The Ex-Client's Experience of Attitudinal and Structural Barriers to Therapy, Prior to and During the Therapeutic Relationship.

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Abstract

People's reluctance to seek/secure counselling/psychotherapy is an area requiring further attention. This study sought to add to existing research by undertaking phenomenological interviews exploring ex-clients experiences of seeking/securing help. Semi-structured, qualitative interviews were conducted with five participants who had experience of the counselling process. Transcribed interviews were analysed using the constant-comparative method and five themes emerged: public stigma, self-stigma, the counselling/psychotherapeutic environment, privacy/confidentiality, and waiting time to secure counselling. Results indicated public/self-stigma had affected participant experience, as had the counselling environment. Privacy/confidentiality was a concern with waiting times being less so. Recommendations to reduce the negative impact of public/self-stigma and the counselling environment are offered, as are areas requiring further research including advertising, location of service, self-stigma and home counselling/psychotherapy.

Declaration

The work is original and has not been submitted previously in support of any qualification or course. ……

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This study is dedicated to Brenda, Abigail and Peter Hunt, without whom none of this would have been possible.

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List of Abbreviations

1) BACP: British Association for Counselling and Psychotherapy.

Chapter: 1 Introduction

I first came up with the idea of this research in 2010, after a conversation with another counsellor about his belief that clients should be able to choose where they have counselling - rather than be obliged to attend their counsellor's choice of practice as is usually expected (Bond, 2000). This seemed to breach one of what I saw as the 'Holy Grails' of counselling and I became immediately interested in the idea. The counsellor mentioned reading a book passage that suggested 'warriors should choose their own battlegrounds' (Castaneda, 1981). This appealed to me as I felt it could have implications for counselling men, due to findings that males often prefer to deal with mental health issues alone, as a result of internalising the traditional masculine stereotype that asking for (psychological) help is 'weak' (Tedstone Doherty, & Kartalova-O'Doherty, 2010; Allen, 2010; Smith, Tran, & Thompson, 2008). I felt that men seeking counselling could well be described as being warriors, fighting an internal battle between perceptions of masculinity and issues they felt unable to resolve on their own. As a result I wondered if allowing men to choose their 'battleground' (counselling location), would both empower and encourage them to seek help by giving them some control - thereby reducing their negative self perception of 'weakness'.

I searched for the book passage through the internet and eventually located it in a book called 'The Eagle's Gift' (Castaneda, 1981), a book concerning the culture of Toltec warriors. In reading a little deeper it emerged that the warriors were both male and female. Initially I had intended

to work only with male participants however, after some research it emerged that 'help-reluctance' affects both males and females - although admittedly more males than females are affected (Tedstone Doherty, & Kartalova-O'Doherty, 2010). I therefore decided to include members of both sexes in the study. I was also aware that this would make recruiting participants easier, but this was less of a consideration at the time.

Initially, the subject of clients choosing their counselling location was going to be the sole focus of my research. However, having discussed this with a tutor, I realised that my proposed study was relatively limited in its scope and there was an opportunity to examine the wider area of the individual's experiences of entering and 'being in' counselling - alongside the original theme of the location where counselling takes place. As a result, I chose to widen the scope of my study to look for factors which may negatively impact upon the individual's decision to enter counselling and whether or not these factors continue to have an effect during the course of the counselling relationship. Furthermore, I felt the study also provided an opportunity to identify any factors which may negatively impact upon the client's decision to remain in counselling/psychotherapy. My hope for the study was that in examining this area of client experience, I would be able to identify factors which if addressed, could encourage those wanting help, but reluctant to seek it, to feel able to engage with the counselling process.

Chapter: 2 Literature Review

A recent survey commissioned by the British Association for Counselling and Psychotherapy (BACP), found that nearly one in five people had consulted a counsellor or psychotherapist and almost half of those interviewed claimed to know someone who had (BACP, 2010). The survey further suggested that attitudes towards the talking therapies had become more positive, compared with a similar study conducted in 2004. These results led the BACP to conclude that the public's negative attitude towards those who enter into psychotherapy/counselling is disappearing (BACP, 2010). However, although it is uncertain how many people undertake counselling or psychotherapy each year, it is estimated that in a twelve month period in the UK alone, one in four adults will suffer from a diagnosable mental disorder (Counselling Directory, 2011). Of this number of people who could potentially benefit from psychological therapy, it is estimated that approximately only one third will seek help (Oliver, Pearson, Coe & Gunnell, 2005; Vogel & Wester, 2003; Andrews, Issakidis & Carter, 2001) and often only then as a 'last resort' (Hinson & Swanson, 1993). Research suggests that the majority of individuals will prefer to try and deal with their distress on their own (van Beljouw et al., 2010; Andrews et al., 2001).

Lambert (2007) suggests that the reasons why individuals choose not to engage with therapy is a subject rarely explored and one requiring more attention. However, research in the area is increasing (Mackenzie, Knox, Gekoski & Macaulay, 2004) and as a result many factors that may contribute

towards an individual's reluctance to seek help have been identified (Setiawan, 2006). Initially these were grouped into three categories: personal, socio-cultural and agency factors (Fischer, Winer and Abramowitz 1983, cited in Setiawan, 2006). However, Issakidis and Andrews (2002), suggest these groups can be more accurately categorised as either 'structural' or 'attitudinal' barriers to therapy.

Structural barriers to therapy include the cost of therapy (Setiawan, 2006; Leaf, Bruce, Tischler, & Holzer, 1987; Stefl & Prosperi, 1985), a lack of time/the time taken to access therapy (Thompson, Hunt & Issakidis, 2004; Hicks & Hickman, 1994) and the availability of counselling/psychotherapeutic services (Thompson et al., 2004). Research has shown that structural barriers to therapy have less impact upon those seeking help than attitudinal barriers (Wells, Robins, Bushnell, Jarosz & Oakley-Brown, 1994), with the exception of treatment cost (Thompson et al., 2004). However, whilst treatment cost can become an issue, especially in countries not offering free healthcare (Issakidis & Andrews, 2002), cost alone does not account for the low numbers of individuals engaging with counselling/psychotherapy across countries (Mansfield, Addis & Courtenay, 2005; Andrews et al., 2001).

Attitudinal barriers (beliefs about mental illness and attitudes towards its treatment), include 'Stoic' attitudes (individuals preferring to deal with their issues themselves) (Meltzer et al, 2000), a lack of knowledge and understanding of the counselling process (North, 2002), not knowing where to get help (Thompson et al., 2004) and concerns over confidentiality and privacy (Lovseth & Aasland, 2010; Mansfield et al., 2005). However, despite

previous findings that suggest a lack of knowledge, or understanding of the counselling process are the greatest reasons behind people's reluctance to enter therapy (Thompson et al, 2004), stigma has been identified as the greatest attitudinal factor influencing individuals' willingness to seek help (Vogel & Wade, 2009; Quinn, Wilson, MacIntyre & Tinklin, 2009; Halter, 2004; Komiya, Good & Sherrod, 2000).

Social-stigma is defined as the public's negative attitude towards, stereotyping of, and rejection of those individuals who exhibit socially undesirable behaviours, appear physically 'different', or suffer from mental illness (Quinn et al., 2009; Vogel, Wade & Hackler, 2007). In addition to the social-stigma associated with mental illness and physical 'difference', research has suggested there is a 'public-stigma' directly related to those seeking professional help (Vogel et al., 2007; Vogel, Wade & Haake, 2006; Sibicky & Dovidio, 1984). Findings show people are more negative towards those who seek professional help, than those with similar distress who do not, viewing them as more emotionally unstable, less interesting and less confident (Ben-Porath, 2002; Sibicky & Dovidio, 1984). Corrigan (2005) argues that these public perceptions are not lost on those considering counselling/psychotherapy, suggesting help-avoidance may be an attempt to avoid public-stigmatisation. Bathje and Pryor (2011) agree, suggesting that stigma is connected to help-avoidance in two ways. Firstly, people avoid seeking help in an attempt to prevent being publicly labelled as mentally ill, and secondly, in seeking the help of a counsellor/psychotherapist, the individual is accepting the negative label of someone who needs psychological help (Bathje & Pryor, 2011). Vogel and Wade (2009) suggest

that accepting or 'internalising' this negative labelling is a 'self-stigma', which they believe may be more directly related to help-seeking than public stigma.

This distinction is useful as it allows the two stigmas to be defined (Bathje & Pryor, 2011). Whereas public stigma can be seen as a form of prejudice, resulting from a stereotypical societal belief about people who seek psychological help (Bathje & Pryor, 2011; Corrigan et al., 2005), self-stigma can be defined as the internalisation of these negative societal beliefs, which can lead to the individual's loss of self esteem, regard and confidence (Bathje & Pryor, 2011; Vogel & Wade, 2009). As a result, the more the individual experiences the effects of self-stigma, the less likely they are to seek professional help (Vogel & Wade, 2009). It therefore appears that amongst the help-reluctant, it is perceptions of public-stigma that affect willingness to seek help and self-stigma that prevents active help-seeking. However, Corrigan, Watson & Barr (2006), suggest that the individual must be both aware of public stigma and internally endorse it before the effects of self-stigma can impact upon their decision to seek help. They argue that the effects of public stigma can neither impact upon the individual who has no knowledge of it, nor the individual who may be fully aware of the public stigma attached to help-seeking, but personally disagrees with it and therefore doesn't internalise its effects, thereby negating the development of self-stigma (Corrigan et al., 2006).

Vogel and Wade (2009) agree, concluding that it is perceptions of public stigma that lead to development of self-stigma, which then impacts

upon attitudes toward help-seeking and ultimately engagement with counselling/psychotherapy. Therefore, it can be argued that reducing the effects of self-stigma could encourage more individuals to engage with therapy. Corrigan (2004) has suggested this could be achieved by empowering those considering seeking help. He suggests 'Reframing' the seeking of psychological help, from its current stereotype of being seen as an act of weakness, to being seen as an act of courage (Corrigan, 2004). This approach may be particularly effective for men, as shifting the normativeness of behaviours from negative to positive has been found to change male perceptions of what is masculine and therefore acceptable to men - especially those who adopt traditional masculine roles and are therefore more likely to self-stigmatise (Pederson & Vogel, 2007; Addis & Mahalik, 2003). Similarly, Rosen (2003) has suggested that the feelings of shame and guilt associated with an Individual's perceptions of self-stigma may be reduced if they are given an explanation for their symptoms, which normalises them, informs them they are reversible and tells them they are not at fault for needing help.

Some researchers have suggested that cognitive-behavioural strategies may help in reducing the effects of self-stigma, through changing negative beliefs whilst providing accurate information and building self-acceptance (Hayward and Bright, 1997). Corrigan and Calabrese (2005, cited in Vogel & Wade, 2009) have suggested desensitisation to the fear of stigma and that 'cognitive reframing' may decrease the impact of self-stigma on the individual. Here it can be noted that many of these interventions require the individual to attend therapy – the very thing that self-stigma would prevent

them from doing, suggesting these interventions may not reach the most severely affected individuals. However, research suggests internet-based cognitive-behavioural programs may help these individuals as they have been found to have at least some effect in reducing stigma (Griffiths, Christensen, Jorm, Evans & Groves, 2004). Furthermore, the effects of self-stigma may still impact on the individual once they have entered counselling/psychotherapy (Vogel et al., 2007), which may account for some of the drop-out rate in therapy, which tends to happen early in the relationship and is neither gender nor therapy specific (Connell, Grant & Mullin, 2006).

If the assumptions of self-stigma development are correct and affected individuals are less likely to enter therapy (Vogel & Wade, 2009), it can be argued that a more useful way to encourage them to engage with counselling could be to target the development of public-stigma, thereby preventing self-stigma from developing. Corrigan and Penn (1999) suggest three possible ways of reducing public-stigma: 'Education', 'Protest' and 'Contact'. 'Education' includes television, radio and newspaper campaigns to provide the public with accurate information about psychotherapy – all of which have been found to change negative attitudes towards mental health (Pinfold et al., 2003). In terms of 'Protest', Vogel and Wade (2009) suggest that those involved in counselling/psychotherapy have a duty to protest against the stereotypical and often negative portrayals of counselling/psychotherapy by the media, with research finding that inaccurate representations increase public-stigma (Price, 2008; Vogel, Gentile & Kaplan, 2008; Orchowski, Spickard & McNamara, 2006). Finally, 'Contact' refers to meeting those who

have experienced therapy, or 'come out' by openly admitting suffering from mental illness/distress (Angermeyer, Matschinger & Corrigan, 2004). This method is most effective when such individuals are popular, of similar status, or seen as belonging to the individual's 'in-group' (Bathje & Pryor, 2011; Corrigan & Penn, 1999). Similarly, it has been found that the influence of significant others can encourage individuals to both seek and secure help (Tedstone Doherty and Kartalova-O'Doherty, 2011; Andrews et al., 2001).

