member checks with participants to ensure accuracy of interpretation, and further explores unusual or unanticipated responses. Third, the qualitative research process is an inductive, versus a deductive, one. Researchers use their gathered data to generate concepts, hypotheses, and theories rather than setting out to gather data to prove or disprove a pre-existing hypothesis or theory. Finally, the end product of a qualitative inquiry is richly descriptive in nature, as data in the form of words, quotes, field notes, documents, photos, and / or portions of participant interview transcripts are used to convey the researcher's learnings around a particular phenomenon.

A qualitative inquiry approach to research methodology is particularly appropriate when the goal of the research is to "understand a phenomenon, uncover the meaning a situation has for those involved, or delineate a process" (Merriam, 2002, p.11). Morse and Richards (2002) suggested that research topics amenable to qualitative inquiry are those which have either been relatively ignored in the literature or otherwise require a new approach to examining them. In utilizing a qualitative inquiry approach to this research, the intention was to develop an in-depth understanding of participants' experiences and the meanings they brought to these, with attentiveness to the themes and language of participants' perspectives. The purpose of the current study was to

investigate the experience of accessing counselling through the “eyes” of those who book appointments but then do not show up. The research question that guided this inquiry was: “What is the experience and meaning of attempting to access counselling help?”

### ***Basic Interpretive Design***

Merriam (2002) stated that “learning how individuals experience and interact with their social world, and the meaning it has for them, is considered an *interpretive* qualitative approach” (p.4). Such an approach is particularly appropriate when one seeks to understand and describe phenomenon, and when “depth of understanding” is the goal (Merriam, 2002). Merriam’s (2002) method of basic interpretive qualitative research was chosen and employed to explore and understand participants’ experiences of accessing counselling.

In this design, the researcher and the participant(s) interact to reconstruct the participant(s) social constructions (Denzin & Lincoln, 2000). Researchers employing this design are interested in understanding how participants make meaning of specific situations or phenomena without adhering to a guiding set of philosophical assumptions, as in grounded theory (Merriam, 2002; Caelli, Ray, & Mill, 2003). They set out to discover and understand phenomena, processes, perspectives and worldviews of the people involved in the research (Merriam, 2002). Data is collected through interview, observation and / or document analysis and is subsequently analyzed through identification of recurrent patterns and common themes embedded within that data. The researcher employs the data in an inductive manner presenting findings descriptively in order to accurately convey his or her findings. The basic interpretive design possesses all

of the characteristics set forth for qualitative inquiry. It does not, however, set out to create new theoretical concepts as does grounded theory, for example (Merriam, 2002).

Because the study focused on the *experience* of participants as they attempted to access mental health care (and in particular on the experience of subsequently not coming in), and in what *meaning* this had for them, a phenomenological underpinning seemed appropriate. Research informed by phenomenology “gives us insights into the meanings or the essences of experiences that we may previously have been unaware of, but can recognize” (Morse & Richards, 2002, p. 47), and “focuses attention on people’s lived experience” (van Manen, 1990, p. 9). Lived experience is an individual’s own unique series of sensations, emotions, interpretations and meanings associated with any given circumstance or set of circumstances. Phenomenology considers the unique way in which each individual’s experience unfolds, even though the experience itself may appear to be the same for a number of individuals.

Merriam (2002) pointed out that a basic assumption of phenomenology is that “...people interpret everyday experiences from the perspective of the meaning it has for them.” This study was motivated by a particular interest in these meanings, whatever they were. I began the study wondering if no-show clients felt on some level that coming into therapy meant “turning too much of themselves over” to an unknown and powerful individual who may judge them, and if so, did this create a heightened sense of vulnerability and anxiety? Did some individuals have a negative stigma attached to the idea of counselling itself and/or to those who accessed such services? What was the effect of culture on one’s willingness and openness to enter counselling? What questions did individuals have (perhaps unanswered and/or unasked) about counselling, prior to its

onset? What expectations did individuals bring to counselling and what concerns or fears they might have?

The goal in this study was to understand and describe, in all its complexity and from the client's world-view, the phenomenon of booking an initial counselling appointment. It was a goal well-suited to the research design of basic interpretive qualitative inquiry (Denzin & Lincoln, 2000; Merriam, 2002). Moreover, because there are few studies exploring first-time clients' experiences in the literature, a phenomenological underpinning to this study devoted to understanding these clients' lived experiences best lent itself to this question (Creswell, 1998).

#### *Role of the Researcher*

Qualitative research is a process of informed choice, reflection, flexible planning, and decision-making (Morse & Richards, 2002). As such, my role as researcher was to be wholly involved in, and open to, each of these processes as the research unfolded. Data in qualitative research is *made* versus *collected* because it does not preexist. That is, because we are attempting to understand human complexity, with its many world-views and meanings, we collect not actual events, but representations, usually in the form of individual's reports or accounts of events (Morse & Richards, 2002). As such, humans are the appropriate instrument for garnering data in qualitative research, which necessarily then, is value bound (Lincoln & Guba, 1985). Because qualitative research is an interactive process between researcher and participant, researcher and research, researcher and self, it is vital that the qualitative researcher first articulate his or her values beforehand, and continue self-examination and reflection throughout the research process (Merriam, 2002). Because my data was generated in collaboration with my

participants, another of my roles was that of developing rapport with them. I articulate some of my values in the next section and practiced “reflexive” research by self-reflecting throughout the research process and by keeping a journal and field notes (Merriam, 2002).

### *My Position as Researcher*

As an individual, a woman, a mother, a sister, a daughter, a friend, and a single soul amongst billions on this earth, I envision, perhaps naively, a more loving, peaceful, joyful and accepting world – and I aspire to play a part, however small, in realizing that vision. I have long been passionately interested in social justice and social change, and I believe that the world I envision will come about in one way only--one person at a time (I am told that the Dalai Lama holds a similar belief). I also believe that people are often very much afraid of their “dark” sides, and that they believe they are the only ones with such a side, not recognizing that the same is only part of being human, and imagining their own personal “darkness” to be much more horrible than in fact it is.

It is largely these beliefs and values that moved me to do this study, which I hope will aid our understanding of how to reach such individuals in order to pass along, through modeling, psycho-education, and therapy that it is okay to be more gentle with oneself and with others; okay to place greater value on being kind than on being right, and so on. However, in order to be able to accomplish any of this as therapists, we first need to be able to *encounter* our clients – and that is difficult to do if they don’t come in.

In my position as researcher, I accepted and affirmed my participants and conveyed a genuine desire to know and understand their points of view, entirely respecting these. I assumed that there were commonalities among participants - the

above-mentioned fear possibly being one of these - which would lead to the development of themes in the final analysis, thus allowing a deeper understanding of my research question. I believed that a qualitative paradigm fit well, not only for this study, but for me personally, because I am naturally curious and naturally drawn to try to understand others and their worlds. I saw myself as co-creating the outcome with my participants, because I could not entirely remove myself or my beliefs and assumptions from the process, and because my questions were, in part, guided by those same beliefs and assumptions.

I was aware that in the role of researcher I might be perceived by participants as being in a position of power. Exercising both empathy and humility, as well as fully accepting and affirming each participant individually, helped decrease any sense that a power imbalance existed between us. I was also aware that in my role as researcher it would be necessary for me to “bracket” any and all pre-suppositions and assumptions I had going into the study.

Bracketing refers to one’s ability to set aside all previously held suppositions, expectations, prejudices and assumptions (van Manen, 1990) — its functions are to allow space for new learning, to open oneself up to new possibilities, and to allow for new ways of understanding what one may previously have thought one already “understood.” I strove to be successful in this and continually monitored myself for any new assumptions. It should be mentioned here however, that this is an ideal rather than an all or nothing proposition.

A final assumption I had in my role as researcher was that individuals *would* agree to participate (my classmates actually laughed at me when I explained my research



question, asking in astonishment, “What makes you think if they didn’t come in, in the first place, that they’ll come in to talk about *why* they didn’t come in?!”). While it’s been said that “undoubtedly the difficulty inherent in tracking individuals who have made such limited contact with a clinic has rendered follow-up difficult to accomplish” (Noonan, 1973, p. 43), I was heartened by the suggestion that “researchers should not be reluctant to include inquirers (another term for first appointment no-shows) in their studies, since they are apparently no more resistant to follow-up than are client families...” (Lowman et al., 1984, p. 260). I did have some difficulty recruiting participants and thus, included the option of a phone interview for participants’ comfort and convenience.

### *Establishing Rapport*

Glesne and Peshkin (1992) pointed out that “...trust is the foundation for acquiring the fullest, most accurate disclosure a respondent is able to make” (p. 73). Thus, a big part of the role of the researcher is the establishment of rapport with his or her participants, most particularly when it is a depth of understanding the researcher is seeking. Rapport-building is a basic part of all counsellors’ work especially in the early part of all therapeutic encounters. If one can build rapport, one can build relationship, facilitate trust, quiet anxiety, and foster client’s (or participant’s) comfort, thus increasing the likelihood that they will share themselves and their experience with you openly. Such a state is desirable as it facilitates thick description, a goal in both counselling sessions and in qualitative and phenomenological studies. Through my graduate studies in counselling psychology, and my experiences during the completion of my graduate practicum placement, I have become, I believe, adept at building rapport and facilitating trust. I was confident that my genuine interest in my subject matter, my humility, my

knowledge about rapport-building, and my deep and natural empathy served me well in this regard.

### *Participant Selection*

Because I was interested in studying a particular phenomenon, purposeful sampling was used to select participants who had themselves experienced that phenomenon. Those who had experienced the phenomenon were in the best position to share information and to aid in understanding – they represented those “from which the most can be learned” (Merriam, 2002, p. 12). Purposeful sampling is the process of selecting participants who are likely to be information rich with respect to the purposes of a qualitative research study. Of the many manners in which to conduct purposive sampling, criterion sampling was used. Individuals from a pool of no-show clients tracked by a local counselling agency were screened using the following criteria. Those who met the criteria, and were willing to participate, were selected for the study:

1. Are of adult age (18 or older)
2. Booked an initial counselling appointment within the last eight months and did not arrive for the appointment
3. Could commit the time to be interviewed and to fill out a demographic questionnaire

The intake worker from the agency contacted members of the participant pool to briefly explain the study (simply using the research question), ascertain whether or not potential participants met the above criteria, and invite them to participate in the study. I then made telephone contact with those individuals who expressed interest in participating. At this time I introduced myself, set the context for the study, finalized

willingness to participate, and confirmed a meeting time and place. I had some difficulty recruiting participants. Many agreed to be interviewed, booked interview times, and then did not show up; others suggested I call them back at a better time, then never answered or never returned messages. Many prospective participants expressed a preference for telephone interviews rather than in-person interviews so I obtained permission from the University of Saskatchewan Behavioral Ethics Committee to use telephone interviews. I completed a combination of both in-person and telephone interviews: three participants were interviewed in person, and one interview was conducted over the telephone.

#### *Data Generation*

Once individuals consented to participate in the study, times, dates and places were set for the interviews, according to what was most comfortable for the participants, and according to the necessity that the physical setting be not only quiet, comfortable, and private, but also conducive to audio-taping (Creswell, 1998; Glesne & Peshkin, 1992). In-person interviews were conducted in small interview suites at the University of Saskatchewan. The telephone interview was conducted from my home at a time when I was alone. These participants filled out consent forms or provided oral consent, and completed a brief demographic questionnaire immediately prior to beginning the interviews.

#### *Questionnaires*

All participants were asked to provide demographic information that was obtained using a “closed question” and “fill in the blank” format (see Appendix B). The demographic information requested was a composite of that used in earlier studies found in the literature and was useful in integrating this research with previous research. It

included age, date of birth, address and phone number, marital status, number of children, education, and previous counselling experience.

### *Interviews*

The aim of this study was to uncover the meaning, by describing and understanding it, of the experience of accessing counselling from the perspective of participants who subsequently missed the scheduled appointment. Muller (1994) in a study on understanding empowerment from the perspective of successful women, indicated that it is helpful, when attempting to understand one's participants, to first know who they are and what they believe about life and others. This was true as well in regard to gaining a deeper and more participant-centered understanding of what is commonly termed "the no-show phenomenon." That is, in order to gain a good understanding of the no-show phenomenon, I needed to gain a good understanding of participants, their *experiences* of it, and of their beliefs in relation to it. The only research located, which explicitly attempted to understand client's (in this case families) experiences of not following through to receive even one session of diagnosis or treatment, used a questionnaire format to generate data rather than an open-ended interview format (Lowman et al., 1984). As a result, large portions of the variance were left unexplained (they fell into the "other" category under the question "How were the application procedures a problem?"). I hoped that the use of an open-ended interview format in this study would facilitate the discovery of contextual data the likes of which researchers were perhaps previously unaware. I hoped that findings would be useful in bringing clients in to treatment such that they would be helped to achieve their goals and to realize the life changes they envisioned for themselves.

Fontana and Frey (2000) pointed out that interviews are active interactions between two (or more) people, as opposed to neutral tools of data gathering. As such, the interviewer's beliefs and emotions as he or she approaches her work are important. Although the interviewer can strive diligently to have the meaning being made in the interview reflect that of the participant's reconstruction and reflection as much as possible, he or she must also recognize that the meaning is, to a degree, a function of the participant's interaction with the interviewer (Seidman, 1998). In order to limit tainting participant's interview results with my own assumptions or influence, I did as van Manen (1990) suggested and "bracketed" my preconceptions, or "intentionally set them aside". This facilitated the likelihood that the essential essence of my participants lived experiences would come through without my "injecting hypotheses, questions, or personal experiences into the study" (Creswell, 1998, p.33). As I conducted interviews, I monitored myself and my reactions, recording them in my journal and field notes, along with any biases that arose, and reported these in the final thesis document.

A phenomenological perspective of interviews is to use them as a means for exploring and gathering experiential narrative material that may serve as a resource for developing a richer and deeper understanding of a human phenomenon" (van Manen, 1990, p.66). An open-ended interview format was used to get an understanding of things not seen or measured. I was comfortable with my ability to conduct such an interview, and drew upon all my counselling skills while doing so (e.g., rapport-building, data gathering, observation, questioning, and facilitating exploration). I also self-monitored as I proceeded, with awareness that the relationship while one of co-creation, was not equal.

One pre-existing assumption was that of those participants agreeing to take part, some would have been toying with, or trying to get used to, the idea of asking for help for some time. I believed that those who agreed to be involved would be open and honest. I also assumed that some participants might be shy about being interviewed but that if they agreed to a face-to-face interview, they would come to feel more comfortable with me and with the topic at hand as the research unfolded.

The face-to-face interview(s) and one phone interview were of an unstructured, interactive format. Open-minded responses, situational sensitivity, and flexibility are defining features of this type of interview (Merriam, 2002). Each interview opened with a grand tour question to set the main area of interest, and was followed by a series of additional open-ended questions. These interviews were intended to “elicit (participant’s) descriptions, perceptions, and understandings” in a format that “emphasized the importance of providing a structure for participants to communicate their own understandings, perspectives, and attribution of meaning” (Merriam, 2002, p.166). According to Morse and Richards (2002), unstructured interactive interviews are most appropriate when researchers seek to learn what matters, or how procedures are understood. My goal was to have participants reconstruct their experience within the topic under study (Seidman, 1998).

There were four participants and each was interviewed for approximately 90 minutes, which allowed me to “plumb the experience and place it in context” (Seidman, 1998, p. 11). The first part of the interview established the context and details of participant’s experiences, and the second part allowed them to reflect upon the meaning their experience held for them (Seidman, 1998).

