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The impact of self-efficacy, stigma, subjective distress, and practical factors affecting clients' intent to "no-show"

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ABSTRACT

Therapy is an effective means for helping those who struggle with a mental health concern (APA, 2013; Wampold, 2001); however, 20-50% of individuals who seek counseling do not attend the first counseling session (Swift & Callahan, 2010). Previous research has inconsistently identified many variables that contribute to a client's likelihood to no-show for a scheduled counseling appointment. I sought to clarify these inconsistencies and to fill additional gaps in the literature by examining the effect that self-efficacy, public- and self-stigma, and previously studied no-show variables (e.g., demographic variables, therapist variables, distress) have on participants' intent to attend or fail to attend a hypothetical scheduled counseling appointment. Participants were 290 (192 females; 79% European American) undergraduates at a large university. I randomly assigned participants to read and perspective-take either a 'low distress' or a 'high distress' narrative about a student experiencing depression symptoms. Participants then answered items 1) assessing their intent to attend a first counseling appointment, 2) rating the extent to which 14 variables would influence their intent to attend, 3) rating their sense of confidence with engaging in common therapy tasks, 4) rating the level of public- and self- stigma they perceived for seeking help, and 5) assessing demography and history with counseling. Results indicated that self-efficacy for counseling tasks mediated the relation between self-stigma and intent to attend, and that these two variables accounted for more variance in intent to attend than did other variables. Level of subjective distress, demographic variables, and other variables previously associated with no-show behavior were not found to be statistically significantly related to participants' intent to attend a scheduled counseling appointment. I also discuss limitations, directions for future research, and clinical implications of my findings.

CHAPTER 1. INTRODUCTION

Process and outcome research has demonstrated that therapy is an effective means for helping those who struggle with a mental health concern or some other personal problem (see American Psychological Association (APA), 2013; Wampold, 2001). However, if clients do not make it to their first counseling appointment, they cannot receive the benefits that therapy can offer. Unfortunately, many individuals who could benefit from therapy do not make it to their first counseling appointment. The rate at which clients initially seek out counseling services but discontinue or do not return to counseling after an initial appointment ranges from 20% to over 50% (Swift & Callahan, 2010).

More specifically, there are estimates from various studies that suggest approximately 1/3 of clients who attend an intake appointment at a university counseling center will fail to return for a first counseling appointment after this intake (Epperson, Bushway, & Warman, 1983; Schiller, 1976). This is a significant number of people not obtaining benefit from therapy. Also, in terms of the large incidence range at which clients do not show for a first counseling session, there is cause for concern, as a 20% rate is quite different than a rate of more than 50%. It is important to understand precisely why this phenomenon occurs.

Past Research

The factors affecting the likelihood of clients being a "no-show" for their first counseling appointment are not yet well understood or conceptualized, despite research being conducted on this topic for over fifty years (Barrett, Chua, Crits-Cristoph, Gibbons, & Thompson, 2008). Several issues exist that contribute to the poor state of affairs in investigating this problem. For example, the lack of consistent operational definitions used in this area of research; the bountiful use of basic, descriptive data analysis methods versus more inferential or hypothesis-testing

statistics and comparative methods; and, the inconsistent inclusion of key variables throughout various studies (Barrett et al., 2008; Masi, Miller, & Olson, 2003; Warnick, Gonzalez, Weersing, Scahill, & Woolston, 2012; Wierzbicki & Pekarik, 1993).

Terms and Operational Definitions

There are a variety of terms used and methods employed to operationally define psychotherapy clients who do not complete their therapeutic treatment (Barrett et al., 2008; Masi et al., 2003). Labels such as "dropout," "no-show," "failure," "non-completer," "premature terminator," and "refuser," (Baekeland & Lundwall, 1975; Barrett et al., 2008; Manthei, 1995; Masi et al., 2003) have been used in the literature. Unfortunately, these terms are not consistently connected to the same operational definition, and these terms are often used interchangeably throughout the literature, so that it has become difficult to understand exactly what is being studied (Barrett et al., 2008).

In my study, I used the term "no-show," to define a participant who schedules a hypothetical first appointment but does not intend to attend that first appointment. Other investigators have paired this term and a clinical version of this definition together (see Freund, Russell, & Schweizer, 1991). I was particularly interested in this operational definition as there is even less known about clients who no-show in this manner (Fenger, Mortensen, Poulsen, & Lau, 2008). This definition also seems to be the most anonymous method for clients to end a therapeutic contact, which may have implications for conceptualizing the reasons motivating them to do so.

Previous Methodological and Statistical Shortcomings

Studies on the topic of client no-show behavior have examined sets of variables that may or may not impact clients' likelihood of appearing for a scheduled appointment. Importantly,

individual studies have often failed to examine the same set of factors reported to be significant in other studies. This has resulted in conflicting or unconfirmed findings throughout the literature.

Factors that have been implicated in some research as influencing clients' no show behavior include: client demographic and historical variables (e.g., sex, age, race/ethnicity of client; previous mental health treatment); therapist demographic variables (e.g., sex, race/ethnicity); the degree of distress experienced by the client; the degree of topic agreement in therapy between the client and counselor; the client feeling as though his/her problems have improved before the scheduled session; social cognitive variables (client expectations and perceptions of the therapeutic experience, clients' perceived effectiveness of therapy); environmental and logistical variables (e.g., transportation issues, client or counselor moving away); the placement of the client on a waitlist; the experience level of the counselor with whom the client is assigned to work; the referral source; and, client perceptions of counselor trustworthiness (Baekeland & Lundwall, 1975; Bartle-Haring, Glebova, & Meyer, 2007; Berrigan & Garfield, 1981; Fenger et al., 2011; Frayn, 1992; Heppner & Claiborn, 1989; Hunsley, Aubry, & Verstervelt, 1999; Larsen, Nguyen, Green, & Attkisson, 1983; Manthei, 1996; McCabe, 2002; McNeill, May, & Lee, 1987; Pekarik & Stephenson, 1988; Presley, 1987; Sue, McKinney, & Allen, 1976; Todd, Deane, & Bragdon, 2003; Tracey, 1986; Warnick et al., 2012; Werbart & Wang, 2012; Wierzbicki & Pekarik, 1993).

As to data analytic methods, much of the earlier research conducted around this topic has not utilized the most effective or meaningful methods of data analysis. Many studies have utilized simple box-and-tally methods (Wierzbicki & Pekarik, 1993), and provided results that are simple percentages of clients who left therapy for various reasons. As well, although

researchers have suspected various reasons or causes for no-show phenomena, few have examined these reasons closely or tried to differentiate various levels of certain variables of interest. For example, many researchers suspect that the extent of subjective distress clients suffer has an effect on clients' tendencies to no-show for an appointment. Rarely, though, have investigators manipulated levels of subjective distress to determine exactly how this variable operates in a no-show situation.

Statistically, regression analyses have become more popular in the more recent research on this subject (see Fenger et al., 2011; Werbart & Wang, 2012). Regression equations allow for a simultaneous consideration of several variables and a better understanding of which factors are more heavily weighted in clients' likelihood of failing to appear for a scheduled first appointment.

Social Cognitive Theory

A central issue in this area of research is that much of it has been atheoretical in nature. However, Bandura's Social Cognitive Theory (Bandura, 1986), with its main components of self-efficacy beliefs, outcome expectations, and behavior goals, has been used in a few studies to understand general willingness and likelihood of seeking out therapy (Longo, Lent, & Brown, 1992).

People, their behavior, and the outcome of that behavior, are linearly related such that people choose to engage in a certain behavior and an outcome (whether good or bad) results from that behavior (Bandura, 1977a; Bandura, 1986). Self-efficacy and outcome expectations both influence this linear relationship. Self-efficacy is the perception people have of their abilities to successfully engage in certain behaviors, and it impacts the relation between people and their behavior; people are more motivated and more likely to engage in a behavior when they

have high self-efficacy around that particular behavior and vice versa. Outcome expectations influence the relation between behavior and outcome in a manner referent of the self-fulfilling prophecy.

Another main tenet of Social Cognitive Theory is that people and their environment interact in a reciprocal manner, with people both influencing their environment and the environment influencing people (Bandura, 1977a; Bandura, 1986). Self-efficacy can lead people to act in ways that influence their environment, but peoples' self-efficacy can also be diminished if they have seen others fail at tasks in which they consider engaging. Therefore, self-efficacy is not only determined through reinforcement of one's personal experiences with engaging in certain behaviors, but is vicariously learned through the observation of others' successes and failures with those particular behaviors.

I used Social Cognitive Theory in my study as a way to examine the specific effect that self-confidence in executing therapy-related tasks had on participants' intent to attend a hypothetical scheduled counseling session. As well, I examined in my study how self-efficacy in executing common therapy tasks is related to public- and self-stigma surrounding seeking mental health services and how these relations influence client likelihood to attend a counseling appointment.

Present Study

I worked to address the aforementioned gaps in this area of research on no-show behavior by: 1) clearly denoting the terms and operational definitions I utilized, 2) including and simultaneously examining what have been determined in the literature to be the most frequently cited factors affecting the likelihood of no-show behavior, 3) using more informative data analysis methods, 4) approaching the examination of no-show behavior from a theoretical

perspective (Social Cognitive Theory), and 5) investigating the impact of stigma on participant likelihood of engaging in no-show behavior. In addition, I used a narrative format to manipulate and ascertain the extent to which lower versus higher levels of subjective distress affected the likelihood of participant intent to no-show for an appointment.

Public- and self-stigma surrounding seeking and obtaining mental health services has largely been left out of the no-show literature. Stigma surrounding mental illness and seeking therapy has been demonstrated in numerous studies, and this stigma often prevents individuals from seeking the therapeutic services they need (Eisenberg, Downs, Golberstein, & Zivin, 2009; Vogel, Wade, & Hackler, 2007; Vogel, Wade, & Ascheman, 2009). However, investigators have not closely examined the role of stigma in terms of its potential influence on client no-show behavior. As well, although employed in a few studies, the role of self-efficacy toward therapy tasks has not been examined and this variable is of great import. Not only does self-efficacy have a long standing theoretical, and empirically supported, presence in the psychological literature (Bandura, 1977; Bandura 1986), but understanding the extent to which people feel confident as to their ability to engage in common activities required of them in therapy can offer a potent explanatory device as to why they may choose to no-show for a counseling appointment. Finally, these two variables, stigma and self-efficacy for engaging in counseling tasks, have not to date been examined as to their joint relation to clients' intent to attend a scheduled therapy session.

Importance of the Present Study

The importance of this study is multifold, because when clients fail to appear for mental health appointments systemic difficulties for themselves, other clientele, clinicians, and mental health agencies can result. If clients are not attending therapy, they may not be receiving the help that they need (Baekeland & Lundwall, 1975; Pekarik, 1985; Sue, et al., 1976; Weighill, Hodge,

& Peck, 1983). Clinician productivity and professional self-efficacy are both negatively impacted when clients no-show (Bischoff & Sprenkle, 1993; Klein, Stone, Hicks & Pritchard, 2003; Pekarik, 1985; White & Pollard, 1982). Mental health agency efficiency and financial stability can suffer when clients fail to attend scheduled appointments (Dubinsky, 1986; Garfield, 1986; Klein et al., 2003; LaGanga & Lawrence, 2007; Pekarik, 1985; Sue et al., 1976). Also, appointment slots held for clients who end up not appearing can unnecessarily create a long waitlist at agencies, leaving clients who are willing to appear to have to wait longer for services (Barrett et al., 2008; Bischoff & Sprenkle, 1993; Garfield, 1994; Weisz, Weiss, & Langmeyer, 1987).

Through this study, I attempted to identify, prioritize, and better conceptualize the impact self-efficacy has on likelihood to attend a therapy appointment, general variables that most influence decisions to not appear for scheduled therapy services, and the influence of stigma within these scenarios. Through this effort, I hope to highlight interventions that may be developed to remedy low self-efficacy toward engaging in common therapy tasks, concerns surrounding appearing for therapy sessions, and the stigma involved with help-seeking. Moving this line of research forward has positive practical implications for clients, therapists, mental health agencies, and the public good.

CHAPTER 2. LITERATURE REVIEW

Definitions

There are a variety of terms and definitions to classify psychotherapy clients who do not attend a scheduled counseling appointment (Masi et al., 2003). In my study I used the label *no-show* to describe "*those participants that do not intend to appear for the first hypothetical scheduled counseling session"* (see Freund et al., 1991). This term and the clinical version of this operationalization (clients who do not appear for the first scheduled counseling session) have been previously paired and used in the literature (Freund et al., 1991; Manthei, 1995).

Operationally defining, in a consistent manner, a *no-show client* is a critical step in this area of research, as different definitions have led to varying research outcomes (Barret et al., 2008; Masi et al., 2003). As well, differing definitions of what constitutes a no-show client across studies has been associated with finding different incidence rates of the problem. This, in turn, greatly impacts an accurate understanding of the issue.

As an example, Warnick et al. (2012) examined attrition rates at an outpatient mental health clinic. Across the three different definitions of client attrition utilized in their study, approximately 40% of clients qualified as dropouts across all three definitions, 33% were classified as dropouts under two of the definitions, and 25% were considered to be dropouts under one of the definitions. This trend suggests changes in findings contingent upon how definitions for attriting clients are operationalized. In another study, Wierzbicki and Pekarik (1993) determined that 36% of clients were dropouts when this status was defined as a client who no-showed for a scheduled appointment. However, 48% of clients were classified as dropouts when this status was considered as a client who did not complete as many sessions as was initially determined necessary for treatment. The obvious ambiguity surrounding the

operationalization of definitions in previous research has made findings difficult to generalize (Barrett et al., 2008; Masi et al., 2003).

Based upon a review of the literature, terms that are commonly used to label clients who discontinue counseling *after only a few sessions* include: "premature terminators, terminators, rejecters, discontinuers, and those clients who did not engage in therapy" (Masi et al., 2003, pg. 67). Terms used to define those clients *who had an intake session but did not return for their first session of therapy* have been labeled "refusers, nonbeginners, defectors, failers, and premature terminators" (Manthei, 1995; Masi et al., 2003, pg. 67). There is also the frequently employed term "dropout," which has been used to label clients who do not return after several sessions, clients who refuse to return for further treatment, clients who are disqualified for treatment, or clients who no-show for a scheduled appointment (Baekeland & Lundwall, 1975). There are multiple methods to define clients who discontinue counseling, including 1) objective non-attendance and non-return of the client, 2) *therapist judgment* (Bischoff & Sprenkle, 1993) in which clients are labeled as dropouts if they do not attend as many treatment sessions as the counselor considers necessary, and 3) determining a threshold number of counseling sessions and labelling clients as non-completers if they do not attend this number of sessions.(Baekeland & Lundwall, 1975) Other less conventional methods of defining a psychotherapy dropout include: the point when two consecutive sessions are missed, failure to attend the final session, and discontinuing within the first nine months of beginning treatment (Barrett et al., 2008).

The way in which I defined no-show participants/clients has been significantly less studied as compared with other definitions utilized in the literature. There is less known about the factors that cause a client to no-show for their first appointment (Fenger et al., 2011). Basing clients' drop out status upon their failure to attend a scheduled appointment is also a more

conservative and objective definition, as compared with basing this status upon therapist judgment or total number of sessions attended. My definition tends to reflect a lower dropout rate than the other two methods aforementioned (Wierzbicki & Pekarik, 1993). However, a benefit of this more conservative method is high reliability as it is based upon the more objective attendance (or non-attendance) of a client versus a clinician's subjective determination of whether or not a client is a dropout (Wierzbicki & Pekarik, 1993).

Self-Efficacy and Social Cognitive Theory

Bandura's Social Learning Theory/Self-Efficacy Theory (1977a, 1978), renamed in the last decades to the more broad classification of Social Cognitive Theory (Bandura, 1986), includes the components of self-efficacy beliefs, outcome expectations, and behavioral goals. The perspective of Social Cognitive Theory is that behavior, cognitive and personal factors, and the environment, are all reciprocally determinant (Bandura, 1986).

Self-efficacy is the perception of confidence that people have about their ability to engage in behaviors in order to exact certain outcomes, rather than their actual abilities to carry out behaviors. Self-efficacy is "the conviction that one can successfully execute the behavior required to produce the outcomes" (Bandura, 1977a, p. 79). Self-efficacy is considered by Bandura to be the foundation of human agency (Bandura, 1986; Bandura, 2001). Bandura (1977a) created a model in which he considered the relation between people and their behavior to be moderated by efficacy expectations, and the relation between a person's behavior and the outcome to be moderated by outcome expectations. Counseling is comprised of a set of unique behaviors. Some of these behaviors are also enacted in individuals' daily lives, while others may not occur anywhere else other than the counseling room. Self-efficacy can drive an individual's motivation to engage in a behavior and can increase or decrease the likelihood of an individual

following through on a behavior (Bandura, 1977a). Self-efficacy can also impact the outcome expectations of an event or behavior in which one engages. Clients' efficacy regarding their ability to engage in counseling-related activities should theoretically impact their expectations of treatment outcome as well as their motivation to attend their first counseling session. Low self-efficacy should lead to lower counseling attendance and/or no-show behavior, while higher self-efficacy should lead to greater counseling attendance and no or less no-show behavior.

Also, considering the effect that struggling with a personal or emotional concern can have on people's self-efficacy beliefs, their confidence in engaging in new and/or difficult activities that often arise in the counseling experience can be affected. Self-efficacy has been implicated as contributing to symptom distress and has been found to inversely influence perceptions of symptom severity (Lent, Lopez, Mikolaitis, Jones, & Bieschke, 1992).

Perceived self-efficacy originates from four different possible sources: performance accomplishments (the source that most reliably impacts efficacy expectations), vicarious experience, verbal persuasion, and physiological states (Bandura, 1977a). Situational circumstances have also been cited as impacting efficacy expectations, as certain situations are more demanding of performance and ability and there is greater risk of experiencing negative consequences (Bandura, 1977a). The subjective nature of self-efficacy leaves it open to influence and corruption by other factors in one's environment. As self-efficacy is subjectively based upon individual perceptions, various experiences, and learning opportunities, it is very possible that for a given domain it can be over- or under-representative of actual ability. If one's self-efficacy is inflated without necessary skills, an individual could engage in a behavior that will not have a good outcome, which could lead to an unnecessary failure and bad learning experience. This could prevent that individual from attempting to engage in that behavior in the future, even if in

the future they could successfully engage in said behavior. Conversely, if one's self-efficacy is incorrectly deflated, one will avoid engaging in behaviors in which they could successfully engage (Bandura, 1986). Self-efficacy can even be considered to be a protective factor, preventing bad outcomes from occurring and leading people to only look for situations in which good outcomes will come to fruition. This way, a person will be successful and increase their self-efficacy instead of fail and experience a decrease in self-efficacy. Attempts with low outcome expectancies will also be avoided even if efficacy expectations are high (Bandura, 1989).

The basis of Social Cognitive Theory stems from Bandura's Social Learning Theory. Social Learning Theory asserts that people learn most through behavior reinforcement and punishment experiences that occur either directly or through observation (Bandura, 1977a). Actual or vicarious experiences with positive or negative outcomes for behavior influence people's motivation and likelihood to engage in the behavior in the future. Social Learning Theory also posits reciprocal interaction between individuals and their environment (Bandura, 1977a). People can be impacted by the environment, but also act in ways that change their environmental situation. Self-regulation processes are considered to be a key component in the behaviors that people choose to enact as they give people some degree of control over their actions (Bandura, 1977a). Social impression and considerations of social judgment from the environment also influence self-efficacy and the decision to engage or not engage in a behavior (Bandura, 1986).

This theory has been limitedly used to help explore and explain the issue of client attrition (Longo, Lent, & Brown, 1992). Longo and colleagues (1992) asserted that Social Cognitive Theory could help to explain client attrition, and that clients' beliefs about their ability

to participate in counseling would impact their willingness to engage in therapy despite the difficulties involved. They also hypothesized that clients' outcome expectations would impact their willingness to participate in counseling beyond the intake session. Longo et al. (1992) discovered via a hierarchical multiple regression that client outcome expectations accounted for 23% of the unique variance in client motivation to attend therapy and self-efficacy accounted for an additional 11% of the unique variance in motivation. In turn, both self-efficacy and motivation ("intentions to continue in counseling;" Longo et al., 1992, p. 448) were found to be the most influential factors determining whether or not a client returned to the first counseling appointment after an intake session. Self-efficacy plays a direct role in an individual's choice of whether or not to engage or consistently engage in certain behaviors (Bandura, 1977b; Bandura, 1986). Outcome expectations are also a part of this equation; they can influence the behavior that leads to certain outcomes (Bandura, 1977b). Interestingly, in the Longo and colleagues study, outcome expectations were found to explain more of the variance in client motivation to attend therapy than self-efficacy.