Although potentially effective, these methods are arguably 'top down' in their approach to reducing public-stigma, as they rely on society's consent to allow help-seeking, as opposed to empowering the distressed individual to seek help themselves. However, the public-stigma associated with seeking professional help is related to whether or not the individual perceives that others know they are considering/actively seeking help (Vogel & Wade, 2009). It can therefore be suggested that helping the individual to conceal their intentions to seek/undertake counselling/psychotherapy from the general public, may also reduce the effects of public stigma and thereby the development of self-stigma. It is possible that this could be achieved by widening the scope of client confidentiality beyond the counsellor/psychotherapist's room. Research shows that environmental aspects of counselling/psychotherapy such as practice name (Brown & Chambers, 1986) and practice location (Fox & Butler, 2007) can impact upon the client's experience.

Research suggests counsellors should take care in the name they choose for their practice. Participants showed a significant preference for

ambiguous service names, preferring those that suggested they would be using the service for reasons other than 'mental health' counselling (Athanasiades, Winthrop & Gough, 2008; Brown & Chambers, 1986). It is possible that the more ambiguous the practice name, the less individuals are affected by perceptions of public-stigma on entering the practice. Furthermore, it highlights and extends the importance of confidentiality and privacy to clients/potential clients to the environment outside the counselling room (Lovseth & Aasland, 2010; Mansfield et al. 2005).

These findings are further supported by research which has found that the location of the counsellor's practice is important (McLeod & Machin, 1998). Fox and Butler (2007) found participants showed a preference for counselling rooms located where they were unlikely to be seen entering or leaving. Similarly, Goss and Mearns (1997) found employees were reluctant to use workplace counselling, due to the counselling room's location and concerns over being seen entering the room by colleagues. However, this effect disappeared if the employees felt their colleagues were in favour of counselling (Harlow, 1998). I have noted similar concerns over room location in my own placement, with some clients requesting rooms in discrete locations, sessions outside teaching hours, or clients waiting near the room until they can enter unseen.

A final area of concern to the client is the counselling/psychotherapy room itself. Whilst this may not be an attitudinal barrier as defined by Issakidis and Andrews (2002), the client's attitude towards the room where their counselling/psychotherapy takes place can positively or negatively

affect their experience (McLeod & Machin, 1998). Research supports this, finding that warm 'homely' rooms lead to greater client self-disclosure than 'cold' non-intimate rooms (Chaikin, Derlega & Miller, 1976). The counselling 'space', room size, layout, furnishing, decoration, level of privacy and soundproofing have all been found to influence the client's experience (McLeod & Machin, 1998). Pressly and Heesacker (2001) agree, adding that lighting and temperature can also impact on client experience. They also advocate giving the client some choice over room setting, in areas such as lighting, temperature levels and furniture arrangement (Pressly & Heesacker, 2001).

Cormack (2009) also suggests choice is important to clients and found that participants would have preferred to have undertaken counselling 'over a coffee', or whilst 'taking a walk' outside. However, she acknowledges that moving outside the traditional 'counselling space' could pose problems, not least limiting the client's ability to experience emotions in a public place (Cormack, 2009), although Zur (2001) argues that this can be effective if part of a well thought out treatment plan. Furthermore, Hynan (1990) found that many clients terminated their sessions early in the relationship, due to a dislike of the counselling/therapeutic environment. An alternative to the practitioner's room, or a more public space is the client's own home, an alternative advocated by several researchers including Jordan and Marshall, (2010) and Maxfield and Segal (2008), although the latter do acknowledge the unpredictability of working in client's homes due to interruptions. A final point on the importance of the counsellor/psychotherapist's room comes from recent research carried out by Nasar and Devlin (2011). They found that

as the participant's preference for the room increased (in terms of its personalisation/comfort and order), the more professional, qualified, friendly and caring they perceived the therapist to be and the more likely they would be to seek out that individual for help (Nasar & Devlin, 2011). Furthermore, they found these perceptions to be broadly generalisable, regardless of gender, ethnicity or previous experience of therapy (Nasar & Devlin, 2011).

Although the above evidence is compelling, there is scope for further investigation. Many of the research findings cited in this paper with regard to public and self-stigma (Vogel & Wade 2009; Quinn et al. 2009; Vogel et al. 2007; Corrigan, 2004; Komiya et al. 2000; Sibicky & Dovidio, 1984), counselling service name (Brown & Chambers, 1986), location of the counselling room (Fox & Butler, 2007), dislike of the counselling room (Cormack, 2009) and privacy (Lovseth & Aasland, 2010; Mansfield et al. 2005), were obtained using participants who had neither experience of, nor intention to seek counselling. It could therefore be argued that participant responses were at best speculative. I feel it is therefore justifiable to carry out research with those who have experienced counselling, as the results may offer a more realistic picture of client experience.

Chapter: 3 Methodology

Aims and Objectives

The aims and objectives of the study were to explore factors currently thought to discourage individuals from engaging with the counselling process. These include social and self-stigma (Bathje & Pryor, 2011; Vogel & Wade, 2009; Quinn et al., 2009; Halter, 2004; Komiya et al., 2000), the choice of counselling room (Cormack, 2009; Pressly & Heesacker, 2001; McLeod & Machin, 1998; Hynan, 1990), the name of the counsellor's practice (Athanasiades et al., 2008; Brown & Chambers, 1986), the location of/access to the service (Fox & Butler, 2007; Mansfield, Addis & Courtenay, 2005, McLeod & Machin, 1998) and privacy/confidentiality concerns (Lovseth & Aasland, 2010; Mansfield et al. 2005).

I felt this research would provide an opportunity to investigate whether there are any as yet unidentified factors which may also deter individuals from seeking therapy, or negatively impact upon their experience of the counselling process. As much of the existing research has been carried out with non-clients, it was unclear whether the currently identified discouraging factors actually affect potential clients/clients during the process of seeking and securing therapy. I felt that interviewing ex-client participants who have experience of help-seeking could confirm the findings of previous studies, by identifying the suggested factors as tension-points within the process of seeking/securing counselling. Finally, I hoped that the participant's experiences would suggest ways that counsellors/psychotherapists could adapt their practices to encourage those currently reluctant to seek help, to both enter and remain in therapy.

Key research question

Did ex-clients experience aspects of attitudinal, structural or other barriers to help-seeking that impacted on their willingness to engage with or remain 'in' counselling/psychotherapy?

Philosophical perspective and design

The research design was drawn from the phenomenological approach to qualitative research. This allows exploration of participant experience from their unique perspective and unlike more quantitative approaches, provides an opportunity for participant-researcher interaction, thereby allowing response 'meaning' to be clarified (Finlay, 2009). Unlike a positivist approach, which assumes there is an objective universal reality (Ponterotto, 2010), I felt adopting a social-constructionist stance was closer to the philosophical view of the person-centred approach, in that each individual lives within a 'subjective perceptual field' and therefore there are multiple realities within a population (Mearns & Thorne, 2007; Merry, 2002; Rogers, 1951). Therefore, the research design was in accord with the qualitative approach's fundamental exploratory and descriptive aim of unearthing meaning from the individual's perspective, as opposed to the quantitative approach's aim of testing hypotheses which can be generalised to populations (Cozby, 2004; McLeod, 2001).

Whilst the qualitative approach may lack the statistical power and generalisability of the quantitative approach (Cozby, 2004), its goal of 'discovery' compliments the quantitative goal of confirmation or explanation, by providing descriptive depth and developing theory which may be later examined quantitatively (Morrow, 2007; Nelson & Quintana, 2005). Finally, using a semi-structured interview design allowed the participants a 'voice' within the research (the interaction including me as an integral part of the process) - although the post-hoc analysis meant the design was 'non-emergent' (McLeod, 2001; Maykut & Morehouse, 1994). However, although

not as desirable as an emergent design, this method can suggest directions for further research (Maykut & Morehouse, 1994), which I felt was desirable given the small sample size.

Sampling

I intended to employ a 'Purposive'/'Snowball' sampling strategy to recruit six participants of either gender and felt a 'Purposive' strategy was optimal due to the research requirement that participants must have experienced counselling/psychotherapy and concerns that a random sampling technique risked selecting participants outside this target population (Cozby, 2004; Patton, 1990). I also felt that utilising a 'snowball' sampling strategy (Cozby, 2004) would be useful, as participants may be aware of others who had also experienced counselling/psychotherapy. I also intended to approach my placement/personal supervisors and ask them to pass on a research advertisement (Appendix A) to any potential participants they may know of. This document contained contact details which interested participants could use to contact me, whereupon I would send them an information booklet (Appendix B) and a copy of the interview questions (Appendix C) to read through prior to our meeting.

I feel the 'Snowball' sampling method (Cozby, 2004) was relatively effective, as it achieved recruitment of two participants from contact with a third - who later felt unable to participate. The remaining three participants responded to the research advertisements (Appendix A). Although I didn't manage to recruit the desired number of participants, after consulting with my research supervisor, it was felt that five participants would be sufficient to carry out the study.

The participants were five females aged between 40 and 55 years old; they all had professional backgrounds and were educated to degree level or

equivalent. All participants disclosed having sessions with counsellors as opposed to psychotherapists, although one participant described some aspects of cognitive behavioural therapy, suggesting her counsellor adopted a more 'eclectic' approach to therapy (Mearns & Thorne, 2007). All participants had undertaken more than five sessions of counselling, with one participant reporting having had sessions with more than one counsellor. I was disappointed that no male participants came forward, as I felt this would limit any conclusions the study may draw to female help-seekers. However, male participants are possibly more difficult to recruit than females due to the stigma surrounding counselling and are therefore less likely to volunteer to participate in studies such as this (Nam et al., 2010; Addis & Mahalik, 2003; Deane & Chamberlain, 1994).

Data Collection

I intended to carry out data collection by undertaking semi-structured interviews (van Scoyoc, 2010) with the ex-client participants. Interviews would take place at either my placement, the university's interview rooms or if neither were suitable, the participant's home. Each participant would be interviewed for approximately one hour, answering questions about their experiences of counselling. I felt this method would allow the topic area to be explored, but unlike 'closed' questions - or a hypothetico-deductive approach, enable expansion and further exploration as new information emerged (Cozby, 2004).

I first produced a series of questions (Appendix C) based on the findings of previous research in the area of help-seeking, designed to explore the participant's experiences of seeking, securing and being 'in' counselling/psychotherapy. I felt this could act to both confirm the existing research and identify new issues for exploration. For this reason, I utilised open-ended questions, as they allow participants more 'response flexibility' (Collins & Kneale, 2000; Maykut & Morehouse, 1994).

Cozby (2004) states that many problems with research questions stem from participants being unable to understand them. To avoid this I took care not to formulate questions using technical terms participants may be unfamiliar with, were vague, contained ungrammatical sentence structure, or used phrasing that 'overloaded' the participants with information (Cozby, 2004). I attempted to keep the questions simple to understand, avoiding where possible double-barrelled questions, loaded questions or negative

wording and attempted to construct them to avoid participant 'Yea, or nay-saying' (Cozby, 2004; Collins & Kneale, 2000). The final questions were produced after several drafts and the approval of my supervisor; I then piloted the study with a colleague who felt the questions were 'fit for purpose' (Collins & Kneale, 2000). Although I remain happy with the choice of questions, with hindsight I feel question three (Appendix C) was double-barrelled and would have been better being split into two different, yet related questions.

Having responded to the research advert (Appendix A), participants were sent a copy of the interview questions (Appendix C) and an information booklet (Appendix B) providing more in-depth information about the research project, their right of withdrawal and data protection information. It also invited them to contact me if they still wished to participate; this was intended to allow the participants to withdraw from the study without having to notify me. Prior to the interviews commencing, I obtained informed consent from each of the participants, which was recorded by both they and I signing a consent form (Appendix D).

Three of the five interviews were undertaken in counselling rooms at my placement, the fourth took place in an interview room at the University of Chester, the final interview taking place at the participant's home due to the distance she lives from both my placement and the University of Chester. Initially, I felt this would not be problematic as the participant's family were out and a mutual friend had travelled with me to introduce me to the participant and look after her dog during the interview. Further steps were

taken to avoid any interruptions such as doors being closed and telephones being switched off or ‘taken off the hook’. However, during the interview the participant’s daughter returned home unexpectedly, at which point both she and the dog entered the ‘interview room’. Fortunately this was towards the end of the interview and the participant didn’t feel the interruption impacted upon her later responses; however, this incident highlights problems of interviewing in participant’s homes.