Initial questions were broad enough to leave space for individual response and freedom (e.g., “Could you tell me a little bit about what important things were happening for you in your life and in your family at the time you first contacted the counselling agency?”). Subsequent questions were more focused than the previous ones (Merriam, 2002). For example, “What needed to happen for you to feel ready to go?” “How do you understand counselling? What is it to you?” “What did you find particularly helpful in your intake experience?” “What did you find most surprising about accessing counselling?” Each participant signed a data and transcript release form. Each participant was also given the opportunity to see the final transcript summary, validate same, and/or suggest changes to more accurately reflect their meaning, if necessary, prior to the information’s release.

#### *Observations, Field Notes and Journaling*

Observational data can enhance description (van Manen, 1990). The assumption is that observation allows the researcher to learn what is taken for granted in a situation (Morse & Richards, 2002). Observations were largely captured in field notes. Observations during interviews were noted (as much as is possible without appearing inattentive) and recorded on a dicta-phone immediately following each interview. They were transcribed later, and reported in the final document (Morse & Richards, 2002). These notes contained both descriptive data (e.g., the setting, the participants, my reactions) and reflexive data (e.g., my hunches, experiences, and learnings) (Creswell, 1998).

A journal was kept that contained feelings, thoughts and ideas as well as facts that unfolded along the way (van Manen, 1990). Here is where I worked out problems, noted

impressions, clarified earlier impressions and interpretations, speculated, commented on process (e.g., how participant and researcher interacted and affected one another, how topics affected each, what points appeared to act as “triggers” ) and basically “thought out loud” on paper. Lincoln and Guba (1985) noted that field notes can add to a study’s trustworthiness. I kept these on a daily basis throughout the study, and in fact, felt completely lost without them. They became an extremely important aspect of the study and were crucial in helping me to “see” patterns and themes in my work.

#### *Data Analysis*

Data analysis was an ongoing process that took place *simultaneously* with data-generating/data collection (Merriam, 2002), which allowed me to make adjustments as needed and to “test” emerging concepts, themes and categories against subsequent data (Merriam, 2002). A constant comparative method of data analysis, which is inductive in nature, was used to compare one piece of data to the next, all the while looking for common themes across data (Merriam, 2002). Bracketing was used, as was coding and cross-coding.

#### *Constant-Comparative Analysis*

Data were recorded and transcribed data immediately upon receipt, for the purposes of carrying out a preliminary analysis. This entailed coding and re-coding of data until themes begin to emerge using the constant comparative method of data analysis (Merriam, 2002). The constant comparative strategy was one of continuous and simultaneous collection *and* processing of data (Lincoln & Guba, 1985). As data were recorded and classified, they also were compared across categories in an ongoing manner. Thus, the discovery of relationships or themes began with the very first observation, or



piece of data, which was then continuously refined throughout the data collection and analysis process (along with every subsequent piece of data), by being fed back into the process of category coding. This allowed for every single piece of data to continuously inform the category coding process. As new data was constantly compared with previous data (both that already coded and otherwise – i.e., material that did not yet appear to fit any specific category), new typological dimensions, as well as new relationships, emerged (Lincoln & Guba, 1985). Once tentative meanings were generated based upon these themes, these meanings were “checked out” with participants to ensure their voices and meanings were being accurately represented. These member checks increased the dependability of the final findings in the study, which unveiled themes that ran throughout all the data, and represented essential recurring features of the phenomenon.

### *Quality Control*

It would be unconscionable to enter into a study of this magnitude with intent to represent the voices of a number of individuals and to report final findings or meanings based on these, without employing measures for quality control. As such, several such measures were employed. Lincoln and Guba (1995) espoused several criteria which lead to a study’s “trustworthiness;” that is, a measure of the degree of comfort with which one can rely upon, or “accept,” a study’s findings. The espoused criteria include strategies such as triangulation, member checks, purposive sampling, thick description, and practicing reflexivity. These were all employed as well as several “emerging” criteria espoused by Lincoln (1995), such as positionality, community, voice, critical subjectivity, reciprocity, sacredness, and sharing the perquisites of privilege. Employment of these

criteria aided in strengthening the study's claims of both credibility and trustworthiness (Lincoln & Guba, 1995).

### *Triangulation*

Triangulation, with respect to *data*, involves multiple sources (or methods or investigators) being checked against other sources (or methods or investigators).

Triangulation helps to ensure credibility of results (Lincoln & Guba, 1985). In this study, the extant research literature, demographic information, in-depth interviews, field notes, and observation served a multiple sources of data that could be triangulated.

### *Member Checks*

With respect to *constructions*, I verified my interpretations and tentative meanings based on the information provided by participants with the participants themselves. The same process was implemented with regard to the study's final results. Participants were asked if the analysis/interpretation made sense to them, and whether or not these represented, or "fit" their individual experiences (Lincoln & Guba, 2000).

### *Purposive Sampling and Thick Descriptions*

Purposive sampling was used to recruit participants who were likely to be "information rich" in regard to the phenomenon of interest. This allowed for "thick descriptions." Thick descriptions allow readers to experience the text through evocation of context. In the present study, interview quotes, documentary evidence, and excerpts from field notes for example (Merriam, 2002) were used to paint a picture of the phenomenon and to bring readers along in the process of fully discovering and experiencing it. The goal was to garner thick description such that readers, both

professional and otherwise, would be able to vicariously experience the phenomenon of interest.

### *Practicing Reflexivity*

This is a framework for practice with which I was quite familiar. Reflective practice is an accepted (and expected) aspect of working in the counselling field. It is incumbent upon all counsellors to practice in a reflective manner (to engage in ongoing self-reflection on a daily basis). There are a number of reasons for this, the most salient of which for research purposes, were those mentioned previously (dealing with the need to avoid contaminating participant's stories, meanings, and understandings with researcher perspectives and assumptions, so that to the greatest extent possible, participant voices, experiences, and meanings were represented versus the researcher's). Throughout the study I was clear about assumptions, biases, and internal and external responses, noting the same in a reflexive journal, which was kept together with field notes. These were included in the final analysis and reported in the final document.

### *Positionality*

Beginning the study with a frank and unambiguous statement about my position, (or stance), in relation to the research topic demonstrated "positionality," (or "standpoint epistemology"). This represented another kind of self-awareness in relation to the research, and therefore is an additional type of quality control in which my position is outlined in relation to the research.

### *Community / Relationality*

According to Morse and Richards (2002), "People are considered to be tied to to

their worlds...and are understandable only in... context...of their relationships to things, people, events, and situations” (p. 45). The research situation itself inevitably occurs within, and is addressed toward, a community. Studies that “integrate research, critical reflection, and action” are said to demonstrate “community” (or “relationality”) (Lincoln, 1995, p.281). Through a combination of each of these factors, this study strove to integrate, reflect upon, and extend current research knowledge in the area of the no-show phenomenon, in order to ultimately lead to action or change that will better serve my community, both professionally and otherwise.

#### *Voice*

Lincoln (1995) referred to the concept of voice as dealing with the notion of “...who speaks, for whom, to whom, (and) for what purposes...” (p. 282). In this study, participants and I were interconnected to some degree, as their voices were filtered through me, and through my writing. I aimed to ensure that through use of direct quotes and member-checks, for example, their voices lost as little as possible as a result of this filtration process.

#### *Critical Subjectivity*

This refers to a kind of “high quality awareness” of self and others, for the purpose of “understanding with great discrimination subtle differences in the personal and psychological states of others” (Lincoln, 1995, p. 283). Lincoln stated that this criterion is “absolutely required” in order to understand one’s psychological and emotional states throughout the research process, and beyond. I felt I had strong capabilities toward noting such states in others, and that the use of a reflexive journal and field notes equipped me well to monitor the same in myself on a continuing basis.

### *Reciprocity*

Reciprocity is a term used to describe an aspect of relationship that develops between researcher and participant in qualitative studies – an aspect characterized by “a deep sense of sharing that opens all lives party to the enquiry to examination” and involves “a deep sense of trust, caring, and mutuality” (Lincoln, 1995, p. 284). By its very nature, interpretive qualitative research is a person-centered endeavor, which makes reciprocity essential. It was facilitated in this study through the use of an active listening approach characterized by warmth, genuineness, empathic concern, and unconditional positive regard.

### *Sacredness*

Sacredness deals with the relationship between science, ethics, and ecology. Researchers interested in sacredness have a deep appreciation for the human (and global) condition; they choose to create egalitarian relationships rooted in mutual respect and dignity, rather than in unequal power. Implicit in this stance is “a profound concern for human dignity, justice, and interpersonal respect” (Lincoln, 1994, p.284). I mentioned earlier my deep interest in social justice; I didn’t mention a personal struggle with acceptance to law school at the same time as acceptance to a counselling psychology program. My decision was based on my belief that in a counselling profession, I would be less likely to face situations in which I might have to compromise my dignity and/or that of clients; and on my belief that interpersonal respect is much more highly valued in the counselling profession than it is in the profession of law – these values were worth far more to me than the perceived prestige or power of the Bachelor of Law designation. This study was conducted from a stance of sacredness.

*Sharing the Perquisites of Privilege*

“Our research is written for ourselves and ... earns us the dignity, respect, prestige, and economic power...that those about whom we write frequently do not have” (Lincoln, 1995, p.285). Lincoln submitted that a debt is owed to those whose lives are portrayed, and that researchers need to “come clean” about the benefits accrued, as well as to give something back. Successful completion of this study will earn me a M.Ed. (Psych) degree. I am honored to have the opportunity to begin to know myself as a researcher, and it is my hope that each participant’s involvement in this study resulted in benefits not only for myself, but for them as well. Such benefits might have included a heightened sense of self-awareness (and other-awareness); the opportunity to “get over a hump” and perhaps to begin moving in a long-desired direction of personal growth and empowerment; increased self-esteem and confidence; and satisfaction in the knowledge that they have contributed to facilitating understanding in an area where previously little was known.

*Community as Arbiter of Quality*

In studying the experience of accessing counselling, my intention was not to publish a thesis which then sat on a distant and remote shelf in some library of academia, never to be seen again, or worse, never to gain public audience. Rather, I hoped that this work would serve the community in which it was conducted (Lincoln, 1995). To do so will require presentation in both academic and professional settings. Specifically, this thesis contains implications for practice for both individual clinicians and for agencies involved in mental health care provision. Upon completion, it is my hope that this thesis will offer new perspectives on what it is like for individuals to access counselling, and on

how it is that practitioners and agencies alike can mediate this process, for the benefit of both their communities and their clients.

***Participant Protection and Ethical Approval***

Participants were protected through the regulations and conditions for research protocol approval endorsed by the University of Saskatchewan Advisory Committee on Ethics in Behavioral Science Research (see Appendix A). Participation was strictly voluntary and participants had the right to withdraw from the study at any time without penalty. Informed consent was established prior to interviews being conducted and audiotapes of the interviews were available to the researcher alone. Data will be securely stored for the required five years in the office of the study's supervisor in the Department of Educational Psychology and Special Education in accordance with University of Saskatchewan regulations.

## CHAPTER 4: RESULTS

In this chapter, I start by describing the identified shared meaning of the experience, then move on to detail three more themes. For the purpose of maintaining the confidentiality and anonymity of my participants, I selected pseudonyms for each of them. The names of spouses/partners and children, as well as geographic indicators, have also been altered. Direct quotations by participants have been edited for both confidentiality and ease of reading, such that “filler” words (“um-hmm”, “you know”) are deleted and represented by ellipses. Where words have been added, parentheses are used as indication of same. Finally, participants’ individual voices have been retained in the writing that follows. I felt that this choice, as opposed to the use of a singular, more “global” voice to represent findings and experiences, denotes utmost respect for each participant’s own unique lived experience.

### *Participants*

Jeanette, Kevin, Julia and Randy, the four individuals who participated in the research, were middle class individuals, Caucasian, and between the ages of 27 and 33 years. Education levels ranged between “some grade twelve,” “completion of trade / technical school,” and “some university.” Two of the participants were in common-law relationships while one was separated and living alone, though seeing someone. The fourth participant was married at the time of the interviews. All were employed; three in full-time jobs and one in part-time employment. Three participants had children who ranged from two to ten years of age. The participants could be described as being at different points in a journey that involved negotiating and solidifying a meaning about



what it meant for them to access counselling, finding a way to reconcile, “What does it mean about me that I need to access counselling help?”

Only one of the participants, Julia, had never participated in counselling. In contrast, each of the others, at some point in their lives, had done so. Both Jeanette and Kevin had accessed counselling for personal reasons and Randy had done so for his child. Despite the differences between members of this small group of individuals, there were commonalities intersecting their experiences and the meaning of booking an appointment to access counselling services.

***Shared Meaning of Accessing Counselling:***

*“What Does it Mean About Me That I Need Counselling Help?”*

Before calling to request a counselling appointment, each participant described living with an ongoing and unmanageable situation for a lengthy period of time. Randy delineated a period of 6 months, Kevin 4 years, and Julia 2 months of fighting with her husband for permission to take their child in for counselling. Jeannette delineated several different periods that ranged in length from a few months to a year. During these times, each thought about accessing counselling help but did not do so. Rather, each participant attempted to negotiate their problems on his or her own for as long as possible. They delayed and avoided accessing counselling help in what seemed to be an effort to convince themselves that they could manage without help. This avoidance seemed to be an effort to maintain a positive self image, and to remain “on the other side” of the social stigma associated with those who access counselling. Each had a keen awareness of this stigma, and a strong, if unspoken, desire to avoid it.

As a result of this avoidance, in each case the problem, or area of concern, escalated to the point where participants experienced a crisis (e.g., becoming suicidal), which catalyzed action to access counselling help. They indicated a sense of dire need, of “having to do this” at the time of booking and/or accessing. In fact, it appeared that crisis was the necessary element in getting participants in to the counsellor’s office.

Each participant spoke of “having to admit to not having all the answers” and for some, this was very difficult to accept. Julia, in particular, struggled with not having the answers as her problem was a parenting concern and Julia believed that parents “should” know what their children need.

Most notably, each participant appeared to struggle with the question “What does this (needing counselling help) mean about me?” Each participant attributed, at least initially, a negative response to this question, and thus avoided accessing. Kevin, on his journey, was actively engaged in the struggle to access counselling at the time of the interviews, though had not yet done so. This was true as well for Jeanette, who indicated a long history of booking appointments and then not attending them. Randy, who had accessed counselling during the end of a relationship, felt he could not return to counselling again when his problems worsened. He perceived that doing so indicated a failure on his part to carry through “correctly” with previously offered counselling suggestions. On the other hand, Julia struggled with differences in perception between herself and her husband, who did not believe in counselling and was not open to accessing it for their child. Julia, on the other hand, wanted to try it for their child and was less concerned about self-stigma.