Before Longo and his colleagues began applying Social Cognitive Theory to the problem of client attrition, Bandura (1977b) considered self-efficacy as part of a useful model to help explain psychological and behavioral changes within the realm of diverse therapeutic treatments, as he considered self-efficacy to be the most important factor contributing to engagement in a behavior (Bandura, 1986). For example, Brown and colleagues (2014) examined the pattern of clients' self-efficacy for engaging in treatment, along with outcome expectations, throughout cognitive-behavioral treatment for an anxiety disorder. Increases in self-efficacy, and outcome expectations, predicted decreased anxiety symptoms (the outcome). One additional example is the study conducted by Maric and colleagues (2013), who found that self-efficacy mediated the

outcome of cognitive-behavioral treatment for adolescents who refused to attend school due to fear. Outcomes of CBT included increases in school attendance and decreases in fear about attendance.

Mental Illness and Help-Seeking Stigma

The stigma surrounding mental health treatment is a key variable in potentially explaining no-show behavior. Some limited research has found a link between stigma and premature termination (see Sirey et al., 2001), although generally, there has been an under-examination of stigma in the no-show literature.

The stigma surrounding suffering from mental health problems and seeking mental health treatment is widely prevalent in general society (Vogel, Wade, & Hackler, 2007). This public stigma held by society can lead to negative attitudes and stereotypes about counseling and about those who struggle with a mental illness (Vogel et al., 2007). As well, negative attitudes can be internalized by those who suffer from mental illness; which, in turn, become detrimental to an individual's self-concept (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989; Vogel et al., 2007). Both public stigma and experiencing internalized self-stigma can lead those needing counseling services to avoid them (Cooper, Corrigan, & Watson, 2003; Corrigan, 2004; Vogel et al., 2007).

The collegiate years are a specific time when many mental illnesses have their onset (see American Psychiatric Association, 2013; DSM-5, 2013). According to the results of the National Comorbidity Replication Survey, the majority of lifetime mental disorders (e.g., mood, psychotic, anxiety, personality disorders) have their initial onset or episode between the ages of 18 to 24 (Kessler et al., 2005).

Definitions: Public and Self-Stigma

There are two overarching types of stigma that can affect people with mental illness, public stigma and self-stigma. Public stigma is global and other-oriented, while self-stigma is individual and internally-focused (Corrigan, 2004; Vogel, Wade, & Haake, 2006; Vogel & Wade, 2009). Vogel and Wade (2009) defined public stigma as "*society's rejection of a person due to certain behaviours or physical appearances that are deemed unacceptable, dangerous, or frightening* (p. 20)." Another way to phrase the definition of public stigma is *"the perception held by a group or society that an individual is socially unacceptable*" (Corrigan, 1998; Corrigan, 2004; Vogel et al., 2006, p. 325). Self-stigma is defined as "*labeling oneself as unacceptable because of having a mental health concern*," and develops via a process of internalizing the public stigma associated with mental illness (Corrigan, 2004; Vogel et al., 2006; Vogel & Wade, 2009, p. 20).

Within these two overarching categorizations of stigma are subtypes related to: 1) having a mental illness, and 2) seeking professional help for a mental illness. Again, each of these subtypes occur at both a public- and a self-level (Vogel & Wade, 2009). The stigma attached to seeking psychological help is less concerned with actually having the mental disorder than it is with the act of seeking and receiving help for a disorder (Vogel & Wade, 2009). "*The stigma associated with seeking mental health services is the perception that a person who seeks psychological treatment is undesirable or socially unacceptable* (Vogel et al., 2006, p. 325)." Vogel and Wade (2009) assert that a person's sense of self-esteem, self-regard, and self-confidence can suffer due to the self-stigma present when an individual seeks professional help. Individuals who consider help-seeking to threaten their self-esteem, self-regard, or self-confidence are less willing to engage in help-seeking behavior. Self-efficacy has also been found

to be important in the stigma literature, and is related to stigma in an inverse manner – the greater the self-stigma, the lower an individual's sense of efficacy (Corrigan, 2004). The vicarious learning that occurs through negative media portrayals of mental illness negatively impacts self-esteem and self-efficacy. Having to seek counseling for help with a personal concern can be interpreted as a failure, and can lower individuals' confidence that they can help themselves (Corrigan, 2004; Vogel et al., 2006).

Help-Seeking Outcomes of Stigma

The majority of adults with mental disorders do not receive treatment or professional help (Wang et al., 2005). Research indicates that public stigma, mediated by self-stigma, negatively affects the intentions and willingness of people to seek professional help for a mental illness, (see Cooper et al., 2003; Corrigan, 2004; Corrigan & Rusch, 2002; Eisenberg et al., 2009; Vogel et al., 2007). Individuals may avoid counseling in order to maintain their self-esteem or in order to avoid displaying any sign of weakness or failure, which many individuals believe that seeking counseling would convey (Corrigan, 1998; Corrigan, 2004; Fisher, Nadler, & Whitcher-Alagna, 1982; Fisher, Nadler, & Whitcher-Alagna, 1983; Nadler & Fisher, 1986). As stigma can prevent individuals from seeking help when they are struggling with a mental disorder, stigma is a reasonable factor to consider when examining reasons why participants/clients fail to appear for first counseling appointments.

Extent of the Problem

Clients failing to show up for scheduled appointments and clients dropping out of treatment in the initial stages are relatively common occurrences. For example, Baekland and Lundwall (1975) found outpatient client dropout rates of 30%-60% across all types of clinical settings. Other investigators have found it to be typical for more than 40% of clients to attend

only 1-2 therapy sessions (Ciarlo, 1979; Fiester, Mahrer, Giambra, & Orniston, 1974; Pekarik, 1983). In fact, rates of not returning after an initial intake interview at a psychiatric clinic have been shown to be as high as 57% (Overall & Aronson, 1962).

In more recent studies, Carter and colleagues (2012) found that between 30% and 70% of clients dropped out of eating disorder treatment. Fenger et al. (2011) indicated that 27% of their sample was no-shows, with an additional 12% of their sample dropping out of therapy. Werbart and Wang (2012) sampled 1,498 psychotherapy clients and found that 14% of the clients never started therapy after their initial intake session and 17% dropped out of treatment prematurely. In a longitudinal study, Wang et al. (2006) discovered that during a 5-year period, approximately 30% of potential marriage and family therapy clients who completed an intake did not end up engaging in therapy.

Impact of No-Show Behavior

Clients who do not appear for their first psychotherapy session can have a far-reaching impact on themselves, their clinicians, the mental health service delivery system, and other individuals who are seeking mental health treatment. The extent of this issue can be understood through a review of pertinent literature.

Impact on Clients

Clients who do not follow through with therapy are often considered treatment failures, and clinicians assume these clients are unlikely to be helped with their presenting problems (Baekeland & Lundwall, 1975; Pekarik, 1985; Sue et al., 1976; Weighill et al., 1983). Research has shown that a good number of therapy sessions, beyond an intake or first session, are typically required for individuals to improve their situation and make positive treatment gains (Lorr, McNair, Michaux, & Riskin, 1962; Luborsky, Chandler, Auerback, Cohen, & Bachrach, 1971).

There is a general conclusion in the psychotherapy literature that those individuals who complete psychotherapy treatment are "better off" than those who do not (Pekarik, 1992, p. 379). In fact, clients in substance abuse treatment who attend only one or two therapy sessions have counseling outcomes comparable to individuals who have no exposure to therapy at all (Stark, 1992). Hansen, Lambert, and Forman (2002) analyzed data from multiple sources in regard to the number of needed counseling sessions in order to see clinically significant improvement in clients. They found the majority of clients in the studies they reviewed did not attend enough therapy sessions (only 3-5 sessions on average) to gain this improvement, and that approximately 18 sessions were necessary to see 50% improvement in a client. In one of the databases from which some of this information was gathered, the average number of sessions was less than five and only 20% of clients in that sample saw improvement of 50% or greater in their symptoms. Similarly, Pekarik (1992) found in his study that clients who dropped out after a greater number of sessions were better adjusted and had gained more improvement than those clients who dropped out after just a few sessions. There is not sufficient time for treatment to be effectively administered when clients do not show up after an initial intake session or if they drop out in the early stages of treatment (Garfield, 1986; Pekarik, 1985).

In addition to treatment related factors, virtually every mental health service facility utilizes a "waitlist" for service provision, and no-show clients create longer waitlists by failing to show for appointments for which others in need would have been willing to attend (Barrett et al., 2008). These no-show incidences are especially critical given that higher numbers of people are seeking mental health treatment than there are clinicians and help centers available (Sue et al., 1976). When a client fails to follow up with treatment or a client returns to treatment for just one or two sessions and terminates before adequately being helped, valuable resources from which

other clients could benefit are lost (Barrett et al., 2008; Bischoff & Sprenkle, 1993; Garfield, 1994; Weisz et al., 1987). Sometimes waitlists serve as a discouragement for those seeking mental health services. Some individuals withdraw their names rather than place themselves on a long wait list or lose their desire, motivation, or courage to engage in counseling once an opening finally arises (Freund et al., 1991).

Impact on Clinicians

A client no-show or premature termination is a frustrating experience for most clinicians. Clinicians may spend time preparing for a particular client by reviewing treatment notes, assessment results, and other applicable information, only to have that preparation time become unproductive when clients do not attend scheduled appointments (Pekarik, 1985). Clinicians who are paid per appointment or by direct contact hours lose money when a client no-shows, especially if the agency does not collect a no-show fee (Pekarik, 1985). There are some employment situations within which counselors' professional competencies (e.g., counseling skills) are evaluated and based upon client attendance. White and Pollard (1982) found that when clinicians experience higher no-show rates with their clientele, there is an increase in the possibility of those clinicians receiving more negative peer and supervisor ratings of their competence and therapeutic effectiveness (White & Pollard, 1982).

Clinician self-esteem and self-efficacy can also suffer when a client does not show up for a counseling session (Bischoff & Sprenkle, 1993; Klein et al., 2003; Pekarik, 1985). Clinicians may feel less than competent if a client no-shows, may doubt their counseling and rapport building abilities, may develop a cynical view of clients and client commitment to therapy, or may lose confidence in the mental health care system (Pekarik, 1985; Presley, 1987). Piselli, Halgin, and MacEwan (2011) concluded that therapists often experience a combination of

sadness or loss, a sense of failure or shame, anger or frustration, and possibly responsibility or regret when clients prematurely terminate. Clinician emotions and confusion over no-shows have also been found to have more lasting effects, and are not always resolved quickly (Piselli et al., 2011).

Impact on Mental Health Service Delivery Systems

A large amount of coordination, planning, and significant fiscal expenditures are involved in the running of a mental health agency (private practice, hospital, community mental health center, university counseling center, etc.). Opportunities to increase the number of professional staff are frequently based upon the number of clients seeking services at an agency. The need for staff clinicians can be severely underestimated and finances impacted when service delivery hours are lost to no-show behavior by clients (Klein et al., 2003). As a result, situations can arise where more clients need mental health services than there are staff and services available (Baekeland & Lundwall, 1975). This situation is a concern, as there are more individuals seeking psychological services than there are trained professionals to provide those services (Imber, Frank, Gliedman, Nash, & Stone, 1956). Along with this, when there is a high frequency of client no-shows, mental health agency personnel may have a higher risk of job dissatisfaction and job performance, which could lead to agencies needing to cope with higher turnover rates for clinicians (Pekarik, 1985). Finally, in terms of insurance or other subsidized funding for mental health services, clients who do not show up for appointments decrease the cost-effectiveness of treatment (Dubinsky, 1986; Garfield, 1986; Pekarik, 1985; Sue et al., 1976) because they often need more sessions overall.

The financial situation for the mental health system has been so impacted by the phenomenon of client no-show behavior that providers have begun to consider ways in which to

offset losses. Lesaca (1995) suggested that mental health agencies should require a fee if a client does not show up for an appointment or call to cancel in advance. This raises the issue of how to best enforce and collect those fees when the client fails to appear for an appointment.

No-show clients can also impact agency funding, particularly if funding is based upon direct client hours. Insurance companies billed for sessions not attended by clientele raise the price of coverage for mental health services for all clientele. Another consequence is that clients may use up their covered sessions through no-show charges and be left without coverage when they need it, or have to pay higher, out-of-pocket rates once a pre-approved allowance of sessions has been used (Bischoff & Sprenkle, 1993). Publically-funded agencies (e.g., community mental health centers funded through United Way), with missions typically intended to serve less advantaged and impoverished populations, are not able to make the best use of those funds provided to them. Last, mental health service agencies with a high number of client no-shows may gain a negative reputation when clients seem to not want to attend appointments or receive treatment from a particular agency (Pekarik, 1985).

In sum, clients, clinicians, service agencies, and mental health systems can all feel the impact of the clients who do not attend their scheduled psychotherapy appointments. The issue of no-show clientele clearly inhibits the mental health delivery system from being maximally effective and adequately serving all those who are in need. In the next section, I review general reasons for which clients terminate therapy; then go on to review no-show behaviors as they relate to specific situational, clinical, and demographic variables.

General Reasons for Terminating Therapeutic Services

Many clients successfully complete the full length of treatment prescribed by a mental health professional or make significant enough progress to not be labeled a premature terminator.

There are a variety of reasons why these "completion" clients choose to discontinue services. Understanding general reasons for discontinuance is important so that any similarities and differences in contributing factors leading to client no-show or premature termination can be clearly determined.

Todd and colleagues (2003) explored both client and therapist perspectives on why clients choose to terminate. The reason clients most frequently cited for ending therapy was the client or therapist moving away. Degree of clinical improvement was also another major factor as to why clients decided to discontinue treatment. Client dissatisfaction with treatment, or avoidant and unmotivated clients accounted for a small percentage (10%) of the reasons offered. Therapists also identified the client or therapist moving away and degree of client improvement to be the top reasons for clients to end services.

Westmacott and Hunsley (2010) conducted an examination of reasons why psychotherapy clients terminate treatment. Feeling better or degree of improvement, perceiving a lack of help with presenting concerns, or having reached the decided upon number of sessions were common reasons cited. Less common reasons were that the individuals felt embarrassed about seeking therapy (suggesting the need to examine public and self-stigma), as well as issues such as transportation or childcare.

Major Studies Examining Premature Termination of Therapy

Sue et al. (1976) conducted a wide-scale study assessing variables related to the premature termination of community mental health facility clients. Across seventeen Seattle community mental health facilities, 13,450 clients were evaluated on seven demographic and five service variables. The demographic variables were: residential area, age, sex, marital status, educational level, gross monthly income, and race/ethnicity. The service variables were:

personnel performing the intake interview, diagnosis, program assignment, goal of program, and service assignment.

Sue et al. (1976) utilized partial and multiple correlations to assess their data. These analyses indicated that approximately 40% of the participants had failed to return after an initial counseling session. These service terminators were more likely to be people of color, not assigned to individual therapy, earning lower incomes, of lower educational backgrounds, diagnosed as psychotic, assigned to a paraprofessional for intake, or assigned for diagnostic evaluation. These factors were all partially, as well as multiply, correlated to termination after one session.

Fenger and colleagues (2011) examined the demographic and clinical variables connected to psychotherapy no-show and dropout clients in a naturalistic, cross-sectional study involving 2,473 non-psychotic patients in a Denmark community mental health center. Sex, age, marital status, number of children at home, vocational/university education, employment status, and current amount of sick leave available were the demographic variables in the study. The clinical variables were: primary diagnosis, comorbidity of disorders, duration of symptoms, Global Assessment of Functioning (GAF) score, previous psychological treatment, whether clients were prescribed antidepressants, and client substance abuse.

Logistic regression analysis odds ratios indicated that persons below age 25 years, with 9 years of education, no sick leave, a personality disorder, a GAF score below 40 or above 70, no previous psychiatric/psychological treatment, no prescribed antidepressants, and those suffering from substance abuse problems were most likely to engage in no-show behavior. Interestingly, the variables significantly predicting early terminators were slightly different; these included age below 45 years, up to 11 years of education, no vocational or higher education, being

unemployed, and those suffering from substance abuse problems. From these results the authors concluded that demographic variables have a better ability to predict no-show behavior, and that being younger and less educated increased likelihood to engage in no-show behavior and lead to an 'early terminator' label.

Werbart and Wang (2012) examined variables impacting clients' likelihood of not starting treatment after an initial contact, of starting treatment but then dropping out, and of starting and continuing treatment. Data were collected from 1,498 outpatient psychiatric patients in Sweden. In comparison to those patients who started treatment, nonstarter patients were older, male, unemployed or on sick leave, and had a lower educational level. Clinically, non-starters reported poorer initial therapeutic alliances, were rated by therapists as more dangerous to themselves and others (β = -.57), received higher ratings of pathological or psychotic features (β = -.20), more often had an Axis I diagnosis (β = -.56), had worked with younger therapists (β = -.02), and were seen in clinics with lower levels of organizational stability (β = .59). Comparisons made between dropouts and non-dropouts demonstrated that dropouts were younger, had no previous psychotherapy, had fewer bereavement/loss experiences, had more reports of acting out and criminal acts, and were more likely to be treated at more highly unorganized and unstable clinics.

This research suggests that several demographic and historical factors can contribute to or correlate with clients failing to appear for initial counseling sessions or ending therapy early. Later, I will outline a general list of factors that have been examined to date and present findings associated with studies surrounding those factors.

Specific Factors Contributing to No-Show Behavior

As reflected by conflicting findings in the literature, there is inconsistency in which no-show variables are included for examination as well as inconsistency in the effects that these variables are found to have on failure to show for appointments (Carter et al., 2012).

In this section I review studies across various topical areas in terms of their influence on clients' likelihood of failing to appear or prematurely terminating from psychotherapy. The studies reviewed concern adults primarily, although a few studies included adolescents. The latter was pertinent as the focus of my study will be on a university counseling center population (i.e., adolescents and young adults). I also focused on general psychotherapy; specialized variations such as substance use/abuse interventions were not incorporated.

Demographic, Environmental, and Clinical Variables

Demography. Clients with lower income, lower SES, less education, who are people of color, who are unemployed, and who are younger in age have all been found to be more likely to no-show or prematurely terminate than their counterparts (Berrigan & Garfield, 1981; Fenger et al., 2011; Sue et al., 1976; Warnick et al., 2012; Werbart & Wang, 2012; Wierzbicki & Pekarik, 1993). On a point of conflicting findings, Werbart and Wang (2012) noted in their study that those who failed to start treatment tended to be older. Finally, the cost of therapy can be inhibiting (Manthei, 1996), especially for individuals who do not have insurance coverage and/or are less financially secure.

Client and counselor sex may also play a role in who starts therapy versus who does not. With respect to clients, being male leads to a greater risk of not starting treatment (Werbart & Wang, 2012). Regarding counselor sex, evidence is equivocal; clients are more likely to return for future counseling sessions if they encounter a female intake counselor. In a sample of 141

clients, 83% of male clients and 85% of female clients who had a female intake counselor returned for counseling while 68% of male clients and 69% of female clients did who had a male intake counselor (Betz & Shullman, 1979). However, a replication study conducted by Krauskopf, Baumgardner, and Mandracchia (1981) found no difference in client return rate based upon the sex of the intake counselor.

Clients of color are more likely to drop out than European American individuals (Wierzbicki & Pekarik, 1993). In a study conducted with children and adolescents, African American clients were more likely to drop out of treatment prematurely (Warnick et al., 2012). Culturally diverse clients who are more deeply enculturated (i.e., endorse more culture-specific beliefs and attitudes) were more likely to drop out of therapy than culturally diverse individuals who did not identify with their cultural beliefs to as great an extent. Finally, the similarity of race/ethnicity between counselor and client does not appear to impact clients' likelihood of prematurely terminating (McCabe, 2002).

Environmental reasons. Clients moving away, time conflicts with therapy appointments, transportation difficulties, illnesses, being influenced by others to discontinue treatment, an inability to take time off from work, finding another mental health provider, and improving for reasons unrelated to therapy, all fall under the category of environmental reasons for no-shows or premature termination (Fenger et al., 2011; Hunsley et al., 1999; Manthei, 1996; Todd et al., 2003). In the case of couples or family therapy, lack of cooperation from partners or family members may prevent potential clients from making or keeping a first therapy appointment (Wang et al., 2006).