In an attempt to gain as much information as possible from the participants, I produced a question sheet for my own use (Appendix E) which contained ‘prompts’ for further information dependent upon the participant’s responses. I used these during each interview and found them to be a useful addition to the questions, as they helped to obtain information I may otherwise not have gained and also helped prevent participant ‘yea or nay-saying’ (Cozby, 2004). The interviews were recorded electronically for later transcription, as this is a more effective method of gathering information than note-taking during interviews (Cozby, 2004). At the end of each interview the participants were debriefed, asked to supply a pseudonym, thanked for participating and reminded of their right of withdrawal. The pseudonyms chosen by the participants were as follows:

Cat

Anna

Carrie

Sparrow

Sinead

Having never carried out a study of this nature before, I found conducting the interviews more difficult than I had first imagined. However, I felt I improved as the interviews progressed, finding myself increasingly able to elicit responses from the participants. I was also surprised that the interviews averaged forty minutes as opposed to the hour I had originally envisaged. However, the average wordcount of 7000 words per interview was far higher than I had expected.

Data Analysis

Whilst I acknowledge that a Grounded theory approach (Glaser & Strauss, 1967, cited in Maykut & Morehouse, 1994) could have been employed to analyse the data, the aim of the research was an exploration of experience, rather than an attempt to develop theory. Therefore, I chose to analyse the data using the constant comparative method, developed by Glaser & Strauss (1967, cited in Thorne, 2000) for use in grounded theory research. I felt this method was the most appropriate for this study as it allowed me to compare the participants' responses, identifying both similarities and differences in their perceptions of a similar experience, allowing commonalities to emerge, analytical questions to be asked and tentative conclusions to be drawn (Cozby, 2004; Thorne, 2000). Furthermore, this method of analysis also allows minimal interpretations to be made, an important factor when considering the idiosyncratic/cultural nature of language and description of experience (Cozby, 2004; Thorne, 2000; Maykut & Morehouse, 1994).

I began the first stage of the analysis, which was to transcribe the interviews, as soon as possible after they were conducted. Transcription was undertaken using a computer and Microsoft 'Word' software. Maykut and Morehouse (1994) suggest that the data should be coded so it can be traced back to its source. The system I employed was to use the question and page number, followed by the participant's response number and their pseudonym i.e.:

Q1, P1, 1 Anna "..."

In preparation for the next stage of analysis, I printed out the transcripts and using adhesive tape joined the participant's responses to each question together. This reduced the transcripts from159 pages of text to 14 'sets' of text for each participant, each 'set' pertaining to a specific question. Using the constant comparative method in this way and 'Grouping' the answers allowed a cross-case analysis to be carried out, revealing the participants' individual perspectives of the same question (Dye, Schatz, Rosenberg & Coleman, 2000; Patton, 1990).

The next step was 'unitizing' the data into 'units of meaning' (Lincoln & Guba, 1985, cited in Maykut & Morehouse, 1994). I achieved this by examining the participants' answers to the same question, then writing their responses on a sheet of paper under the related question, this allowed each unit of meaning to be understood in context with the relevant question, as suggested by Maykut and Morehouse (1994). This process produced 251 individual units of meaning (Appendix F).

Having identified the units of meaning, I cut them from their individual pages, coding and taping them together so all the participants' responses to the same question could be examined together (Appendix G). Patton (1990) suggests this stage requires careful judgments to be made about which data is significant and meaningful. Therefore, during this stage I carefully edited the data, removing that which lacked meaning or significance, and also data which repeated earlier statements made by the same participant' i.e. if a participant showed a preference for a spacious room more than once, this preference would only be included once within its specific category.

This process allowed me to further reduce the data from five sets of answers to one set for each of the fourteen questions. Analysing this reduced set of data allowed me to produce discovery sheets of recurring themes and concepts (Appendix H) (Maykut and Morehouse, 1994). During this process I collapsed the participant's responses to questions 13 and 14 (Appendix C) into other questions their responses were relevant to. Rather than reduce the information, I was surprised to find that it increased from the responses to the (by now) twelve questions, to the production of sixteen discovery sheets. However, McLeod (2003) suggests that this is often the case with qualitative analysis, as new themes emerge, data may 'grow'.

I then took the discovery sheets and combined any overlapping ideas to form the provisional categories (Appendix J) (Maykut & Morehouse, 1994). However, due to limited space I was unable to use the recommended large sheets of paper. Therefore, in carrying out these 'large paper processes' (Maykut & Morehouse, 1994), I analysed each discovery sheet in turn, wrote down the ideas emerging from them and using 'spider diagrams' (Appendix I), was able to determine the overlapping ideas. I found this system was also useful in identifying ideas which were associated with the overlapping ideas, yet contrary to them, allowing questions such as "why are these different" or "why are these connected" to be asked (Thorne, 2000). Having carried out this stage, I wrote the overlapping themes on paper and then compared them with all other themes to form the twenty one provisional categories (Appendix J) (Maykut & Morehouse, 1994). During this stage any reference to question numbers became irrelevant, as categories emerged from across the data rather than from the individual questions.

Applying rules of inclusion to ‘tentatively propose’ the statements of fact arising from the data, I developed the provisional categories (Appendix J) into more refined categories (which later became the sub-themes) (Appendix K) (Dye et al., 2000; Maykut & Morehouse, 1994). Having completed this part of the analysis, I noted that the categories could be further refined into five main categories (main themes), which could be further refined under two ‘umbrella’ categories (umbrella themes) (Appendix L) (Dye et al., 2000; Maykut & Morehouse, 1994). Having completed this stage, I felt that there were no more refinements to be made and that the analysis was complete.

Validity and Trustworthiness

Lincoln and Guba (1985, cited in Maykut & Morehouse, 1994) state that trustworthiness is key to the believability of a researcher's findings. I have therefore taken the following steps to ensure the validity and integrity of the study to the highest possible degree. In order to ensure the questions (Appendix C) had meaning to the participants, or content validity (Coolican, 1990), I conducted a pilot study which confirmed the questions were both relevant and understandable (Cozby, 2004). I also attempted to carry out member checks (Lincoln & Guba, 1985, cited in Maykut & Morehouse, 1994), although only two participants took up this opportunity, both reported they were happy with the accuracy of the transcription.

Lincoln and Guba (1985, cited in Maykut & Morehouse, 1994) also suggest trustworthiness can be achieved through building an audit trail which allows others to be 'walked through' the research. This 'Transparency' has been employed throughout the paper in an attempt to allow the reader to follow the progression of the study from the beginning, through the analysis to the final conclusions made (Rawson, 2006; McLeod, 2003). In undertaking this study using the constant comparative method of data analysis (Maykut and Morehouse, 1994), I have built an extensive audit trail comprised of the initial interview recordings, verbatim participant interview transcriptions, unitized data (Appendices F, G), the recurring themes (Appendix H), the emergent themes (Appendix L) and how these were determined during the analysis stage (Appendix I). Finally, I feel the presence of my research supervisor 'overseeing' the study adds validity to the research, in helping to

ensure that data was accurately collected, analysed and interpreted, avoiding both falsification and plagiarism (Coolican, 1990).

Limitations

One of the main limitations to this study was the small sample size, although it is noted that a small sample size restricts the ability to generalise the study to a wider population, some tentative generalisations may be made, as 'truths' emerging from the research sample may be true of the population the sample is drawn from (Patton, 1990). A second limitation was the all-female cohort and their similar age range. However, this may not affect any generalisations being made, as Clarkin and Levy (2004) found that neither age nor gender is important in counselling/psychotherapy retention and Vogel et al. (2006) found stigma was a greater predictor of help-seeking than gender. Due to the analysis being carried out by myself as the single researcher, there is a risk that an experimenter bias may have been present in this research (Cozby, 2004; Coolican, 1990). However, I feel this was limited due to the presence of a research supervisor providing 'oversight' throughout the study. Finally, the research may lack the validity of more rigorous quantitative research, as analysis demanded a more interpretive approach as opposed to statistical testing and therefore other interpretations of the data are possible (Cozby, 2004; McLeod, 2001; Maykut & Morehouse, 1994).

Ethical Considerations

A key ethical issue which arose during the planning of this research surrounded the selection of participants who had experienced counselling/psychotherapy (Palmer, 2008). However, I felt that recruiting 'ex-client' participants was both necessary and justifiable, as the research focus was on the experience of seeking and undertaking counselling. Therefore, I felt that the group best qualified to comment upon this were those individuals who had experienced counselling/psychotherapy.

Although Palmer (2008) warns that re-traumatisation is a risk when researching with this group, I felt that such risks in the proposed study were low, as the research was aimed at aspects of help-seeking not concerned with counselling/psychotherapy itself and I did not explore the issues which led the participants to therapy. Furthermore, I was encouraged by the qualitative research carried out by Etherington (2001), which found that ex-clients could actually benefit from participating in such research. However, as I was aware that there was a possibility problems could arise as a result of carrying out research with this group (Palmer, 2000), I provided each of the participants with the contact details of several counselling services in the event that their participation raised issues or concerns for them (Appendix B). Furthermore, during the interviews I took the utmost care to monitor the participants for signs of distress and ensured that the interviews did not descend into 'inappropriate counselling sessions' (Mearns & Thorne, 2007). Moreover, I debriefed each participant at the end of their interview to ensure that they felt comfortable about having participated and had no concerns as a result (Bond, 2004). Finally, the research was carried out in accordance with

both the BACP's ethical guidelines for researching counselling and psychotherapy (Bond, 2004) and also with the ethical approval of the University of Chester's department of social and communication studies.

Chapter: 4 Results

The analysis revealed the following Umbrella themes, main themes and sub-themes:

Umbrella Theme: 1 Participant Experiences of Attitudinal Barriers

Main Theme: 1 **Public Stigma**

Sub-theme: 1.2 My perception of other people's views of my need to have counselling.

Sub-theme: 1.2 The location of the counsellor's practice.

Sub-theme: 1.3 Advertising the counsellor/psychotherapist's practice.

Sub-theme: 1.4 Maintaining the confidentiality of the counselling relationship.

Main Theme: 2 **Self Stigma**

Sub-theme: 2.1 The view of self having decided to have counselling.

Main Theme: 3 **The Counselling/Psychotherapeutic Environment**

Sub-theme: 3.1 The effect of the counselling room on my experience.

Sub-theme: 3.2 How my counselling environment could have been improved.

Sub-theme: 3.3 Counselling/psychotherapy in the participant's home.

Main Theme: 4 **Privacy/Confidentiality from family**

Sub-theme: 4.1 Keeping telephone contact with my counsellor private from my family.

Sub-theme: 4.2 Keeping my counsellor's contact details private from my family.

Umbrella Theme: 2 Participant Experiences of Structural Barriers

Main Theme: 5 The time taken to secure an appointment with a counsellor

In the previous chapters of this paper where I have referred to the subject of psychological help and helper, I have referred to practitioners as counsellors/psychotherapists and the type of help as counselling/psychotherapy. However, all the participants in this study revealed they received counselling as opposed to psychotherapy, therefore for the remainder of this paper I will only refer to counsellors and counselling. The reader should understand that such references and recommendations are also intended to be applicable to psychotherapists/psychotherapy.

To aid the reader, the results are presented in the order the themes are presented on the first page of this chapter. Quotations from the participants are included to give them a 'voice' within the study. Three dots '...' are used to denote missing lines of text, these appear where I felt that the inclusion of the deleted text was not necessary to convey the participant's meaning. Finally, '(omitted)' appears in the text where the inclusion of the deleted material would risk revealing aspects of the participants' identities.

Umbrella Theme: 1 Participant Experiences of Attitudinal Barriers.

Main theme 1 from this umbrella theme is public stigma, which is comprised of four sub-themes:

Sub-theme: 1.1 My perception of other people's views of my need to have counselling.

Sub-theme: 1.2 The location of the counsellor's practice.

Sub-theme: 1.3 Advertising the counsellor/psychotherapist's practice.

Sub-theme: 1.4 Maintaining the confidentiality of the counselling relationship.

Main Theme: 1 Public Stigma

Sub-theme: 1.1 My perception of other people's views of my need to have counselling.

Most participants felt some people would view their decision to have counselling as positive, although Cat and Anna acknowledged that some may view them negatively. Here it appeared the positive views of others or a positive view of their actions may have acted as mitigating factors. Conversely, Sinead reported being unconcerned about other's opinions, citing her desperation for help as the reason.