*Kevin*

Kevin described his struggle and his need to believe he was managing well on his own when he said:

*I am avoiding it more than probably anything...see if it got any worse then I'd probably just go and do it right (access counselling), but I'm kind of dealing with it right now and life is going on and it's not going so bad but it's kind of like I say I don't need it right now, I don't need it right now, but then deep down inside I could use it.*

He placed emphasis on being honest with himself, yet had some awareness that the same honesty he saw as necessary to accessing counselling, also functioned as a barrier:

*It was tough, not so much that I had to go in there and get help, but that I had to open up to my problems and deal with them. The hardest was basically admitting you have a problem. You kind of have to admit that, to realize that yeah there is a problem here, and I have to do this (access counselling). The next hardest is walking in there and telling somebody for the first time why you're there and what you want help with. I knew that it wasn't that everything was just gonna be okay (because I was in counselling) I knew it would be a longer process, but just to have somebody to help work it through...there were a lot of hurt feelings. I had hurt feelings but also other people that I affected did and you just can't walk into a counsellor's office and repair that...I had to forgive myself for the things I did in order to kind of deal with them...it was hard to accept*

As a youngster, Kevin had been referred to counselling for behavior problems while in school. In more recent years, he had developed a gambling problem and had often

thought about asking for some counselling help for this, but never did so. Most recently, Kevin had been physically abusive to his girlfriend. This latest development triggered a profound emotional response for Kevin:

*It (gambling) was affecting me but it was also affecting others...the main thing was taking it out on others and (he pauses) and the violence; it made me violent (the financial stress)...I was abusive to my girlfriend which really affected me 'cause it wasn't her fault after I'd realized everything...it was emotionally very stressful (the guilt), very tough, very hard to deal with...that's when I really realized that I had to do something about it...I wanted to commit suicide because of some of the things I had done...(I was feeling) not safe with myself and not safe with others....*

Kevin had come to a place that he described as “hitting rock bottom,” in which he saw himself as worthless, teetering on the brink of life and death. At that point, “with nothing left to lose” and “already feeling like a total shit,” Kevin walked into a counselling center, without an appointment, and ended up accessing help in the form of addictions counselling for gambling and attendance at a narratives group for men who are abusive to their partners, a group that he completed.

Kevin indicated that for him, it was more difficult to admit the extent of his problems and the details associated with them to himself, than it was to discuss these same things with a counsellor once he had self-admitted. In response to the clarifying question, “Do you mean it was harder to share this (the reality of your actions and the difficult details associated with them) with yourself than it was with somebody else?”

Kevin responded affirmatively, “Yeah, oh definitely, yeah.” When asked about accessing counselling at that crisis point and what that was like for him, he said:

*At the time I didn't know what it was gonna do for me...I really didn't think anything was gonna help but I didn't have any other choice. It was just something you have to do. It's either that or things aren't gonna get any better and they could get worse, you could end up in a worse situation than you're already in so you kinda just have to pull yourself in there....you don't have answers for some things and so you basically have to go in there and get some answers, some ways to work through...it was just something that had to be done....*

At the time of the interview, approximately one year after Kevin began counselling, he experienced some relapse and actively wanted to access further counselling help and support. Even though he had experienced his previous counselling as very positive and helpful, he continued to delay in the same way he had previously, as he put it, “telling myself I don't need it right now” and “basically avoiding it.”

When asked what he thought might be a reason people book an appointment and then don't keep it, Kevin's first thought was “Well, they may feel (pause) like they might be humiliated...”

Kevin had booked an appointment to access counselling for his relapse symptoms just a month or so before his research interview, but had not attended that appointment.

At the time of the interview, he had not re-booked again.

#### *Jeanette*

Jeanette, a single Mom who experienced anxiety, had also accessed counselling previously. Like Kevin, she experienced counselling positively, seeing counselling as “a

place for healing, a support system, a place for self-care and a place to practice new learnings.” She spoke extremely highly of two particular counsellors she had worked with, and did not identify a single negative experience in counselling or in the process of accessing same. Nonetheless, she indicated a long and continuing history of booking appointments and then not keeping them. She spoke directly of “changing her mind” each time she felt the need for help, and described the emotional effect of this struggle:

*I have a very long history of starting counselling and stopping, or just making that contact and not going, so I'm probably perfect for your research (laughs) I've been reaching out for assistance through counselling and different community services since I was probably nineteen, so a long time....I usually end up going a couple months later, a few months later, maybe once crisis occurs, I'll go to see a counsellor 2, 4, maybe 5 times then quit. When I change my mind it's just horrible, because it's such a pattern for me and I can see it coming and I feel the same feelings: I start to think "Oh I don't need to go because I don't have time for this" or "Oh I feel better now, my moment of crisis is over and I'm okay" or "I can handle all my stuff by myself and I don't need the support." And then that little voice in my head goes, "Oh but Jeanette this is what you've always done in the past and you really should go, you need to break that pattern" and so I have that inner dialogue, and I feel a lot of guilt because I know my mother raised me right that you should never just stand somebody up and so I feel all this guilt because I usually don't cancel, I usually just don't show up, and so I feel really crappy about that too, so that's part of it, but I feel, I just feel gross, like I'm...its almost like self-loathing.*

Jeanette was aware that her struggles with accessing counselling cost her emotionally; yet, she continued to struggle while also maintaining some humor and hopefulness:

*You know it's very funny because when I was first contacted about this I was having a sip of tea with my Mom and my partner and we were on the front steps of the house and the phone rang and I came out a few minutes later and they said was it anyone important? And I said, "I was asked to be part of an interview" and they said, "Oh, what's it about?" and I said "People who don't keep their appointments in counselling" and they both just howled with laughter because they both know very clearly that I try to access and that this goes on for me and it's almost a running joke amongst the three of us, so it made me feel really good actually when I was called because it did validate for me that I'm not the only person that does this.*

Jeanette went on to share a personal sense of experiencing others as better able to "handle life" than herself:

*I always had this notion that I was different than the people around me and I felt like I wasn't able to sort of handle life in the same way as other people so that was a part of my thought process in reaching out, just thinking, "Why am I not capable of doing these sort of adult things and why do others seem to be able to?"*

She spoke of frustration with herself around her attempts to access counselling help in relation to "handling life:"

*It's sort of that "Oh, I'm doing this again!" feeling, sort of beating myself up; that inner dialogue of "Oh Jeannette, why can't you do this better, or handle life*

*better?” and then that other voice that says, “its okay, be gentle with yourself.”*

*So all that goes on in my head, but I don't feel uncomfortable or afraid per se.*

Jeannette described growing up in a family where counselling was looked down upon and where talking with others about personal or family problems was taboo:

*I come from a family where “you don't do that,” where counselling is frowned upon. We don't consider it that way any longer. That was quite a long time ago, but that was very much a part of my upbringing, that what happens in our family stays in our family and we don't tell strangers about it, “chin up little camper and continue on,” that sort of attitude....it (counselling) was almost considered to be shameful.*

While she indicated having no fear of counselling itself, and finding it helpful when she did attend, Jeanette clearly struggled with what it means about her that she needs to access counselling: “Why can't I handle life like others can?” Jeannette's struggles with accessing the help and support she desires are evidence that she applies a negative self-stigma to accessing counselling help.

#### *Randy*

Randy had accessed counselling at an earlier point in his life for one of his children, but never for himself. When he felt the need to do so during the break up of his marriage, Randy found it more challenging to make the first call to ask for help, than to show up once an appointment was booked:

*I have a real hard time, a real difficult time with asking people for help because I feel I should be able to do it myself, that was the biggest thing, the most difficult*



*part, that I couldn't deal with it myself, I think that's probably the biggest thing for me.*

Randy spoke of letting his problems get “really big” before reaching out, and of struggling on in a life that had become unmanageable for a period of “about six months” prior to calling for an appointment. He explained that he'd reached a point of feeling totally out of control, which catalyzed the phone call:

*I'm the type of person that sometimes I wait too long...I wait till a problem's really a problem before I take it to somebody. There was a point when I just went into a tunnel vision mode and I couldn't think, couldn't multi-task...my ex was calling me constantly at work and harassing me, and I kept picking up and answering the phone and engaging in these arguments at work. I was getting to work, but I was showing up late, not caring. My employment was probably not going to last much longer...I couldn't concentrate, and my work is very important, I like to know I'm getting paid each week. That was the biggest thing for me really that turned things around. I was looking at losing a lot of things that were very important to me...my work, my new relationship. I was really just at a point where I honestly didn't know where to turn.*

Eventually, Randy reached a point of readiness to seek help:

*I'd pretty much come to terms with myself that I needed to talk to somebody...I was going to accept anything (in the way of help). I was at a point in my life where I needed somebody to help me, and somebody neutral, I was talking to too many people who weren't neutral so I wasn't feeling I was getting good advice....I wasn't getting the blunt answer, and sometimes I need that.*

Although Randy eventually accessed and found his counselling helpful, he spoke of a strong sense that he could not go back once some strategies had been offered. When his problems re-surfaced after a period of time he said:

*Things were getting out of control again but I realized I wasn't really doing a solution or an idea she had given me so I can't really go back...the stresses and harassment, they kind of continued but we (the counsellor and I) had already dealt with them so I didn't really want to come back with them again...*

*Sometimes I would make a call for counselling or something like that and then something would just come to me on my own before counselling or something like that...and I'd go that route.*

When asked whether returning would cause him to feel that he appeared ineffective or inadequate, Randy responded, "Yeah that would be a part of it, yeah." His response indicated that for Randy, subsequently missed appointments were due, at least in part, to the same self-stigma that had delayed his initial appointment. Randy's sense of personal adequacy and a related belief that asking for help somehow diminished him (self-stigma), was problematic for him. It represented a major stumbling block in his ability to access counselling help initially, and continued to do so at a future time when the need arose again.

#### *Julia*

Julia, the only participant who had never accessed counselling before, wanted to do so for her child who had recently begun acting out, both at home and at school. A major problem in booking a counselling appointment was her husband's negative perception of counselling, which was so strong that he completely rejected counselling as an option:

*Greg and I deal with things differently. He's not a big believer in it (counselling). I was 110% behind it but Greg was out there on the fence...back in his teens his Mom tried to force him into counselling cause he was a partier and kind of partied a little bit too much and drank and she tried to push him into counselling so he had a really bad taste in his mouth for it.*

Julia spoke of increased tensions between the couple during this time. She described trying to manage the problem on her own, putting off calling for help, accessing the internet for solutions, receiving unhelpful advice from friends and family, and reaching a felt crisis point before finally calling to book a counselling appointment. Julia explained that the differences of opinion between she and her husband around accessing counselling had a negative effect on the family. When asked “had you wanted to call earlier?” Julia responded:

*I did but he (Greg) was like “we'll figure it out.” It bothered Greg; he doesn't like talking about that kind of stuff. I was like “Can I do this? (take our child in to see a counsellor) and he was like, ‘I don't think we need to’ (so) we were on the internet and doing anything and everything, and people said “well try this” and “try that,” and then the acting out really started, and that was of course when Grandma was really ill....Greg and I were arguing more and not realizing that we were, and so the kids saw us fighting more, and then you know Grandma's in the hospital and nobody's telling why, and things just kept getting worse.*

Greg resisted accessing counselling because he perceived it to be about his shortcomings as a parent. He wanted them to “figure things out” on their own, even as circumstances

continued to escalate with the couple's child. Greg seemed to believe that 'not accessing help when one needs it is better than admitting a need for help,' help that Julia intimated her husband perceived as a weakness.

Although Julia experienced less dissonance about accessing counselling than her husband, Julia did have her own concerns about accessing as well. She spoke of the most difficult thing about calling being admitting that she did not have all of the answers all of the time, even for her own daughter. In response to the question "what was the most difficult part for you of deciding to ask for some counselling help... recognizing that maybe there wasn't a difficult part for you?" Julia responded:

*Yeah there was. It kind of got to that point where you know what? Obviously there's people in the world that are smarter than me that are going to know what I need to be doing because I'm obviously not doing something, and I need someone to tell me what that might be...I was feeling like a bad mom.*

For Julia, not knowing all the answers equated with "being a bad Mom," which demonstrated a different kind of social stigma – one associated with motherhood / parenthood. Her husband, on the other hand, seemed to have internalized a negative social stigma associated with counselling and with all the questioning and learning that go with it.

Julia finally did schedule a counselling appointment when a teacher called about the severity of their child's behavior at school. However, Julia and her husband, Greg, ended up missing the appointment because a family member was abruptly hospitalized. The family was unavailable for the counselling appointment because they prioritized being at the hospital with their family member:

*We couldn't go because there was a complication... and for that whole week we were all at the hospital ... we just kind of...never re-booked after that.*

After missing their appointment, and during the week at the hospital, Julia had occasion to speak with another family member who was a helping professional. The uncle offered the suggestion that the couple share the truth about Grandma's illness with their children and allow them to ask questions.

*We weren't telling them anything because we thought that would be better. Once we sat down, it was funny cause we never even thought they had just learned about Terry Fox and that he died, and when we first told them that Grandma was very ill, one said "well now they're gonna cut off Grandma's leg and put her in the ground like Terry Fox" and I thought "Oh, my goodness!" So once we explained things and then this child talked to grandmother - cause we're really, really close - and asked "Grandma are you okay?" and "what's happening?" it was so much better ... felt better about things once it became okay to ask questions...and then Grandma ended up getting a bit better, she went into remission, and then things started going a bit better in school and it all just corrected itself almost.*

While the negative stigma attached to counselling was primary in blocking this family's access to counselling help, finding appropriate help elsewhere and having the problem begin to resolve on its own were additional factors in their not keeping, or not re-booking, their appointment.

*Summary*

The theme of wanting to feel competent at “managing” or “dealing with” one’s problems is evident in participants’ statements. More notable still is evidence of the shared meaning of self-stigma, in which participants internalize the socially held negative stigma associated with counselling and with those who access it. Participants themselves experienced their need for counselling as a weakness - as a form of justification, or a reasonable basis for, emotions such as humiliation and the experience of diminished self-worth; even shame - rather than as a form of personal strength in asking for what one needs.

***Theme 1 - Fears of Judgment, Ridicule, Reprimand***

***“What if they tell us we’re doing this wrong? What if they say I’m crazy?”***

In addition to the participants’ experiences of self-stigma about accessing counselling, each participant also indicated concerns about what the counsellor might ask and what he or she might say or think. Some indicated quite clearly a fear of being judged, humiliated, ridiculed or reprimanded by the counsellor. Intensifying this fear was the discomfort of discussing highly personal subjects with a stranger and the resulting high degree of vulnerability one exposes oneself to in doing so. Randy indicated his discomfort when he said:

*I wasn’t sure if I really wanted to discuss what was going on with a stranger...I’m a very private person, I keep a lot of things within myself.....It (the avoidance) was a bit of that (discomfort at sharing) and a bit of not knowing where to go or if my concerns were important enough.*

Randy was the only participant who did not tell another person, not even his girlfriend, that he was accessing counselling. He said this was because he is a very private person. Randy was concerned that he might be embarrassed if his problems did not ‘warrant’ counselling help and was hugely relieved when he was patched straight through to his counsellor. This response to Randy’s phone call relieved his fears of ridicule and judgment at needing help for something that others might see as trivial. It also validated his concerns. Randy expressed being relieved that no-one ever said “I’m sorry we can’t help you” or “this isn’t the kind of thing one brings to counselling.”

Randy also indicated hidden concerns about being reprimanded when he spoke of a single joint counselling session (the first session in fact) with his ex. He was relieved at what he learned about counselling in that session; namely that it is non-blaming:

*...there was one session I did have with my ex; she (the counsellor) wanted to have one session together with us, and the counsellor basically told me “I’m not going to point fingers”*

Kevin was very clear about his worries and his fears of judgment. He spoke of the thoughts that ran through his mind as he contemplated accessing help:

*You’re thinking “What are they gonna say?” and you’re worried about being judged and about getting into fine detail about it (the problem). People don’t feel comfortable with it, no-one likes to backtrack on that kind of stuff...I sort of knew what to expect (in counselling) from when I was a kid, but you know, this was a different situation (gambling and domestic abuse)...*

Several times throughout the interview Kevin mentioned his appreciation that no-one “centered him out” or reprimanded him, and like Randy, he expressed privacy and containment concerns related to his fear of judgment:

*(I appreciated) the lack of judgment, it was a lot better than I thought, you don't want to have someone shaking their finger at you or saying “that was wrong.” Obviously I know it was wrong; that's why I was there, so yeah, the way it was dealt with was a lot easier than I expected....(I was concerned that) the intake counsellor wasn't the person you'd see...you could maybe get a little more into detail (if it was) and maybe that'd make people feel more comfortable at the time they call, to know when they go in they'll see that same person that already knows what you're coming in for.*

In this excerpt, Kevin communicated a desire to minimize the number of people with whom he would have to share his behavior, and/or the number of times he would have to speak of it; perhaps fearing a negative perception of him by others.