Environmental reasons can also involve clinicians. Trainees and interns frequently leave mental health agencies and move on as a natural course of their training, effectively ending

therapeutic relationships with clients and leading to a natural course of termination (Hunsley et al., 1999). Also, clients may not feel comfortable with having a student-trainee as a therapy provider, and this can inhibit them from initiating or continuing therapy (Wang et al., 2006). Interestingly, clients who are assigned to work with a different counselor than the counselor who completed their intake (clients were told at intake which therapist they would be assigned to for future treatment) were more likely to return for the first therapy session after the intake (Krauskopf et al., 1981).

Organizational factors such as clinic stability in the community affect clients' approach to services (Werbart & Wang, 2012). As well, clients' referral source to an agency can be a factor impacting their decision to prematurely terminate. Pekarik and Stephenson (1988) found that when clients were not self-referred, they were more likely to discontinue treatment early.

Topic determination. Topic determination in counseling is the agreement between the counselor and the client on the topic(s) to be discussed in a counseling session, the degree to which the particular focus between the counselor and client in a session is similar, and how each individual views his/her own role and the other's role in the counseling process (Tracey, 1986). In relation to a client's likelihood of continuing in or prematurely terminating therapy, Tracey (1986) found that a greater consonance of topic determination and a stronger therapeutic alliance led to higher client satisfaction with therapy and less likelihood of premature termination for clients. Accordingly, an intake counselor accurately recognizing clients' presenting problems and desired focus in treatment may make clients more likely and willing to return to their first counseling appointment (Epperson et al., 1983; Krauskopf et al., 1981).

Symptom severity and distress level. The severity of clients' symptoms and corresponding subjective level of distress influences clients' likelihood of remaining in treatment or dropping

out prematurely. Symptom severity and distress level have been represented in a number of ways. For example, for eating disordered clients, low body weight indicates higher severity/distress (Carter et al., 2012). Often, although counter-intuitive, clients with greater symptom severity and distress levels are *more likely* to leave treatment early, as are clients who have had previous high distress and negative experiences with previous therapy (Carter et al., 2012; Frayn, 1992). Carter and colleagues (2012) speculated that this counter-intuitive finding could be due to the fact that individuals with a history of greater distress and greater symptom severity may have attempted therapy in the past, and it may not have been helpful. This past "failure" could lead to poor outcome expectations for current treatment. Previous failures can also negatively impact self-efficacy to engage in that failed behavior, and can therefore lead to a decrease in motivation to attempt that behavior (Bandura, 1977a). Greater distress can also frequently decrease thoughts of self-esteem, self-worth, and self-efficacy. Therefore, individuals in greater distress may have more negative perceptions of their self-efficacy to engage in counseling-related tasks, a hypothesis that was examined in my study.

Client Global Assessment of Functioning (GAF) is another method used to measure distress. When GAF scores are low (i.e., below 40; indicating high distress) or high (i.e., above 70; indicating low distress) clients are more likely to *not appear* for a scheduled first-session counseling appointment (Fenger et al., 2011), suggesting a potential exponential or curvilinear relationship between distress level and therapy attendance. A more clinically serious indicator of client severity and distress level is the level of danger clients' pose to themselves or others. As well, the presence of psychotic features is also considered a high distress situation. Werbart and Wang (2012) found that clients like these were less likely to start therapy. Individuals who are diagnosed with personality disorders are more likely to no-show for an initial counseling

appointment, as are depressed clients who are not taking antidepressants. Those with no prior treatment history are also more likely to no-show for, or drop out of, treatment (Werbart & Wang, 2012).

Waitlists and delay between intake and first session. The length of delay between an intake and the first counseling session has been found to increase no-show rates (Baekeland & Lundwal, 1975), and clients who dropped out of therapy had experienced longer wait list times than those clients who had completed therapy (Carter et al., 2012). In addition, clients experiencing longer wait times tended to dropout of treatment before they had completed their prescribed amount of sessions (Warnick et al., 2012).

Being placed on a waitlist encourages clients to seek help elsewhere, therefore leading them to miss appointments at agencies where they had been waitlisted (Manthei, 1995). However, this finding has been challenged; Freund et al. (1991) determined that length of delay was not a factor in clients declining to attend their first therapy session, and found there was no significant difference in time spent on the waitlist between those clients that attended their first scheduled appointment and those that did not. The average time spent on a waitlist in that study was 20 days for no-show clients and 25 days for the clients that did continue treatment. Freund et al. (1991) did note that a few of the no-shows did attribute their behavior to being placed on the waitlist.

Client improvement. When clients are placed on a waitlist for mental health services, they often seek relief elsewhere, improving their situation or reducing their distress by the time their appointment arrives (Manthei, 1995; Presley, 1987). As shown in multiple studies (see Wang et al., 2006), problem improvement may be one of the most significant reasons for clients to fail to

make a first appointment, fail to attend an appointment after an initial intake, or prematurely terminate therapy.

For example, Presley (1997) found that of a sample of clients who had terminated treatment after only one counseling session, approximately 80% of them had done so due to improvement in their situation. Manthei (1995) found that 84% of the clients who failed to appear for appointments attributed their behavior to improvement in the problem that had initially led them to seek services. In this same study, 61% of clients who had terminated therapy after only one session also attributed the termination to improvement. The reasons clients reported for their situation improving included: feeling helped by a single counseling session, seeking counseling elsewhere, and various self-help efforts (Manthei, 1995). Finally, clients who terminate after multiple sessions may feel as though they have accomplished their therapeutic goals and see no use in continuing treatment (Hunsley et al., 1999).

Dissatisfaction with therapist or treatment. Clients who feel dissatisfaction with the services that they are receiving leads them to discontinue their use of therapy (Hunsley et al., 1999). This dissatisfaction can take several forms: clients may not have confidence in the therapist; feel uncomfortable with the therapist; think therapy is not progressing adequately; feel their concerns are not being addressed; feel no improvement in their symptoms, or, even that therapy is making their problems worse (Hunsley et al., 1999). Client perceptions of the therapist (i.e., the therapist is young or inexperienced), can also prevent clients from not beginning therapy after an intake session (Pekarik & Stephenson, 1988; Sue et al., 1976; Werbart & Wang, 2012).

Hunsley et al. (1999) found that therapists could accurately predict when clients terminated therapy due to having accomplished their original therapy goals, but were much less able to predict when clients left therapy due to dissatisfaction with them or the services that they

were providing. On the other hand, clients listed dissatisfaction with their therapists or the services they received as a highly influential reason for discontinuing treatment. Finally, clients discontinue therapy because they simply no longer have the time or interest to continue.

Client expectations of treatment. Similar to topic determination is the subject of client expectations of treatment. Clients often perceive a certain length of time they expect to be in therapy, and they have a certain length of time within which they expect to see results (McCabe, 2002). If these expectations are not met, there is a greater probability that clients will drop out after a single session of counseling (McCabe, 2002). There are frequently differences that arise in expectations between clients and therapists, particularly in regard to the goals or the duration of treatment (Pekarik, 1985). These differences can cause a rift in the working alliance and can lead a client to prematurely terminate therapy. Clients also tend to have preconceived notions of what therapy will be like, and they have therapy outcomes that they expect to occur. Some research has found that pre-therapy expectations do not significantly impact a client's likelihood of remaining in therapy or prematurely terminating (Hardin, Subich, & Holvey, 1988).

Present Study

There continues to be a relative lack of robust research focusing on the issue of no-show clients (Longo et al., 1992; Meyer, 2001; Wierzbicki & Pekarik, 1993), in part as this is a difficult sample to reach and from which to gather information (Fenger et al., 2011). Studies in which actual no-show samples have been utilized tend to have poor response rates (see Wang and colleagues, 2006).

The available literature has contradictory, ambiguous, and inconsistent evidence (Hunsley et al., 1999; Manthei, 1995; Pekarik, 1985). Although difficult to determine exactly why a client will no-show for an appointment, and to identify what the most significant factors

are influencing an individual to not appear for a scheduled counseling session, a chief reason for these contradictory findings has to do with a key methodological flaw surrounding inconsistent operational definitions of what constitutes a "no-show," "prematurely terminating," or "dropout" client (Barrett, 2008).

To build and improve upon previous literature, my study adopted a clearly stated working definition of what constitutes a no-show. My study also aimed to determine which previously examined variables and reasons for failure to appear carry the greatest weight in explaining the likelihood of participant no-show. Many previous studies conducted in this area have used simple frequency counts for subsets of suspected causative factors related to no-show. Or, when reviewing studies in the area, authors have used techniques like box and tally scoring of related factors across studies. In contrast, I simultaneously assessed all the major variables related to no-show behavior that the literature demonstrated as impactful, and used MANOVA analysis to better understand how these factors related to one another as well as how they related to participants' likelihood of failing to appear for a scheduled counseling appointment.

Further, I incorporated the contribution of help-seeking stigma to participant no-show behavior. Manthei (1995) identified feelings of self-consciousness and clients being unable to force themselves to attend sessions among those who no-show for appointments, but asserted that these factors are less common reasons for clients not appearing. McCabe (2002) indirectly investigated stigma by using a five-item subscale examining the degree of shame held by participants seeking help, but did not find that stigma in this case played a major role in clients' decisions to no-show. However, these two studies were not a thorough investigation of the effect of stigma on help-seeking; in fact, help-seeking stigma has been found to be strongly associated

with reluctance to seek help for a mental health concern (see Cooper et al., 2003; Corrigan, 2004; Vogel et al., 2007).

Finally, I included the impact of self-efficacy for engaging in counseling behaviors on intent to attend or no-show in my study, as self-efficacy has been found to be a major enhancer or detractor of engaging in particular behaviors and influences both motivation as well as outcome expectations (Bandura, 1977a). The inclusion of self-efficacy, and more broadly Social Cognitive Theory, was also an attempt to approach the no-show phenomenon from a theoretical lens, which has not frequently occurred within this subset of research.

Previous research has taken a retrospective approach, surveying clientele after they have no-showed or discontinued treatment. In my study, I took a prospective view, adding to the current knowledge base by trying to determine which factors the college population considers to be reasons they would not keep a scheduled appointment before the opportunity to attend arises. Greater understanding of these factors, for which potential future therapy clients are already at risk, could add a better understanding of what steps could effectively be taken prior to or during an initial intake session to prevent client no-show. Along with the goal of elucidating a clearer understanding of the no show phenomenon, I hoped to be able to acquire sufficient information to begin conceptualizing educational interventions to reduce the risk of clients not-showing for initially appointed sessions.

CHAPTER 3. METHOD

Participants

Participants in my study were undergraduate college students at a large Midwestern university. I sought a sample size of approximately 280 participants, based on the results of a power analysis (Faul, Erdfelder, Buchner, & Lang, 2009) as well as guidelines regarding the number of participants needed for a factor analysis (Fastinger, 1987) I planned to carry out on the Social Cognitive Instrument, an author-adapted instrument used to evaluate the influence of self-efficacy in this study.

A total of 305 undergraduate students participated in the study. Fifteen cases had to be removed as these participants responded to only one of the study items, so a total of 290 cases were included for data analysis. The sample had a mean age of 19 years old and consisted of 192 female participants (66% of the sample). Most of the sample (78.6%) identified as European American, with 9.5% identifying as International, 3.9% identifying as Hispanic/Latino American, 3.2% identifying as African American, and 1.4% identifying as Asian American. The majority of participants, at 86.4%, were of either freshman or sophomore standing. The vast majority of participants identified as being single (95.8%). The sample consisted mainly of participants from a middle class or upper middle class socioeconomic status (78.2%).

Participants were recruited through the SONA system through the Department of Psychology. Students were awarded one research credit for their participation in this study Courses that require research credit within the department include: Introduction to Psychology, Developmental Psychology, Social Psychology, and Introduction to Communication Studies. Each participant was enrolled in at least one of these courses.

Measures and Materials

Narratives

The author-devised narratives (see Appendix A) describe a college student who is dealing with distress and experiencing symptoms that are similar in nature to depression, and who has scheduled a counseling appointment with the university counseling services to seek assistance in coping with his/her concerns. I used two versions of this narrative, identical except for the degree of subjective distress described - a low distress and a high distress level. Participants were randomly assigned to one of the two narrative versions. Gender pronouns were not used in the narratives; instead, the pronoun "you" was used to enhance the ability of participants to imagine themselves experiencing the appropriate level of distress as they completed the research materials.

Intent to Attend Item

There was one general "Intent to Attend" item that served as the primary dependent variable. This item asked participants how likely they would be to attend their scheduled counseling appointment, using a Likert scale ranging from 1 = *certain I would not attend* to 5 = *certain I would attend* (see Appendix B). This item was completed prior to participants completing the FANSI (described below), so that consideration of individual reasons for no-show behavior would not contaminate responses to the general, overall attendance item that was used to understand participants' degree of intent to no-show.

Social Cognitive Instrument

The Social Cognitive Instrument is an author-adapted measure consisting of 21 items, each rated on a 7-point Likert scale (1 = *not at all confident, 7 = definitely confident*). The items are intended to elicit participants' sense of self-efficacy surrounding the tasks that occur during

therapy (see Appendix C). Participants were instructed to rate the extent to which they feel confident engaging in these therapy tasks; for example, "Use counseling to get a better understanding of others and myself." The total of all the items was divided by the number of items to generate a score consistent with the Likert scale anchors.

I adapted the Social Cognitive Instrument from Howard Tinsley's Expectations of Counseling – Brief Form (EAC-B) scale. The EAC-B is derived from Tinsley's original Expectations of Counseling (EAC) scale. The EAC instrument assesses participants' expectations about therapy that are believed to impact therapy outcome, as well as what they expect of their therapist in therapy (Tinsley & Harris, 1976; Tinsley, Workman, & Kass, 1980). The expectations evaluated with the EAC-B include four sub-scales: client attitudes and behaviors, counselor attitudes and behaviors, counselor characteristics, and counseling process and outcome (Tinsley, Holt, Hinson, & Tinsley, 1991). For the purposes of my study, I needed an instrument to assess participants' self-efficacy around completing therapy tasks, so I chose and changed 21 of the original 53 items on the EAC-B to evaluate participants' sense of confidence in performing therapy tasks, instead of assessing their expectations of therapy. Tinsley's original EAC has established reliability coefficients ranging from .69-.89 across the seven expectancy scales (Tinsley & Harris, 1976). In 1980, Tinsley and colleagues continued to develop the EAC, and in this study they derived 17 expectancy scales, with reliability coefficients ranging from .77-.89 (median .82). They also conducted a factor analysis on the 17 expectancy scales of the EAC in which the four expectancy factors (noted above with the EAC-B sub-scales) were determined. Tinsley and colleagues (1982) reported that the EAC-B scores correlated at .83 with scores on the original version of the EAC. Coefficient alpha reliabilities for the EAC-B scales ranged from .69 to .82 with a median of .77. Test-retest reliabilities ranged

from .47 to .87, with a median of .71. As I used an adapted version of the EAC-B, established validity and reliability are not wholly applicable.

Perception of Stigmatization by Others for Seeking Help (PSOSH)

Vogel, Wade, and Ascheman (2009) created the PSOSH to measure individuals' perceptions of the degree to which those in their immediate environment stigmatize them for seeking professional help for a psychological problem. There is a presumed link between perceptions of others' stigma beliefs toward psychological help-seeking and willingness to seek help for a mental health-related problem (Vogel et al., 2009). I used the PSOSH to measure participants' anticipation of stigmatization by others when participants seek help for a psychological problem. This allowed for an exploration of the effects such perceptions have on appearing or not appearing for a scheduled counseling appointment.

The PSOSH has five items, each of which is rated on a five-point Likert scale (1 = *not at all*, 5 = *a great deal*). On the PSOSH, participants are instructed to rate how the people they interact with would react to learning that the participant is considering seeking psychological help. An example of the items on the PSOSH is "*To what degree do you think the people you interact with would react negatively to you*" (see Appendix D). On the original instrument, a total score is derived by summing the five items; higher scores signify greater perceptions of stigma from the people in one's immediate environment, although specific ranges denoting low, medial, and high levels of stigma were not specified. In my study, I divided the total score by the number of items to generate a score consistent with the Likert scale anchors.

With respect to evidence of validity, PSOSH scores have a negative correlation of -.66 ($p < .001$) with attitudes toward seeking psychological help as well as positive correlations with two help-seeking stigma measures and the one public stigma of mental illness measure. The

correlations for the Stigma of Seeking Professional Psychological Help scale, the Self-Stigma of Seeking Help scale, and the Devaluation-Discrimination scale with the PSOSH are .31 ($p <$ .001), .37 ($p <$ .001), and .20 ($p <$ .001), respectively, (Vogel et al., 2009). These correlations demonstrate that the PSOSH measures a similar yet distinct aspect of stigma and that it can accurately identify self-stigma more accurately than can other measures of public stigma. The PSOSH has an internal consistency that ranges from .84 to .89 in college student samples, and exhibited an internal consistency of .78 in a clinical sample (Vogel et al., 2009). The internal consistencies in the college sample have been shown to be similar across racial/ethnic groups (Vogel et al., 2009). Test-retest reliability was twice established across a three-week span (Time 1 = .84, Time 2 = .85) and a correlation between scores from the first and second tests of .77 ($p <$ .001).

Self-Stigma of Seeking Help (SSOSH)

The SSOSH (Vogel et al., 2006), assesses individuals' attitudes toward seeking professional help for personal, emotional, and mental-health related concerns. As well, the SSOSH examines the implication these attitudes have on individuals' willingness to seek those services. I used this instrument to measure participants' self-stigma toward seeking professional help and to explore the effect this stigma has on attending or not attending a scheduled counseling appointment.

The SSOSH is a 10-item instrument, with items constructed on a 5-point Likert scale (1 = *strongly disagree*, 5 = *strongly agree*). The ten items are summed; items 2, 4, 5, 7, 9 are reverse scored prior to summing. Total scores on the SSOSH are divided by the total number of items to generate a score consistent with the Likert scale anchors. Under this classification system, low stigma applies to scores between 1 and 2.2, medial stigma applies to scores between 2.3 and 3.2,

and high stigma applies to scores between 3.3 and 5. Examples of items included in the SSOSH are "*I would feel inadequate if I went to a therapist for psychological help*," and "*My self-confidence would not be threatened if I sought professional help"* (see Appendix E).

Vogel et al., (2006) provided validity evidence for the SSOSH. Vogel et al. (2006) asserted that construct validity for the SSOSH has been shown via its positive correlations with the Disclosure Expectations Scale Anticipated Risks scale ($r = .47$, $p < .001$) and the Social Stigma for Seeking Psychological Help scale ($r = .48$, $p < .001$). As well, the SSOSH had negative correlations with the Disclosure Expectations Scale Anticipated Benefits scale ($r = -.45$, $p < .001$); the Attitudes Toward Seeking Professional Psychological Help Scale ($r = -.63$, $p < .001$); and, the Intentions to Seek Counseling Inventory ($r = -.38$, $p < .001$). The internal consistency of the SSOSH, across multiple samples, has ranged from .89 to .91 (Vogel et al., 2006). A test-retest reliability coefficient of .72 was obtained across an administration span two months apart (Vogel et al., 2006), suggesting that the construct of stigma has a good degree of stability across time.

Factors Affecting No-Show Instrument (FANSI)

The Factors Affecting No-Show Instrument (FANSI) is an author-devised measure. The items included on the FANSI were gleaned from studies in the psychological literature that empirically demonstrated particular issues, causes, or reasons that lead to client no-show behavior for therapy sessions.

No validity and reliability has been established for the FANSI, as it was developed for this study. All items were obtained by conducting a systematic and thorough search of the no-show and premature termination literature, in psychology as well as related fields (e.g., psychiatry, medicine). After collecting and reviewing all pertinent articles, I employed a process

of box-and-tally scoring. The criterion for inclusion of an item in the final draft of the FANSI was if an issue, cause, or reason led to client no-show behavior for therapy sessions, in a statistically significant or meaningful way, in at least three independent empirical studies. I will use the FANSI in my study to evaluate the degree to which each of the included reasons for no-show impact individuals' decisions to attend or not attend a scheduled counseling appointment.

The FANSI consists of 14 items, each rated on a five-point Likert scale (1 = *would not influence me at all*, 5 = *would influence me extremely*). Participants were asked to consider themselves in the distress situation of the narrative they read, and were then instructed to rate the extent to which each item on the FANSI would influence their decision to *not* keep their scheduled appointment at the counseling center. Sample items on the FANSI include "*Having access to transportation to and from your therapist's office*" and "*Knowing that you have been assigned to work with a new or less experienced therapist* " (see Appendix F).

All items are equally weighted on the FANSI, with the sum total of items divided by the total number of items to generate a score consistent with the Likert scale anchors.