Carrie: "...I thought they'd see it as a positive step, to do something, to help myself really."

Sparrow: "...I'm actually doing something about, my issues, if anybody's interested..."

Cat: "...some people who knew a little about it would think "well maybe she needs a little help or support" and some people who'd think "well she's obviously lost it""

Anna: "... I thought other people may see you as weak... But on the other hand, I think recently counselling has had a higher, priority...so it can be seen as a forward thinking method..."

Sinead "I didn't care, what other people thought because I was so desperate to get out of the black hole..."

The perception of other's views about their need to have counselling was reflected in the participants' willingness to reveal their intention to seek help. Both Cat and Anna revealed reservations, whilst Sparrow and Sinead appeared unconcerned. These differing viewpoints could mean public stigma had not only to be perceived, but perceived as a threat to 'self' to have an effect.

Cat: "Well I didn't really disseminate the information, I just sort of basically went along and did it and only discussed it with my best friend at the time."

Anna: "I don't think I would have been happy to, initiate, a conversation that said I was going to have counselling... However, with certain friends...I wanted to discuss...having counselling."

Sparrow: "No it didn't really bother me that, if anybody knew I was going to see a counsellor."

Sinead: "They all knew"

"...breathed a sigh of relief when they found out..."

Sub-theme: 1.2 The location of the counsellor's practice.

Three of the counselling practices used by the participants were connected to other services and appeared to be in quite ambiguous locations, with the other two practices being based in towns – although not Cat's home town or a town Anna was familiar with.

Carrie: "it was in (omitted) so it was part of... where I was working."

Sparrow: "It was attached to a doctor's surgery."

Sinead: "The counsellor's practice was a room inside the doctor's surgery."

Cat: "It was on the main street...it was, not in not in (omitted, participant's home town)."

Anna: "it was on the main road... I was new to the area there were quite a lot of places in the town I didn't know..."

However, circumstance as opposed to public stigma appeared to be the reason behind this apparent ambiguity. Most participants didn't choose their counsellor, four were referred by others and although Anna 'freely' chose to enter counselling, it appeared her choice was limited by knowledge of the availability of counselling.

Cat: "It was my ex-husband... [He] said "Right I'm going to get my private insurance to pay for it"...the doctor actually recommended somebody else."

Carrie: "I didn't actively seek it...I was here and I was given the number by my boss basically"

Sparrow: "...the counsellors were assigned and that's the top and bottom of it, through the GP..."

Sinead: "It was chosen for me because - it was the doctor's suggestion"

Anna: "Well I'd only really heard of this one...I probably would be a bit more choosey next time"

Three of the participants reported no feelings of concern when entering the counselling practice. However, both Anna and Carrie disclosed some concern, suggesting an awareness of public stigma.

Cat: "it didn't bother me y'know, being seen going in there."

Sparrow: "...didn't feel as though "Oh people know I'm seeing a counsellor.""

Sinead: "I wasn't worried... there was no "Oh I'm seeing a counsellor.""

Anna: "I do remember it crossed my mind as to "I wonder if anybody will see me?""

Carrie: "one of the people I worked with had been for counselling, so would have known...and so that was a little bit difficult really."

Amongst those participants who revealed no concern over being seen entering their counsellor's practice, the location did appear to be the reason for this lack of concern. Cat felt unlikely to be seen entering, whilst both Sparrow and Sinead's counsellor's worked from doctor's surgeries - essentially 'hiding' their practices. Interestingly, Sinead revealed a concern about being seen when her appointments fell outside surgery hours, indicating she could no longer be perceived as a patient as opposed to client.

Researcher: "you didn't expect to be seen entering by people that you'd know?"

Cat: "...probably some of that, yes."

Sparrow: "I didn't mind at all. I could have been going to see anybody."

Sinead: "I was going into the doctor's surgery... I did sometimes think "I wonder what people think I'm doing here at half past one... because surgery was closed from one 'til two o'clock..."

The majority of participants felt the doctor's surgery was the most suitable location for a counselling practice, with Carrie disclosing a preference for neutral ground. The only reason given for the preference of the doctor's surgery was that it would allow access to counselling without other people knowing. This perhaps infers a perception of public-stigma and an attempt to neutralise its effects by 'hiding' the counselling practice within a socially acceptable location.

Cat: "I would think attached to a medical practice... if you go to a medical centre - you could be going for anything..."

Anna: "you could be going to the doctor for any other number of different things so it's not obvious that you're going for counselling."

Sparrow: "Well personally would think part of the, the GP's surgery environment...if you'd never seen a counsellor before you wouldn't know that that person was a counsellor"

Sinead: "I felt secure going to the doctor's surgery, I don't know whether I would have felt secure going anywhere else."

Carrie: "I suppose somewhere that's probably detached from... just on neutral ground really..."

Sub Theme: 1.3 Advertising the counsellor/psychotherapist's practice.

Three of the participants said there were no signs outside the practice that clearly advertised it as a counselling service. Of the two that confirmed there were signs, both suggested the signs were ambiguous.

Carrie: "No"

Sparrow: "No, just a name"

Sinead: "No, nothing that advertised it"

Cat: "It had a sign outside... it said consulting. So that was a fairly ambiguous"

Anna: "Yes there was a plaque but it was one of several, brass plaques. I don't know if it actually said 'Counselling Service'..."

Four of the participants felt that a sign advertising their counsellor's practice would not have affected their decision to have counselling at that address, with only Carrie stating that it would have affected her decision as it took away her sense of anonymity.

Cat: "Given a free choice no, I don't think so because once you've made the decision to go, then...you go and you see"

Anna: "I think probably if it'd had a ...sign over the top saying "Counselling Service" then that would have been different but...it wouldn't have affected me really..."

Sparrow: “at the time I don’t think I’d have minded…”

Sinead: “No… I would have still used it cos everybody knew…”

Carrie: “Yes, because it takes away, the anonymity a bit doesn’t it.”

Despite claiming that they would have been unaffected by the presence of signage that identified the function of their counsellor’s practice, four of the participants felt signs were inappropriate, with Carrie offering an alternative option. These responses could mean that contrary to their answers to the previous question, they may have been affected by the presence of signage; otherwise I would have expected them to suggest that signs were not an issue.

Cat: “you could put people off… So I think something discreet which gives a name but not necessarily y’know a list of what you do.”

Anna: “I think it would put people off if, if there was a big sign outside”

Carrie: “you could have a sign, but just the person’s name.”

Sparrow: “I don’t think that would be appropriate.”

The participant's preference for discreetness in advertising signage was echoed by their suggestions of places where counsellors should advertise. In each case the participants suggested media which allowed content to be easily accessed, but in ways which shielded the intention to seek counselling from others. This may have resulted from the participants feeling others would view help-seekers negatively if they knew they intended to seek counselling.

Cat: "I don't see what's wrong with advertising in a paper or yellow pages, because... you don't necessarily have to flag it up to everybody... But somewhere that's a commonly used source of information..."

Anna: "newspapers, doctor's surgeries, anywhere where you'd do normal advertising really... you could be looking at anything else on that page couldn't you."

Sparrow: "Word of mouth, cards, and advertising discreetly through large institutions. I think discretion has to be a big part of it"

Carrie: "Well like here there's posters and cards...or I suppose in directories..."

Sub Theme: 1.4 Maintaining the confidentiality of the counselling relationship.

The participants' preferred places to keep their counsellor's contact details suggested they wished to keep them confidential. This was further evidenced by the finding that in each case, the contact details were kept ambiguous, with no details connecting them with a counsellor or counselling.

Cat: "...kept it in my handbag... It just said '(omitted) consulting' on it."

Anna: "...I just kept it on a card in my bag... I can't remember it saying any details and then a phone number."

Carrie: "On the phone, but just as (omitted, counsellor's name)."

Sparrow: "...in my desk drawer at home, or possibly on a bookshelf, where I tend to keep repeat prescriptions and appointment cards...It would be from that establishment and it wasn't the counsellor [Name]..."

Sinead: "I kept it in, my diary... (In the home telephone book) It was under surgery, but on the diary it was (omitted, counsellor's name)."

Four of the participants said they had given their counsellor permission to contact them, with Sparrow being unable to remember. Cat and Carrie had given their mobile phone numbers only, which they said no one else had access to, Sinead had given her home phone number only, stating she was unconcerned if a family member answered because they knew she was having counselling. Anna had given both her home and mobile phone

numbers. However, she had assumed that her counsellor wouldn't have revealed his identity if he had called. Here it is possible that Cat, Carrie and Anna had only wanted their counsellors to speak to them in person, which could mean a desire to keep the relationship confidential.

Sparrow: "in all honesty I can't say that I remember."

Cat: "Yes I gave him my mobile phone number."
Researcher: "Did you allow anyone else access to that phone"
Cat: "no"

Carrie: "...he had my mobile number."
Researcher: "Do you allow anyone else to answer this phone?"
Carrie "No, that's just mine"

Anna: "Yes I did, I think I gave my home and my mobile, phone..."
Researcher: "Even though anyone else could've answered the phone?"
Anna: "...I didn't see that as a problem...There's ways and means really aren't there, I mean sometimes y'know if you say "It's so-and-so" rather than "Oh it's the counsellor"... I just assumed that, that wouldn't be a problem..."

Sinead: "Yes, she could contact me, she had the telephone number... I was open about what I was having done."

All the participants claimed they would have acknowledged their counsellor if they had seen them in public, regardless of whether or not either had company.

Cat: "Yes"

Anna: "Yeah I think I would..."

Carrie: "yeah if, I met him in the supermarket or something."

Sparrow: "I would have been tempted to say "Ooh hi"."

Sinead: "Yes, in fact I did..."

Initially I found these responses quite surprising, as I expected the effects of public stigma would have left the participants reluctant to acknowledge their counsellor. However, whilst Sparrow's counsellor refused public acknowledgement and Sinead was unconcerned about others knowing, both Anna and Carrie's justification for acknowledging their counsellors was equally surprising and neatly side-stepped the issue of public stigma. In both cases they felt acknowledgement neither suggested nor informed any third party that they shared a counselling relationship, hence no perception of public stigma emerged.

Sparrow: "I was told immediately, in the first session by the counsellor that if she saw me outside of the session she would not acknowledge me"

Sinead: "Yeah – and I've got here, "why not?"."

Anna: "they don't have a big sign over the top of their head saying 'counsellor'...I probably could have even said "Oh he's a counsellor"...It doesn't mean he's my counsellor..."

Carrie: "I could justify knowing [omitted – counsellor's name], so I could just say "oh, he works at the (omitted, participant's workplace)."

The final question surrounding this theme concerned the participant's willingness to tell others they had experienced counselling. Whilst four said they would reveal this, Carrie admitted she tended not to.

Cat: "I do tell anybody who's interested really because I think that it's important that the stigma is removed from it"

Anna: "I'm quite happy to reveal it if the situation allows."

Sparrow: "Yeah to, to a small degree."

Sinead: "if I can sing the praises of counsellors, I will do."

Carrie: "No, I tend not to."

Despite claiming they were willing to reveal their counselling history, further exploration revealed Cat would refrain from telling an employer, Anna was not always happy to disclose having counselling, and Sparrow preferred not to talk about her experience. Perhaps the effects of public stigma may be present after the counselling relationship has ended, as the reluctance to disclose the association with counselling appears to be connected with avoiding being seen negatively by others.

Cat: “employer probably not... because you don’t know whether people have got a prejudice against it...”

Anna: “I’m not always happy to tell people that I’ve had counselling.”

Sparrow: “I don’t think it’s anything to be ashamed about at all. But I try not to mention it.”

However, it can be noted that all the participants said that they would disclose having counselling to someone who revealed they had also experienced counselling.

Cat: “Yes”

Anna: “I have mentioned it to people, yeah”

Carrie: “Yes...”

Sparrow: “I may do yeah, yeah”

Sinead: “...(I’d) give them all the encouragement I could”

Main Theme 2: Self-Stigma.

Main theme 2 from umbrella theme 1 contains only one sub-theme:

Sub-theme: 2.1 The view of self having decided to have counselling.

Four of the participants revealed that once they had accepted their need for counselling they viewed themselves negatively. However, Sparrow revealed that she didn't view her need for counselling as a weakness; conversely, she viewed herself positively – possibly meaning she was either unaware, or unwilling to accept notions of self-stigma.

Sparrow: "Weak? No, I had problems."

Researcher: "...you saw yourself in a positive light?"

Sparrow: "In that respect, in terms of that, yes..."