Julia indicated that her husband Greg had significant fears around being judged and she had some of her own as well:

*Greg doesn't like talking about that kind of stuff (personal things), he doesn't mind talking about it to me though, but to bring in a stranger! He was really like ... “What are they gonna think?” and “What if they tell us we're doing this wrong?” so I had more anxiety for him because he was asking me these things.*

Julia indicated her own concerns when she offered information about why she thinks individuals may not keep their appointments:



*I think it may be the anxiety, you know you have that anxiety of “they’re probably gonna think I’m this” or “they’re gonna think I’m that.”*

Julia further indicated some of her own vulnerabilities when she spoke of her relief at the kindness and non-judgmental attitude of the intake counsellor:

*The lady was very nice...I said, “You know I’m so frustrated I don’t know what else to do or where to go” and she was very good about that, she was like “well you know you made the right call” and “we’ll help you out” and “we’ll answer any questions that we can” and “we’ll pull you through” so that made me feel like I wasn’t a completely bad mom.*

Fear of judgment was clearly high on the list of items that provoked anxiety for this couple in relation to accessing counselling.

Jeannette spoke of the concerns she had the first time she accessed counselling. Various fears were noted: the unknown; that others might learn she was seeing a counsellor; what the counsellor might say to her; how counselling might affect her as well as fear of being judged:

*I didn’t know what to expect, so I was nervous about the unknown, I was young and I was concerned that somehow they would tell my parents or my family, which I KNEW wasn’t the case but it was still a fear, and I was afraid that they would tell me that I was crazy...and even then when I was a student, I was concerned that counselling would cause a big upheaval in my life and I was very aware that I didn’t really have the; well I FELT like I didn’t have the space for that to happen so I was worried about that too.*

Jeanette shared that she did have fears of being judged in the beginning, but not any more, at least not by counsellors or intake workers. She shared the circumstances under which she HAD felt judged, and in doing so, she described a self-stigma:

*The only time I've honestly ever felt judged by an intake call is sometimes I judge myself: if the demographic questions are very long and so I find myself listing off a whole bunch of my history and it feels like – to me; it's me doing it to myself – this long list of mistakes, or things perhaps I could have done differently in my life - its me judging me though it's never them judging me. It's just a long list and you know we're not able to flesh it out or fill in the gaps, and of course they don't need to at that point. They just sort of see it as thing long list of mistakes or mishaps or whatever, but I've never felt judged by them.*

Jeannette's words call to mind the saying that 'we are our own toughest critics.' With this group of participants, this statement appears to be quite true. Certainly they described vulnerabilities that were very real.

### *Summary*

The fear of being negatively judged by others, including the counsellor, was evident in all of the participants' experiences with accessing counselling. Randy feared being judged by others and told no-one that he was seeing a counsellor. In addition he feared ridicule should his concerns not be deemed "important enough" for counselling. Kevin feared judgment and reprimand from the counsellor for the gambling and abusive behaviors which brought him into counselling, as well as for his suicidal feelings. Jeanette indicated early fears of others learning she was seeing a counsellor as well as of being told she was crazy. While Jeanette speaks of no longer fearing judgment from

counsellors, she also indicates concern around the long list of “mistakes” the intake counsellor sometimes hears out of context. Finally, Julia and her husband feared the unknown as well as being told they were “doing this (parenting) wrong.”

***Theme 2 – Positive Emotions Associated with Accessing Counselling***

Kevin, Julia, Jeanette and Randy all observed they felt better after finally reaching out and booking an appointment. Each observed a sense of accomplishment, control, hope and calm at the time of booking, and for those who made it to their first appointments, these emotions continued beyond the first appointment as well. Kevin found the experience of accessing counselling difficult but rewarding. He spoke of the benefits he received in both individual and group counselling, and the inner strength he relied on to pull himself through:

*I'm not really a quitter...it was tough through the start, but after a few times of going you kinda feel a lot better after you know everybody and fit in...people who want the help stay and the ones that weren't really serious about getting help obviously didn't stay cause they weren't there at the end. There were 16 that started but only 8 finished...it was hard...emotional...because you really have to open up to everybody (about) why you're there. Towards the end we kind of bonded...you wanted to go 'cause you were actually accomplishing something and you're actually helping other people accomplish something as well. The addictions counselling actually wasn't as bad as I had thought...after I went a couple of times I felt really comfortable. The guy I had was really good, he didn't center you out or nothing, he didn't point you in the wrong direction...I felt really secure. Actually I don't mind talking about my problems with somebody, that's*

*the way I've learned to deal with them. You can't just let them build up, which I have, it's taken me a long time to learn.*

Kevin spoke of walking into the counselling agency as follows:

*Yeah I just walked in, so I told them why I was there, the secretary, and I remember them saying 'well I'll get someone to help you.' So I had to sit there and wait and I was nervous of course with all the things running through your head and I knew I'd have to open up with some of the things that I'd done or bring some of it back up which no-one likes talking about. But I expected to talk about it that day...to tell them why you're there and (learn) whether or not they're gonna be able to help you...the guy that took me in, I felt very comfortable with him, you could tell there were some touchy subjects and that there was more there, and he moved me toward it....like at first I only mentioned the abuse against my girlfriend, but it all got brought up, suicide, gambling, everything.... and he offered me the help that I needed in a different way than I expected.... I never would have expected getting into that (narratives) program that day, but he pointed me in the right direction... there was a sense that there was some help available, a calming effect... I really didn't know what was gonna happen after he addressed everything with me ....but nothing that I predicted happened in there that day and it went a lot smoother than I thought it would...I had a sense of hope and some direction. The best thing I guess was the guidance that he gave me.*

For Kevin, his intake experience generated a sense of purpose and of hope that he had not felt in a very long time. He was glad he went in that day. Kevin shared he grew up in a

home where domestic violence was present. He was grateful for his counselling experiences and wanted to continue them:

*Yeah, I grew up with it (domestic violence) and I thought it had left me but when I got into a relationship it was a lot harder, especially with all the stress that I had brought with it. It's still there. It's just a matter of dealing with it, well not the abuse, well there's still some verbal abuse, I can be bad for that, but not the physical. So I still haven't, I'm doing a lot better but I could be doing even better still...I'd like to be able to go (to counselling) once a month or so, no matter what.*

Kevin was still together with his girlfriend of three years and his sentiments may be seen as intentionally wanting to create the healthy home environment which he did not have while growing up.

Julia also indicated a sense of relief and of hope after calling to book an appointment, and re-iterated that her intention had been to attend:

*After we had made the call and booked everything I just felt better cause I thought, "You know what? There's gonna be something good come out of this at the end of the day." And like I said the only reason we didn't get in is the week it was a family member going through some pretty serious medical treatments... and we were pretty much living at the hospital for that whole week...it just seemed more important at the time...if the appointment had been the week before, we would have made it.*

Julia's sense that "something good will come of this" indicates the hope and peace she had found in finally coming to agreement with her husband around booking a counselling appointment and in finally addressing the problem with their child directly.

When Randy eventually went in and saw a counsellor, he also found it quite helpful. He described his experience as positive and offered an example of one of the strategies his counsellor offered him:

*It wasn't so bad once you got into it...we have an EFAP and we can phone these people for just kind of free counselling. You can phone and you can ask a few questions and they'll try and help you out a little and sometimes they'll refer you to someone else and I'm pretty sure that's how I was referred to FSS...(when I called) they patched me right through, it happened that the counsellor was available that I was going to see so I talked to her briefly... once I was there I was right in there....it was about backing away, I needed to learn to back away... she (the counsellor) worked with me....(one suggestion was) to just quit picking up the phone at work and that my ex would eventually just get the point and to give (my ex) a time slot that she can call after work at home and anything before or after that to just not pick up. I'd pick up once in a while and she'd (my ex) kind of get back at it, but it's definitely toned things down a lot.*

For Randy, a man who is very private and finds it particularly difficult to ask for help, making the call to book an appointment was a powerful accomplishment. He spoke about what was most helpful about his intake call:

*...the fact that I was gonna be getting help, and that I actually took initiative and went ahead and talked to somebody, or found somebody to talk to...I felt pretty good about my decision (to call)...I felt it was the place I needed to be.*

Randy felt grounded and empowered by reaching out and finding that help was there. He felt a sense of accomplishment in doing so that led to a sense of faith and hope:

*I had pretty good faith that it would help me out, I kind of went in not really knowing what to expect actually so I can't say I had full confidence in that it was gonna work, but pretty much as soon as I started I was right in there....I was at a point in my life I think where anything was going to be a help. What I got out of counselling is that they point you in the right direction and they let you make the decisions, they basically provide you with a tool ...it's not like they go "this is your problem; this is what you need to do."*

Randy indicated that both booking an appointment and accessing counselling, together with the "tools" it gave him, provided him with a sense of some power and control over a situation in his life in which, previously, he had felt hopeless, powerless and out-of-control.

Jeanette echoed similar sentiments in speaking of the first time she called for help:

*Oh, I was terrified but I felt good about the decision to call because deciding to do something, even if turned out in the end to be the wrong decision, felt better than doing nothing at all....generally I tend to feel pretty good; often when calling I'm in a lot of emotional distress and usually when I get off the phone I feel much more calm because I've taken a step. And so that action just makes me*

*feel a lot better because a lot of my crises tend to involve feeling like my life is out of my control.*

Jeannette indicated that she consistently found both comfort and empowerment in reaching out for counselling help. Each time she reached out, she re-affirmed that she can ‘manage’ to access the help and support she needs when she needs it.

### *Summary*

Each of the participants indicated a positive outcome to their struggle with accessing counselling. Each learned something about the counselling process, about themselves and about dealing with the difficulties present in their lives. In effect, as each of them stated, they took a step forward and gained some control over situations they previously experienced as unmanageable. They also lowered their perceived stress and in so doing, rendered their lives more hopeful and positive.

### ***Theme 3 – Accessing Counselling: Unexpected Surprises and Possible Solutions***

Each of the participants encountered surprises or events other than they had expected when accessing counselling. They all expressed a desire to see some things be different about this process, and shared thoughts on what might make it easier or more comfortable for people to access counselling. Jeanette spoke about how she would like to see public attitudes toward counselling changed to make it easier for people to access help:

*I think that our society needs to change its attitudes towards counselling, especially for men. I think people really need to embrace it as a positive option... as self care...instead of attaching stigma and notions of guilt or shame or weakness to it the way that they still do, particularly for guys...a lot of people*



*tend to hold those views that if you're going to counselling then there's something wrong with you and you're not strong enough or you're not good enough. Or if you're going to counselling then there's something horrible that happened to you and it's this dirty secret, and like people need to stop thinking that kind of stuff because it just makes it harder for people to access.*

She elaborated on the idea of counselling as self-care in our culture and spoke of the settings where counselling often takes place:

*We don't embrace self-care generally as a culture, or mental health in the same way we do physical health....and they need to redecorate those bloody offices (laughs) you know when you walk in the whole building looks so clinical, usually with those horrible taupes and those hospital greens.*

As a single Mom in the middle of a messy divorce who had attempted suicide at least once, the act of accessing counselling presented additional layers of fear and concern for Jeannette. She shared that in the past when she has felt suicidal, the divorce situation, together with confidentiality ethics, constrained her ability to speak freely, openly and honestly with her counsellors:

*I have felt in the past like that (information on limits to confidentiality) has limited my ability to be completely honest...I never felt as if I could say "I'm feeling suicidal at this point in my life" because then my fear would be that if I went to a counsellor and said, "Oh I'm feeling suicidal right now" what would the outcome of that be? Would they notify the police? Would my children be removed? Those kinds of concerns, and I think those are valid concerns for a lot of women to be honest.*

This concern functioned as a barrier for Jeanette, and perhaps many other women, who want to access counselling yet feel compromised in doing so fully. Another concern raised by Jeanette was a perception that entering counselling might compromise her ability to function well on a daily basis in what she experienced as her primary role, that of mother to her children:

*I've been a single Mom for more of my children's years than not, so I need to be sort of together; I don't have the luxury of taking a year out of my life to be an emotional basket case and go through my counselling, I need to be there for my kids and be constantly on the ball...maybe not every day I know, but certainly there would be days when I wouldn't be able to function very well and I just, I don't have the time for that...I know big picture that what my children need is to have a Mom who's healthy, so I know that when they're older they would very much appreciate the fact that Mom took time out to do her healing and do her counselling, I know that they would think that was of value. But they're little right now and they need Mom to go to work and put food on the table and help with their homework and all of that.*

For Jeanette right now, NOT going to counselling IS taking care of her children: “That’s the way I see it,” she stated. In addition to this concern, Jeannette identified concerns about re-opening old wounds and about lengthy time commitments associated with accessing counselling as well as around the question of whether or not she could successfully “do” counselling. She believes that each of these was necessary eventualities and / or requirements of accessing counselling:

*It would be long-term and a lot of work and it would dredge up a lot of issues because my anxiety is linked to my past trauma which is linked to my childhood, there's so much there...I know that quick fixes don't exist but I think there's a part of me that is still hoping that I can go for a few sessions, get some really practical skills, and then feel equipped to continue with my life and not have to make counselling a long term commitment in my life...so yeah, I do have a lot of fear about that, and maybe I'm scared of the hard work, I don't know, I'm not sure that I can do it.*

Jeannette has given counselling a lot of thought. She experiences it very positively, finds it very supportive and most helpful, but appears to struggle with what she perceives it may mean about her as well as with what it may require of her.

Uncertainties about what sorts of problems or concerns were appropriate for counselling acted as a barrier for Randy in accessing counselling. Although he was under a lot of stress trying to cope with a difficult situation he had never encountered before, he was uncertain as to whether or not his concerns warranted a counsellor's help:

*Sometimes I would think about phoning and then it would just be a process of (pauses) I wasn't sure if what I was going in there with was important enough. I didn't have much to bring or I didn't feel it was important enough to take it to counselling for some of my situations. Some of my stresses, like financial-wise, I wasn't sure that's something I could really bring to counselling.*

The process of how to access help was also very unclear to Randy: "I felt no reluctance to ask for counselling help (once I'd decided to do so), but how to go about it, yeah, very

reluctant.” Randy experienced trepidations about what to say when contacting somebody. He elaborated on his struggle about how one asks for counselling help:

*I didn't know how to bring my concerns to counselling. I guess it was just a reluctance to not even know how to bring some of these things to the table. When I was making the call and getting patched through to whoever was going to help me out, I honestly didn't know what I was going to tell them. Like I didn't know what I was going to talk to them about, what I was going to say. I was just kind of jumping into it blind. I wondered 'Can they help me? Am I going to the right people?'*

Randy spent a significant amount of time trying to figure out what to say to the intake worker, and whether or not a counselling agency was the right place for him to look for help with what were essentially new concerns to him. The whole experience was shrouded in doubt and anxiety.