Manipulation Check

I utilized a one-item manipulation check to confirm that the distress level conditions in the narratives worked as intended. Participants were asked to report, using a six-point Likert scale (1 = *none*, to 6 = *the highest amount I could*), how much psychological distress they imagined themselves experiencing as they completed the research materials (see Appendix G).

Demographics and History Information

Participants also completed a demographic questionnaire. Data was obtained on participants' sex, age, year in school, race/ethnicity, marital status, family socioeconomic status, previous consideration of use or actual use of mental health services, and whether or not

participants had a history of scheduling and not appearing for counseling appointments (see Appendix H).

Procedure

Students voluntarily signed up for participation in the study through the online SONA system. Upon sign-up for the study, participants were directed to a Qualtrics® survey site, where they were instructed to complete research materials. No e-mail or IP addresses were acquired from participants in order to ensure the anonymity of their responses.

I obtained approval for this study from the ISU Human Subjects Institutional Review Board (IRB). I also obtained informed consent from participants at the beginning of the study (see Appendix I). After obtaining informed consent, participants were randomly assigned to read one of two versions of a narrative asking them to imagine themselves suffering from an unidentified personal issue that causes them enough distress to make an appointment at the university counseling center (see Appendix A). One version of the narrative was written to elicit the idea that the student participants are experiencing an extremely high level of subjective distress. Alternatively, the other version of the narrative was written to elicit the idea that the student participants are experiencing a somewhat lower, but still significant, level of subjective distress. The narratives are written in the first person perspective, and instructions directed participants to consider themselves as experiencing the distress that is described in the narrative while they complete the research materials.

After reading the narrative, participants were asked to identify how likely they would be to attend the hypothetical scheduled counseling appointment. Then, participants were instructed to give ratings for a series of potential reasons (e.g., sex of the counselor or expectations of the counseling experience) that may incline them to fail to appear for the counseling appointment

they have scheduled. Next, participants responded to items assessing their self-efficacy regarding participation in common counseling session tasks. Participants also completed items assessing their perceptions of public- and self-stigma in regard to seeking psychotherapy services. Then, participants rated the degree of distress they had imagined experiencing as they completed the items (manipulation check). Finally, participants provided demographic information and relevant historical data (e.g., sex, race/ethnicity, age, history of receiving mental health service). At the end of the survey, participants were instructed to follow a link where they verified their participation in order to receive research credit.

Research Questions

General Research Questions of Interest

Question 1. Specifically, does self-efficacy for completing tasks common in psychotherapy account for variance in clients' intent to fail to appear for a scheduled counseling appointment?

Question 2. Specifically, does public or self-stigma surrounding seeking treatment for a mental health problem, account for variance in clients' intent to fail to appear for a scheduled first counseling appointment?

*Question 3***.** Does level of subjective distress affect clients' willingness to attend a scheduled counseling appointment?

Question 4. When simultaneously examined, which common reasons for client no-show are the most influential in account for variance in clients' intent to fail to appear for a scheduled first counseling appointment? Do these reasons vary by level of subjective distress?

Question 5. Does self-efficacy moderate or mediate relations between other variables affecting participants' intent to appear?

Specific Hypotheses to be Tested

Hypothesis 1. Self-efficacy for therapy tasks will be directly related to clients' intent to attend a scheduled first counseling appointment. Specifically, higher endorsed levels of self-efficacy will contribute to a greater likelihood of clients' intent to appear for an established counseling appointment.

Hypothesis 2. Public and self-stigma surrounding seeking treatment for a mental health problem will be indirectly related to clients' intent to attend a scheduled first counseling appointment.

Hypothesis 3. Those with higher levels of imagined subjective distress will endorse a greater likelihood to fail to appear for an established first counseling appointments compared to those with lower levels of imagined subjective distress.

Hypothesis 4. Self-efficacy will moderate or mediate the relations of stigma with participants' intent to attend a scheduled first counseling appointment. See Figures 1 and 2 for predicted moderation equations.

Hypothesis 5. Common reasons for client no-show will vary by level of subjective distress.

Hypothesis 6. Clients who are male, people of color, of lower SES, in a lower year of school, and endorse no previous history of receiving mental health services, will endorse a greater intent to fail to appear for a first counseling appointment.

Data Analysis

The significance level for all statistical tests was set at $p < .05$ unless otherwise specified; multiple tests were run with Bonferroni-corrected, family-wise alpha rates. Descriptive statistics (means, standard deviations, ranges) were calculated for all variables of interest. As well, a zero-

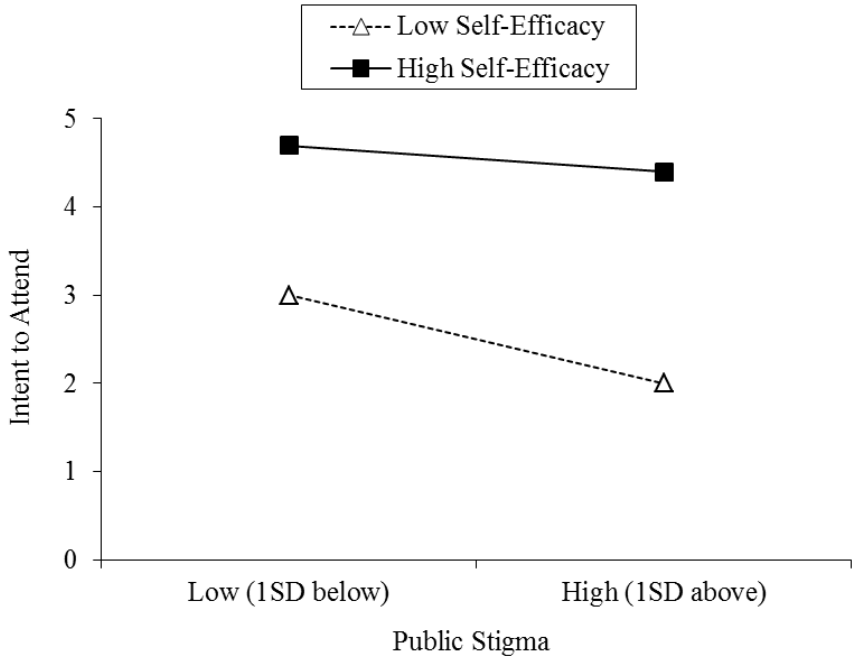

Figure 1. Predicted Moderation Effects of SCI on the Relation Between Public Stigma and Intent to Attend

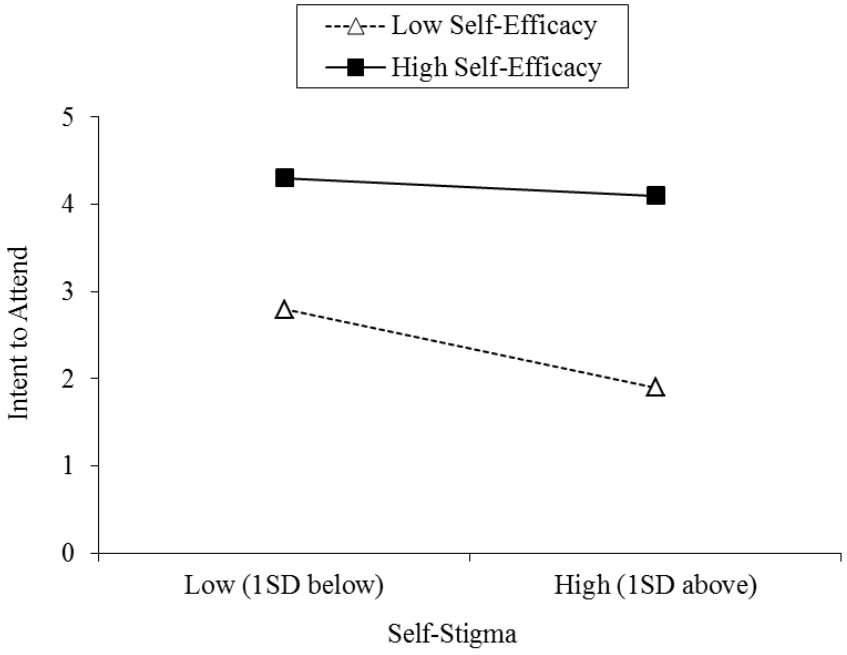

Figure 2. Predicted Moderation Effects of SCI on the Relation Between Self-Stigma and Intent to Attend

order correlation matrix was calculated to examine relations among all key variables. Alpha coefficients were calculated where appropriate.

Exploratory Factor Analyses of the Social Cognitive Instrument

The 21 items on the Social Cognitive Instrument were initially subjected to an exploratory factor analysis (EFA), in order to determine if I should reduce the items to conceptually definable subtests for later analyses. Data was subjected to principal axis factoring (PAF) with no rotation. An EFA approach will stringently initially test and support the presence of an appropriate number of factors, identify emergent structures inherent in the items, and identify potential items that do not contribute to or, in fact, detract from factor stability and interpretability. Standard thresholds were used to retain items (discrete item loading weights of .40 and above, see Tabachnick & Fidell, 2010). Emergent factors were examined using the Kaiser rule (eigenvalues greater than 1) and scree test (examining viable factors up to the asymptote line) (Tabachnick & Fidell, 2010).

Analyses of Variance (ANOVA & MANOVA) Statistics

One-way ANOVA analyses were conducted to assess the success of the distress manipulation, the impact of distress on intent to attend a scheduled counseling appointment, the impact of distress on extent of FANSI variables endorsed, and the influence of various demographic factors on intent to attend a scheduled counseling appointment.

Regression Analyses

Regression analyses were conducted to examine the influence of self-efficacy and stigma on intent to attend as well as the possibility of moderation and mediation effects of self-efficacy on the relation of public stigma and self-stigma on intent to attend a scheduled counseling

appointment. A regression analysis was also used to examine the influence of the 14 items on participants' intent to attend.

CHAPTER 4. RESULTS

Three hundred and five people participated in the study; however, only 290 cases were utilized for data analysis. Fifteen cases were discarded because these participants responded only to one item and then discontinued the survey. Participants were approximately equally distributed between the two distress conditions, with 137 participants in the "low distress" condition and 153 participants in the "high distress" condition.

Descriptive Analyses

In this section, I present the means, standard deviations, alpha coefficients, and zero-order correlations among the SCI, PSOSH, SSOSH, FANSI, and Intent to Attend items (see Tables 1 and 2). These analyses address my first and second hypotheses in which I predict that self-efficacy will be positively correlated with intent to attend and stigma will be inversely correlated with intent to attend, respectively.

Table 1.

Means, SD, and Ranges of SCI, PSOSH, SSOSH, FANSI, & Intent to Attend Items

Items	*Mean*	*SD*	*Range*
1. SCI	4.54	1.06	1-7
2. PSOSH	1.88	0.91	1-5
3. SSOSH	2.81	0.66	1-5
4. FANSI	3.29	0.58	1-5
5. Intent	3.88	0.91	1-5

Table 2.

Inter-correlations, alphas of SCI, PSOSH, SSOSH, FANSI, and Intent to Attend Measures

Note. *Coefficients significant at $p < .05$. ***Coefficients significant at $p < .001$. Alpha coefficients are on the diagonal.

Items	SCI	PSOSH	SSOSH	FANSI
1. SCI	*.96*			

Table 2 (continued).

Items	SCI	PSOSH	SSOSH	FANSI
2. PSOSH	-.25***	*.91*		
3. SSOSH	-.36***	.33***	*.85*	
4. FANSI	.13*	.11	.06	*.79*
5. Intent	.50***	-.29***	-.26***	-.01

SCI Descriptives

The means, standard deviations, and inter-correlations of all SCI items are presented in Tables 3 and 4. The 21 items of the Social Cognitive Instrument, evaluating participant self-efficacy for engaging in typical counseling behaviors was summed for a total score and divided by the number of items on the instrument. Higher totals indicate greater participant confidence in engaging in the counseling behaviors presented. In the case of these missing values, the total participant average for that item was used in place of the missing value. Items were in response to the stem: "*Using the scale below, please rate the extent to which you feel confident in your ability to participate in the given situations that may occur during a counseling appointment."*

Table 3.

Means and Standard Deviations of Individual SCI Items

Items	*Mean*	*SD*
1. Take any psychological tests that might be necessary	4.59	1.50
2. Form a positive relationship with my counselor	4.66	1.39
3. Gain experience in new ways of solving problems	4.55	1.37
4. Express my emotions regarding self and my problems	4.11	1.60
5. Do assignments outside sessions	3.80	1.43
6. Take responsibility for making my own decisions	4.89	1.42
7. Talk about my present concerns	4.74	1.52
8. Understand purpose of what happens in the counseling session	4.71	1.38
9. Get practice in relating openly and honestly to another person	4.43	1.44
10. Practice the things I need to learn in the counseling relationship	4.52	1.32
11. Use counseling to get a better understanding of others and myself	4.79	1.37
12. Stay in counseling, even if at first I am not sure it will help	4.26	1.55
13. See my counselor for the first interview	4.66	1.61

Table 3 (continued).

Items	*Mean*	*SD*
14. Stay in counseling even though it may be painful or unpleasant	3.99	1.57
15. Contribute in terms of expressing my feelings and discussing them	4.48	1.44
16. Use the counseling to identify problems on which I need to work	4.72	1.38
17. Use counseling to learn how to better help myself in the future	4.92	1.39
18. Feel comfortable enough with my counselor to really say how I feel	4.42	1.58
19. Use counseling to improve my relationships with others	4.81	1.46
20. Ask counselor to explain when I do not understand something	4.77	1.55
21. Work on my concerns outside my counseling sessions	4.41	1.43

PSOSH Descriptives

The means, standard deviations, and inter-correlations for each of the PSOSH items are presented in Tables 5 and 6. For the purpose of analysis, the five public stigma items forming the PSOSH were summed for a total score and divided by the number of items. Higher totals indicate greater perceptions of public stigma for seeking counseling. In cases where one item of the five was unanswered by a participant, that number was filled in with the average across all participants for that specific public stigma item. All items were in response to the stem "*Imagine you had an emotional or personal issue that you could not solve on your own. If you sought counseling services for this issue, to what degree do you believe that the people you interact with would…"*

Table 4.

Inter-correlations of SCI Items

Items	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
1.	-																				
2.	.54	-																			
3.	.48	.70	-																		
4.	.38*	.48	.48	-																	
5.	.40	.43	.43	.47	-																
6.	.44	.55	.49	.40	.50	-															
7.	.48	.58	.47	.64	.40	.45	-														
8.	.45	.54	.51	.46	.39	.40	.59	-													
9.	.37	.53	.52	.57	.43	.38	.63	.57	-												
10.	.44	.59	.60	.55	.50	.50	.58	.55	.80	-											
11.	.50	.62	.61	.46	.47	.53	.57	.51	.54	.65	-										
12.	.40	.44	.48	.43	.50	.33	.46	.40	.46	.53	.54	-									
13.	.54	.46	.35	.36	.35	.46	.49	.42	.30	.37	.48	.41	-								
14.	.45	.47	.46	.42	.49	.45	.51	.49	.45	.49	.46	.62	.60	-							
15.	.46	.49	.46	.59	.43	.46	.65	.52	.58	.59	.55	.54	.58	.65	-						
16.	.47	.50	.50	.53	.39	.52	.61	.57	.56	.61	.60	.51	.55	.60	.75	-					
17.	.48	.51	.51	.49	.40	.47	.55	.52	.54	.59	.65	.58	.47	.54	.67	.80	-				
18.	.36	.48	.39	.63	.42	.43	.64	.44	.56	.55	.51	.53	.51	.58	.75	.65	.66	-			
19.	.44	.57	.54	.47	.46	.47	.59	.51	.55	.59	.68	.56	.52	.55	.65	.65	.70	.66	-		
20.	.41	.51	.43	.44	.42	.47	.51	.43	.46	.48	.52	.42	.53	.49	.56	.55	.49	.55	.57	-	
21.	.40	.48	.48	.45	.56	.50	.46	.40	.50	.56	.49	.50	.47	.55	.55	.53	.52	.56	.63	.67	-

Note. *Coefficients significant a $p < .01$. All other coefficients significant at $p < .001$.

Table 5.

Means and Standard Deviations of Individual PSOSH Items

Items	*Mean*	*SD*
1. React negatively to you	1.88	1.03
2. Think bad things of you	1.99	1.06
3. See you as seriously disturbed	1.91	1.13
4. Think of you in a less favorable way	2.03	1.08
5. Think you posed a risk to others	1.64	0.99

Table 6.

Inter-correlations of PSOSH Items

Note. ***Coefficients significant at $p < .001$.

Items	1	2	3	4	5
1.	-				
2.	.80***	-			
3.	.60***	.68***	-		
4.	.69***	.78***	.78***	-	
5.	.59***	.55***	.63***	.63***	-

SSOSH Descriptives

The means, standard deviations, and inter-correlations of the SSOSH items are presented in Tables 7 and 8. Prior to additional SSOSH analyses, five of the ten self-stigma items were reverse scored, and then all items were summed and divided by the number of items. Higher total scores indicate greater levels of self-stigma around seeking counseling. If one of the items was left blank by a participant, the average across participants for that item was inserted. Items were in response to the stem "*People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean…rate the degree to which each item describes how you might react in this situation."*

Table 7.

Means and Standard Deviations of Individual SSOSH Items

Items	*Mean*	*SD*
1. I would feel inadequate if I went to a therapist for help	2.85	1.07
2. My self-confidence would *not* be threatened if I sought help	3.05	1.09
3. Seeking help would make me feel less intelligent	2.64	1.11
4. My self-esteem would increase if I talked to a therapist	3.16	0.96
5. My view of myself would not change	2.95	1.00
6. It would make me feel inferior to ask a therapist for help	2.70	1.05
7. I would feel okay about myself if I made the choice to seek help	3.51	0.89
8. If I went to a therapist, I would be less satisfied with myself	2.45	0.98
9. My self-confidence would remain the same if I sought help	2.95	0.91
10. I would feel worse about myself if I could not solve my problems	3.07	1.07

Table 8.

Inter-correlations of SSOSH Items

Note. All coefficients significant at $p < .001$.

Items	1	2	3	4	5	6	7	8	9	10
1.	-									
2.	-.51	-								
3.	.51	-.48	-							
4.	-.25	.43	-.31	-						
5.	-.21	.36	-.33	.32	-					
6.	.53	-.41	.53	-.26	-.21	-				
7.	-.37	.39	-.36	.40	.26	-.40	-			
8.	.49	-.46	.56	-.40	-.26	.54	-.37	-		
9.	-.23	.37	-.28	.15	.38	-.28	.32	-.22	-	
10.	.43	-.35	.47	-.26	-.23	.47	.46	-.28		-

FANSI Descriptives

The means, standard deviations, and inter-correlations of each of the FANSI items can be found in Tables 9 and 10. All of the FANSI items were summed for a total score and then divided by the total number of items. The higher the FANSI item score, the more influence the item had to affect participants' attendance at an initial scheduled counseling appointment.

Missing values were replaced with the total participant average of each item. Items were in response to the stem: *"Keeping in mind how you were instructed to think/feel while reading the narrative, use the scale below to rate how much each of the following items would influence whether or not you would attend the appointment you made at the university counseling services."*

Table 9.

Means and Standard Deviations of Individual FANSI Items

Items	*Mean*	*SD*
1. Assigned to work with a new therapist	2.95	1.03
2. Not knowing how therapy works	2.92	1.11
3. Anticipating therapy will help negative or painful feelings	3.74	1.14
4. Referred to seek counseling by someone else	3.24	1.12
5. Improvement or relief in symptoms	3.74	0.99
6. Placed on a waitlist and having a significant delay	3.41	1.16
7. Assigned to work with a male therapist	2.42	1.32
8. Assigned to work with a female therapist	2.16	1.24
9. Feeling that counselor cares about helping you	3.70	1.10
10. Clear agreement and understanding on concerns	3.66	1.08
11. Commitments that make it hard to find time for therapy	3.54	1.05
12. Access to transportation to and from therapist's office	3.29	1.25
13. Can really trust the therapist to which you are assigned	4.12	1.02
14. Seeking and getting help elsewhere	3.13	1.00

Exploratory Factor Analysis of the Social Cognitive Instrument

The sample data (N = 290) was subjected to an exploratory factor analysis; specifically, principal axis factoring (PAF) without rotation. A non-rotated solution was examined because self-efficacy has generally been found to be domain specific (cf. Bandura, 1986), and I intended the SCI to measure a specific, single factor indicative of confidence surrounding behavioral tasks needed to engage in counseling.