Cat: "Initially I felt that I was kind of a failure really"

Anna: "Asking for anybody's help, there's always an element that you see that as, being weak"

Carrie: "I just thought... it's the beginning of just losing control because I can't cope"

Sinead: "I thought I was a failure"

The participants who expressed a negative view of self offered some explanation for this self-perception. It emerged that previously they had always felt able to cope; therefore their need for counselling may have represented an inability to cope which they viewed as a failure/weakness on their part.

Cat: "I'd always been, strong and able to cope with anything y'know really that came my way, and it was really, almost in the beginning as a sort of admission of failure really that I hadn't been able to cope"

Anna: "I don't know where that feeling of weakness really comes from for me, I suppose it's because I am fiercely independent and I usually can work things out for myself."

Carrie: "I felt I'd coped in that past, I should be coping a bit better"

Sinead: "I was so used to doing things on, my own and being a success at them."

Despite viewing themselves as failures/weak/unable to cope, the participants seemingly affected by self-stigma offered explanations for how they overcame this and entered counselling. Cat cited the influence of friends, whilst Anna, Carrie and Sinead seemingly recognised the value of counselling as able to help them.

Cat: "A friend of mine said to me "actually, it's a sign of you being too strong for too long and y'know that, that, you need this help now.""

Anna: “I saw value in it so that’s why y’know, I decided to, go for counselling”

Carrie: “Well it would help me...”

Sinead: “I was eager to go, but at the same time had a reluctance to go... I wanted help but at the same time, but like I say, reluctance to say ‘well I can’t cope”...”

Main Theme 3: The Counselling/Psychotherapeutic Environment

Main theme 3 from umbrella theme 1 contains three sub-themes:

Sub-theme 3.1 The effect of the counselling room on my experience.

Sub-theme 3.2 How my counselling environment could have been improved.

Sub-theme:3.3 Counselling/psychotherapy in the participant's home.

Sub-theme: 3.1 The effect of the counselling room on my experience.

The participants described their counsellor's rooms in both positive and negative terms. Aspects of the rooms which the participants found positive were their comfortableness, spaciousness, lighting levels and those which gave a sense of safety and security. Conversely, aspects which were viewed negatively were a lack of sense of security, lighting which couldn't be adapted to suit the participant, or rooms which were too small, with Cat reporting that her counsellor's attempts to control the high temperature resulted in a lack of confidentiality. The importance of the room setting is highlighted by Anna's statement that her room negatively affected her experience and Sinead's disclosure that she would miss a session rather than be in a room she found unsuitable.

Cat: "...it was very nice inside...quite comfortable..."

"in the summertime it was...quite warm, so the (the counsellor) would open the door... it wasn't terribly discreet...or sort of confidential..."

Anna: "...it was secure so you wouldn't be overheard...the room itself was quite spacious, it was comfortable..."

"...it could have been a better experience if it had been in a better, environment... I probably would be a bit more choosey next time"

Carrie: "It was, it was ok..."

"...the rooms were a bit small"

Sparrow: “...fine, comfortable, light, not claustrophobic...light, airy, safe.”

Sinead: “I wanted it to be comfortable...I quite liked the lights being dimmed and the curtains shut”

“(if I didn’t like the room), I would quite definitely say “Oh I’m not going”, and I’d go home.”

Sub-theme: 3.2 How my counselling environment could have been improved.

Changes to their counselling rooms which the participants felt could have improved their experiences were solely linked to aspects of their own counsellor's rooms they had been dissatisfied with. This indicates areas such as temperature, lighting levels, room size, comfort, and privacy are important and left unaddressed may risk negatively affecting clients' counselling experience.

Cat: "I suppose the temperature really... something with sort of, quite light and bright, but you feel that it is maybe soundproof..."

Anna: "...natural light is important to me..."

Carrie: "something big enough, (where) I didn't feel, boxed in... and that it's just... a private space"

Sinead: "a room more like a lounge...not actually something that looks like a counselling room"

Sub-theme: 3.3 Counselling/psychotherapy in the participant's home.

Although the participants showed some dissatisfaction with their counsellor's room, none of them felt their own home was a suitable space for counselling. Cat, Anna, Sparrow and Sinead had concerns about being interrupted during sessions, with Anna, Sinead and Carrie also stating a wish to keep counselling separate from their home life. Sparrow also raised the issue of control, implying that counselling at home removed her choice of whether or not to attend.

Cat: "I wouldn't have been able to do that...my parents live in the house...my mother is, really really nosey..."

Anna: "...I don't think, that I would've liked, to do it at home...things can happen, somebody comes to the door or whatever..."

"I wanted to keep it separate from the rest of my life..."

Carrie: "No, I don't think so...because again it's blurring the edges isn't it"

Sparrow: "No, no. That's my home..."

"If you were at home the phone might ring..."

"...do I still want to see that person? Am I going to make the effort to turn up?"

Sinead: "No I wouldn't want it at home and I can't tell you why really..."

"...you get interruptions..."

Main Theme: 4 Privacy/Confidentiality from family.

Main theme 4 from umbrella theme 1 contains two sub-themes:

Sub-theme: 4.1 Keeping telephone contact with my counsellor private from my family.

Sub-theme: 4.2 Keeping my counsellor's contact details private from my family.

Sub-theme: 4.1 Keeping telephone contact with my counsellor private from my family.

Four of the participants revealed that their families/partners were aware they were having counselling. However, three of the participants appeared to want to keep contact with their counsellors' private from their families. Both Cat and Carrie achieved this by not giving their home telephone numbers as contact points, whilst Anna gave both her mobile and home telephone numbers. However, Anna said she didn't expect her counsellor to reveal his identity if he rang her home number, possibly meaning she felt she could still keep her counselling relationship private from her family. The reasons for securing this privacy may be connected with an attempt to avoid public stigma initiated by their family members.

Cat: "My family knew about it..."

Researcher: "...you wouldn't have given him (counsellor) your home phone number because anyone could have answered?"

Cat: "Yes..."

"my ex-husband decided to tell his friends...I was having counselling, so I'd obviously, was having some kind of breakdown."

Carrie: "my husband wasn't happy because... I don't think he likes the whole thing of counselling himself..."

"what I wouldn't want is my landline number, because I've got an answerphone"

Anna: "...the decision (to have counselling) had already been made by the time I mentioned it to them (her family), so I didn't ask their opinions...because I felt I knew what the reaction would be."
"...if it wasn't, the family member answering the phone who was receiving the counselling, you probably wouldn't preface it with "Is so-and-so there, it's the counsellor speaking"..."

Sinead: "They all knew"

Sub-theme: 4.2 Keeping my counsellor's contact details private from my family.

All the participants kept their counsellor's contact details ambiguous and in secure locations no one else had access to. However, it can be noted that the three participants who kept contact with their counsellors private, also kept their counsellors details with them in person, rather than leaving them at home where presumably only a family member would have access to them. Again this may mean an intention to keep the counsellor's contact details private not just from 'others' but the family as well.

Cat: "I usually...threw the last one in the bin, kept the current one and kept it in my handbag, because...I knew that's where it was."

Anna: "I always knew where it was going to be anyway...it was just on a card in my handbag"

Carrie: "On the phone, but just as (counsellor's name), so it didn't give any information out...I just find that a mobile's the most, private, secure really"

Umbrella Theme: 2 Participant Experiences of Structural Barriers

This umbrella theme is comprised of only one main theme:

Main Theme: 5 The time taken to secure an appointment with a counsellor.

Two participants were affected by what they felt were excessive waiting times. Both felt that once the decision to undertake counselling was made, they were ready to speak to someone there and then, rather than having to wait for weeks or months. Furthermore, both felt that by the time counselling became available it risked being too late to help with their issues.

Anna: "it was like "Oh there could be a two month wait"...you just don't want to wait that long...it's taken a lot to come to this point where you're making the appointment and you don't then want said "Oh come back in eight weeks."

Sparrow: "...you might be waiting five or six months, meanwhile you've stabilised, and I think that is a potential issue...because you still want somebody to talk to, you want somebody to listen to you."

Chapter: 5 Discussion

The results of this study broadly agreed with previous research and found that both the attitudinal themes of public stigma, self-stigma, the counselling environment, privacy/confidentiality and the structural theme of waiting time, appeared to impact upon the participants' experience of the counselling process. However, I found that the participants' unique experiences sometimes indicated views and perspectives supporting alternative findings and theories. Therefore, any connections I have made to existing theory due to similarities in our findings remain interpretive and I acknowledge that the reader may have equally valid alternative interpretations, which are both encouraged and invited. I will discuss the results in the order they appeared in the previous chapter, grounding them within the existing research findings where possible. Due to the limited wordcount of this study, the reader should note that the discussion is by no means exhaustive and as a result I acknowledge that some of the participants' meaning may have been lost in my attempt to be concise.

Cat and Anna's apparent perceptions of other people's views of their need for counselling as negative supports Vogel and Wade's (2009) suggestion, that the perceived negative view of others impacting upon the individual's view of self is public stigma. Vogel and Wade (2009) also suggest these perceptions can lead to help-seeking reluctance. However, because neither participant was discouraged from help-seeking, mitigating factors may have been involved. For Cat this may have been the influence of a best friend she said had encouraged her to seek help. I found evidence for this

effect in Andrew et al's (2001) study, which found friends can positively affect help-seeking. For Anna, it appeared that her positive view of counselling may have negated any effects of public stigma she perceived to be present. If true, this would support Corrigan et al's (2006) suggestion that public stigma has to be accepted to have an impact upon the individual.

Similarly, both Sparrow and Carrie's positive view of self suggested neither were affected by public stigma. It is possible that their belief others would view their need for help positively was responsible for this perception, again supporting Corrigan et al's (2006) suggestion that stigma must be perceived to have an effect. However, Sinead cited her desperation for help as being more important than other's views of her need for counselling, she also stated that 'everybody knew' about her association with counselling. Here it could have been Sinead's desperation for help which overrode any perceptions of public stigma. However, it is also possible that her desperation may have represented 'counselling as a last resort', after other attempts to resolve her problems had failed (van Beljouw et al., 2010; Hinson & Swanson, 1993).

Current research suggests that clients prefer counselling locations where they can enter or leave the practice without being seen, in an attempt to avoid stigmatisation (Fox & Butler, 2007). Because Sparrow and Sinead's counsellors practised from doctor's surgeries, it is probable that both participants' egression would have been seen by others; despite this, neither participant reported perceptions of public stigma. When I explored this further, they both explained that because it was a doctor's surgery, they felt

other people wouldn't know they were there for counselling. An interesting addendum to this is Sinead's disclosure that she became concerned about other's perceptions of her, when attending counselling outside surgery hours. Perhaps because in this instance she could no longer 'hide' in the guise of a patient, instead viewing herself as client, she possibly became vulnerable to the effects of public stigma as suggested by Bathje and Prior (2011).

Carrie's counsellor's room was located at her workplace and similarly to the findings of Goss and Mearns (1997), she reported some concern over being seen entering by colleagues, especially those who understood the room's function, as also suggested by Fox and Butler (2007). However, that she attended counselling may have been due to the sense of support she said came from her work colleagues. This suggestion is in accordance with Harlow's (1998) findings, that the effects of stigma related to workplace counselling often disappear if the client feels supported by colleagues. Because Carrie was referred to workplace counselling by her immediate supervisor, it is possible this support had Harlow's (1998) mediating effect, thereby reducing Carrie's concerns enough to allow her to attend counselling.

Both Cat and Anna's counsellor's premises were located on high streets in towns unfamiliar to them. Whereas Anna reported some concern over being seen by others at the location, Cat reported no concern at all. However, she qualified this by admitting she didn't expect to be seen by anybody she knew. Although Vogel and Wade's (2009) definition of public

stigma applies to the client's perception of the views of others in general, as opposed to the views of individuals unknown to the client, it is possible that Cat's belief was people in the town would not know she was attending counselling, whereas those known to her would have cause to wonder why she was there. It is therefore possible that perceptions of public stigma could have emerged if Cat had been seen by someone she knew.

It is notable that the three participants who attended counselling not based at medical practices reported some concern/potential concern about being seen entering by others, whilst those attending surgery-based practices did not (Sinead's unease being associated with appointment timing as opposed to location). This finding makes one wonder if medical practices could be the optimum locations for counselling services, as in providing the counsellor's practice with anonymity; they appear to extend this to the client and in doing so possibly reduce the development and subsequent impact of public stigma. The participant's preferences for the location of counselling services seem to echo this possibility, as with the exception of Carrie, who spoke of 'neutral ground'. The remaining participants all felt medical practices were the ideal location, further supporting Fox and Butler's (2007) findings that public stigma can emerge as a result of being seen entering/leaving a counsellor's practice.