Both Jeanette and Kevin indicated struggles with fees, each describing the fees as problematic. Although Jeanette appreciated that her partner had Employee Family Assistance Plans (EFAP) that she could access, as she had none of her own, Kevin described Employee Family Assistance Plans (EFAP) as inadequate:

*Well I'm making it seem like I can't afford it, but if I really broke down I could pay the money and then I'd obviously just have to wait to get it back again and be done...I am covered with so much per year, which is only 3 visits which is not very much...I'd like to go once a month or so no matter what, but like I said I can't really afford to do that, but yeah, the thought's still there that I'd like to go.*

Kevin indicated a desire for more EFAP coverage and lower fees or a different billing system in which the session is offered first and billed later. He wished counsellors operated like dentists, providing services first and billing later, especially for those in danger of harming themselves:

*It's just kind of a surprise when a person is calling and asking for help why the money subject would even get brought up...it kind of puts a halt to the whole thing. It seemed like it was more important than anything else...it felt like a lawyer, or buying a car, where you need the money down before you get the goods... maybe there's some people that might not be so extreme but maybe this other person is seeking help and maybe he's seeking help today and for him there ain't gonna be a tomorrow...*

As mentioned earlier, Jeanette believed that counselling was a long-term commitment that would render her “a basket case” and interfere with her ability to function as a mother to her children. She also indicated fears of not being able to “do” counselling:

*...but it does feel like quite a commitment, it really does and its just sort of one more thing you have to do when you're already often tired or strapped out or whatever...maybe I'm afraid of the hard work....I don't know that I could do it.*

Julia was troubled by the wait time. She felt she missed her appointment, in part, because the three week wait was too long:

*It (the wait time) was three weeks...that was a little disappointing because I mean of course I'm frustrated and upset and I kinda wanted to get in like now... I*

*didn't like that, and maybe if we didn't have to wait so long we would have been able, well we would have been able to make the appointment.*

Julia and Greg were also troubled by uncertainties about what would happen once they entered counselling. They were not alone with this worry. Each participant spoke of wondering about what the counsellor might ask; what he or she might do or expect of them. Julia's husband wanted to know, "What are they gonna be asking?"

*He was like "what are they gonna ask us?".... and I don't know what they're gonna ask us....at that time it was just such an emotional roller coaster for our family and we didn't really know what to do or where to go and maybe if someone just would have talked to us a little bit more about what was gonna happen when we, when we DID go in there (it might have made a difference)*

Julia indicated uncertainty around process and surprise at the number of questions asked during the intake call, especially since she called from work:

*They asked more than I was expecting, I remember thinking, "Boy this is a lot of questions for booking an appointment." I was expecting it to be like a doctor's appointment; you phone and it's "Can I come in on Tuesday?" like that...I guess it would help even if they initially warn you when you book the appointment and say "Do you have a five or ten minutes; I'm gonna ask you a few questions and its gonna take a few minutes"...just to let you know that they do have a few things to ask you.*

Randy indicated that the wait time was problematic for him as well, even though it was just one week. He was concerned that his immediate issues, mood, and level of coping might not be the same on the day of his appointment as on the day of his intake call;

*It was a little tricky cause I thought well I made the call and I'm in this frame of mind now but in a week or two what kind of frame of mind am I gonna be in? And am I gonna be able to bring to the table what my concerns were then? I was frustrated and upset and I wanted help like now...it would have been nice to be seen sooner.*

Child care and transportation were also mentioned as areas where participants would like to see some change. Jeannette said:

*I think it would be wonderful if counsellors had it that you could come and leave your children with a little day care or child care provider that they have there and then that way it makes it easier for parents to come to counselling. I think they could bus you there and that would be great.*

#### *Summary*

Kevin, Julia, Randy and Jeanette had several suggestions or requests about how to make counselling easier and more comfortable to access. Some of these recommendations had to do with misunderstandings or misinformation about counselling in general, while others concerned more practical issues like child care and fees.

Jeanette, Randy and Kevin actively wanted to continue accessing counselling help and had called at least once to book additional appointments. At the time of the research interviews, none had followed through with these appointments.

#### ***Theme 4 – Children as Pivotal Consideration in Process of Accessing Counselling***

Children appeared to be an influential consideration in accessing counselling. For example, Randy described guilt about leaving his children as part of ending his relationship with their mother as an important motivator that moved him into counselling.

Paradoxically, the emotions about his children's welfare also functioned as a barrier because, like the self-stigma associated with asking for counselling help, his guilt was difficult to accept and acknowledge and therefore, took time. Randy shared that his ex-spouse was quite hostile and the children were exposed to that hostility. His guilt about this together with the children's questions brought his concern for his children to the fore:

*I had guilt running through me too to deal with because I was breaking up and there were two kids involved...if there weren't kids involved it wouldn't have been that big of an issue but I was leaving the kids behind with their mother... the hostility concerned me for the children's sake. So that was another thing that got me to counselling was concern about how to deal with the hostility... there was guilt but also confusion (about) how I'd deal with the situation, when you're in that situation, when you walk out and you have kids, how to deal with the kids when they start asking questions (is confusing).*

Concern for his children allowed Randy to access counselling earlier than he may otherwise have done. The same appeared true for Jeannette, who also identified a distinct difference in accessing counselling for her children as opposed to accessing counselling for herself:

*When issues have come up to do with my children and I've reached out for counselling assistance or support, I do it immediately and waste no time, so that I think, is good, but when it's to do with myself I usually wait till crisis occurs and then start calling very badly.*

Julia explained that it was when it became very clear to her that their child's education was being threatened by behaviors at school, she finally reached out for help.



Education was described as something important in Julia's family so when the teacher called Julia to speak of the behavioral concerns they were seeing at school, the focus on education as an entry point for counselling allowed Greg to be a bit more comfortable with seeking counselling:

*Then the teacher phoned and asked, "What's going on?" She said there was acting out again that was "totally out of control" and she said our child had spent the morning in the principal's office, and I was like (shocked). I phoned Greg at work and said "Okay listen, our child just spent the morning in the principal's office and what, what, what are we gonna do?" and I was like "Okay well now we gotta, we gotta do something about this....and we thought they're gonna be banished as a bad kid...and that's when he said," Okay then we'll call." It was just what was best for our child. Even Greg was okay with it then cause once we had actually said okay this was what we were gonna do and we're doing this for our child, once we kind of got that mind set, we were both good with it. We were so, just so frustrated by the time we actually got to that point (of calling)...I just wanted somebody to tell me how to fix it...*

Once the concern was re-focused on their child's education as opposed to on Julia and Greg's parenting abilities, Greg was more readily able to agree to enter counselling. It was possible that the 'cost' of avoiding help was now perceived as higher than the 'benefit' of avoiding....and that this may have been true for each of the participants in relation to their children or loved ones.

*Summary*

The shared meaning of booking an initial counselling appointment and subsequently changing one's mind was one of struggle with self-stigma primarily, and of a secondary fear of judgment, ridicule or reprimand by others, including the counsellor. All participants found their counselling experiences to be positive and helpful and to lead to personal growth and all wished that counselling was easier to access and more acceptable. Finally, all of the participants experienced the concerns of children and / or loved ones as externalizing factors with the capacity to more quickly move them into counselling than perhaps they otherwise would.

## CHAPTER 5: DISCUSSION

This basic interpretive qualitative study (Merriam, 2002) was conducted to understand more about the experience of accessing counselling, with special emphasis given both to clients perceived difficulties in accessing and to their positive experiences in doing so. This chapter reviews and summarizes the main findings of the study, extending these to existing literature on (a) the no-show phenomenon, (b) the stigma associated with mental health, (c) self-stigma, and (d) therapist approaches to clients who do not show up for pre-booked appointments. Practice implications, strengths and limitations of the present study, and areas for future research are delineated.

### *Summary of Findings*

The shared meaning of Jeannette, Kevin, Julia and Randy's lived experiences in accessing counselling was one of significant inner turmoil which led to each of them asking, "What does it mean about me that I need counselling help?" That is, the act of accessing counselling help was perceived by every participant as signifying a personal inadequacy, both to others and, more importantly, to themselves. This self-stigma functioned as a significant barrier to accessing services. Each of the participants attempted to maintain a positive self-image by avoiding counselling, and the stigma associated with those who access it, for as long as he or she could stand to do so. During these periods of avoidance and image maintenance, the internal struggle with self-perception and stigma, together with escalating external stressors, led each participant to experience ever-greater levels of stress, pain, and suffering, which in turn led to ever-greater losses in function, and, for some, severe suicidality, prior to reaching out for counselling help. Jeannette indicated that she had experienced several periods of self-

stigma-related struggle in accessing counselling which varied from a few months to a year in length. Kevin stated he'd avoided asking for counselling help for a period of 4 years, turning instead to alcohol and gambling in an attempt to self-manage his areas of concern. Randy struggled with what needing counselling meant about him for six months before seeking help, and Julia spent a period of two months arguing with her husband in an attempt to gain his blessings in taking their young daughter in for counselling help. This self-stigma was so strong that even if, as in Jeannette and Kevin's cases, previous counselling experiences had been perceived as extremely positive and deemed helpful, participants still struggled with the question, "What does it mean about me that I need counselling help?" with each successive attempt at accessing. It appeared that those who had accessed counselling before felt previous counselling should have "fixed" them and that perceived relapse or subsequent difficulties were a sign of personal failure. At the time of the study, Randy was engaged in avoiding further counselling for this stated reason. Each participant indicated that it was the reaching of a crisis point that finally brought him or her to call and attempt to access counselling. Jeannette shared that she frequently booked an appointment and then did not show up for it, so strong it seemed was her desire to avoid the self-stigma she had internalized around accessing counselling help. Her desire was to perceive herself as "capable" not "weak," "inadequate," or "unacceptable."

In addition to a common shared meaning, I also identified four pertinent themes from the data: a) fears of judgment, ridicule or reprimand, b) positive emotions associated with accessing counselling, c) unexpected surprises and possible solutions, and d) children as pivotal consideration in the process of accessing counselling. Jeannette,

Kevin, Julia and Randy's lived experience with attempting to access counselling was characterized by fears of judgment, ridicule, or reprimand by the counsellor. They feared humiliation as well. Randy was concerned that the counsellor might tell him his concerns were not important enough, or did not warrant, counselling help. A related concern for him was *when* to access, i.e., how "bad" did the problem have to be to "warrant" counselling help. Randy struggled greatly with fears of humiliation around the process of accessing help. He was uncertain about "how" to access counselling help, about "what to say" and "who to call." Kevin indicated fears of being negatively judged, even blamed, by the counsellor for the problems that brought him in. Even though Kevin had accessed counselling before during his school years, he was worried about being judged and about being blamed for his problems this time around because "this was a different situation." Kevin feared that the counsellor would not empathize with his difficulties with gambling, suicidal feelings, and being violent to his girlfriend; but rather, would express negative judgment, reprimand and blame. Jeannette feared being told she was "crazy," and Julia and her husband feared being told they "weren't doing this (parenting) right." All the participants were anxious about having to share their difficulties with more than one person, i.e., tell their stories to an intake worker and then a counsellor, thus risking humiliation or reprimand more than once. They all feared a loss of confidentiality (i.e., that others might find out they were seeing a counsellor) and Jeannette feared how counselling might affect her emotionally; how it might impact her ability to continue parenting effectively; how a long list of "mistakes" might be heard out of context by an intake worker and lead to negative judgment of her. All were sensitive about the levels of vulnerability and trust that accessing counselling both exposed them to, and required of

them. All were anxious and fearful too about the unknown; about what to expect or what counselling “looked like.” Julia, Kevin, and Jeannette spoke of concerns about “what they might ask me” and about “talking with a stranger” about personal topics.

During the interviews, all four participants talked about how they felt better when they finally reached out and booked an appointment. Common emotional experiences were those of a sense of accomplishment, empowerment, control, hope, faith, and calm. Each participant indicated a great sense of relief at finding the counsellor did not blame or judge them. Kevin stated that it went a lot smoother than he thought it would, and Randy indicated relief at finding counselling was a “blame-free” process. Randy’s relief was heightened by the sense of control he gained over a situation in which previously, he’d felt hopeless, powerless and out-of-control. Jeannette indicated a sense of power and accomplishment in facing a terrifying situation (i.e., both making herself vulnerable and talking to a stranger about highly personal topics) and overcoming her fears. Julia indicated that calling for help left her with a sense of faith that “something good will come of this.” What each indicated, in fact, was a positive outcome to their struggle to access counselling: perceived stress was lowered, hope was renewed, and participants’ senses of personal empowerment were restored. Jeannette, Kevin, Julia and Randy successfully managed to access the supports they needed after much deliberation. They took steps to ask for what they needed and were rewarded with a sense of feeling unburdened in doing so. In taking action, each participant demonstrated effectiveness in taking care of themselves and their families. By accessing counselling help, Jeannette, Kevin, Julia and Randy rendered their lives more hopeful and positive.

Each participant experienced unexpected barriers in the process of accessing counselling, and each expressed a desire that these barriers be removed in order to make counselling easier to access. Unsurprisingly the first thing they wanted to see changed was this stigma associated with seeking help. Jeannette, Randy, Julia and Kevin all felt strongly that counselling would be much easier to access were this stigma not present; that the internal struggle with shame and with diminished self-worth would be nullified if there were no stigma attached to accessing counselling or other mental health care services.

Each participant wished he or she did not have to deal with the stigma. Jeannette put it very well. She imagined a culture in which emotional and mental health were valued in the same way physical and dental health care were valued, and in which counselling and other mental health care services were seen as self-care in the same way physical and dental health care were. But because stigma does exist, she and Randy were concerned that someone might “find out” they were seeing a counsellor, which generated confidentiality concerns. In addition to someone ‘finding out’ that they were seeing a counsellor, all participants were surprised that they had to tell their ‘stories’ to more than one person, i.e. an intake counsellor *and then* their therapist(s). In each of their experiences, it was ‘hard enough’ to tell their stories to a stranger in the first place (and to trust in the system’s claim to confidentiality) let alone to do so more than once. Each ‘re-telling’ of their story felt to Jeannette, Kevin and Randy like upping the ante of risk; either that others would ‘find out’ they were seeing a counsellor (the more people who know, the more risk of a “leak”) or that they themselves would be negatively judged or reprimanded by the person they were telling their stories to. The participants indicated

that they would prefer for the intake counsellor and therapist to be the same individual. Where this is not possible, it appears that direct contact with the therapist prior to the initial appointment, such as that experienced by Randy when “patched right through to his counsellor” during the intake call, leads to greater feelings of safety, comfort, and assuredness in accessing counselling.

A related area involving confidentiality was concern about the limits to confidentiality. Jeannette experienced these as a barrier, particularly as she was in the midst of a painful divorce where her husband was pursuing custody of their children. She feared that her accessing counselling could be used against her as demonstrating weakness or incapacity to care for her children. Jeannette particularly feared that knowledge of her suicidal ideation would place her at risk for losing her children. Jeannette did not feel safe enough to trust that taking steps to keep herself safe *for* her children would be viewed as a positive thing, either by the counsellor or by the judicial system and the public. She did not know about the process of suicide risk assessment; was not told of it; and did not feel safe enough to ask about what would happen if she disclosed suicidal ideation. Rather, she believed that if she mentioned suicide, she’d be “sent away” and her children taken from her. It seems very important to provide information that sharing suicidal ideation does not lead automatically to the “loony bin.” Sharing information about suicidal ideation assessment, the degrees of suicidality (levels of risk), and emphasizing the intent to keep clients safe would be helpful. Clients could, and should, be informed that the steps involved in committing someone to hospital / long-term psychiatric care against his or her will, and the associated right to appeal, is not a simple or quick process.