Research methodologists have argued that an initial EFA approach to theory-driven instruments provides a much more stringent approach to examining factor structure than a

Table 10.

Inter-correlations of FANSI Items

Note. *Coefficients significant at $p < .05$. **Coefficients significant at $p < .01$. **Coefficients significant at $p < .001$.

Items	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1.	-													
2.	.47***	-												
3.	.19**	.22***	-											
4.	.16**	.17**	.45***	-										
5.	.16**	.15*	.51***	.25***	-									
6.	.33***	.35***	.26***	.15*	.16**	-								
7.	.29***	.21***	.11	.11	.00	.19***	-							
8.	.11	.14*	.07	-.02	.00	.00	.55***	-						
9.	.22***	.17**	.40***	.25***	.35***	.23***	.14*	.12*	-					
10.	.24***	.28***	.45***	.25***	.41***	.21***	.08	.09	.62***	-				
11.	.27***	.30***	.22***	.20***	.31***	.37***	.02	-.07	.22***	.23***	-			
12.	.15**	.18**	.22***	.18**	.22***	.23***	.08	.10	.21***	.23***	.49***	-		
13.	.21***	.24***	.36***	.20***	.40***	.27***	-.02	-.02	.45***	.48***	.35**	.44***	-	
14.	.19***	.21***	.16**	.14*	.05	.19***	.22***	.15**	.18**	.19***	.18**	.22***	.26***	-

parameter-specified confirmatory factor analysis (e.g., Tabachnick & Fidell, 1996; Thompson, 2004). An EFA approach can initially test and support the presence of a specific number of factors as well as indicate items that do not contribute to or detract from factor stability and interpretability.

The results of the EFA clarified how the SCI can be used in data analyses. The PAF suggested an initial three-factor solution, accounting for 58.97% of the variance in the 21 SCI items. The three factors accounted for 52%, 3.8%, and 3.2% of the variance, respectively. The factor structure of the items converged after 8 iterations. Eigenvalues were calculated; for Factor 1 at 11.32, Factor 2 at 1.13, and for Factor 3 at 1.08. A scree plot analysis, suggested the presence of one clear factor, a severe drop to the X-axis, and two other factors slightly above the asymptote.

I examined the factor loading weights, and considered as stable only those items loading with weights of .40 or above (cf. Tabachnick & Fidell, 1996). This strategy ensures at least a moderate loading weight, and when coupled with items having non-significant cross-loaded weights on other emergent factors, provides for a good measure of confidence in the strength and stability of the item within the observed factor.

The observed weights yielded by the analysis, which ranged from .61 to .82, found all 21 items to be strongly loaded items on the first factor. Only five of the 21 items loaded above .30 on the remaining two factors, none above .38, and the remainder of the items loading weakly on the second and third factors. Item loadings and weights are shown in Table 11. Given the results of the PAF on the SCI items, I used the measure as a single factor instrument, with a summed score divided by 21, in order to retain the usefulness of the Likert scale qualitative anchors in interpretation. The EFA appears to demonstrate the SCI is a stable, single factor construct

accounting for the majority of variance among items in measuring client confidence in carrying out tasks in therapy.

Table 11.

Social Cognitive Instrument (SCI) Exploratory Factor Analysis Factor Loadings and Weights

	Factor 1	Factor 2	Factor 3
Take any psychological tests that might be necessary	**.61**	.07	.25
Form a positive relationship with my counselor	**.73**	.31	.17
Gain experience in new ways of solving problems	**.69**	.37	.12
Express my emotions regarding self and my problems	**.68**	.04	-.21
Do assignments outside sessions	**.61**	.09	.11
Take responsibility for making my own decisions	**.64**	.09	.23
Talk about my present concerns	**.76**	-.01	-.17
Understand purpose of what happens in counseling	**.67**	.13	-.05
Get practice in relating openly and honestly to another person	**.73**	.24	-.38
Practice things I need to learn in the counseling relationship	**.78**	.26	-.19
Use counseling to get a better understanding of others, myself	**.76**	.16	.08
Stay in counseling, even if at first I am not sure it will help	**.67**	-.06	.02
See my counselor for the first interview	**.65**	-.27	.33
Stay in counseling even though it may be painful or unpleasant	**.72**	-.21	.14
Contribute in terms of expressing feelings and discussing them	**.82**	-.29	-.14
Use the counseling to identify problems on which to work	**.81**	-.18	-.08
Use counseling to learn how to better help myself in the future	**.78**	-.13	-.07
Feel comfortable enough with my counselor to say how I feel	**.77**	-.30	-.22
Use counseling to improve my relationships with others	**.80**	-.08	-.01
Ask counselor to explain when I do not understand something	**.69**	-.10	.13
Work on my concerns outside my counseling sessions	**.71**	-.06	.11

Manipulation Check on Distress Level

A one-way analysis of variance was conducted as a manipulation check on the item asking participants to rate the level of distress they imagined experiencing as they read the narrative and completed the research materials. I found a statistically significant difference between the narrative conditions by imagined distress. The participants in the high distress condition (M = 4.16, SD = 1.18) endorsed a statistically significantly higher level of distress than

that imagined by participants in the low distress condition (M = 3.76, SD = 1.04), F (1, 286) = 9.24, $p < .01$.

Intent to Attend by Distress Condition

To test my third hypothesis regarding my prediction that I would find that individuals with greater subjective distress would endorse lower intent to attend a counseling appointment, I conducted a one-way ANOVA to examine mean differences in participant-reported likelihood to attend a scheduled counseling session by distress condition. I found a statistically significant difference between the mean intent to attend of participants in the low distress (M = 3.77, SD = 0.93) versus high distress conditions (M = 3.97, SD = 0.89), F (1, 288) = 3.79, $p < .05$. Participants who were assigned to the high distress condition were statistically significantly more likely to attend their scheduled counseling appointment than were participants in the low distress condition.

Public and Self-Stigma by Level of Distress

A one-way ANOVA demonstrated no significant differences between the low (M = 1.88, SD = 0.92) and the high distress conditions (M = 1.90, SD = 0.91) on public stigma, F (1, 286) = 0.05, $p > .05$. Neither were differences by distress condition on self-stigma statistically significant between the low (M = 2.84, SD = 0.66) and high distress conditions (M = 2.78, SD = 0.67), F (1, 287) = 0.64, $p > .05$. The sample, as a whole, reported medium levels of self-stigma according to ranges set forth in Vogel et al. (2006).

Intent to Attend, Self-Efficacy & Stigma Regression Analyses

To investigate my fourth hypothesis, in which I predicted that self-efficacy would moderate or mediate the relation between public- and self- stigma and intent to attend, I conducted regression analyses.

Mediation

The findings generated indicated that self-efficacy was not a mediator of public stigma and its relation with participants' intent to attend their scheduled counseling session. A second analysis, examining the indirect effects of self-efficacy on the relation of self- stigma to intent to attend demonstrated strong mediating effects. See Tables 12 and 13 for regression results.

Table 12.

Mediation Effects of SCI on the Relation Between Public Stigma and Intent to Attend

Note. ***Coefficients significant at $p < .001$.

Model	*b*	SE *b*	*β*	R^2	ΔR^2	ΔF (df)
Model 1 (SCI as DV)				.063	.063	19.08***
PSOSH	-.292	.067	-.251***			(1, 284)
Model 2 (ItA as DV)				.085	.085	26.60***
PSOSH	-.292	.057	-.292***			(1, 286)
Model 3 (ItA as DV)				.276	.194	75.96***
PSOSH	-.172	.052	-.172***			(1, 283)
SCI	.391	.045	.455***			

Table 13.

Mediation Effects of SCI on the Relation Between Self-stigma and Intent to Attend

Note. ***Coefficients significant at $p < .001$.

Model	*b*	SE *b*	*β*	R^2	ΔR^2	ΔF (df)
Model 1 (SCI as DV)				.131	.131	43.02***
SSOSH	-.578	.088	-.362***			(1, 285)
Model 2 (ItA as DV)				.067	.067	20.45***
SSOSH	-.354	.078	-.258***			(1, 287)
Model 3 (ItA as DV)				.259	.191	73.16***
SSOSH	-.125	.075	-.091			(1, 284)
SCI	.401	.047	.469***			

Moderation

The findings generated indicated that self-efficacy was not a moderator of public stigma and its relation with participants' intent to attend their scheduled counseling session. A second analysis, examining the moderating effects of self-efficacy on the relation of self- stigma to intent to attend demonstrated non-significant, but trending ($p < .06$), moderating effects. See Tables 14 and 15 and Figures 3 and 4 for regression results.

Table 14.

Moderation Effects of SCI on the Relation Between Public Stigma and Intent to Attend

Note. * Coefficients significant at $p < .05$. ***Coefficients significant at $p < .001$.

Model	*b*	SE *b*	*β*	R^2	ΔR^2	ΔF (df)
Step 1				.082	.082	25.28***
PSOSH	-.286	.057	-.286***			(1, 284)
Step 2				.276	.194	75.96***
PSOSH	-.172	.052	-.172***			(1, 283)
SCI	.391	.045	.455***			
Step 3				.282	.006	2.43
PSOSH	-.501	.218	-.501*			(1, 282)
SCI	.248	.102	.289*			
PSOSH x SCI	.076	.049	.339			

Table 15.

Moderation Effects of SCI on the Relation Between Self-stigma and Intent to Attend

Note. *Coefficients significant at $p < .05$. **Coefficients significant at $p < .01$. ***Coefficients significant at $p < .001$.

Model	*b*	SE *b*	*β*	R^2	ΔR^2	Δ(df)
Step 1				.068	.068	20.80***
SSOSH	-.357	.078	-.261***			(1, 285)

Table 15 (continued).

Model	*b*	SE *b*	*β*	R^2	ΔR^2	Δ(df)
Step 2				.259	.191	73.16***
SSOSH	-.125	.075	-.091			(1, 284)
SCI	.401	.047	.469***			
Step 3				.272	.013	5.07*
SSOSH	-.781	.301	-.571**			(1, 283)
SCI	.007	.181	.008			
SSOSH x SCI	.140	.062	.543*			

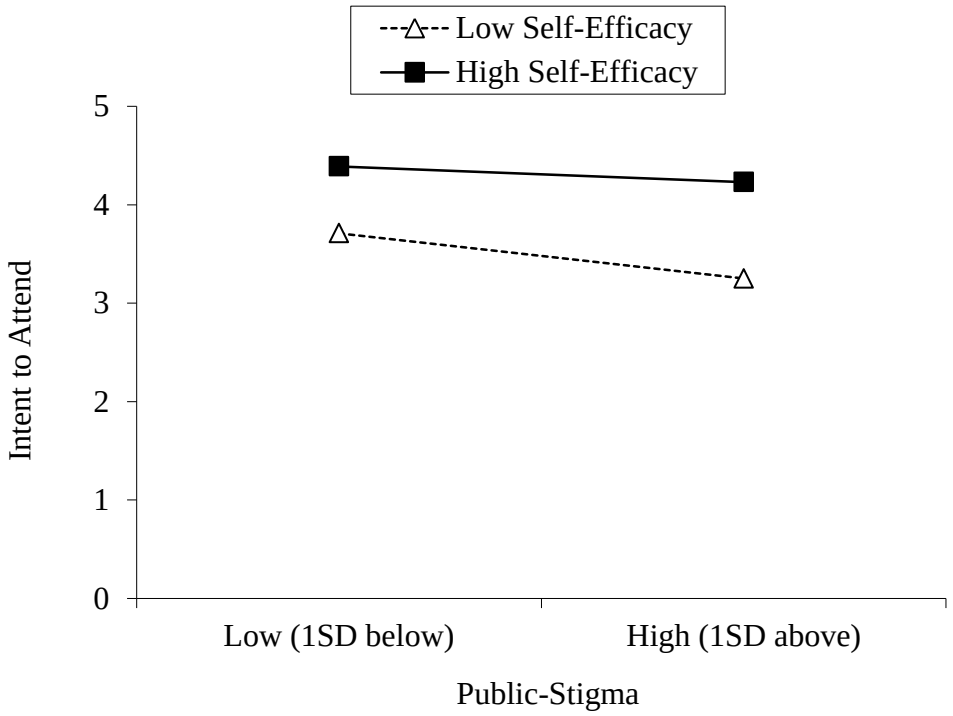

Figure 3. Moderation Effects of SCI on the Relation Between Public Stigma and Intent to Attend

Note. Regression equation: Y' = b_0 (3.06) + b_1 (-.501) + b_2 (.248) + b_3 (.076).

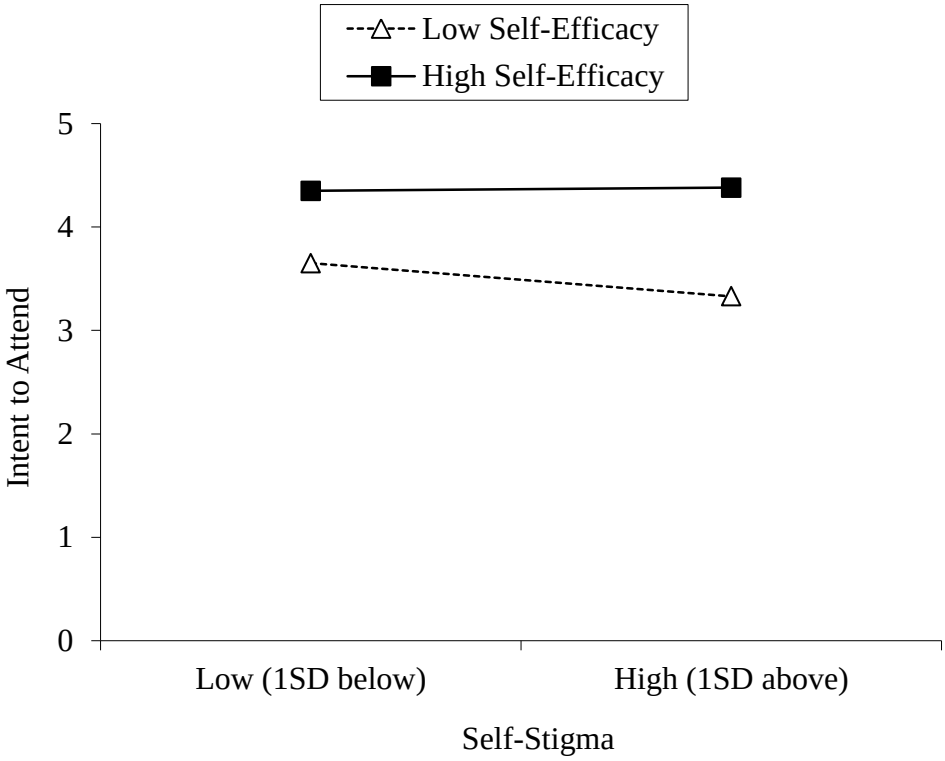

Figure 4. Moderation Effects of SCI on the Relation Between Self-Stigma and Intent to Attend

Note. Regression equation: $Y' = b_0 (4.28) + b_1 (-.781) + b_2 (.007) + b_3 (.140)$

An examination of slope values associated with the trend indicates that when standardized scores on the SCI are one standard deviation below the mean, the variable of self-efficacy for therapy tasks acts to moderate the relation between self-stigma and participants' intent to attend a scheduled counseling session, by increasing the likelihood that participants will not attend their scheduled session. No such effect is present at mean and upper score levels. See Table 16 for the slope values at the mean and $\pm$ one standard deviation above and below the mean SCI score. The effect of this moderation at low levels of self-efficacy for carrying out therapy tasks warrants additional consideration.

Table 16.

Moderation Effects of SCI at Low, Mean, and Upper Values

SCI	Effect	se	t	p	Low CI	Up CI
-1.0796	-.243	.1203	-2.01	.05	-.4795	-.0056
.0000	-.108	.0854	-1.26	.21	-.275	.0606
1.0796	.028	.1015	.27	.79	-.1724	.2271

FANSI

MANOVA Analysis

To determine if various factors affecting no-show behavior were impacted by level of distress (which I predicted would occur in my fifth hypothesis), I ran a one-way multivariate analysis of variance of the 14 FANSI items, by distress condition. The omnibus Wilk's test was non-significant, F (14, 275) = 1.25, $p > .05$; Wilk's Lambda = 0.94; no significant difference was found for endorsement of the FANSI items by distress level.

Regression Analysis

The 14 FANSI items were entered into a multiple regression equation and regressed against the dependent variable Intent to Attend. A forward selection procedure was employed in this regression analysis. Four of the FANSI items met the forward selection criterion of *p-in* < .05. FANSI items 2 (*"Not knowing what is supposed to happen during therapy or how therapy works"*), 9 (*"Feeling satisfied that the mental health agency and staff you made your appointment with care about helping you"*), 7 (*"Knowing you have been assigned to work with a male therapist"*), and 4 (*"Being referred to seek counseling by someone (e.g., a family member, a friend, Dean of Students Office, your advisor) instead of reaching the decision for yourself"*) accounted for 11.6% of the variance in participants' intent to attend the scheduled counseling appointment. See Table 17 for more detailed results of the regression analysis.

Table 17.

Multiple Regression Analysis of FANSI items x Intent to Attend

Note. *Coefficients significant at $p < .05$. ** Coefficients significant $p < .01$. *** Coefficients significant $p < .001$.

Model	*b*	SE *b*	*β*	R^2	ΔR^2	ΔF (df)
Step 1 (Item 2)				.039	.039	11.76***
Uncertainty about therapy	-.162	.047	-.198***			(1, 288)
Step 2 (Item 9)				.075	.035	10.96***
Uncertainty about therapy	-.188	.047	-.230***			(1, 287)
Mental health agency cares	.158	.048	.191***			
Step 3 (Item 7)				.100	.025	8.08**
Uncertainty about therapy	-.162	.047	-.198***			(1, 286)
Mental health agency cares	.172	.047	.209***			
Working with male therapist	-.114	.040	-.164**			
Step 4 (Item 4)				.116	.016	5.09*
Uncertainty about therapy	-.175	.047	-.198***			(1, 285)
Mental health agency cares	.148	.047	.209***			
Working with male therapist	-.119	.040	-.164**			
Outside referral	.107	.047	.131*			

Additional Analyses

Given the fact that several of the FANSI items were negatively correlated with the intent to attend item, a conceptually unexpected finding, I re-examined the FANSI items as well as the correlations between each FANSI item and intent to attend.

FANSI items 1, 2, 6, 7, 8, 11, and 12 were inversely correlated with the dependent variable, intent to attend. The inversely correlated items suggest that the more those items influence a participant's intent to attend, the less likely that participant will be to attend. Items that are positively correlated with the dependent variable indicate that the more those items influence a participant's intent to attend, the more likely that participant will be to attend. A rank

ordering of individual FANSI items both positively and negatively correlated with intent to attend, were examined. See Table 18 for means and correlations with intent to attend.

As a group of 14 items, the FANSI generated a mean of 3.28; standard deviation of .58; and a 95% confidence interval of (lower bound) 3.21 – (upper bound) 3.35.

Table 18.

FANSI Item Means by Positive and Negative Correlation with Intent to Attend

Item	Mean Score	Intent to Attend (r)
13. Can trust the therapist	4.12	.07
3. Anticipating therapy will help	3.74	.11
5. Improvement in symptoms	3.74	.16
9. Feeling that counselor cares	3.70	.15
10. Clear agreement on concerns	3.66	.08
11. Hard to find time for therapy	3.54	-.08
6. Delay before seeing therapist	3.41	-.08
12. Transportation to/from therapist	3.29	-.05
4. Referred to seek counseling	3.24	.12
14. Seeking/getting help elsewhere	3.13	.02
1. Work with inexperienced therapist	2.95	-.03
2. Not knowing how therapy works	2.92	-.20
7. Work with a male therapist	2.42	-.18
8. Work with a female therapist	2.16	-.11

The items most influential to participants in terms of affecting their decision to attend an appointment were items #13 (trusting therapist); #3 (anticipating therapy will help); #5 (improvement in symptoms); #9 (feeling that your counselor cares about you); #10 (agreement on concerns to work on); and, #11 (hard to find time for therapy). These items were both above the midpoint anchor of the FANSI scale (3 = *affect me somewhat*), as well as above 3.5, the midpoint between anchors 3 (*affect me somewhat*), and 4 (*influence me a lot*).

These items suggest that participants' sense of trust, caring and collaboration with the therapist they would see, experiencing a sufficient and continuing amount of subjective distress until their appointment time arrives, anticipating that therapy will release them from their

distress, and not having impediments to attending therapy are the most influential factors increasing the likelihood of participants attending their scheduled appointment. None of the correlations are of any magnitude that warrant consideration; interestingly though, the FANSI item most correlated with intent to attend was "Not knowing what is supposed to happen during therapy or how therapy works". Although the relation between this item and intent to attend accounted for less than 5% of shared variance, it would seem that knowing what therapy entails and believing one can carry out those tasks appears to have some import in intent to attend a scheduled counseling sessions.