Although none of the participant's practitioners used signs which advertised their premises specifically as counselling services, only one of the participants felt the presence of such a sign would have impacted upon them. However, the remaining participants showed a preference for

ambiguous signs or none at all. This preference may have been to allow them to enter counselling premises without being seen and judged negatively by others, again supporting the findings of both Athanasiades et al. (2008) and Brown and Chamber's (1986), regarding the stigma surrounding practice location.

This preference for anonymity extended to the advertising of counselling services in general. The four responding participants all suggested advertising in media that could be either accessed privately such as the internet, or advertised in public media not directly connected to counselling, such as newspapers, leaflets and magazines. The participants appeared to show a desire for counselling services to be advertised widely and openly, whilst also 'hidden in plain sight'. Again, this could be due to their awareness of the negative views of others towards help-seeking and help-seekers - echoing their preference for 'hidden' counselling service locations.

Three of the four responding participants provided contact information intended to ensure their counsellor would only speak to them, with Sinead reporting no concern since she had the support of her family and Sparrow being unable to remember. However, all the participants admitted keeping their counsellor's contact details ambiguous and in private locations only they expected to have access to. It is possible this was an attempt to keep the counselling relationship confidential from both intentional or accidental discovery and supports Lovseth and Aasland's (2010) findings that privacy and confidentiality are important, as 'hiding' their association with

counselling from others may prevent clients having to cope with others' negative views of their need for help.

Based on these findings, I expected to find the participants reluctant to acknowledge their counsellor in public, especially if either were in company, thereby maintaining the confidentiality of the counselling relationship. However, the overwhelming response from the participants represented what Maykut and Morehouse (1994) refer to as one of the 'unexpected twists and turns' of research, as all the clients disclosed a willingness to acknowledge their counsellor in public. However, Carrie disclosed that she could justify knowing the counsellor as a colleague, whilst Anna reasoned that other people would not necessarily know the counsellor's occupation, or if they did, it would not mean that they were sharing a counselling relationship. These responses may represent both Carrie and Anna's awareness of the public stigma surrounding counselling and furthermore, an awareness that the negative effect of public stigma may have limits.

This apparent awareness of the possible limits of public stigma also appeared to be evident in whom the participants chose to disclose their association with counselling to. Initially all but Carrie claimed they would tell other people, yet further exploration revealed Cat, Anna and Sparrow had some reservations regarding who they would tell. This reluctance to disclose their experience is possibly due to both an awareness of, and attempt to avoid a belief that others may hold negative views of them. Furthermore, the finding that all the participants were willing to reveal their association with counselling to another 'ex-client', may result from a perception that these

individuals would not view them negatively, possibly viewing them as ‘kindred spirits’.

That Sparrow viewed herself positively supports Corrigan et al’s (2006) suggestion that a negative view of self (self-stigma), cannot develop unless the negative views of others are first perceived and ‘internalised’. Therefore, the remaining participant’s negative view of self as a result of their decision to have counselling points to self-stigma as being a possible causal influence, as suggested by Vogel and Wade (2009). However, the mechanism Bathje and Prior (2010) suggest leads to the development of self-stigma, is the internalisation of public stigma. Although they may have done, none of the participants appeared to have internalised public stigma and all may have been aware of it, as they all appeared to have attempted to avoid it. It may be that the participant’s negative self-perceptions were due to their view of themselves as weak, or failures, which may have arisen from their perceived inability to cope when previously they had always felt able to.

Vogel and Wade (2009) suggest that the more self-stigma is perceived, the less likely the individual is to seek help. As those participants with negative self perception entered counselling, it may have been due to them not experiencing self-stigma to any great degree. However, such interpretations risk inaccuracy, as it can be noted that with the exception of Anna, the participants were referred and/or encouraged to enter counselling by others, including doctors, colleagues, friends and family - rather than seeking counselling for themselves. However, the findings of Tedstone Doherty and Kartalova-O’Doherty (2011), show that the influence of

significant others can encourage the help-reluctant to seek help, which may explain why the participants entered counselling. As with her perceptions of public stigma, it may also have been Anna's value of counselling that overrode her sense of weakness, supporting Rosen's (2003) suggestion that knowledge of the counselling process can reduce the effects of self-stigma.

McLeod and Machin's (1998) findings that clients' attitudes toward their rooms can impact upon their experience, was supported by my findings. Although all the participants initially responded positively about their counsellor's rooms, four later disclosed that there were some issues which had negatively affected their counselling experience. These concerns were raised again when the participants revealed how they felt their experience could have been improved, in each case their suggestions for improvement echoed what they had disliked about their respective rooms.

Cat's dislike of the high temperature in the room and her counsellor's attempts to control this by opening the door, subsequently affecting Cat's perception of confidentiality, supports Pressly and Heesacker's (2001) findings on temperature preference and also McLeod and Machin's (1998) findings on privacy. Anna and Cat's preference for brightly, naturally lit rooms and Sinead's for dimmer lighting also supports Pressly and Heesacker's (2010) recommendations, that lighting should be adjustable to suit the client. As a sufferer of claustrophobia, Carrie's greatest concern was understandably the size of her counsellor's room and again, McLeod and Machin (1998) have found that room size is an important factor for many clients. With the exception of Sparrow, the participants all mentioned the

comfort of the room as being either a positive they had experienced, or a desired preference. This supports Chaikin et al's (1976) findings which despite being relatively dated, come with a warning. Their research also found that clients are less likely to disclose in rooms they find 'cold' and non-intimate as opposed to 'warm and homely' rooms.

Despite the commonly held belief amongst counsellors that the most important aspect of counselling is the relationship (Mearns & Thorne, 2007; Merry, 2002), it would appear that their room may also seriously impact on the counselling process. Anna's dislike of her room led her to disclose that if the situation ever arose, she probably would not use the same service again. Similarly, Sinead revealed that if she did not like a particular counselling room, she would cancel the session rather than stay in a room she felt uncomfortable in, both of these disclosures supporting Hynan's (1990) findings. Interestingly, neither participant mentioned the counselling relationship as a reason to stay/return. This finding supports Nasar and Devlin's (2011) research, which found the client's attitude towards their practitioner's room affected both their decision to use that service and furthermore, their perception of the practitioner's competence. Both these and Nasar and Devlin's (2011) findings may mean that the counselling environment presents a greater barrier to client experience than has perhaps been acknowledged.

Cormack (2009) suggests clients should have a greater choice regarding their counselling room/location. Based upon the participant's experiences, perhaps the differing needs of clients could make their own

homes the ‘ideal counselling space’. Rationally this would appear to make sense, as the client would have full control of the room and be able to adjust it to their individual needs; as previously suggested by Jordan and Marshall (2010) and Maxfield and Segal (2008).

This aspect of counselling was one of great interest to me and I felt fairly certain that the vast majority of clients would prefer counselling in their own homes. However, I was surprised to find that without exception, the participants all rejected this idea, four of them being concerned about being interrupted and Sparrow stating that it would remove her choice not to attend counselling. Although some of the participants attempted to explain their objections in terms of keeping counselling ‘separate’ from their home lives, there did appear to be something intangible in their objections that they couldn’t quite articulate, highlighted by Sinead’s comment that she didn’t want counselling at home but couldn’t say why. However, because the participants were unable to fully voice their negative attitudes towards counselling at home, it would perhaps be unwise to make any comparisons with research that my findings may appear to refute.

Another theme emerging from the research I initially found surprising, was four of the participant’s attitudes towards keeping both contact with their counsellors, and their counsellor’s contact details private from their families. Initially this appeared strange, because the responding participants reported their families knew they were having counselling. That Carrie disclosed her husband was unhappy with her having counselling, perhaps explains her attempts to ‘shield’ the relationship from him, thereby possibly

avoiding any perceptions of stigma. Conversely, neither Cat, nor Anna nor Sinead reported a negative response from their respective families, making their attempts to 'hide' their relationships from them somewhat puzzling. However, Lovseth and Aasland (2010) offer an explanation which may apply to the participants in question. They suggest such actions may be an attempt to maintain 'emotional capability', thereby avoiding being seen as weak by their families (Lovseth & Aasland, 2010). It is possible that this apparent perception of 'public stigmatisation' from their families may have been the reason they chose to maintain the privacy of their counselling relationships.

Similarly to the research of Vogel and Wade (2009), Thompson et al. (2004) and Wells et al. (1994), there was little evidence that the participants encountered any structural barriers (The availability, access, cost of, or transport to counselling), which negatively impacted upon their experience - with only Anna and Sparrow referring to this barrier. In each instance, both participants felt that the time it took to see a counsellor was too long; supporting the findings of Thompson et al. (2004). However, within a society where counselling is delivered through a National Health Service, voluntary organisations or private practitioners, it is possible that issues pertaining to waiting times only apply to those unable/unwilling to pay for counselling, the possible ethical/moral implications of this being too wide a scope for discussion within this paper.

Chapter: 6 Conclusion

Despite some participants' claims that they did not feel others would view them or their need for counselling negatively, it appears that they all took steps to hide their association with counselling from those they perceived would view them negatively. Furthermore, all the participants showed a preference for contact with counsellors/counselling that effectively hid this relationship from others. It therefore appears that there was a perception of public stigma amongst the participants, mitigated by factors including the support of others, the need for help outweighing the fear of stigma, the ambiguity of counselling services and maintaining the confidentiality of their counselling relationships. Furthermore, it appears that public stigma not only affected the majority of participants prior to, and during the counselling process as suggested by Vogel et al. (2007), but possibly continued to be of concern after the counselling relationship had ended, with participants still reluctant to reveal their experience of counselling. What is perhaps most promising about the findings of this study is that many of the participant's concerns may be relatively easy to address and reconcile, as they largely appear to be matters requiring a raising of awareness about the effects of public/self-stigma on potential clients/clients amongst counsellors/psychotherapists, with many changes to reduce this being relatively minor, as opposed to large scale changes at 'grass-roots' level.

Recommendations

Although the small sample size may make generalisation of the findings unrealistic, there were several areas where the majority of participants were in agreement. For this reason I feel the following recommendations arising from their responses may have some validity. However, I recognise that further research is needed before conclusions applicable to the wider population can be drawn.

Because the participants showed concern about being seen entering their counsellor's practices, counsellors/psychotherapists setting up services may benefit from considering their choice of location from the client's perspective. A more anonymous location may prevent clients from feeling negatively judged by others who may see them entering the practice (Fox & Butler, 2007). Furthermore, this anonymity may also encourage them to remain in counselling/psychotherapy (Connell et al., 2006).

Somewhat counterintuitively, counsellors/psychotherapists may attract clients to their practice by not openly advertising, but by maintaining discreet premises (Athanasiades et al., 2008; Brown & Chambers, 1986) and 'hiding' their advertising in newspapers, magazines or via the internet. This could allow prospective clients to access the service without others knowing of their intentions and possibly avoid experiencing stigma which may discourage them from entering counselling/psychotherapy. Furthermore, practitioners could also aid their clients in maintaining privacy by ensuring telephone contact is with the client only and any documentation such as

business cards do not reveal the practitioners occupation and thereby reveal the clients association with counselling. Finally, the participant's issues with their counsellor's rooms largely revealed problem areas which could easily be addressed. Practitioners could improve their client's experience by making their rooms more 'homely' and allowing them some control over the room, in terms of lighting, and heating levels (Pressly & Heesacker, 2001).

Areas Requiring Further Research

As a result of the study, several areas I feel warrant further investigation emerged. Firstly, Anna's positive view of counselling appeared to reduce the impact of both public and self-stigma. This finding echoes Corrigan and Penn's (1999) suggestion that educating the public could reduce the impact of self-stigma. However, rather than simply providing 'education', perhaps research could concentrate on the impact of actively promoting counselling/psychotherapy.

The location of the counsellor/psychotherapist's practice also appears to be an area requiring further research. This study found the location of the practice was directly or indirectly a concern shared by all the participants, which risked negatively impacting upon them. Furthermore, existing research regarding the counselling environment appears to focus on the waiting room/counselling room, as opposed to the environmental location of the practice (Pressly & Heesacker, 2001; Chaikin et al., 1976).

I feel self-stigma is an area requiring further research, as current definitions suggest it emerges as a result of internalising other's negative views of counselling/psychotherapy (Bathje & Prior, 2011; Vogel & Wade, 2009). However, this study found that self-stigma also seemed to emerge as a result of the participants viewing their current 'selves' negatively, compared to their perceived 'previously-able-to-cope selves'. This finding could mean that addressing public stigma alone may not reduce self-stigma, as it may also arise from the individual's negative view of self - as well as

from the internalised negative views of others. Because the findings of this study appeared to unanimously reject the idea of counselling in the client's home and previous studies have suggested this may be beneficial to clients (Jordan & Marshall, 2010), I feel it an area requiring further research to clarify this seemingly 'grey' area.