Julia was surprised that accessing counselling was not the same as accessing a medical appointment. That is, she was surprised that one didn't just call up and say, "I'd like to book a spot next Tuesday afternoon please." She was surprised by the number of questions asked and the length of time of the call – all the more so because she'd called from work. Julia indicated she would have preferred for the intake counsellor to inform her that she would need ten minutes or so of Julia's time and to ask Julia if she had that time, and some privacy, available. Julia was also surprised that after her intake call she still had no idea of what would happen when she and her husband actually *went* for their appointment. Julia indicated that if someone had actually told them "a little bit about what would happen when (they) actually went in there" they may have made it in for their pre-booked appointment.

Without exception, the participants would have liked some knowledge 'going in' of what to expect around the process of accessing counselling. This was true, even when they had accessed before. For each new or successive problem or concern, the process of accessing was "new," as evidenced by Kevin's statement that "this time" he was accessing for "a different situation" and therefore didn't know what to expect. Randy, Kevin, Jeannette and Julia all indicated that it would have been helpful to have had information about (a) what sorts of concerns 'warrant' counselling help; (b) who to call; (c) what counselling is and what it isn't, i.e. non-judgmental, supportive, not a 'quick fix'; (d) what kinds of information they'd be asked to provide and why; (e) how long it would take to do so; (f) what sorts of options might then be available to them (different services for different presenting problems); (g) how connections to these services might be made and how long that might take; (h) what a typical first session might look like;

and (i) what the counsellors responsibilities are versus the clients', i.e. what might be expected of them. This finding of successive acts of accessing counselling appears to follow a pattern similar to that of the addiction cycle with periods of doing well and periods of risk, relapse, and crisis

Jeannette was concerned that "doing her healing" in counselling would require that she re-live painful and traumatic past events and that this would render her "a basket case," unable to care for her children on a daily basis. She saw not accessing as a way of taking care of herself, a way of avoiding an anticipated loss of functioning. This belief kept her on a see-saw of wanting counselling, but fearing it at the same time. Jeannette stated she wished there was a way to just go in, get some quick and highly usable techniques, and be able to go off then and function better. It would have been helpful for Jeanette to know that one need not re-live trauma in order to heal from it. Jeannette was also concerned that she might not be able to "do" counselling right or successfully. It would be helpful for clients to know that there is no "right" or "wrong" way to "do" counselling.

Kevin was surprised that payment for counselling services was different than making a dentist or lawyer's appointment in which the service is accessed and billing follows the service. He struggled with the fee structure, finding that the questions around payment and insurance tended to minimize his presenting concerns, functioning in this way as a barrier to accessing. Kevin felt that this way of doing business might be fine for some people, but he also felt it might keep others in dire need from accessing. Kevin highlighted an example of someone attempting to access, being asked how he or she planned to pay, feeling shut down as a result (because they *can't* pay), and perhaps going

off and committing the suicide whose ideation and plan had prompted his or her call. Kevin's concerns seem warranted. If nothing else, it seems important that at intake, a thorough assessment be completed prior to any questions being asked about payment. As such, callers and their situation and functioning need to be *well understood* before discussing payment practicalities, and if need be, services should be offered in dire circumstances, and connections made, regardless of ability to pay.

Julia was quite surprised by her wait-time of three weeks. She wanted something sooner and was looking for help *at the time of her call*. Each of the other participants also minded the wait time, although some were more prepared for it than others. Randy was concerned that his state of mind and his concerns might be different on the day of his appointment than they were at the time of his intake call. He worried that he would not be able then to express his concerns in the same way he had during the intake interview. Jeannette, on the other hand, had had very positive experiences with one Intake counsellor in particular, and found that occasional accessing of an appointment at Intake helped her to function for periods of time without entering 'full-blown' counselling. Jeannette perceived this as beneficial but also difficult and painful. It would seem important then to offer coping strategies and community-based supports, along with empathy and understanding, during the intake process so that clients are better prepared to get through the wait time to their appointment. It also makes sense to do all one can to decrease wait times.

Child care and transportation were two other surprises. Jeannette, and to a lesser extent, Randy, indicated that it would be nice to have some provision available to them

for child care, and Jeannette would have liked to see some provision for transportation for single moms on fixed incomes.

The three participants who had children, appeared to access counselling sooner than for the one participant who did not have children. Randy's feelings of guilt about leaving his children's mother, and his concern for what the children were being exposed to in terms of turmoil led him to set his concerns about accessing aside in order to do so earlier than he otherwise would have. Julia and her husband had been putting off calling for a counselling appointment for quite some time. They finally did so when it became clear that their child's education was being adversely affected by family dynamics. It seemed that this situation allowed Julia's husband to feel that the area of concern was one of education versus one of parenting abilities, which increased his comfort with accessing counselling. Jeannette indicated a marked difference in how she accessed counselling for her children as opposed to how she did so for herself. She did not wait at all for her children's concerns but she always did so for herself. Perhaps accessing for the purpose of helping their children was easier for Randy, Julia and Jeannette than it was for themselves because culturally, it is accepted that children need, and are deserving of, help, whereas an adult needing help is "weak" or "incapable" for example . Alternatively, it is possible that being able to see the problem as "removed from oneself" externalized the concern enough to increase comfort with accessing help.

### ***Integration of Findings to Existing Literature***

The present findings confirm previous research findings that the stigma associated with mental health care and with those who access it functions as a barrier to accessing counselling. The current findings also confirm that the internalization of this public

stigma to a “self-stigma” functions as an even more entrenched barrier to accessing, causing individuals to struggle with the question, “What does it mean about me that I need counselling help?” The present findings raise questions as well about the intake process, including the limits to confidentiality, and about clients’ understandings of counselling: what it is and isn’t; how it’s accessed; and what it will require of them. But perhaps most of all, the present findings raise questions about clients’ understanding of counsellor and therapist roles, as demonstrated in the unanimous fear of my participants that they might be judged, ridiculed or reprimanded *by the counsellor*. This finding presents a new understanding not previously explored in research on the no-show phenomenon or on accessing counselling. While there have recently been several studies on the stigma associated with mental health care, and ways to reduce it (e.g., Corrigan & Penn, 1999; Corrigan, 2004; Rusch, Angermeyer & Corrigan, 2005; Corrigan, Watson & Barr, 2006; Kelly & Jorm, 2007; Vogel, Wade & Hackler, 2007), there does not appear to have been any previous research specifically on client conceptualizations of counselling, what it requires of them, the experience of accessing counselling, or the emotions associated with this process.

#### *Stigma and Accessing Counselling*

The present study’s findings support previous research that identified public stigma as a significant barrier to accessing mental health services (Corrigan & Penn, 1999; Corrigan, 2004) and self-stigma, an internalization of public stigma, as frequently precluding clients accessing the care they need and desire (Rusch et al, 2005; Corrigan et. al. 2006; Kelly & Jorm, 2007; Vogel et. al., 2007). Self-stigma has been defined by Corrigan (2004) as consisting of (a) stereotypes (“those seeking mental health care are

weak and incompetent, therefore I am weak and incompetent”), (b) prejudice (agreement with the belief and negative emotional reaction such as fear of counselling or anger at needing it) and (c) discrimination (a behavioral response to prejudice such as avoidance or failing to seek help). Corrigan studied why people with mental health problems fail to engage in treatment and concluded that it was to avoid the label of mental illness and the harm brought by that label. In the present study, each participant struggled with the question, “What does it mean about me that I need counselling help?” Each worried that the answer to that question might place them among the population of those with mental health concerns. But Randy, Jeannette, Kevin and Julia all wanted to be someone who was competent and did not need any help; as someone who “can manage life.” Accessing counselling however confirmed the self-stigma of being somehow “less than.”

Each of the participants attempted to avoid accessing counselling help and to manage on his or her own for as long as he or she possibly could. Each felt he or she “should” be able to handle problems alone, without counselling or mental health care help. Furthermore, each participant was keenly aware of the stigma associated with mental health care, actively expressing a wish that the stigma did not exist “so it would be easier to access counselling.” They struggled with the application of mental health stigma to themselves, attempting to avoid that label by avoiding engagement in counselling, which would ‘mark’ them as a member of the stigmatized group.

The avoidance behavior, according to Corrigan (2004), represents the second and third features of the model of self-stigma. The second feature is prejudice (agreement with the belief and/or negative emotional reaction such as fear or anger) and the third feature is discrimination (a behavioral response to prejudice such as avoidance of care-

seeking). By disclosing fear associated with counselling and counsellors, and by demonstrating avoidance behaviors in relation to counselling, Kevin, Jeannette, Julia and Randy's experiences clearly exemplify a model of self-stigma associated with accessing mental health care.

The avoidance behavior, in particular, fits with Corrigan's (2004) finding that "label avoidance is the most significant way in which stigma impedes care seeking." Corrigan pointed out that people do not want to be labeled or to suffer the harm the label brings, so they avoid the institutions associated with that label.

Interestingly, Link and Phelan's (2001) framework of stigma included notation that as a pre-condition for stigma, differences between persons or groups must be noticed, regarded as relevant, and labeled accordingly. Link and Phelan also noted that for stigma to have deleterious effects, the stigmatizing group must be in a more powerful position than the stigmatized group. Randy was the only participant who did not tell anyone that he was accessing counselling, not even his girlfriend. The fact that Randy told no-one of his access plans indicates that he saw the differences between "Randy who sees a counsellor" and "Randy who does not see a counsellor" as relevant, and his preference was to belong to the latter and more powerful group. Jeannette also did not tell anyone when she first accessed counselling. The fact that each participant was afraid at some point during the accessing process that others would 'find out' they were seeing a counsellor, supports the criteria of "differences being noticed" and "regarded as relevant." Furthermore, the stigma *itself* of those who access counselling as 'incompetent and incapable,' when internalized, places the participants in a less powerful group, which thereby fulfills the second societal factor in Link and Phelan's (2001) model of stigma:

that is, the stigmatizing group (non-clients) being more powerful than the stigmatized group (clients).

Corrigan (2004) stated that “to avoid the label of mental illness and the harm it brings, people decide not to seek or fully participate in care.” This was certainly the case for Jeannette, who repeatedly cycled through her reticence to access counselling and her desire to “handle life” in the same way others do. She spent months internally struggling with self-stigma, attending counselling briefly, then quitting, and then beginning the cycle all over again. Kevin too, spent four years trying to avoid the label of mental health stigma, during which time his concerns and stress levels progressed and his functioning diminished. The same was true of Randy and Julia. Randy indicated there were times when he wanted to go back to counselling after he’d accessed but he did not because he viewed doing so as “failure.” Once again he applied the mental health stigma to himself, that is, that he “should” be able to manage on his own, *especially* after having already gone to counselling. Experiencing difficulties after completing counselling was interpreted by Randy as indicating an *even more significant evidence of incompetence*.

In terms of the harmful consequences of mental illness stigma, Corrigan (2004) notes that stigma diminishes self-esteem and self-efficacy, and robs individuals of social opportunities. I think it is fair to say that Jeannette, Julia, Randy and Kevin suffered lowered self-esteem and self-efficacy as a result of the self-stigma they experienced. The data, however, is not rich enough to comment on whether or not any of the four participants suffered restricted social opportunities as a result of self-stigma. Rusch et al. (2005) described the consequences of stigma in more global terms: (a) everyday life discrimination in interpersonal interactions and in stereotyping and negative images of



mental illness in the media and (b) structural discrimination such as private and public institutions that intentionally or unintentionally restrict opportunities of persons with mental health concerns. It is not clear whether or not any of the four participants dealt with job loss or housing difficulties as a result of their mental health concerns, which included depression, anxiety, substance addiction, gambling addiction, childhood sexual abuse, bipolar-affective disorder, parenting concerns, and interpersonal concerns.

Housing and job loss as a result of stigma and/or discrimination were not areas of study in this research. Kelly and Jorm (2005) argued that the fact that self stigma and perceived stigma influence people to avoid or delay seeking treatment for mental illness is itself a negative and harmful impact of stigma.

Vogel, Wade and Hackler (2007) found that perceptions of public stigma contributed significantly to the experience of self-stigma, which, in turn, significantly influenced help-seeking attitudes and eventually help-seeking willingness, diminishing same. I think the present study's findings bear this out, particularly Julia's struggle with her husband, who held extremely negative views of counselling, to allow their child to see a counsellor. I would venture to add to the list of documented harmful consequences of mental illness stigma. The effects of waiting to access or avoiding accessing while one struggles with self-stigma at minimum increase individuals' pain and suffering and, at worst, may increase individuals' risk for suicide, as seen with both Kevin and Jeannette.

### *Fear*

#### *Fear of the counselling process*

Noonan (1973) found that 23% of his participants (N=64) indicated that “anxiety about what they might encounter or become involved in” (p. 44) was the reason for failing to access counselling. Paolillo and Moore (1984) also noted anxiety as a reason for missed appointments. This was echoed in the participants’ experiences. Julia and Randy in particular, each of whom had never accessed counselling for themselves before, were extremely anxious about “what would happen when they actually go in there.” Jeannette feared that she would not be able to “do” counselling and that counselling would render her “a basket case.” Noonan (1973) also noted that among those citing anxiety as a factor in not accessing counselling, all still intended to follow through when they felt ready. This indicated a strong desire for counselling but unfortunately, an even stronger fear that led to avoidance behaviors. Kevin, Jeannette, Randy and Julia described similar experiences. Each felt anxiety about calling to access counselling as well as about what would happen *in* counselling, and each avoided calling for varying lengths of time. After they did call and book appointments, each failed to attend their appointments, some, like Jeannette, doing this repeatedly. Kevin and Jeannette were still contemplating accessing at the time of their interviews.

It is remarkable to me that in the 34 years since this finding, very little, if anything, has been done to decrease individual’s anxiety around accessing and participating in counselling. This anxiety is something apart from the stigma associated with counselling – it involves, as stated, fears around the processes of same, and, as in Randy’s case, around the process of getting into counselling in the first place – about whom to call, for example. For Jeannette, there was much anxiety around what counselling would *require* of her (“what she’d be getting herself into” to echo Noonan).

That this should be a factor in clients' failing to access counselling, a barrier to them getting the help they want and need in fact, and that it should go unaddressed this length of time, is shameful to me

Given that both anxiety and fear are emotional responses to discrimination, this finding fits with Corrigan's (1999) models of stigma and self-stigma. Yet, in response to open-ended questions about their experiences, no participants indicated having experienced any discrimination, at least not publicly. Jeannette indicated that the only "blame" she ever experienced at intake was that which she extended to herself. This again appears to support Corrigan's (1999) model of self-stigma. Admittedly the area of public discrimination was not assessed in any detail, but I suspect that the anxiety represented in Corrigan's (1999) models is that related to the self – that is, that it is of the "What does this mean about me?" variety. The anxiety indicated by fears about "what might happen in counselling" and "how do I access counselling - are my concerns legitimate" is different. These fears are anxieties related to the counselling process as opposed to anxieties related to the self. This difference appears particularly true given the participants' statements that it would have been easier for them to access counselling, and to follow through, if someone had given them information about what would happen when they got there and if the process of accessing counselling was better known (e.g., if they had prior knowledge about what types of concerns "warrant" counselling help).

Furthermore, the fact that participants feared counselling *as an unknown* marks a new understanding in the literature. Where previously it was believed that the stigma associated with counselling, and labeling as "mentally ill," was, in large part, what barred clients from accessing counselling, it seems now we are on the cusp of realizing it is more

than this. That is, perhaps counselling, mental health care, and psychotherapy have been shrouded in darkness and mystery for far too long, and the mystery itself is fearful for clients. It would seem that some knowledge and understanding of the processes involved in accessing and experiencing counselling would be most helpful for clients at the outset – and indeed for counsellors, agencies, and communities alike as such an understanding may very well help to bring clients “through the front door!”