Intent to Attend by Demography

A series of $p < .01$ Bonferroni-corrected one-way ANOVA analyses were run in order to examine any variations in intent to attend the hypothetical scheduled counseling appointment by various demographic and historical variables (sex, race, SES, year in school, and history of counseling experience) and to test my sixth and final hypothesis. In this hypothesis I had predicted that males, persons of color, lower middle class individuals, freshman and sophomores, and those with no previous counseling experience would endorse a lower intent to attend. As the vast majority (78.6%) of the sample identified as European American and the remaining 21.4% were distributed among five other racial/ethnic groups, the race variable was dichotomized into "White" and "People of Color" groups. There were no statistically significant differences found on any of these demographic variables, as categorized, according by intent to attend.

CHAPTER 5. DISCUSSION

The purpose of my study was to examine and understand the influence that self-efficacy, stigma, and other previously studied reasons for client no-show, have on participants' likelihood to attend a scheduled counseling appointment. The main goal of my research was to advance an understanding of why clients feel enough distress to schedule a counseling appointment, but then fail to appear for that first counseling session.

Many previous studies in this area lacked consistent definitions, theoretical bases, and failed to examine some significant and important variables (e.g., stigma, self-efficacy for engaging in counseling tasks). I attempted to move past these research limitations by including and examining all of these aforementioned variables simultaneously. I also examined the effects of subjective distress on participants' intent to attend a scheduled counseling appointment, the relations among frequently cited reasons in the literature for no-show behavior and participants' intent to attend a scheduled counseling appointment, and the role of stigma in participants' intent to attend a scheduled counseling appointment. In addition, I developed an instrument to assess participants' confidence in carrying out tasks necessary during therapy, and examined relations among stigma, self-efficacy, and participants' intent to attend a scheduled counseling appointment.

I hoped that by gaining further information on no-show behavior, in the future investigators can take steps to reduce the frequency with which no-show behavior among clients occurs. If the prevalence of no-show behavior can be reduced, then clients, clinicians, and mental health agencies will benefit.

Self-Efficacy

Self-efficacy is the confidence one has in his/her abilities to participate in a specific behavior that will likely lead to a successful outcome (Bandura, 1986). Self-efficacy influences

the relation between a person and his/her environment in a moderating manner, and behavior directly relates to outcome while being moderated by outcome expectations (Bandura, 1977a, Bandura, 1977b; Bandura, 1986). When self-efficacy is higher people are more likely to engage in the particular behavior as they are more motivated and more likely to believe that engaging in the behavior will lead to a desired outcome. When self-efficacy is lower people are less likely to engage in the behavior or to persevere in a behavior when there are obstacles to overcome, as they are less likely to believe in a happy outcome. This model applies to the realm of psychotherapy, in that self-efficacy has been shown to be a predictor of positive psychological and/or behavioral outcome (Brown et al., 2014; Maric et al., 2013). In my study, I predicted that confidence to engage in counseling tasks (self-efficacy) would influence participants' intent to attend a counseling appointment (behavior).

The Social Cognitive Instrument (SCI), which I developed using Tinsley's Expectations About Counseling short form (Tinsley, 1982), was subjected to exploratory factor analysis. The SCI held together well as a single factor measure of participants' confidence in carrying out tasks in therapy. The factor structure and reliability of the measure (r = .96) lend support to the validity of the instrument and show promise for future development efforts and cross-validation.

Using this instrument, I found self-efficacy for engaging in counseling behaviors to be an important and statistically significant variable influencing participant likelihood to appear for a scheduled counseling appointment. Self-efficacy was highly related to participants' intent to attend a scheduled counseling appointment (r = .50), supporting my first hypothesis.

My findings corroborate the findings of the few studies that have been previously conducted on how self-efficacy issues affect clients' perspective on engaging in therapy. Longo et al. (1992) found self-efficacy for engaging in counseling tasks to account for a statistically

significant amount of the variance in client motivation to engage in counseling. Self-efficacy, generally speaking, can also influence the effort and persistence with which people will pursue engaging in counseling (Bandura, 1977a). If people have low self-efficacy for completing tasks typical of therapy, they may be much less likely to schedule a counseling appointment, and even if such an appointment is made, they may be even less likely to attend that scheduled appointment. The role that self-efficacy has been found to have on no-show behavior has major implications for future research. Increasing clients' self-efficacy to engage in the typical tasks of therapy might be instrumental in ensuring their attendance at scheduled sessions. Helping clients, through direct experience and reinforcement or through vicarious learning (Bandura, 1986), to see that they can carry out tasks associated with participating in therapy, may substantially increase client attendance at therapy sessions.

Stigma

This sample expressed low to medium levels of perceived public stigma and self-stigma for mental health help-seeking behaviors, and there were no differences found in reported stigma between the low and high distress conditions. The low-medium levels of stigma found within this sample could be due to the fact that participants were not actually struggling with a mental health concern (this information was not asked for) nor were they engaged in help-seeking behavior. It is also possible that participants responded to the stigma items in a biased, socially desirable manner. Low-medium levels of public and self-stigma have also been found in previous studies that have used college samples (e.g., Vogel et al., 2007).

Despite low-medium levels of stigma found in this sample, self-stigma was found to be an important variable influencing participants' intent to attend the scheduled counseling appointment. Self-stigma was statistically significantly inversely correlated with intent to attend

(r = -.26) as was public stigma (r = -.29), demonstrating that greater levels of endorsed stigma lead to greater endorsement of intent to not attend a scheduled counseling appointment. This relation between stigma and intent to attend fits with previous research that has shown a link between stigma toward help-seeking behaviors and avoidance of therapy (Cooper et al., 2003; Corrigan, 2004; Vogel et al., 2007). These findings also address the limited previous exploration of the impact of stigma on no-show behavior.

Self-stigma and self-efficacy were also found to have an important relationship, in which self-stigma was greatly influenced by self-efficacy, such that when self-efficacy around counseling tasks was high, self-stigma had a much weaker impact on intent to attend. No similar relation was found between public stigma and self-efficacy for counseling tasks.

Self-efficacy as a mediator or moderator of self-stigma

Self-efficacy not only demonstrated a direct relation on intent to attend, but was also a statistically significant mediator of the relation between self-stigma and intent to attend, which is what I predicted with my fourth hypothesis. I also found self-efficacy to have a weak moderating effect on the relation between self-stigma and intent to attend. This moderation effect was strongest when self-efficacy for engaging in counseling tasks was low. When self-efficacy was low, self-stigma had more of a direct effect on intent to attend. As this was a non-significant, weak effect, this would be a beneficial trend to study in future research.

Self-stigma and self-efficacy have been linked in previous stigma literature. Corrigan (2004) found an inverse relationship between self-stigma and self-efficacy, in which greater self-stigma and lower self-efficacy were connected. I found in my study a similar relationship, but in such a way that self-efficacy moderated the relationship between self-stigma and intent to attend. Vogel and Wade (2009) discovered in their study that when self-confidence is threatened by the

idea of engaging in help-seeking, people are less likely to engage in counseling. Here again stigma and self-efficacy are intertwined. Social consequences and social judgment have been considered to be an influential factor in individuals' judgments of self-efficacy and their decisions of which behavior to engage or not engage in (Bandura, 1986), suggesting that stigma can influence self-efficacy. Self-efficacy has been studied as a mediating variable before this study; in previous research, self-efficacy was found to mediate behavior and behavior change (Lent et al., 1992). This suggests that self-efficacy for counseling tasks, if present at least in moderate to high levels, should have a mediating effect of self-stigma such that behavior surrounding an intent to attend scheduled counseling appointments could be heightened.

In a commonly studied stigma model, self-stigma mediates the relation between public stigma and intentions/willingness to seek help (Corrigan et al., 2003; Corrigan, 2004; Corrigan & Rusch, 2002; Eisenberg et al., 2009; Vogel et al., 2007). In my study, self-efficacy did not have a statistically significant role in the relation between public stigma and intent to attend, yet it did have a major impact on the relation between self-stigma and intent to attend. It is possible that, if assessed in a path analytic method, public stigma is internalized and becomes self-stigma, and then self-efficacy for counseling tasks exerts its indirect effects on attendance behavior of people seeking services. This supposition is supported empirically when my findings and previous research are integrated (Corrigan et al., 2003; Corrigan, 2004; Corrigan & Rusch, 2002; Eisenberg et al., 2009; Vogel et al., 2007). This newly established mediating effect of self-efficacy for counseling tasks might also explain variable effects across studies in the relation between self-stigma and willingness to follow through with counseling.

In short, the mediated relation between self-stigma and intent to attend a counseling appointment by self-efficacy suggests that while stigma directly influences intent to attend or to

no-show, the self-efficacy to engage in counseling tasks that individuals possess can reduce stigma to non-significant levels. Individuals learn about behavioral outcomes through both direct and observational experiences, which can influence their outcome and efficacy expectations (Bandura, 1977a). Perhaps individuals with someone close to them who has successfully engaged in counseling will have greater self-efficacy to engage in counseling themselves due to their vicarious learning experience. Then, those individuals with greater self-efficacy have reduced levels of self-stigma, making it easier for them to seek counseling. Observational experiences in which individuals who attend counseling are negatively judged and stereotyped may negatively influence individuals' efficacy expectations for engaging in counseling. Self-efficacy can also influence coping as well as anticipatory fear and inhibitions; thus, if individuals are experiencing or perceiving stigma around an activity in which they are anticipating engaging, this fear and lowered self-efficacy may decrease resources to cope with this stigma and may heighten anticipatory fear of the outcome expectations for engaging in that activity.

As past research indicates stigma can prevent individuals from seeking counseling at all (Cooper et al., 2003; Corrigan, 2004; Vogel et al., 2007), it is reasonable that stigma would continue to be an obstacle preventing people from following through once scheduling a counseling appointment. Stigma toward help-seeking can also follow the path of indicating that people who need counseling are helpless or despondent, and self-efficacy has been shown to be negatively impacted by learned helplessness and despondency (Bandura, 1982).

Future researchers should continue to examine the link between self-efficacy and self-stigma, not only within the context of no-show behavior but in other aspects of the psychotherapy domain as well. Future investigators should also consider the possibilities of

using self-efficacy as an intervention strategy to reduce self-stigma and to remove the barriers to seeking help that stigma can erect.

Distress

Past research has suggested that individuals seeking therapy who are in greater psychological distress are more likely to *not* appear for therapy than individuals experiencing less distress (Carter et al., 2012; Fenger et al., 2011; Werbart & Wang, 2012). In my study I found statistically significant differences between the low and high distress conditions in the manipulation check as well as in participants' intent to attend. Participants in the high distress condition endorsed a greater likelihood to attend the scheduled counseling appointment than did participants in the low distress condition. However, there were no other differences throughout the study by distress (i.e., no differences by distress on self-efficacy, stigma, or FANSI items).

These distress results are rather surprising, and in opposition to my hypothesis, as the literature suggests that the impact of distress should be opposite of what I found (high distress should lead to less likelihood to attend the counseling session). The literature also suggests that there should be differences in motivation and self-efficacy to attend counseling based upon distress. Longo and colleagues (1992) found a negative correlation between distress and self-efficacy, which is what I hypothesized would occur in my study as well. Vogel and Wade (2009) stated that there may be less self-stigma around seeking help when distress is higher, as counseling is then considered needed and potentially mandatory. When distress is lower, counseling may not be considered as necessary, and stigma therefore increases.

There are several potential reasons that I found the opposite effect of distress on intent to attend a counseling appointment than has been discovered in previous studies. One reason could be that findings surrounding the influence of distress on intent to attend a counseling session are

not robust, and individuals experiencing high levels of distress are actually more likely to attend counseling. A second reason could be that when people are asked to imagine distress and are not actually experiencing psychological distress, they believe that they would be more likely to want to be involved with counseling if they are struggling with greater distress. Empirically, in my study, one reason that I likely did not find more difference by distress is that even though there were statistically significant differences between the distress conditions, the actual mean difference was small (low distress $M = 3.76$, high distress $M = 4.16$), with both conditions reporting approximately "medium" levels of distress on the rating scale provided. Thus, the most likely reason I found any difference between the distress conditions was due to the power of my sample. Finally, it may be that distress operates in a more curvilinear fashion, such that truly high subjective distress and truly low subjective distress raise a greater intent to *not* attend a scheduled session, while a moderate level of distress (such as that endorsed by my sample) leads to a greater intent to attend.

Future research should examine naturally occurring differences in subjective distress among clinical samples and variations by distress in no-show reasons, self-efficacy, and stigma. In future non-clinical samples, differences in the distress manipulated in the use of narratives or vignettes should be amplified.

Factors Affecting No-Show Behavior

Throughout previous literature on no-show behavior, multiple variables have been cited as impacting clients' decisions to no-show for a counseling appointment, including demographic variables (e.g., sex, race, SES), logistic variables (e.g., transportation), therapist variables (sex, trustworthiness), and expectation variables (e.g., understanding how therapy works). Contrary to my final hypothesis and previous research, limited significant results were found with the

variables included in the FANSI. There was not a statistically significant difference between the distress conditions in participants' endorsement of FANSI items. In regression analysis, four of the fourteen variables were found to account for 11.6% of the variance in intent to attend. This is a much smaller degree of variance for which I had predicted the variables would account.

These limited findings could be due to several reasons. First, the wording of the FANSI items was not without issue. For example, differently directional wording might have brought about unexpected negative correlations with intent to attend. Second, my results could mean that for each individual person, there are a specific set of variables that will impact them, but these variables are not the same across individuals or are not significantly impacted by distress in the same way for all individuals. Third, as self-efficacy and stigma were found to be important to intent to attend, the non-significant findings indicate that the variables represented on the FANSI are not as important as the impact that self-efficacy and stigma have on counseling attendance. Future research should continue to modify the FANSI items and possibly further develop the FANSI as a possible no-show prediction instrument. If continued examination of these items results in non-significant findings, this may be an indication to researchers and clinicians that these more external variables are not of great import, or of less import, in preventing client no-show behavior as compared with intra-psychic variables like stigma or self-efficacy.

Limitations

Sample

A convenience sample of college students was used; therefore, my findings may not be generalizable to community samples. However, as college students are a primary client base for many agencies (e.g., university college counseling centers) it is helpful to understand the self-

efficacy these individuals experience around engaging in counseling activities as well as the reasons that may impact them in their decision to actually attend a counseling appointment.

Drawing from a non-client student pool also limited me to a hypothetical scenario in this study. It may have been difficult for participants to place themselves in the hypothetical situation described by the instructions, potentially limiting the ability to find significant results as well as results that are generalizable to real world settings. Individuals who have not had experiences with depression or mental illness could have a difficult time understanding the distress that individuals in these situations experience and could have difficulty considering the obstacles that could arise for them were they to consider actually engaging in therapy. While this sample may not have been as generalizable as a clinical sample would have been, a college sample can still be very informative.

One additional limitation of this sample is that it is predominantly female and of European American origin. There was not enough cultural diversity in participants in order to determine if there were differences among various people of color in counseling behavior self-efficacy or likelihood to attend a counseling appointment.

Distress Manipulation

The two versions of the narrative that participants were asked to read - low distress and high distress - were found to be statistically significantly different in the amount of distress that was expressed; however, the differences between the means was rather small (low distress M = 3.76, high distress M = 4.16). The means were also grouped around the center of the Likert scale that clients used for their responses, indicating that participants in both conditions imagined experiencing some degree to a fair amount of distress. Perhaps the small difference in subjective

distress "experienced" between the distress conditions prevented more significant results from being acquired and a true difference by distress from being found.

Measures and Instruments

As some of the instruments I used were either author devised or adapted for the purpose of this study, validity and reliability considerations must factor into result interpretation in a different manner than when using well-established measures. Validity was established for the Social Cognitive Instrument via the factor analysis, and the instrument from which it was adapted had established validity and reliability. The FANSI, the other author devised instrument, has content validity as the items were drawn from a thorough examination of previous research and specific selection criteria. However, future research should make efforts to assess greater evidence for validity of these instruments, and build on their utility.

Future Research

Future research should look to move past the limitations within this study. In the future, investigators should seek a clinical sample in order to examine the impact that self-efficacy, stigma, and other no-show variables have on *real* clients' likelihood to appear for a scheduled counseling appointment. A comparison of findings from a community or actual clinical samples will help to highlight commonalities and indicate which variables have the greatest influence across client bases. Future studies should also seek to replicate my findings with more culturally diverse samples.

As aforementioned, another future direction would be to continue establishing the validity of these new instruments I created/adapted in my study – the FANSI and the Social Cognitive Instrument. The Social Cognitive Instrument could be an informative instrument that could further the understanding of the role that self-efficacy plays for clients who engage in

counseling and typical counseling behaviors. The role of client self-efficacy for engaging in counseling is an understudied topic in our field and there is a lack of resources from which to draw upon in order to examine this topic. The FANSI could potentially be a helpful instrument for clinicians to utilize in their work with clients to understand which clients are at greater risk for appointment no-show behavior.

Future research using Social Cognitive Theory as a lens from which to understand client no-show behavior should also examine the role of outcome expectations. I did not focus on the impact of outcome expectations; however, this element is an important part of Social Cognitive Theory and can impact, or be impacted by, efficacy expectations. In Bandura's model, outcome expectations impact the relation between a person's behavior and the outcome of his/her behavior (Bandura, 1977a).

An additional and relevant area for future research is how to use and apply the results found in this study. The main purpose behind conducting this study was to better understand what leads clients to not show for a first scheduled counseling appointment in hopes that intervention methods could be developed around the specific variables found to influence this phenomenon. For example, investigators should examine the usefulness of recent short videos created by APA, as well as other established stigma reduction interventions, as to their ability to reduce stigma and increase self-efficacy for counseling tasks. Clinicians should also potentially focus more on combating low self-efficacy for counseling tasks than on combating self-stigma around mental illness and counseling, as in my study increasing self-efficacy was found to significantly weaken the impact of self-stigma on intent to attend a counseling appointment. Finding methods to increase client self-efficacy to engage in counseling behavior, reduce stigma associated with psychological help-seeking, and reduce the other variables impeding client

counseling attendance could greatly help clinicians and agencies to be more effective service providers.

Implications for Practice

Based upon the findings of my study, clinicians should recognize the importance of incoming clients' self-efficacy regarding common counseling tasks. This self-efficacy not only influences likelihood of client counseling attendance and decreasing no-show behavior, but also minimizes and potentially even nullifies the self-stigma toward seeking mental health help services that individuals endorse. Practitioners should also consider the influence of self-stigma on clients' intent to attend first counseling appointments. Even if clients have been able to schedule the first counseling appointment, and/or attended an intake session, stigma can continue to negatively influence clients beyond that initial step toward seeking help. Having this knowledge can prepare clinicians to address self-efficacy and stigma concerns in an intake session or over the phone with clients who are scheduling first counseling appointments. If these steps are taken, perhaps clinicians will struggle less with client no-show behavior and will benefit from greater counseling attendance.

A variety of interventions have been developed and attempted to reduce help-seeking stigma and the impact that stigma has on counseling utilization. One method of reducing stigma in a psychopathology course is by incorporating first-person narratives into the curriculum (Mann & Himelein, 2008). Another stigma reduction strategy concerns the use of an informational session that provides potential consumers with facts about mental illness, typical mental illness symptoms, as well as personal stories from those who have experienced mental illness (Spagnolo, Murphy, & Librera, 2008). A review conducted by Dalky (2012) discovered that educational and contact-based strategies (e.g., an event in which individuals with mental

illness share their experience with individuals who have not experienced mental illness) successfully reduced the stigma around mental illness. Lannin, Guyll, Vogel, and Madon (2013) found that engaging in a self-affirmation writing task helped individuals experiencing psychological distress reduce self-stigma and increase willingness to seek counseling. Enhancing personal empowerment, and "coming out" to supportive others about mental illness have also been found to successfully reduce self-stigma (Corrigan, Kosyluk, & Rusch, 2013). This allows the individual with the mental illness to have the power for how information about their experience is transmitted as well as diminishes the negative feelings that can surround feeling as though one has to hide a piece of oneself. These and newly developed methods that focus on decreasing self-stigma, should be utilized to help those who need counseling to attend their sessions.