Finally, the participant's apparent wishes to be able to access counselling confidentially and the counsellor/psychotherapist's need to be able to advertise their practice (especially if working privately), could mean that researching the most effective way to bring these two groups together could have benefits for both parties, as ensuring public stigma is minimised may well encourage the help-reluctant to become help-seekers, thereby providing counsellors/psychotherapists with clients. Furthermore, the apparent importance of advertising to the participants, coupled with a lack of current research, suggests it is an area requiring further attention.

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List of Appendices

Appendix A

Research Advert

Volunteers Needed for Counselling Research!!

Hi my name is Andy Hunt. I'm a third year student studying for an M.A. in Clinical Counselling at Chester University and I'm currently carrying out a research study titled:

"The Ex-Client's Experience of Attitudinal and Structural Barriers to Therapy Prior to and During the Therapeutic Relationship"

I'm looking for volunteers who are not currently 'in' therapy but have had counselling in the past. I would like to ask you about your experiences of finding a counsellor and your views about your counsellor's practice, in a one-to-one interview which should take about an hour. This study will provide you with an opportunity to talk about what you liked and didn't like about your counselling experience and also an opportunity to suggest ways in which you think it could have been improved.

If you're interested please contact me at the following:

Telephone/text: (Removed)
Or
E-mail: (Removed)

Thank you for your interest!!

Appendix B
Participant Information Leaflet

Information about This Research

Dear Participant

You are invited to take part in a research study titled: "The Ex-Client's Experience of Attitudinal and Structural Barriers to Therapy Prior to and During the Therapeutic Relationship". This information sheet will tell you a little more about the study.

Who am I?

My name is Andy Hunt. I am a Post-Graduate student studying the final year of a three year M.A. in Clinical Counselling at the University of Chester. As part of this course I am required to carry out a research study in the area of counselling/psychotherapy.

What am I researching?

I am researching the reasons why people who think counselling could help them decide not to approach a counsellor for help. I am also interested in exploring the client's experience of their counselling environment.

Why have you been chosen?

You have been invited to take part in this study because you have first hand experience of both seeking counselling and the counselling environment. You have also been asked because you meet the research criteria of being over 18 and no longer in counselling.

What you will be asked to do

If you agree to take part in this study, you will be interviewed by me for approximately one hour and asked a number of questions about your experiences of finding a counsellor and the place where you had counselling. You will not be asked about anything you discussed with your counsellor. To help me examine your answers, the interview will be recorded for later transcription. You will be invited to read the transcript and be allowed to change or remove any part of it you are unhappy with. You also have the right to withdraw from the research at anytime up

until the dissertation is submitted, in which case your interview transcript will be securely destroyed and the recorded interview will be deleted.

What are the risks of participating?

Because the interviews will not be exploring the issue(s) which led you to seek counselling, the risks of taking part in the study are low. However, if you feel affected by the interview or become distressed during the course of the interview, you are free to stop at any time. The names and telephone numbers of some local counselling services are provided at the end of this information sheet should you require them.

Is the research approved?

Yes, the research is approved by the ethics board of the University of Chester and will be carried out under the supervision of Dr Valda Swinton who is both a lecturer and programme leader for the M. A. in Clinical Counselling at the University of Chester. As a student member of the BACP (British Association of Counselling and Psychotherapy), I will be carrying out my research in accordance with their ethical code of conduct.

Confidentiality

Although complete confidentiality can never be guaranteed, the utmost care will be taken to ensure your identity will not revealed during or after the study. Although your name will appear on the consent form, it will not appear on any of the research literature or in the dissertation. Instead you will be allowed to choose a pseudonym.

Because the research is being carried out as part of an M.A. qualification, the transcript of the interviews may be seen by my research supervisor, my counselling tutors and possibly an external examiner. However, all these people are bound by the BACP's Ethical Framework for Good Practice in Counselling and Psychotherapy. It is also possible in the future that the University of Chester may make the final dissertation available to other university students electronically and that some of the material in the dissertation may be used for publication and/or presentations at conferences or seminars. Again, should this arise, every effort will be taken to ensure your complete confidentiality and your name will not appear in any of the above literature.

Data Protection

In accordance with the data protection act, the research data will be stored for five years and then securely disposed of. The interview recordings will be destroyed after the M. A. has been awarded.

My contact details

If you require any further information you can contact me at the following:

E-mail: (Removed)

Mobile: (Removed)

Or:

V. Swinton (Removed)

University of Chester: *Removed

Thank you for showing an interest in this research.

Andy Hunt

26/6/2011

Some useful contact numbers:

The Samaritans: 01244 377999

MIND (Chester): 01244 343489

C.A.I.S Drug and Alcohol Agency: 0845 0612112

Stepping Stones: (For adult survivors of childhood sexual abuse) Wrexham: 01978 352717

CRUSE Bereavement care: 0151 3573235

Relate (Chester): 01244 342747

The Dove Service (South Cheshire & Staffordshire): 01782 683155/153

Appendix C

Interview Questions (Participant Copy)

Andy Hunt
(Address
Removed)

Dear

Thank you again for showing an interest in this study.

Please find attached to this letter a copy of the questions I will be asking you during the interview. You may find it helpful to take a little time to read through the questions before we meet as this may help you with your answers. You do not need to write anything on this form, but please feel free to make any notes if this will help you.

If you would still like to participate in this study - or have any further questions - could you please contact me at the following:

E-mail: (Removed)
Mobile: (Removed)

Yours sincerely
Andy Hunt

Interview Questions

1) When you first considered seeing a counsellor, what did you believe other people would think about your need to have counselling?

---

2) How did the decision to have counselling affect the way you saw yourself?

---

3) Could you tell me about the location of your counsellor's practice and how you felt as you approached it (with regard to being seen entering by others)?

---

4) How did you feel about the room where you had your counselling sessions?

---

5) Still thinking about your counsellor's room, if you had been given a choice, where would you have preferred to have had your counselling sessions?

---

6) Thinking about your choice of counselling practice, could you tell me why you chose that service over any others you could have used?

---

7) Did your counsellor have a sign or plaque outside their premises that clearly advertised it as a counselling practice?

---

8) Did you give your counsellor permission to contact you and if so was this by ringing or texting your mobile phone, by e-mail, or your home telephone?

---

9) Where did you keep your counsellor's telephone number/contact details?

10) If you had seen your counsellor in public would you have acknowledged him/her?

11) How comfortable do you feel telling other people you've had counselling, or is it something you don't do?

12) What do you feel could have improved your experience of finding a counsellor?

13) What do you feel could have improved your experience of being in counselling?

14) Are there any other comments you would like to make about your experience of counselling?

Appendix D

Participant Consent Form

University of Chester
M. A. in Clinical Counselling Research Consent Form

Consent form

Audio Recording of Interview

I……hereby give consent for the details of a written transcript based on an audio recorded interview between me and Andrew Hunt to be used in preparation and as part of a research dissertation for the M.A. in Clinical Counselling at the University of Chester. I understand that my identity will remain anonymous and that all personally identifiable information will remain confidential and separate from the research data. I further understand that the transcript may be seen by Counselling tutors and the External Examiner for the purpose of assessment and moderation. I also understand that all these people are bound by the British Association for Counselling and Psychotherapy Ethical Framework for Good Practice in Counselling and Psychotherapy.

I understand that I will have access to the transcribed material should I wish to and would be able to delete or amend any part of it. I am aware that I can stop the interview at any point, or ultimately withdraw the interview before the publication of the dissertation. I also understand that excerpts from the transcript, and possibly the entire transcript will be included in the dissertation.

A copy of the dissertation will be held at the University of Chester and will be made available to other students in both electronic and hard copy formats. In accordance with University of Chester policy the data obtained from the interviews will be held securely by me, the researcher, for a period of five years and then destroyed.

Without my further consent, some of the material may be used for publication and/or presentations at conferences and seminars. Every effort will be made to ensure complete anonymity.

Finally, I believe I have been given sufficient information about the nature of this research, including any possible risks, to give my informed consent to participate.

Signed [Participant]……

Date……

Signed [Researcher]……

Date……

Appendix E

Interview Questions
Researcher Copy (with prompts)

Ask client to read and sign consent form.

How many sessions did the participant have in total?

Reiterate that the subject of the interview is not about the issue that led the participant to seek counselling, but their experiences of seeking and being in counselling.

---

1) When you first considered seeing a counsellor, what did you believe other people would think about your need to have counselling?

Positive – So you would quite happily have told other people such as family/friends/your employer/colleagues that you were having counselling?

Negative – What steps did you take to ensure nobody would find out you were seeing a counsellor?

---

2) How did the decision to have counselling affect the way you saw yourself?

Changed – Do you feel this change was for better or worse?

Unchanged - So once you'd decided you wanted to speak to a counsellor, you didn't view yourself any differently than someone who didn't feel they needed counselling?

---

3) Could you tell me about the location of your counsellor's practice and how you felt as you approached it (with regard to being seen entering by others)?

Unconcerned – Is this because it was located out of plain view, in a quiet road, in a multi-use building, down a side street or in a private house (how private – in a cul-de-sac-how about neighbours knowing the counsellor's business?).

Unconcerned – Is this because you didn't expect to be seen entering your counsellors premises by anyone you knew?

Unconcerned - How would you have felt if you saw a member of your family/friends/work colleague/employer as you were about to enter your counsellor's practice?

Concerned – What steps (if any) do you feel could have been taken to put you more at ease?

Concerned – What do you feel is the best location for a counsellor's practice?

---

4) How did you feel about the room where you had your counselling sessions?

Positive – So there was nothing you would change about the room at all, the size, layout, décor, seating etc.

Negative – What would you have changed about the room to improve your experience?

Didn't notice – So you didn't feel the room itself was important or played any part in your sessions?

---

5) Still thinking about your counsellor's room, if you had been given a choice, where would you have preferred to have had your counselling sessions?

Same room – So there was something about your counselling room that positively affected your experience of counselling?

Elsewhere – what is it about having counselling sessions elsewhere that you feel would have been more helpful?

Elsewhere – how would you have felt about having counselling at home?

---

6) Thinking about your choice of counselling practice, could you tell me why you chose that service over any others you could have used?

No reason – so you chose the service at random and didn't know what to expect, you didn't check its location or how to get to it first?

No Reason - Would you have chosen the same practice if it had been in your village/town/street?

Reason – recommended by others, Price, Location, anonymity

---

7) Did your counsellor have a sign or plaque outside their premises that clearly advertised it as a counselling practice?

A) If yes - how did you feel about this when you entered?

Unaffected – So you felt quite happy knowing that anyone who saw you walk into the building would've assumed you were having counselling – including family members/friends/work colleagues or your employer?

Affected - So what steps do you feel your counsellor could have taken to reduce your concerns, yet still make the premises identifiable to clients going there for the first time?

Affected – How do you feel counsellors should advertise their practice if they don't have a sign outside their premises?

B) If no - would it have affected your decision to use that service if it had?

Unaffected – So you would still have used the service knowing that anyone who saw you enter the building would've assumed you were having counselling –including family members/friends or your employer/work colleagues?

Affected – So what steps do you feel your counsellor could have taken to reduce your concerns, yet still make the premises identifiable to clients going there for the first time?

Affected – How do you feel counsellors should advertise their practice if they don't have a sign outside their premises?

---

8) Did you give your counsellor permission to contact you and if so how?

If home phone – Could anyone else have answered this phone?

If Mobile – Do you allow anyone else to answer this phone/read text messages?

If e-mail – Does anyone else have access to this account? / is it password protected?

---

9) Where did you keep your counsellor's telephone number/contact details?

Is this private, or could anyone have seen the details?

Did you store the information under the name "counsellor", your counsellor's first/second name, or something else?

---

10) If you had seen your counsellor in public would you have acknowledged him/her?

Yes – if you had been with your family (inc children)/friends/employer/ Colleagues?

Yes – If your counsellor had been with someone else you didn't know?

No - Can I ask why you wouldn't have acknowledged them?

11) How comfortable do you feel telling other people you've had counselling, or is something you don't do?

Comfortable – So you'd be happy to reveal to a family member/friend/work colleague/employer that you'd had counselling? If not, why not??

Uncomfortable- So if the subject came up in conversation you wouldn't reveal you'd spoken to a counsellor?

If someone told you that they had seen a counsellor would you then reveal that you had?