*Fear of Judgment, Ridicule, and Reprimand*

Of primary importance was the finding that participants feared not only the counselling process itself and how to access it, which largely represents the proverbial “unknown,” but that they also feared judgment, ridicule and reprimand *from the counsellor*. This represents a new understanding in the research on the no-show phenomenon and on stigma. It implies that, for some reason, counsellors themselves may be perceived by clients as being *part of the stigmatizing body*. Taking Link and Phelan’s (2001) social requirements of mental health stigma into account – that is for stigma to be deleterious, the stigmatizing group must be in a more powerful position than the stigmatized group - this perception would indicate that clients see counsellors as *not needing counselling*, and therefore, as members of “*the competent part*” of the population.

Kevin feared humiliation and ridicule by the counsellor, even though he had previously accessed counselling and “knew” a bit about what to expect. He explained this fear as a function of his reason for accessing at the time of interview, saying, “But this was a different situation, a different problem.” Whereas previously Kevin had seen counsellors in school for minor behavior concerns, he was now accessing for problems of

domestic abuse, a gambling addiction, and suicidality, all problems he felt shameful about. Kevin indicated relief that “no-one shook their finger at him” or “told him what he’d done was wrong.” Julia and her husband had fears around the question, “What if they tell us we’re doing this (parenting) wrong?” They were afraid of being blamed for their problems. Randy was relieved to find he was not blamed in counselling or otherwise made to feel badly, indicating this had been an expectation of counselling for him. All were pleasantly pleased to find they were treated with empathy and respect, indicating they had anticipated negative judgments. Randy and Kevin both indicated “it went better than I thought” in this regard.

There appears to be no research completed in this area. Studies on factors related to no-show behavior have been quantitative in nature and have not assessed client fears associated with counselling. I suspect these particular findings lie within the 24% of the variance accounted for by the “other” category in quantitative studies of the no-show phenomenon, studies that examined demographic variables and practical variables such as transportation, location of clinic, and childcare (e.g., Lowman, 1984; Peeters & Bayer 1999). Allan (1988) did report that “nerves” were cited by 40% of participants (N = 197), as the reason for not showing for a previously booked counselling appointment, and Noonan (1973) found that 23% (N=64) cited “anxiety” as the reason for not attending an appointment. It is possible that with further investigation, these citations too, may have revealed deeper layers of fear associated with counselling.

#### *Other Findings*

During the interviews, all four participants talked about how they felt better when they finally reached out and booked an appointment. Despite seemingly insurmountable

fear and anxiety around accessing counselling, Kevin, Jeannette and Randy accessed anyway. They overcame their fears, and in doing so, attained a new and heightened state of mental and emotional well-being. Common emotional experiences were those of accomplishment, empowerment, control, hope, faith, and calm. Common thoughts were, “this was easier than I thought it would be” and “I am capable of managing, I just needed some reassurance to get past this crisis point.”

All four participants indicated a great sense of relief at speaking with a counsellor did not blame or judge them. Kevin stated that it went a lot smoother than he thought it would, and Randy indicated relief at finding counselling was a “blame-free” process. Randy’s relief was heightened by the sense of control he gained over a situation in which previously, he had felt hopeless, powerless and out-of-control. Jeannette indicated a sense of power and accomplishment in facing a terrifying situation (both making herself vulnerable and talking to a stranger about highly personal topics) and overcoming same. Julia indicated that calling for help left her with a sense of faith that “something good will come of this.” What each indicated, in fact, was a positive outcome to the struggle with accessing counselling such that stress levels were lowered, hope was renewed, and to a man, participants’ senses of personal empowerment were restored. Jeannette, Kevin, Julia and Randy successfully managed to access the supports he or she needed after much difficult soul-searching and deliberation. Each took steps to ask for what he or she needed and was rewarded with a sense of freedom for doing so. In taking action, each of them demonstrated their own effectiveness in taking care of themselves and their families. In accessing counselling help, Jeannette, Kevin, Julia and Randy experienced their lives as more hopeful and positive.

Nolan and Badger (2005) reported that patients felt better after learning that clinicians understood their struggles with depression and did not blame or judge them, however I did not locate further research specific to the positive emotions associated with accessing counselling after avoiding doing so for a period of time. This finding of the present study adds to the current literature on accessing counselling. It also complicates the literature on the no-show phenomenon, because even after experiencing positive emotions associated with accessing, participants continued to avoid accessing for subsequent concerns despite indicating a willingness to do so. It is possible that, after having accessed counselling, what we are seeing in participants willingness to access again, is an attitude change toward counselling as a result of the dynamic whereby as part of the theory of cognitive dissonance (Festinger, 1957), participants changed their belief to fit with their behavior (counselling is good versus bad, after accessing so as to decrease dissonance over having behaved in a way that didn't fit with their beliefs). As well, researchers have indicated that attitudes toward counselling are positively impacted by client expectations of a positive outcome in counselling, particularly in adolescent boys (Corrigan, 2004, citing *The National Annenberg Risk Survey of Youth*, 2002). Meltzer, Bebbington, Brugha, Farrell, Jenkins and Lewis (2003) parallel this finding in a study done on adults with neurotic disorders in which members of this group were less likely to seek therapy when they believed no-one could help them. These findings fit with Blau's (1964) social exchange theory, which indicates that benefits need only be perceived in order to have an impact. It fits as well with the findings of the current study in which two of the participants currently plan to access counselling again in the near future, and in which the remaining two participants indicate they would do so if the need were to arise

again. Having previously experienced positive outcomes in counselling, as three of the four participants indicated they have done, it makes sense that they would expect another positive experience in future accesses (only Julia had never accessed before for any reason). The finding that attitudes toward counselling are impacted by expectations of a positive outcome is important for two reasons: 1) because, we can begin to change attitudes by changing expectations, and 2) because, as Kelly and Jorm (2007) pointed out, adolescence is frequently the age of onset of mood disorders, so improving attitudes in this age group may have a positive impact on help-seeking intentions and behavior of youth in the future, therefore addressing the problem of stigma 'in the bud' as it were. If attitudes can be positively impacted at a young age, we can influence a whole generation and more quickly eradicate the stigma associated with mental health that has existed for far too long.

Some of the findings in this section are new to research on no-shows in mental health care, and therefore these findings extend the research literature. For example, the finding that the limits to confidentiality are problematic for clients, though likely suspected by clinicians, does not appear in the research literature. Also, the finding that clients would like a better understanding of the counselling process and of what a typical first session looks like appears new, as does the finding that clients would like more information on what types of concerns "warrant" counselling help. In addition, the finding that clients would like to know what counselling will require of them is an extension to current literature. Randy's comments extended the literature, and highlighted the desire to 'contain' private information, when he indicated that he'd like for the Intake counsellor to be the individual he would see when he arrived for his counselling appointment. This



notion is congruent with Larsen and colleagues (1983) study in which researchers had assigned therapists call clients within four days of contact to both remind them of their appointments and to provide them with a direct verbal contact with the therapist prior to intake. Finally, the finding that clients fear the counselling process and the counsellor as someone who might judge, ridicule or reprimand clients was new, although it may have been alluded to as 'anxiety' which kept clients from attending previously booked counselling appointments (Noonan, 1973; Paolillo & Moore, 1984). Each of these findings suggests implications for counselling practice, which will be discussed later in this paper.

Other findings that clients found surprising have been previously addressed in the research on no-show behavior. Participants' desire to see the stigma associated with mental health concerns dissipated so that counselling is easier to access fits with the findings of several researchers that this stigma functions as a barrier to accessing mental health services (Yen, 2005; Corigan, 2004; Corrigan & Penn, 1999; Kelly & Jorm, 2007; Rusch, et al. 2005; Vogel et al, 2007). Findings that fees, wait times, child care and transportation can be problematic for clients and can lead to no-show have been cited in several studies (Lowman, et. al., 1984; Orme & Boswell, 1991; Noonan, 1973).

In terms of client demographics, Orme and Boswell (1991) found that among adults seeking treatment for themselves, those with children were significantly more likely to show up than were those without. The present study's findings support Orme and Boswell's work. Jeannette indicated she tended to access help immediately if a concern impacted her children, but did not do so if not. Randy and Julia both indicated

that it was concern for their children that moved them to access counselling earlier for themselves than they otherwise would have.

Lowman et al. (1984) reported that families who did not follow with family therapy at a CMHC tended to (a) have children older than 8 years of age, (b) have more behavioral and fewer personality problems, (c) have demonstrated problems earlier than client groups, and (d) have parents who were slightly older. The present study's participants' children were both younger than and older than, 8 years of age, yet all participants indicated they accessed earlier because of the children. In addition, participant ages were fairly young, the eldest being only 33 years old (not a number I would consider to be "slightly older"), yet all but Julia accessed counselling.

In summary, the present study findings support and detail Corrigan's (2004) and Link and Phelan's (2001) models of stigma, and confirm existing literature in the area of stigma and self-stigma reporting that stigma negatively impacts help-seeking behavior (Corrigan & Penn, 1999, Corrigan, 2004; Corrigan et. al., 2006; Rusch et. al., 2005; Vogel et. al, 2007). The present study also adds to the current literature on failure to access counselling by elaborating 1) clients' fear of the unknown processes associated with accessing and attending counselling, 2) clients' fear of judgment, ridicule and reprimand by the counsellor, 3) clients' continued fears of these even after having positive experiences in counselling and 4) clients' genuine positive emotions associated with accessing counselling. Finally, the present research raises questions about client conceptualizations of counselling, of the intake process associated with same and of what counselling will require of them. It raises questions as well about client conceptualizations of therapist expectations and roles. Perhaps most of all, this study

raises questions about whether or not the stigma associated with mental illness, which has to date been seen as the primary force barring client access to mental health care services, is in fact the primary force. It may be that legitimate fears of the unknown, which is what counselling represents to many prospective clients, is a major factor in failure to access counselling services.

This seems particularly plausible given findings that attitudes toward counselling are positively impacted by expectations of a positive outcome (Corrigan, 2004 citing The National Annenberg Risk Survey of Youth, 2002). If counsellors and the counselling process are seen as mysterious and shrouded in fear of the unknown, it follows that expectations of a positive outcome are less likely than if counselling was recognized as a legitimate and empathic form of health care. The four individuals involved in this study all indicated a desire to know, prior to starting counselling, what was expected of them, and what they could expect of both their counsellor and the counselling service. Ads on television explain what optometrists do and state “your eyes deserve an optometrist” – perhaps it’s time similar ads highlight counselling and state something to the effect of “your mind and emotions deserve a counsellor.””

### ***Strengths of the Current Study***

Three key strengths characterized this study. First, research in the area of client experiences in accessing counselling is virtually non-existent. The few studies that have examined stigma and failure to access mental health care are not qualitative in nature, and have not examined client experiences in attempting to access counselling. Rather, these studies have focused on the discriminatory impacts of stigma and how to reduce this stigma. The one qualitative study I found that was remotely applicable explored aspects

of the relationship between doctors and depressed patients that enhance satisfaction with primary care (Nolan & Badger, 2005). Studies on the no-show phenomenon are typically aimed at predicting, reducing, or responding to clients who do not show up for previously booked appointments (e.g., Allen, 1988; Folkins et. al, 2980; Lesaca 1995; McLean et. al, 1989; Paolillo & Moore, 1984; Westra, 2000). These studies are quantitative in nature and do not investigate client experiences with attempting to access counselling. As such, this study adds rich detail to the research on failure to access mental health care / counselling services.

Second, by presenting an in-depth examination into the lived experiences and resulting meaning-making of clients who've attempted to access counselling services, and both succeeded and failed to do so, my hope is that others will be motivated toward further research in this area, that this study in fact will function as a catalyst.

A final, and perhaps the most profound, strength of this study is the growth opportunity it represented for my participants, each of whom was thankful, and appreciative, of the opportunity to discuss, and thus process, some of his or her experiences and conceptualizations around past attempts at accessing counselling, along with the internal struggle that doing so represented for them. While the purpose of the research was not to offer counselling or support, evaluation criteria of critical subjectivity and reciprocity were both evident and beneficial for Jeannette, Kevin, Julia and Randy.

### ***Limitations of the Current Study***

As with all research, the present study must be understood in context. First it is neither possible to generalize the study's findings to the larger population, nor to claim any cause-and effect relationships among them. The study's purpose was to provide in-

depth rich data into the lived experiences of these four individuals' attempts to access counselling services, not to generalize about populations at large or to claim cause-and-effect relationships in this area.

A second limitation involves the role of demographics. The individuals involved in the study were all Caucasian, middle class, employed, and possessed of at least a high school education. Findings may have looked very different were any of these factors changed. For example, age and culture may impact how much stigma is associated with counselling. Access may also be impacted by socioeconomic status and education.

A third limitation is that the study was written over a period of approximately two and a half years, during which time new research was completed in the area of stigma and mental illness. These new findings were integrated into the data analysis but did not inform the development of interview question and the data collection process. As such the findings of this thesis study may not 'build' upon previous findings in the area of stigma and no-show to the extent they otherwise may have. On the other hand, the "fit" between the present study's findings and recent research enhances the findings' credibility given that the data were collected uninformed by developments in this area of research.

A final limitation of the study is that there is little research in this topic area. One or two older references were included to ensure a thorough literature review; however, their dated context limited their pertinence and these older studies did not factor heavily into the final analysis.

### *Implications for Counselling Practice*

The shared meaning of Jeannette, Kevin, Randy and Julia's attempts at accessing counselling involved struggles with the self-stigma-based question, "What does it mean about me that I need counselling help?" This struggle led to avoidance behaviors such that each of the participants failed to access help even when their problems were quite severely affecting their coping and functioning. This shared meaning raises interest for helping professionals (e.g., psychologists, counsellors, psychiatric nurses, social workers, therapists, and psychiatrists) as to how they can best ease clients' fear and anxiety around accessing counselling. Four pertinent domains for counselling practice were identified: a) awareness and education aimed at reducing the stigma associated with mental health issues, b) awareness and education aimed at normalizing and de-mystifying both counsellors and the counselling process / experience itself, c) use of both Social Exchange Theory and Cognitive Dissonance Theories to transform public and client perceptions of mental health care, and d) practical suggestions made by clients for what would make accessing counselling a more comfortable experience for them.

First, the present study highlights the importance of disseminating its findings to helping professionals. One evaluation criterion, 'community as arbiter of quality' (Lincoln, 1995), speaks to this notion. I believe that publishing and presenting these findings will lead to an increased awareness and to the beginnings of a broad-based education platform for decreasing client struggles with mental-health-based stigma. The fact that participants in the present study 'missed' their previously booked appointments because of fears of a stigma they had internalized rather than for practical reasons such as wait-times or transportation difficulties, together with the fact that their levels of

functioning continued to decline over the period of avoidance, indicates a strong need for earlier access and thus, decreased levels of both social and self-stigma. Counselling needs to be reframed in a way so as not to be perceived as indication of an existing “mental health concern” which deserves a stigmatized response; that is, public perception of counselling needs to be shifted to include “normal” concerns of everyday living such as relational concerns, parenting concerns, communication concerns in addition to “mental health concern” which themselves, need to be shifted in the public view to be seen as a “normal” part of health care. It would be most helpful as well, as we move towards this goal, for both practitioners and potential clients to be made aware that individuals, despite stigma-based fears, can access counselling and experience positive emotions and enhanced functioning as a result. For example, Jeannette, Randy and Kevin did just that, though it should never have been as difficult as it was for them, and nor should relapse be seen as failure.