Common themes of these stigma-reduction interventions include informing individuals about mental illness and providing insight around the experience of living with a mental illness. In addition to this important educational component, it appears that contact with a person who has been diagnosed with a mental illness is beneficial for individuals who have not had such an experience. Diminishing the myths and secretive nature of mental illness and counseling helps to break down the barriers and reduce the stigma surrounding them as does enhancing the power of individuals with mental illness and their positive self-concepts.

Methods to increase self-efficacy can be found in a variety of domains, but rarely for client self-efficacy for engaging in common counseling tasks. Potentially drawing from tools and techniques used to increase self-efficacy for other domains could lead to the development of self-efficacy interventions for clients in counseling settings. Informational motivation techniques were cited as a beneficial method to increasing treatment self-efficacy in a sample of individuals

diagnosed with HIV/AIDS, suggesting that providing individuals with specific information about the process of treatment and their condition can improve self-efficacy to engage in the treatment (Nokes et al., 2012). The use of motivational interviewing strategies in general could also enhance client self-efficacy, as the basis for motivational interviewing is increasing clients' readiness for change as well as helping them to understand and resolve any ambivalence they have around treatment (Hettema, Steele, & Miller, 2005). Perhaps incorporating self-efficacy and information about treatment with motivational interviewing could lead to a successful intervention to boost self-efficacy. Latimer-Cheung and colleagues (2013) found with individuals who had recently had spinal cord injury that engaging in a single session of motivational counseling either via phone or in person helped to increase self-efficacy and engagement in healthful recovery behaviors. Betz and Schifano (2000) found an intervention that increased women's self-efficacy for realistic occupations. In this intervention, participants viewed professionals modeling realistic behaviors, instructors demonstrated the tasks, and instructors assisted and encouraged the participants through successful completion of the previously demonstrated tasks.

Key ingredients of these self-efficacy interventions appear to be information and education about the process/course of treatment, motivational enhancement, and support and encouragement. Attempts to alter these already successful interventions to increase self-efficacy could be tailored to the counseling domain and may be a way to strengthen clients' self-efficacy for engaging in counseling and increase client attendance at counseling sessions.

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

American Psychological Association. (2013). Recognition of psychotherapy effectiveness. *Psychotherapy, 50*(1), 102-109. doi:http://dx.doi.org/10.1037/a0030276

Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior, 36*(1), 1-10. Retrieved from http://hsb.sagepub.com/

Baekeland, F., & Lundwall, L. (1975). Dropping out of treatment: A critical review. *Psychological Bulletin, 82*(5), 738-783. doi:http://dx.doi.org/10.1037/h0077132

Bandura, A. (1977a). *Social learning theory.* Oxford: Prentice-Hall.

Bandura, A. (1977b). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review, 84*(2), 191-215. doi:http://dx.doi.org/10.1037/0033-295X.84.2.191

Bandura, A. (1978). The self-system in reciprocal determinism. *American Psychologist, 33*(4), 344-358. doi:http://dx.doi.org/10.1037/0003-066X.33.4.344

Bandura, A. (1982). Self-efficacy mechanism in human agency. *American Psychologist, 37*(2), 122-147. doi:http://dx.doi.org/10.1037/0003-066X.37.2.122

Bandura, A. (1986). Social foundations of thought and action: A social cognitive theory. Englewood Cliffs, NJ: Prentice-Hall.

Bandura, A. (1989). Human agency in social cognitive theory. *American Psychologist, 44*(9), 1175-1184. doi:http://dx.doi.org/10.1037/0003-066X.44.9.1175

Bandura, A. (1999). Social cognitive theory: An agentic perspective. *Asian Journal of Social Psychology, 2*(1), 21-41. Retrieved from http://onlinelibrary.wiley.com/journal/10.1111/%28ISSN%291467-839X.

Barrett, M. S., Chua, W., Crits-Christoph, P., Gibbons, M. B., & Thompson, D. (2008). Early withdrawal from mental health treatment: Implications for psychotherapy practice. *Psychotherapy: Theory, Research, Practice, Training, 45*(2), 247-267. doi:http://dx.doi.org/10.1037/0033-3204.45.2.247

Bartle-Haring, S., Glebova, T., & Meyer, K. (2007). Premature termination in marriage and family therapy within a Bowenian perspective. *American Journal of Family Therapy, 35*(1), 53-68. doi:http://dx.doi.org/10.1080/01926180600550528

Bergin, A. E. & Garfield, S. L. (2013). The client in Psychotherapy (pp. 219-257). In M. J. Lambert (Ed.), *Handbook of psychotherapy and behavior change* (6th ed.). New York: John Wiley and Sons, Inc.

Berrigan, L. P., & Garfield, S. L. (1981). Relationship of missed psychotherapy appointments to premature termination and social class. *British Journal of Clinical Psychology, 20*(4), 239-242. Retrieved from http://onlinelibrary.wiley.com/journal/10.1111/%28ISSN%292044-8260

Betz, N. E., & Schifano, R. S. (2000). Evaluation of an intervention to increase realistic self-efficacy and interests in college women. *Journal of Vocational Behavior, 56*(1), 35-52. Retrieved from http://www.journals.elsevier.com/journal-of-vocational-behavior/

Betz, N. E., & Shullman, S. L. (1979). Factors related to client return rate following intake. *Journal of Counseling Psychology, 26*(6), 542-545. doi:http://dx.doi.org/10.1037/0022-0167.26.6.542

Bischoff, R. J., & Sprenkle, D. H. (1993). Dropping out of marriage and family therapy: A critical review of research. *Family Process, 32*(3), 353-375. Retrieved from http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1545-5300

Brown, L. A., Wiley, J. F., Wolitzky-Taylor, K., Roy-Byrne, P., Sherbourne, C., Stein, M. B.,… Craske, M. G. (2014). Changes in self-efficacy and outcome expectancy as predictors of anxiety outcomes from the CALM study. *Depression and Anxiety, 31*(8), 678-689. doi:http://dx.doi.org/10.1002/da.22256

Carter, O., Pannekoek, L., Fursland, A., Allen, K. L., Lampard, A. M., & Byrne, S. M. (2012). Increased wait-list time predicts dropout from outpatient enhanced cognitive behaviour therapy (CBT-E) for eating disorders. *Behaviour Research and Therapy, 50*(7-8), 487-492. doi:http://dx.doi.org/10.1016/j.brat.2012.03.003

Ciarlo, J. A. (1979). Annual evaluation report for 1975 of the Northwest Denver Mental Health Center. In C. Windle (Ed.), *Reporting program evaluations: Two sample community mental health center annual reports*. Rockville, MD: Department of Health, Education, and Welfare.

Cooper, A. E., Corrigan, P. W., & Watson, A. C. (2003). Mental illness stigma and care seeking. *Journal of Nervous and Mental Disease, 191*(5), 339-341. doi:http://dx.doi.org/10.1097/00005053-200305000-00010

Corrigan, P. W. (1998). The impact of stigma on severe mental illness. *Cognitive And Behavioral Practice, 5*, 201-222. doi:10.1016/S1077-7229(98)80006-0

Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist, 59*, 614-625. doi:10.1037/0003-066X.59.7.614

Corrigan, P. W., Kosyluk, K. A., & Rüsch, N. (2013). Reducing self-stigma by coming out proud. *American Journal of Public Health, 103*(5), 794-800. doi:http://dx.doi.org/10.2105/AJPH.2012.301037

Corrigan, P. W., & Rüsch, N. (2002). Mental illness stereotypes and clinical care: Do people avoid treatment because of stigma? *Psychiatric Rehabilitation Skills, 6*(3), 312-334. doi:http://dx.doi.org/10.1080/10973430208408441

Dalky, H. F. (2012). Mental illness stigma reduction interventions: Review of intervention trials. *Western Journal of Nursing Research, 34*(4), 520-547. doi:http://dx.doi.org/10.1177/0193945911400638

Dubinsky, M. (1986). Predictors of appointment non-compliance in community mental health patients. *Community Mental Health Journal, 22*(2), 142-146. Retrieved from http://link.springer.com/journal/10597

Edwards, J. H. (1991). Attrition in family and marital therapy: A decay curve approach. *Dissertation Abstracts International*, 6100-6101. Retrieved from http://www.worldcat.org/title/dissertation-abstracts-international-a-the-humanities-and-social-sciences/oclc/1566776

Eisenberg, D., Downs, M. F., Golberstein, E., & Zivin, K. (2009). Stigma and help seeking for mental health among college students. *Medical Care Research and Review, 66*, 522-541. doi:10.1177/1077558709335173

Epperson, D. L., Bushway, D. J., & Warman, R. E. (1983). Client self-terminations after one counseling session: Effects of problem recognition, counselor gender, and counselor experience. *Journal of Counseling Psychology, 30*(3), 307-315. doi:http://dx.doi.org/10.1037/0022-0167.30.3.307

Fassinger, R. E. (1987). Use of structural equation modeling in counseling psychology research. *Journal of Counseling Psychology, 34*(4), 425-436. doi:http://dx.doi.org/10.1037/0022-0167.34.4.425

Faul, F., Erdfelder, E., Buchner, A., & Lang, A.-G. (2009). Statistical power analyses using G*Power 3.1: Tests for correlation and regression analyses. *Behavior Research Methods, 41*, 1149-1160. Retrieved from http://www.gpower.hhu.de/en.html

Fenger, M., Mortensen, E. L., Poulsen, S., & Lau, M. (2011). No-shows, drop-outs and completers in psychotherapeutic treatment: Demographic and clinical predictors in a large sample of non-psychotic patients. *Nordic Journal of Psychiatry, 65*(3), 183-191. doi:http://dx.doi.org/10.3109/08039488.2010.515687

Fiester, A. R., Mahrer, A. R., Giambra, L. M., & Ormiston, D. W. (1974). Shaping a clinic population: The dropout problem reconsidered. *Community Mental Health Journal, 10*(2), 173-179. Retrieved from http://link.springer.com/journal/10597

Fisher, J. D., Nadler, A., & Whitcher-Alagna, S. (1982). Recipient reactions to aid. *Psychological Bulletin, 91*(1), 27-54. doi:http://dx.doi.org/10.1037/0033-2909.91.1.27

Fisher, J. D., Nadler, A., & Whitcher-Alagna, S. (1983). Four conceptualizations of reactions to aid (pp. 51-84). In J. D. Fisher, A. Nadler, & B. M. DePaulo (Eds.), *New directions in helping: Vol. 1*. San Diego, CA: Academic Press.

Frayn, D. H. (1992). Assessment factors associated with premature psychotherapy termination. *American Journal of Psychotherapy, 46*(2), 250-261. Retrieved from http://www.ajp.org/

Freund, R. D., Russell, T. T., & Schweitzer, S. (1991). Influence of length of delay between intake session and initial counseling session on client perceptions of counselors and counseling outcomes. *Journal of Counseling Psychology, 38*(1), 3-8. doi:http://dx.doi.org/10.1037/0022-0167.38.1.3

Garfield, S. L. (1986). Too much attrition? *PsycCRITIQUES, 31*(11), 875-876. doi:http://dx.doi.org/10.1037/024239

Garfield, S. L. (1994). Research on client variables in psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 190-228). Oxford: John Wiley & Sons.

Hansen, N. B., Lambert, M. J., & Forman, E. M. (2002). The psychotherapy dose-response effect and its implications for treatment delivery services. *Clinical Psychology: Science and Practice, 9*(3), 329-343. doi:http://dx.doi.org/10.1093/clipsy/9.3.329

Hardin, S. I., Subich, L. M., & Holvey, J. M. (1988). Expectancies for counseling in relation to premature termination. *Journal of Counseling Psychology, 35*(1), 37-40. doi:http://dx.doi.org/10.1037/0022-0167.35.1.37

Heatherington, L., Stets, J., & Mazzarella, S. (1986). Whither the bias: The female client's "edge" in psychotherapy? *Psychotherapy: Theory, Research, Practice, Training, 23*(2), 252-256. doi:http://dx.doi.org/10.1037/h0085606

Hettema, J., Steele, J., & Miller, W. R. (2005). Motivational interviewing. *Annual Review of Clinical Psychology, 1*(1), 91-111. doi:http://dx.doi.org/10.1146/annurev.clinpsy.1.102803.143833

Heppner, P. P., & Claiborn, C. D. (1989). Social influence research in counseling: A review and critique. *Journal of Counseling Psychology, 36*(3), 365-387. doi:http://dx.doi.org/10.1037/0022-0167.36.3.365

Hu, L., & Bentler, P. M. (1998). Fit indices in covariance structure modeling: Sensitivity to underparameterized model misspecification. *Psychological Methods, 3*(4), 424-453. doi:http://dx.doi.org/10.1037/1082-989X.3.4.424

Hu, L., & Bentler, P. M. (1999). Cutoff criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives. *Structural Equation Modeling, 6*(1), 1-55. Retrieved from http://www.tandfonline.com/toc/hsem20/current#.U49aJPldU1Y

Hunsley, J., Aubry, T. D., Verstervelt, C. M., & Vito, D. (1999). Comparing therapist and client perspectives on reasons for psychotherapy termination. *Psychotherapy: Theory, Research, Practice, Training, 36*(4), 380-388. doi:http://dx.doi.org/10.1037/h0087802

Imber, S. D., Frank, J. D., Gliedman, L. H., Nash, E. H., & Stone, A. R. (1956). Suggestibility, social class and the acceptance of psychotherapy. *Journal of Clinical Psychology, 12*, 341-344. Retrieved from http://onlinelibrary.wiley.com/journal/10.1002/(ISSN)1097-4679

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 593-602. doi:10.1001/archpsyc.62.6.593

Klein, E. B., Stone, W. N., Hicks, M. W., & Pritchard, I. L. (2003). Understanding dropouts. *Journal of Mental Health Counseling, 25*(2), 89-100. Retrieved from http://www.amhca.org/news/journal.aspx

Krauskopf, C. J., Baumgardner, A., & Mandracchia, S. (1981). Return rate following intake revisited. *Journal of Counseling Psychology, 28*(6), 519-521. doi:http://dx.doi.org/10.1037/0022-0167.28.6.519

LaGanga, L. R., & Lawrence, S. R. (2007). Clinic overbooking to improve patient access and increase provider productivity. *Decision Sciences, 38*(2), 251-276. doi:http://dx.doi.org/10.1111/j.1540-5915.2007.00158.x

Lannin, D. G., Guyll, M., Vogel, D. L., & Madon, S. (2013). Reducing the stigma associated with seeking psychotherapy through self-affirmation. *Journal of Counseling Psychology, 60*(4), 508-519. doi:http://dx.doi.org/10.1037/a0033789

Larsen, D. L., Nguyen, T. D., Green, R. S., & Attkisson, C. C. (1983). Enhancing the utilization of outpatient mental health services. *Community Mental Health Journal, 19*(4), 305-320. Retrieved from http://link.springer.com/journal/10597

Latimer-Cheung, A., Arbour-Nicitopoulos, K., Brawley, L. R., Gray, C., Justine Wilson, A., Prapavessis, H., . . . Martin Ginis, K. A. (2013). Developing physical activity interventions for adults with spinal cord injury. part 2: Motivational counseling and peer-

mediated interventions for people intending to be active. *Rehabilitation Psychology, 58*(3), 307-315. doi:http://dx.doi.org/10.1037/a0032816

Lent, R. W., Lopez, F. G., Mikolaitis, N. L., & Jones, L. (1992). Social cognitive mechanisms in the client recovery process: Revisiting hygiology. *Journal of Mental Health Counseling, 14*(2), 196-207. Retrieved from https://www.questia.com/library/p608/journal-of-mental-health-counseling

Lesaca, T. (1995). Assessing the influence of a no-show fee on patient compliance at a CMCH. *Administration and Policy in Mental Health, 22*(6), 629-631. Retrieved from http://www.springer.com/public+health/journal/10488

Link, B. G., Cullen, F. T., Struening, E. L., Shrout, P. E., & Dohrenwend, B. P. (1989). A modified labeling theory approach to mental disorders: An empirical assessment. *American Sociological Review, 54*(3), 400-423. Retrieved from http://asr.sagepub.com/

Longo, D. A. (1992). *Relation of self-efficacy and outcome expectations to client engagement in a university counseling center.* Available from PsycINFO. (618195876; 1992-75734-001). Retrieved from http://search.proquest.com/docview/618195876?accountid=10906

Longo, D. A., Lent, R. W., & Brown, S. D. (1992). Social cognitive variables in the prediction of client motivation and attrition. *Journal of Counseling Psychology, 39*(4), 447-452. doi:http://dx.doi.org/10.1037/0022-0167.39.4.447

Lorr, M., McNair, D. M., Michaux, W. M., & Riskin, A. (1962). Frequency of treatment and change in psychotherapy. *The Journal of Abnormal and Social Psychology, 64*(4), 281-292. doi:http://dx.doi.org/10.1037/h0043958

Luborsky, L., Auerbach, A. H., Chandler, M., Cohen, J., & Bachrach, H. M. (1971). Factors influencing the outcome of psychotherapy: A review of quantitative research. *Psychological Bulletin, 75*(3), 145-185. doi:http://dx.doi.org/10.1037/h0030480

MacLean, L. M., Greenough, T., Jorgenson, V., & Couldwell, M. (1989). Getting through the front door: Improving initial appointment attendance at a mental-health clinic. *Canadian Journal of Community Mental Health, 8*(1), 123-133. Retrieved from http://www.cjcmh.com/journal/cjcmh

Mann, C. E., & Himelein, M. J. (2008). Putting the person back into psychopathology: An intervention to reduce mental illness stigma in the classroom. *Social Psychiatry and Psychiatric Epidemiology, 43*(7), 545-551. doi:http://dx.doi.org/10.1007/s00127-008-0324-2

Manthei, R. J. (1995). A follow-up study of clients who fail to begin counselling or terminate after one session. *International Journal for the Advancement of Counselling, 18*(2), 115-128. doi:http://dx.doi.org/10.1007/BF01421563

Maric, M., Heyne, D. A., MacKinnon, D. P., van Widenfelt, B. M., & Westenberg, P. M. (2013). Cognitive mediation of cognitive-behavioural therapy outcomes for anxiety-based school refusal. *Behavioural and Cognitive Psychotherapy, 41*(5), 549-564. doi:http://dx.doi.org/10.1017/S1352465812000756

Masi, M. V., Miller, R. B., & Olson, M. M. (2003). Differences in dropout rates among individual, couple, and family therapy clients. *Contemporary Family Therapy: An International Journal, 25*(1), 63-75. doi:http://dx.doi.org/10.1023/A:1022558021512

May, R. J. (1990). Are wait lists really a problem? A follow-up survey of wait list dropouts. *Journal of College Student Development, 31*(6), 564-566. Retrieved from http://muse.jhu.edu/journals/journal_of_college_student_development/

McCabe, K. M. (2002). Factors that predict premature termination among mexican-american children in outpatient psychotherapy. *Journal of Child and Family Studies, 11*(3), 347-359. doi:http://dx.doi.org/10.1023/A:1016876224388

McNeill, B. W., May, R. J., & Lee, V. E. (1987). Perceptions of counselor source characteristics by premature and successful terminators. *Journal of Counseling Psychology, 34*(1), 86-89. doi:http://dx.doi.org/10.1037/0022-0167.34.1.86

Meyer, W. S. (2001). Why they don't come back: A clinical perspective on the no-show client. *Clinical Social Work Journal, 29*(4), 325-339. doi:http://dx.doi.org/10.1023/A:1012211112553

Nadler, A. & Fisher, J. D. (1986). The role of threat to self-esteem and perceived control in recipient reaction to help: Theory development and empirical validation. *Advances in Experimental Social Psychology, 9*. Retrieved from http://www.sciencedirect.com/science/bookseries/00652601

Nokes, K., Johnson, M. O., Webel, A., Rose, C. D., Phillips, J. C., Sullivan, K., . . . Holzemer, W. L. (2012). Focus on increasing treatment self-efficacy to improve human immunodeficiency virus treatment adherence. *Journal of Nursing Scholarship,44*(4), 403-410. doi:http://dx.doi.org/10.1111/j.1547-5069.2012.01476.x

Oldham, M., Kellett, S., Miles, E., & Sheeran, P. (2012). Interventions to increase attendance at psychotherapy: A meta-analysis of randomized controlled trials. *Journal of Consulting and Clinical Psychology, 80*(5), 928-939. doi:http://dx.doi.org/10.1037/a0029630

Olfson, M., Mojtabai, R., Sampson, N. A., Hwang, I., Druss, B., Wang, P. S., . . . Kessler, R. C. (2009). Dropout from outpatient mental health care in the United States. *Psychiatric Services, 60*(7), 898-907. doi:http://dx.doi.org/10.1176/appi.ps.60.7.898