Second, and also incorporating the evaluation criterion of ‘community as arbiter of quality,’ I believe that publishing and presenting the findings about client fears of the process of counselling itself and of the counsellor in particular, will lead to an increased awareness for offering new and healthier frameworks of reference to the public for what counselling is and what it is not. For example, counselling is a legitimate form of empathic health care versus some sort of voodoo ritual or mind-reading exercise performed by a fearful and authoritative medium, witch doctor, or “shrink” who is likely to blame clients for their problems and to negatively judge, ridicule or reprimand them for same. Put succinctly, there is a great need to de-mystify, for clients and the public alike, the counselling process itself (e.g., what to expect when they come in) as well as

counselling professionals, and the processes of accessing them. One way to do this would be through media campaigns such as the “your eyes deserve an optometrist” campaign. Perhaps we could suggest “your mind and emotions deserve a mental health professional.” In addition, when working with clients, counsellors, social workers, and psychologists can continue to re-frame fears, and to normalize client concerns.

Thirdly, the present research suggests that use of both Social Exchange Theory (Blau, 1964) and Cognitive Dissonance Theory (Festinger, 1957) may play positive roles in helping to change public and client perceptions of counselling and mental health care. Corrigan (2004), citing the *National Annenberg Risk Survey of Youth* (2002), indicated that attitudes toward counselling are positively impacted by the expectation of a positive outcome, particularly for adolescent boys. This fits with Social Exchange Theory, which states that benefits need only be expected (versus received), in order to positively impact behavior (Blau, 1964). As such, reaching clients at a young age and demonstrating, perhaps through media ads and through positive client experiences (especially if the experiences are those of well-known youth role models), that counselling can, and does, have positive outcomes, will be most helpful in positively shifting attitudes toward counselling and in turn, willingness to seek mental health care, precisely because it is health care.

Likewise, Cognitive Dissonance Theory (Festinger 1957) suggests that when clients’ behavior is not in accord with their attitudes and beliefs, clients will be moved to either a) change their attitudes or beliefs so that these are more consistent with their behavior (b) acquire new information that supports the attitude or behavior, or (c) trivialize the attitudes/behaviors in question and conclude that they are not important,



thus minimizing distress. Counsellors and therapists, as well as media, can move clients who have accessed, or are contemplating accessing, toward options 'a' or 'b', attitude change that fits with counselling as positive and not deserving of negative stigma, or new information that supports a client's having accessed counselling as a positive form of self-care versus evidence of incompetence.

Finally, the present research delineates several practical suggestions toward easing clients' passage toward accessing the counselling services they need and desire. These can be transposed to counselling interventions. Counsellors can help bring the suicidal client into counselling, and/or 'reach' the suicidal client, by fully explaining to *all* clients, whether they disclose suicidality or not, the realities of suicide risk assessment and intervention (including the many steps to being committed against one's will, and the right to appeal same), along with concern for client safety, during conversations about the limits to confidentiality. Counsellors can share some of the process of suicide assessment and offer information on degrees of suicidality and levels of risk, placing emphasis on the desire to keep clients safe, and offering reassurance on this very sensitive subject.

It would have been helpful for Jeanette to know that she need not re-live trauma in order to heal from it. Jeannette would have been helped as well by indication that there is no "right" or "wrong" way to "do" counselling. We can help to remove the perception that counselling is something one must 'do well' or 'be able to do,' like a test or evaluation, by informing clients that outcome goals are predefined by *them*, not by the therapist and by sharing the information that *any* movement is progress; is growth.

The finding that individuals accessed earlier when they had children indicates that this knowledge may help to bring them in sooner, therefore offer them help sooner.

Perhaps accessing for the purpose of helping their children was easier for Randy, Julia and Jeannette than it was for themselves because culturally, it is accepted that children need, and are deserving of, help, whereas an adult needing help is “weak” or “incapable” for example . Alternatively, it is possible that being able to see the problem as “removed from oneself “externalizes the concern” enough to provide comfort with accessing. Counsellors can aid this process by affirming for clients that caring for themselves is caring for their children.

Based on Julia’s experience of calling intake from her workplace, it would be important to let callers / clients know early on during Intake conversations what the role of Intake is, what sort of information will be required of them, and to ask if callers have time and privacy available to discuss that information. Respecting clients need for time and privacy, and assessing and confirming same prior to getting into the bulk of an intake call lets the client know they are being respected. It is also important at this juncture to explain wait times, what a first session looks like, and how the client will be contacted if, indeed, there is a wait time.

If nothing else, it is extremely important that at intake, a thorough assessment be completed prior to any questions being asked about payment. This is necessary so that the caller’s situation and functioning are *well understood* before, and if, such questions are to be asked. In dire circumstances services should be offered, and community and health care connections made, regardless of clients’ ability to pay.

It is important to offer coping strategies and community-based supports, along with empathy and understanding, during the intake process so that clients are better prepared to get through the wait time to their appointment. Therapists and intake

counsellors can mail brochures about community support groups and programs to clients and/or offer phone contacts for these as a final step in the intake process.

If an agency has it within their means to provide child care and transportation, they should arrange to do so, particularly, if not only, for their struggling single mothers and low income families. Not only does this facilitate client arrivals and thus healthier functioning, but it builds community within and without the agency as well positively impacting client loyalty and, more importantly, client comfort and safety.

Based upon Smoller et al.'s (1998) work and the findings of this study, it would be most helpful to follow up on no-shows on a regular basis as it is possible that the client may be fearful of the therapist, the counselling process, or both. He or she may also fear disclosing suicidality, being deemed "crazy" and/or being stigmatized. As such, every no-show represents an opportunity to diminish each of these barriers by demonstrating caring and concern, normalizing client fears and anxieties, and diminishing stigma associated with the negative client perception of the counsellor as 'authoritative' and counselling as "for loonies only." This approach may, with any luck, one day become a standard of care and would be most effective at easing negative perceptions of counsellors as 'not caring' because clients were not called back upon no-show. This is particularly important in agencies where caseloads can change and clients are thus supported by different therapists.

Finally, it is very important to offer information on what 'warrants' counselling assistance. Specifically, to let clients and the public at large know that *any* concern, if interfering with functioning, is legitimate, and worthy of counselling help.

### *Implications for Future Research*

What are the implications for future research based on the current findings around accessing counselling? They are many. First, future research aimed at reducing mental health stigma would be most helpful, perhaps through such approaches as measuring baseline attitudes toward counselling and then measuring them again after exposure to public ad campaigns in which young and famous role models are seen accessing counselling, despite fears of doing so, and finding same helpful. This would help to demonstrate the positive emotions and personal growth associated with accessing counselling, and to re-frame the stigma associated with “the mentally ill,” particularly if many famous or ‘successful’ people disclosed personal and family histories of ‘mental illness’ such as depression, anxiety, and ADHD.

According to research by Corrigan and Penn (1999) stigma is decreased by contact with members of a stigmatized group, and the contact effects are strengthened when there is equal status among participants, cooperative tasks define the interaction, there is institutional support for contact, there are high levels of intimacy, and the person with the mental illness does not greatly differ from the stereotype. Given that adolescents attitudes toward counselling are positively impacted by expectations of a positive outcome (Corrigan 2004 citing *The National Annenberg Risk Survey of Youth*, 2002), it would make sense to investigate the effects of school-based programs which incorporate Corrigan & Penn’s (1999) suggestions for decreasing stigma. Future research such as this could perhaps have students who access counselling self-disclose and partner with students who do not access counselling toward easily achievable and mutually enjoyable outcomes.

Similarly, based on the current participants' indication that they would like information about what to expect prior to "going in," it seems very important to provide accurate information to clients about what they *can* expect in the processes of accessing and experiencing counselling *prior to* engagement in these activities. The findings of Meltzer, et al., (2003) that adults are less likely to seek help if they believe no-one can help them, and of Overall and Aronson (1963) that magical expectations of a first appointment can lead to subsequent no-shows if those expectations are not met, would appear to support this assertion. Recall that for each new or successive problem or concern, the process of accessing was "new" for the participants, as evidenced by Kevin's statement that "this time" he was accessing for "a different situation" and therefore didn't know what to expect. Randy, Kevin, Jeannette and Julia all indicated they would have appreciated information about (a) what sorts of concerns 'warrant' counselling help; (b) who to call; (c) what counselling is and what it isn't, i.e. non-judgmental, supportive, not a 'quick fix'; (d) what kinds of information they'd be asked to provide and why at Intake; (e) how long it would take to do so; (f) what sorts of options might then be available to them (different services for different presenting problems); (g) how connections to these services might be made and how long that might take; (h) what a typical first session might look like once in counselling; and (i) what the counsellors responsibilities are versus the clients,' i.e., what might be expected of them. This finding of successive acts of accessing counselling appears to follow a pattern similar to that of the addiction cycle with periods of doing well and periods of risk, relapse, and crisis. That is, it appears clients may cycle through periods of suffering that lead to a desire for counselling help, followed by anxiety, fear and stigma brought on *by* the desire for counselling help, which

leads to crisis, and finally the access they desire. The more information we can give them to deflate their fears and anxieties at the front door - to free them from being caught between the rock and the hard place – the more we can help them access the services they are needing and desiring.

Second, and in addition to providing accurate information, research aimed at normalizing and de-mystifying both counsellors and the counselling process/experience is needed. Pre-and post studies involving school-based programs in which counsellors and perhaps even samples of ‘typical’ clients post-successful treatment (e.g., for depression, anxiety, anger management as these are common symptoms bringing youth to counselling) came into the classroom and shared information about counselling and counsellors in a normalizing way (i.e., explaining the processes of accessing, describing first sessions, explaining limits to confidentiality, discussing suicide assessment, process of ‘being committed against one’s will’) would be most helpful in de-mystifying counsellors and counselling. This seems especially so as a ‘real live’ counsellor who appears ‘normal’ would be before the class speaking openly and answering questions, perhaps even showing pictures of a ‘typical’ counselling office and what one might expect to find there (de-bunking the ‘couch’ and ‘shrink’ myths).

This kind of approach strikes me as quite similar to the movement two generations ago to bring sex education into the schools and to the movements approximately one generation ago and currently to normalize homosexuality and same-sex marriage. It seems mental health, and suicidality perhaps in particular, are the “last bastions of taboo” for modern culture. It would be important to include in such programs a reframe of ‘those seeking counselling help as weak’ to ‘those able to ask for what they

need as strong and assertive.’ Examples of famous and successful people asking for what they need would be most helpful, particularly if powerful leaders who regularly delegate authority and/or ask their managers or cabinet ministers for advice are presented as ‘asking for what they need’ because ‘no one knows it all and no-one does it all alone.’ This could be seen as an example of Cognitive Dissonance Theory being used to change attitudes to fit with a negatively perceived behavior such as contemplating accessing counselling.

Finally, future qualitative inquiry and/or research utilizing pre-post designs with any of the eight practical implications for counselling practice suggested in this document would be most helpful in assessing shifts in clients’ comfort levels with accessing counselling and in assessing shifts in clients’ perceptions of either counselling itself and/or those who practice counselling. In the former example of counsellors coming into the classroom to talk with students about counselling, for example, it would be ideal if counsellors informed students that *they themselves, not the counsellor* set counselling goals. This might go a long way toward diminishing views of counsellors as authoritative figures. Sharing such information as that one need not re-live trauma in order to heal from it and that any concern that interferes with functioning warrants counselling help may impact stigma, attitudes toward counselling, help-seeking behavior and no-show behavior. Implementing such practicalities as de-bunking fears of disclosure of suicidality early on, asking at intake if clients have time and privacy, assessing life circumstances before asking about payment, offering community-based supports during wait-times, offering child care and transportation, and always following up with no-shows should help to reduce fears of counselling and counsellors, and therefore ease

clients' experiences with accessing our services. Future research assessing the effects of such implementations on client comfort in accessing counselling is needed. Ongoing research, with larger sample sizes, assessing children's role in the process of accessing counselling for their parents is recommended as well.

### ***Conclusion***

In conclusion, this basic interpretive qualitative study (Merriam, 2002) illuminated the lived experiences of four individual's attempting to access counselling. Carefully listening to their stories revealed the ways in which they struggled between a rock and a hard place with doing so. The shared meaning of their experiences was captured by their internalization of the public stigma associated with mental health issues and their struggle with the question, "What does it mean about me that I need counselling help?" Additional themes identified from the data included fears of both the process of accessing counselling and the experience of counselling as well as a fear of counsellors themselves; positive emotions associated with accessing counselling, surprises in the process of accessing and possible solutions, and children as pivotal in the process of accessing counselling.



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APPENDIX A: Ethic Approval Certificate



UNIVERSITY OF SASKATCHEWAN  
Behavioural Research Ethics Board (Beh-REB)

**NAME:** Jennifer J. Nicol, Educational Psychology and Special Education 03-1345  
Kimberly MacKinnon

**DATE:** 16-Feb-2005

The Behavioural Research Ethics Board (Beh-REB) has reviewed the Application for Ethics Approval for your study "The Experience of booking an Initial Counseling Appointment and Subsequently Changing One's Mind: A Qualitative Exploration of the No-show Phenomenon" (03-1345).

1. Your study has been APPROVED.
2. Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Committee consideration in advance of its implementation.
3. The term of this approval is for 5 years.
4. This approval is valid for one year. A status report form must be submitted annually to the Chair of the Committee in order to extend approval. This certificate will automatically be invalidated if a status report form is not received within one month of the anniversary date. Please refer to the website for further instructions <http://www.usask.ca/research/behavrsc.shtml>

I wish you a successful and informative study.

Dr. Valerie Thompson, Chair  
Behavioural Research Ethics Board (Beh-REB)



APPENDIX B: Demographic Questionnaire

Using a pencil, and PRINTING IN CAPITAL LETTERS, please answer the following questions. Please provide only one response per question, and please answer each question.

**Name:** \_\_\_\_\_

Last First Initial

**Address:** \_\_\_\_\_

\_\_\_\_\_

**Best way to contact:** Phone \_\_\_\_\_ E-mail (circle one) E-mail \_\_\_\_\_

**Phone Number** (day) \_\_\_\_\_ (evening) \_\_\_\_\_

**Gender:** (M or F) \_\_\_\_\_ **D.O.B.** (month/day/year) \_\_\_\_\_

Please write out month's name

**Relationship Status:** \_\_\_\_\_

Please state if single, married, common-law, divorced, separated, widowed, or other (explain)

**Children?:** \_\_\_\_\_ **Child's Age(s)** \_\_\_\_\_

Number of Children

**Education:** \_\_\_\_\_

Please state completed education (e.g., grade 9 or 12; 2<sup>nd</sup> year university; B.A.; M.Sc; etc.)

**Employment:** \_\_\_\_\_

Please indicate whether employed and type of work (e.g., at-home Mom, plumber, not currently working)

**Referral Source:** \_\_\_\_\_

Please state who referred you to Family Services Saskatoon (e.g., Dr.; self; friend; other - explain)

**Do you identify yourself as a member of any particular nationality, culture or race?**

\_\_\_\_\_  
\_\_\_\_\_

(please elaborate)

**Have you ever had counselling before?** (Y or N) \_\_\_\_\_ **If "Y", when?** \_\_\_\_\_

(month & year)

**Agency or treatment center(s) at which you received counselling:** \_\_\_\_\_

\_\_\_\_\_