Overall, B., & Aronson, H. (1963). Expectations of psychotherapy in patients of lower socioeconomic class. *American Journal of Orthopsychiatry, 33*(3), 421-430. doi:http://dx.doi.org/10.1111/j.1939-0025.1963.tb00376.x

Pekarik, G. (1983). Improvement in clients who have given different reasons for dropping out of treatment. *Journal of Clinical Psychology, 39*(6), 909-913. Retrieved from http://onlinelibrary.wiley.com/journal/10.1002/(ISSN)1097-4679

Pekarik, G. (1985). Coping with dropouts. *Professional Psychology: Research and Practice, 16*(1), 114-123. doi:http://dx.doi.org/10.1037/0735-7028.16.1.114

Pekarik, G. (1992). Posttreatment adjustment of clients who drop out early vs. late in treatment. *Journal of Clinical Psychology, 48*(3), 379-387. Retrieved from http://onlinelibrary.wiley.com/journal/10.1002/%28ISSN%291097-4679

Pekarik, G., & Stephenson, L. A. (1988). Adult and child client differences in therapy dropout research. *Journal of Clinical Child Psychology, 17*(4), 316-321. Retrieved from http://www.tandfonline.com/toc/hcap20/current#.UzhUD1cvnvA

Piselli, A., Halgin, R. P., & MacEwan, G. H. (2011). What went wrong? Therapists' reflections on their role in premature termination. *Psychotherapy Research, 21*(4), 400-415. doi:http://dx.doi.org/10.1080/10503307.2011.573819

Presley, J. H. (1987). The clinical dropout: A view from the client's perspective. *Social Casework, 68*(10), 603-608. Retrieved from http://www.researchgate.net/journal/0037-7678_Social_casework

Quintana, S. M., & Maxwell, S. E. (1999). Implications of recent developments in structural equation modeling for counseling psychology. *The Counseling Psychologist, 27*(4), 485-527. doi:http://dx.doi.org/10.1177/0011000099274002

Schiller, L. J. (1976). A comparative study of the differences between client continuers and dropouts at two university counseling centers. *Journal of Counseling Psychology, 23*(2), 99-102. doi:http://dx.doi.org/10.1037/0022-0167.23.2.99

Sirey, J. A., Bruce, M. L., Alexopoulos, G. S., Perlick, D. A., Raue, P., Friedman, S. J., & Meyers, B. S. (2001). Perceived stigma as a predictor of treatment discontinuation in young and older outpatients with depression. *The American Journal of Psychiatry, 158*(3), 479-481. doi:http://dx.doi.org/10.1176/appi.ajp.158.3.479

Spagnolo, A. B., Murphy, A. A., & Librera, L. A. (2008). Reducing stigma by meeting and learning from people with mental illness. *Psychiatric Rehabilitation Journal, 31*(3), 186-193. doi:http://dx.doi.org/10.2975/31.3.2008.186.193

Stark, M. J. (1992). Dropping out of substance abuse treatment: A clinically oriented review. *Clinical Psychology Review, 12*(1), 93-116. Retrieved from http://www.journals.elsevier.com/clinical-psychology-review/

Sue, S., McKinney, H. L., & Allen, D. B. (1976). Predictors of the duration of therapy for clients in the community mental health system. *Community Mental Health Journal, 12*(4), 365-375. Retrieved from http://link.springer.com/journal/10597

Swift, J. K., & Callahan, J. L. (2010). A delay discounting model of psychotherapy termination. *International Journal of Behavioral Consultation and Therapy, 5*(3-4), 278-293. Retrieved from http://www.baojournal.com/IJBCT/IJBCT-index.html

Tabachnick, B. G., & Fidell, L. S. (1996). Using multivariate statistics (3rd ed.). New York, NY: Harper Collins.

Tinsley, H. E. A. (1982). Expectations about counseling. Unpublished test manual. Carbondale, IL: Southern Illinois University, Department of Psychology.

Tinsley, H. E., & Harris, D. J. (1976). Client expectations for counseling. *Journal of Counseling Psychology, 23*(3), 173-177. doi:http://dx.doi.org/10.1037/0022-0167.23.3.173

Tinsley, D. J., Holt, M. S., Hinson, J. A., & Tinsley, H. E. (1991). A construct validation study of the expectations about counseling-brief form: Factorial validity. *Measurement and Evaluation in Counseling and Development, 24*(3), 101-110. Retrieved from

Tinsley, H. E., Workman, K. R., & Kass, R. A. (1980). Factor analysis of the domain of client expectancies about counseling.*Journal of Counseling Psychology, 27*(6), 561-570. doi:http://dx.doi.org/10.1037/0022-0167.27.6.561

Todd, D. M., Deane, F. P., & Bragdon, R. A. (2003). Client and therapist reasons for termination: A conceptualization and preliminary validation. *Journal of Clinical Psychology, 59*(1), 133-147. doi:http://dx.doi.org/10.1002/jclp.10123

Tracey, T. J. (1986). Interactional correlates of premature termination. *Journal of Consulting and Clinical Psychology, 54*(6), 784-788. doi:http://dx.doi.org/10.1037/0022-006X.54.6.784

Vogel, D. L., Shechtman, Z., & Wade, N. G. (2010). The role of public and self-stigma in predicting attitudes toward group counseling. *The Counseling Psychologist, 38*, 904-922. doi:10.1177/0011000010368297

Vogel, D. L., & Wade, N. G. (2009). Stigma and help-seeking. *The Psychologist, 22*, 20-23. Retrieved from http://www.thepsychologist.org.uk/

Vogel, D. L., Wade, N. G., & Ascheman, P. L. (2009). Measuring perceptions of stigmatization by others for seeking psychological help: Reliability and validity of a new stigma scale with college students. *Journal of Counseling Psychology, 56*(2), 301-308. doi:10.1037/a0014903

Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology, 53*, 325-337. doi:10.1037/0022-0167.53.3.325

Vogel, D. L., Wade, N. G., & Hackler, A. H. (2007). Perceived public stigma and the willingness to seek counseling: The mediating roles of self-stigma and attitudes toward counseling. *Journal of Counseling Psychology, 54*, 40-50. doi:10.1037/0022-0167.54.1.40

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings.* Mahwah, NJ: Lawrence Erlbaum Associates Publishers.

Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Twelve-month use of mental health services in the United States: Results from the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 629-640. doi:10.1001/archpsyc.62.6.629

Wang, M., Sandberg, J., Zavada, A., Mittal, M., Gosling, A., Rosenberg, T., . . . McPheters, J. (2006). "Almost there"...why clients fail to engage in family therapy: An exploratory study. *Contemporary Family Therapy: An International Journal, 28*(2), 211-224. doi:http://dx.doi.org/10.1007/s10591-006-9001-3

Warnick, E. M., Gonzalez, A., Weersing, V. R., Scahill, L., & Woolston, J. (2012). Defining dropout from youth psychotherapy: How definitions shape the prevalence and predictors of attrition. *Child and Adolescent Mental Health, 17*(2), 76-85. doi:http://dx.doi.org/10.1111/j.1475-3588.2011.00606.x

Weighill, V. E., Hodge, J., & Peck, D. F. (1983). Keeping appointments with clinical psychologists. *British Journal of Clinical Psychology, 22*(2), 143-144. Retrieved from http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)2044-8260

Weisz, J. R., Weiss, B., & Langmeyer, D. B. (1987). Giving up on child psychotherapy: Who drops out? *Journal of Consulting and Clinical Psychology, 55*(6), 916-918. doi:http://dx.doi.org/10.1037/0022-006X.55.6.916

Werbart, A., & Wang, M. (2012). Predictors of not starting and dropping out from psychotherapy in Swedish public service settings. *Nordic Psychology, 64*(2), 128-146. doi: http://dx.doi.org/10.1080/19012276.2012.726817

Westmacott, R., & Hunsley, J. (2010). Reasons for terminating psychotherapy: A general population study. *Journal of Clinical Psychology, 66*(9), 965-977. Retrieved from http://onlinelibrary.wiley.com/journal/10.1002/%28ISSN%291097-4679

White, G. D., & Pollard, J. (1982). Assessing therapeutic competence from therapy session attendance. *Professional Psychology, 13*(5), 628-633. doi:http://dx.doi.org/10.1037/0735-7028.13.5.628

Wierzbicki, M., & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. *Professional Psychology: Research and Practice, 24*(2), 190-195. doi:http://dx.doi.org/10.1037/0735-7028.24.2.190

APPENDIX A. NARRATIVES

HIGH DISTRESS

Instructions: Please read the following narrative. While you read the narrative, imagine yourself experiencing the *greatest* level of psychological distress you can imagine and feeling the way the narrative below describes.

Narrative: For the past few weeks, I have been dealing with a major problem in my life. I seem to be increasingly unhappy and unable to enjoy things that I used to love to do. I don't want to spend time with my friends or family anymore; I would rather stay home by myself. When I have no choice but to be around others, I tend to avoid interacting with them and find someplace to be alone. I also seem to be very frequently sad, and I cry for long periods of time. I do not always understand why it is that I am sad or crying. I feel tired and unmotivated most of the time and have trouble getting out of bed in the morning. I have missed most of my classes in the last few weeks and have not been doing my homework or studying. I have not had much of an appetite either; I just seem to have no desire to eat. I feel as though things will never get better.

I have become worried about myself and my situation, so yesterday I made an appointment with the university counseling services to see a therapist. I was told that they were so busy that it would take a few days before I could be seen by someone.

As you complete the following survey items, respond to them as if you're experiencing the great amount of psychological distress described in the narrative.

LOW DISTRESS

Instructions: Please read the following narrative. While you read the narrative, imagine yourself experiencing a *low, but still significant,* level of psychological distress and feeling the way the narrative below describes.

Narrative; For the past few weeks, I have been dealing with a problem in my life. I seem to be somewhat unhappy and less able to enjoy things that I used to love to do. I spend less time with my friends and family; occasionally, I would rather stay home by myself. When I am around others I tend to be quieter and not interact as much as I used to. I also can be sad sometimes, and I tear up on occasion. I do not always understand why it is that I am sad or crying. I feel kind of sluggish and less than fully motivated most of the time and on occasion have trouble getting out of bed in the morning. I have missed a couple of my classes in the last few weeks, and have not been keeping up with homework and studying very well. I have had less of an appetite too. I wish that things would get better.

I have become worried about myself and my situation, so yesterday I made an appointment with the university counseling services to see a therapist. I was told that they were so busy that it would take a few days before I could be seen by someone.

As you complete the following survey items, respond to them as if you're experiencing the low, but still significant, level of psychological distress described in the narrative.

APPENDIX B. GENERAL INTENT TO ATTEND

Instructions: Please answer the following question:

How likely would you be to attend the appointment that you scheduled at the university counseling services?

1	2	3	4	5
Certain I would not attend	Unlikely I would attend	Unsure if I would attend	Likely I would attend	Certain I would attend

APPENDIX C. SOCIAL COGNITIVE INSTRUMENT

Instructions: Using the scale below, please rate the extent to which you feel confident in your ability to participate in the given situations that may occur during a counseling appointment:

1	2	3	4	5	6	7
Not at All Confident	Slightly Confident	Somewhat Confident	Fairly Confident	Quite Confident	Very Confident	Definitely Confident

1) Take any psychological tests that might be necessary.

2) Form a positive relationship with the counselor.

3) Gain experience in new ways of solving problems.

4) Openly express my emotions regarding myself and my problems.

5) Do assignments outside the counseling sessions as directed by my counselor.

6) Take responsibility for making my own decisions.

7) Talk about my present concerns.

8) Understand the purpose of what happens in the counseling session.

9) Get practice in relating openly and honestly to another person within the counseling relationship.

10) Practice some of the things I need to learn in the counseling relationship.

11) Use counseling to get a better understanding of others and myself.

12) Stay in counseling for a while, even if at first I am not sure it will help.

13) See my counselor for the first interview.

14) Stay in counseling even though it may be painful or unpleasant at times.

15) Contribute as much as I can in terms of expressing my feelings and discussing them.

16) Use the counseling to identify problems on which I need to work.

17) Use counseling to learn how to better help myself in the future.

18) Feel comfortable enough with my counselor to really say how I feel.

19) Use counseling to improve my relationships with others.

20) Ask my counselor to explain him/herself when I do not understand something.

21) Work on my concerns outside my counseling sessions.

APPENDIX D. PSOSH

Instructions: Imagine you had an emotional or personal issue that you could not solve on your own. If you sought counseling services for this issue, to what degree do you believe that the people you interact with would _____.

1 = Not at all 2 = A little 3 = Some 4 = A lot 5 = A great deal

____ 1. React negatively to you

____ 2. Think bad things of you

____ 3. See you as seriously disturbed

____ 4. Think of you in a less favorable way

____ 5. Think you posed a risk to others

APPENDIX E. SSOSH

Instructions: People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.

1	2	3	4	5
Strongly Disagree	Disagree	Agree and Disagree Equally	Agree	Strongly Agree

1. I would feel inadequate if I went to a therapist for psychological help.

2. My self-confidence would NOT be threatened if I sought professional help.

3. Seeking psychological help would make me feel less intelligent.

4. My self-esteem would increase if I talked to a therapist.

5. My view of myself would not change just because I made the choice to see a therapist.

6. It would make me feel inferior to ask a therapist for help.

7. I would feel okay about myself if I made the choice to seek professional help.

8. If I went to a therapist, I would be less satisfied with myself.

9. My self-confidence would remain the same if I sought professional help for a problem I could not solve.

10. I would feel worse about myself if I could not solve my own problems.

APPENDIX F. FANSI

Instructions: Keeping in mind how you were instructed to think/feel while reading the narrative, use the scale below to rate how much each of the following items would influence whether or not you would attend the appointment you made at the university counseling services.

1	2	3	4	5
Would not influence me at all	Would influence me a little	Would influence me somewhat	Would influence me a lot	Would influence me extremely

1) Knowing that you have been assigned to work with a new or less experienced therapist:

2) Not knowing what is supposed to happen during therapy or how therapy works:

3) Anticipating that therapy will help to make any negative or painful feelings you have go away:

4) Being referred to seek counseling by someone (e.g., a family member, a friend, Dean of Students Office, your advisor) instead of reaching the decision for yourself:

5) Feeling some improvement or relief in the symptoms you were experiencing when you initially made the counseling appointment:

6) Being placed on a waitlist and having a significant delay (more than a week) between making your appointment and actually being seen by a therapist:

7) Knowing you have been assigned to work with a male therapist:

8) Knowing you have been assigned to work with a female therapist:

9) Feeling satisfied that the mental health agency and staff you made your appointment with care about helping you:

10) Knowing that there will be a clear agreement and open understanding, between you and your therapist, of the problem that will be worked on during therapy:

11) Having job, school, or other commitments that make it hard to find time for therapy:

12) Having access to transportation to and from your therapist's office:

13) Feeling that you can really trust the therapist to which you are assigned:

14) Seeking and getting help elsewhere (e.g., family, friends, church leader, a different counselor) before your appointment time arrives:

APPENDIX G. MANIPULATION CHECK

Instructions: Using the scale provided below, rate how much psychological distress you imagined yourself experiencing as a function of the narrative you read.

1	2	3	4	5	6
None	Very Little	Some degree	A fair amount	A large amount	The highest amount I could

APPENDIX H. DEMOGRAPHICS AND HISTORY

Instructions: Please answer the following demographic and history questions.

1) Sex M____ F____

2) Age ____

3) Year in School Freshman____ Sophomore____ Junior____

Senior____ Other____

4) Race/Ethnicity

____ American Indian or Alaskan Native

____ Asian American

____ African American (Black)

____ Hawaiian or Other Pacific Islander

____ Hispanic or Latino American

____ European American (White)

____ International

____ Bi/Multi racial/Other

5) Marital Status

Single Living with partner Married Separated Divorced Widowed

6) Family Income (based on the household income of your parents/caretakers)

____ Less than $30,000 per year

____ $30,000 – $50,000 per year

____ $50,000 - $75,000 per year

____ $50,000 - $75,000 per year

____ $75,000 - $100,000 per year

____ $100,000 - $150,000 per year

____ $150,000+ per year

7) Have you previously thought about seeking mental health services for an emotional or personal problem?

Yes____ No____

8) Have you previously taken part in psychological/mental health services?

Yes____ No____

9) Have you ever made an appointment for mental health services and then not shown up for the appointment?

Yes____ No____

If yes, why?

_____
_____
_____
_____
_____

10) If yes to Question 9, did you call to cancel or reschedule the appointment?

Yes____ No____

If no, why not?

_____
_____
_____
_____
_____

APPENDIX I. INFORMED CONSENT

Title of Study: Factors Influencing Counseling Attendance
Investigators: Kaitlyn Florer, BS; Loreto Prieto, PhD

This is a research study. Please take your time in deciding if you would like to participate.

Introduction
The purpose of this study is to better understand the reasons people have for not keeping a scheduled counseling appointment.

Description of Procedures
Participants will voluntarily sign up to participate in this study via the SONA website. If you decide to participate in this study you will be granted access to a link to an online survey via the SONA website. Your responses to the survey will be confidential, no identifying information will be collected, and all data will be reported in aggregate form.

You will read a narrative asking you to imagine experiencing a life difficulty substantial enough to cause you either a low or very high level of psychological distress. After reading this narrative you will be asked to complete a series of items related to the narratives as well as your views on seeking counseling for mental health concerns. Once you reach the end of the survey, you will be redirected to a new URL, which will automatically grant you SONA credit.

Risks
We do not anticipate that this study will cause participants any discomfort whatsoever, but there is a minimal risk associated with the topic of this study and with participants bringing themselves to imagine experiencing psychological distress. Certain individuals who are currently experiencing psychological distress, who have a history of psychological or mental health difficulties, or who have recently gone through a significant life difficulty may feel some discomfort when imagining a problem or completing the survey. If you feel any discomfort at any point during this study, you may immediately end your participation in the study. Also, listed below are several resources that you can utilize if you are feeling discomfort while or after participating in this study.

- Thielen Student Health Center (ISU: 515-294-5801)
- Student Counseling Services (ISU: 515-294-5056)
- Central Iowa Psychological Services (Ames: 515-233-1122, Des Moines: 515-222-1999)

Benefits
There will be no direct benefits to you; however, through this study we hope to learn information that could help improve counseling services. You have other methods of obtaining the required course research credit. Consult your course syllabi for this information.

Costs and Compensation
You will be awarded one SONA research credit for your participation in this study. The estimated amount of time required to complete this study is 15-30 minutes. Please be aware that you will not be able to save your responses and return to the survey at another time.

Participant Rights
Your participation in this study is completely voluntary. If you would like to refuse to participate or end your participation, you may do so, at any time, without any penalty or negative consequences whatsoever. In order to receive your credit, you must reach the end of the survey. However, you have the right to not answer any questions on the survey that you do not wish to answer (simply skip the questions by using the forward arrow buttons at the bottom of each page on the Qualtrics survey).

Confidentiality
Records identifying participants will be kept confidential to the extent permitted by applicable laws and regulations and will not be made publicly available. However, federal government regulatory agencies, auditing departments of Iowa State University, and the Institutional Review Board (a committee that reviews and approves human subject research studies) may inspect and/or copy your records for quality assurance and data analysis. These records may contain private information.

To ensure confidentiality to the extent permitted by law, the following measures will be taken: 1) no joining of your consent form (or any identifiers) will be made to the record of data you enter online; 2) all consent forms will be kept separate from any raw data (electronic or hard copy) to protect the identities of participants; 3) all materials will be stored in a locked file cabinet in a locked lab; and, all raw data will be kept on password protected computers. If the results are published, your identity will remain confidential and all data will be described in aggregate form.

Questions or Problems
You are encouraged to ask questions at any time during this study.

- For further information about the study contact Kaitlyn Florer at kflorer@iastate.edu (515.294.1742) or Dr. Loreto Prieto at lprieto@iastate.edu (515.294.2455).
- If you have any questions about the rights of research subjects or research-related injury, please contact the IRB Administrator, (515) 294-4566, IRB@iastate.edu, or Director, (515) 294-3115, Office for Responsible Research, Iowa State University, Ames, Iowa 50011.

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PARTICIPANT SIGNATURE

By checking the "Yes, I agree to participate" box, I am confirming that I have read the informed consent form and that I am at least 18 years of age. I voluntarily agree to participate in this study, the study has been explained to me, and I have been given the time to read the informed consent document and understand it. By checking the "No, I do not agree to participate" box, you will end your participation in this study. We advise that you print this form for your records.

Yes, I agree to participate.
No, I do not agree to participate.