---

12) What do you feel could have improved your experience of finding a counsellor?

---

13) What do you feel could have improved your experience of being in counselling?

---

14) Are there any other comments you would like to make about your experience of counselling?

Thank you, there are no more questions.

Remind participant they are free to withdraw from the study at any time up until the dissertation is submitted.

Ask them if they have a preference for a pseudonym to use in the transcript.

Would they like to read through the interview once it's been transcribed?

Do they know of anybody else who has had counselling who may be interested in participating?

Appendix F

Units of Meaning

Duplicate responses have been removed and question numbers are included to allow the units of meaning to be viewed in context.

Q1

Some feel counselling is helpful.
Some view counselling as negative.
I only told my best friend I was having counselling.
I felt guilty because I should be coping better.
Other people made me feel guilty.
Counselling was an alternative to medication.
Counselling means I'm doing something about my issues.
I wasn't bothered if anyone knew.
People view you as weak.
I felt going to counselling was positive.
I wouldn't have told anyone I was having counselling.
I would only tell certain people I have had counselling.
I would hesitate to tell other people.
I was so desperate for help I didn't care who knew I went for counselling.
Everybody knew I was having counselling.

Q2

I saw myself as a failure.
I coped before; I should be able to cope now.
It made me realise I'd reached a low point.
It frightened me; it was the beginning of losing control.
I saw myself as strong for admitting I needed counselling.
Asking for other's help is weak.
A friend encouraged me to seek help.
I forgave myself and saw my decision as a positive thing.
I didn't seek my family's opinion.

Q3

There's anonymity in going to the doctor's surgery.
It drew attention to me, I wondered what people thought.
I was initially concerned at other's thoughts, but then I didn't care.
I was concerned that people would know I was going for counselling.
Even though I said I didn't care, I did.
I felt safe going to the doctor's surgery.
I felt happier going to a place no one knew was a counsellor's.

Q4

I wanted some control over the (counselling) environment.
The décor of the room affected my experience
I wanted the room to convey safety and security.
I would rather leave than be in an unsuitable room.
The room was unpleasant and oppressive but security was more important.
I wanted a spacious room with natural light.
They (the counsellors) should have given more thought to client needs.
The room was bizarre, it lacked discretion and confidentiality.
It would've been hard to address difficult issues in the room.
The room temperature was unpleasant.
I would like to have been asked if the room was ok for me.
I didn't like my counsellor's room.
Privacy and confidentiality is important.

Q5

I would have liked a spacious room with plain décor.
I would not like counselling at my counsellor's home unless it was in a proper 'studio'
I would not like counselling in my home.
I wanted a light private space with a view.
A professional and clinical environment gives validity to counselling.
Counsellors need to raise their profile to appear more professional.
I can focus better on my issues when I'm not at home.
The working relationship is the most important thing.
I want the counsellor to provide a room.

There is no privacy having counselling at home.
I would have liked a homely comfortable room that didn't look like a surgery.

Q6

My counsellor's practice was the only one I'd heard of.
I was unsure how to choose a counsellor, I didn't know how to determine who was qualified.
Choosing a known organisation suggests a certain quality.
Information about counselling needs to be more readily available.
It takes a lot to admit you need counselling and you don't want to wait once the decision is made.
My counsellor was assigned, not chosen by me.
I don't know how to choose a counsellor, how would I know?
It's easier for the doctor to make the choice if you don't know what you're looking for.
I only went because I was referred by the doctor.
The doctor's surgery was anonymous.
My partner chose my counsellor; I would have taken the doctor's recommendation.

Q7

There was a sign outside my counsellor's practice but it was ambiguous.
A sign wouldn't have bothered me unless it was big.
Counsellors should advertise in small-ads or doctor's surgeries.
Advertising should be kept discreet.
Advertising in pharmacies or doctor's surgeries gives added value because it shows that counselling is endorsed by the medical profession.
A doctor's surgery would be a good location to see a counsellor.
Counsellors could advertise on the internet, or in appropriate magazines or on posters.
The counsellor should have something that identifies their premises without revealing the purpose of the premises.
I have no problem if the counsellor has a sign.
I wouldn't have been concerned if there had been a sign because once you've made the decision to go and committed, you approach things differently.

A sign would have affected my decision to attend.
A plaque with a name would suffice.

Q8

I gave my counsellor my home and mobile phone numbers although I didn't expect him to reveal his identity to my family if they answered.
I gave my counsellor my mobile phone number only.
I gave them permission to ring my home and didn't care who answered.
I didn't give them my number; I arranged appointments at the surgery.

Q9

I kept my counsellors contact details private and ambiguous; no one could have known the details were my counsellor's.

Q10

I would not have acknowledged my counsellor in public because they said they would not acknowledge me.
I would have acknowledged my counsellor but would have tried to avoid them.
I would have acknowledged my counsellor because I could justify out relationship as work colleagues.
I would have acknowledged my counsellor regardless of who they or I was with.
I would have acknowledged my counsellor and told people he was a counsellor if they asked, after all it didn't mean he was my counsellor.

Q11

I'm comfortable telling people I've had counselling.

I would reveal I'd had counselling if someone else revealed they had.

I have told other people.

I wouldn't not tell people, but it's not the first thing I'd bring up.

I don't tend to bring it up.

I would tell other people but I wouldn't tell my employer.

Q12

I would have liked the time taken to see my counsellor reduced.

More prominent advertising would have improved my experience of finding a counsellor.

More information, more readily available.

I would have preferred to speak to a person rather than an answerphone.

I would have like more information about counselling.

Q13

Knowing I was secure and being allowed to bring objects for comfort from home.

More choice or 'ownership' of the room.

To feel homely but not at home, to have been offered a drink.

Finding the right counsellor the first time.

A better counselling environment.

More flexibility over appointments.

Q14

No new units of meaning were derived from this question that had not already been expressed.

Appendix G

Example of Collated Unitized data.

Q1) When you first considered seeing a counsellor, what did you believe other people would think about your need to have counselling?

Q1 P1 1 Anna	Well there were two things really, first of all I thought other people may see you as weak, in the fact you're needing help and, in the form of counselling. But on the other hand, I think recently counselling has had a higher, priority sort of thing and so it can be seen as a forward thinking, method rather than trying to analyse the situation yourself.
Q1 P1 2 Researcher	So something about it - the initial thought was that it, people may view you as being weak, however it seems to be coming more acceptable now to have counselling?
Q1 P1 2 Anna	Definitely, yeah the profile of counselling is more acceptable even though, y'know sometimes it's portrayed on American TV and things like that, it's not always portrayed in the best way but it is becoming more of an issue for people to think of, yeah.
Q1 P1 3 Researcher	So, bearing in mind you found it perhaps positive, or not being seen as weak, would you have quite happily told other people, that you were having counselling? This could be people like your friends or an employer, or work colleagues.
Q1 P1 3 Anna	I don't think I would have been happy to, initiate, a conversation that said I was going to have counselling, or was in counselling. However, with certain friends and depending on my relationship with them, I wanted to discuss with them the fact I was having counselling,

---

Q1 P11 Cat	I thought it would probably divide into two camps, some people who knew a little bit about it who would think y'know "Well maybe she needs a little bit of help or support" and some people who'd think "Well she's obviously lost it".

Q1 P1 2 Researcher — Right, so a mix of people who thought counselling was a good thing and counselling's a bad thing. What did you think people would think about you in terms of your need to have counselling as a positive thing or a negative thing?

Q1 P1 2 Cat — I think in general it's a negative thing.

Q1 P2 3 Cat — Cos, y'know considered... Amongst the people I was friends with at the time, or I considered to be my friends at the time, put it that way.

Q1 P2 4 Researcher — So you thought they would view you in a negative way?

Q1 P2 4 Cat — Yes

Q1 P2 5 Researcher — So, what steps did you take to ensure nobody would find out?

Q1 P2 5 Cat — Well I didn't really disseminate the information, I just sort of basically went along and did it and only discussed it with my best friend at the time.

Q1 P1 1 Carrie — I think really, staff here, I thought they'd see it as a positive, positive step, to do something, to help myself really.

Q1 P1 2 Researcher — So, you didn't think they'd see you in a negative light for having counselling?

Q1 P1 2 Carrie — I think some people might do, and I know my husband wasn't... happy... because, I don't, I don't know, I don't think he likes the whole thing of counselling himself.

Q1 P1 3 Researcher — (unclear) So, how did that make you feel?

Q1 P1 3 Carrie — A bit guilty really, as if I should be coping, a bit better really but...

Q1 P2 5 Researcher — A sense, a sense of guilt at having counselling?

Q1 P2 5 Carrie I think so, yeah, but , cos I was on a quite high level of medication, so I didn't want to stay on that for too long so, I saw it as an alternative really.

Q1 P1 1 Sinead I didn't care, er what other people thought because I was so, I've got it written down, I was so desperate to get out of the black hole as I saw it that really it was a lifeline that was offered me, so I didn't care what other people thought. I told other people, I just said "Yes, I've gone for it".

Q1 P1 2 Researcher So you (unclear) quite happily to tell other people like family ,friends, employer –

Q1 P1 2 Sinead They all knew.

Q1 P1 3 Sparrow About me? About, that something I'm actually doing something about, my issues, if anybody's interested, I suppose that's the way I felt at the time.

Q1 P2 4 Researcher So you didn't think people would view you in a negative light for wanting to go and see a counsellor?

Q1 P2 4 Sparrow No, no, probably a positive light, "Yeah, she's doing something about it".

Q1 P2 5 Researcher And you would happily have told people you were going to, thinking about going to see a counsellor?

Q1 P2 5 Sparrow I wasn't unhappy about it, I didn't know how many people I'd told and I really can't remember cos I was so messed up at the time, it's going back quite a time now.

Q1 P2 6 Sparrow No, it didn't really bother me that if anybody knew I was going to see a counsellor.

Appendix H

Recurring Themes and Concepts Derived from Discovery Sheets

Discovery Sheet 1

Related to question1

(Participants' view of others perception's of their need to have counselling)

I will be seen as negative by others.

I didn't care what others thought.

Seeking counselling is a positive step.

I didn't tell anyone I was thinking of seeking counselling.

I didn't care I was desperate.

My decision to seek counselling was influenced by friends.

Discovery Sheet 2

Related to Q2

(Participants' view of self after deciding they needed counselling)

Saw self negatively.

Saw self positively.

Viewed decision as positive.

Didn't view self negatively.

Didn't care what others thought.

Could previously cope.

Had others approval.

Discovery sheet 3

Related to Q3

(Location of Participant's practitioner's premises and perceptions of being seen entering)

The practice location was anonymous.

I didn't expect people to know I was entering a counsellor's premises.

Those who knew would have had to have had or considered having counselling.

I was concerned that someone might see me entering.

Discovery Sheet 4

Related to Q3

(Participant's preference for practice location)

A location offering anonymity.

Others will not know I'm having counselling.

Discovery Sheets 5/6/7/8

Related to Q4/5

(The room where participant's had counselling)

The room was comfortable and felt safe.

I didn't like the lighting.

The room was too hot.

I would have liked natural light.

I would like a comfortable room.

I would like a private/soundproof room.

(Related to having counselling at home)

I wanted to keep counselling separate from home life.

There would be too many distractions at home.

Discovery Sheet 9

Related to Q6

(Why the participants chose the service they used)

I didn't choose

I was referred by GP

The service was recommended by a friend/acquaintance

I wouldn't have gone on my own initiative.

Discovery Sheet 10

Related to Q7

(Did your counsellor have a sign advertising their premises?)

There was no obvious sign present.

I don't think it wouldn't have made a difference if there had been.

Signs should hide the nature of the practice.

Discovery Sheet 11

Related to Q7

Advertising should be discreet

Information should be accessible through a wide range of media.

Discovery Sheet 12

Related to Q8

(Did you give you counsellor permission to contact you?)

I gave my counsellor permission to contact me but ensured contact would be private.

Discovery Sheet 13

Related to Q9

(Where did you keep your counsellor contact details)

I kept the details with me/in a safe place.

The contact details did not reveal they were for counselling.

Discovery Sheet 14

Related to Q10

(Would you have acknowledged your counsellor in public?)

Yes I didn't care who knew.

Yes, regardless of whom I or the counsellor was with.

I felt I could acknowledge him/her without revealing our relationship.

Discovery sheet 15

Related to Q11

(Did the participants reveal they'd had counselling to others?)

I do tell people.

I would tell people.

I'm not always happy to tell people.

There are only certain people I would tell.

Discovery Sheet 16

Related to Q12

(What could have improved your experience of finding a counsellor?)

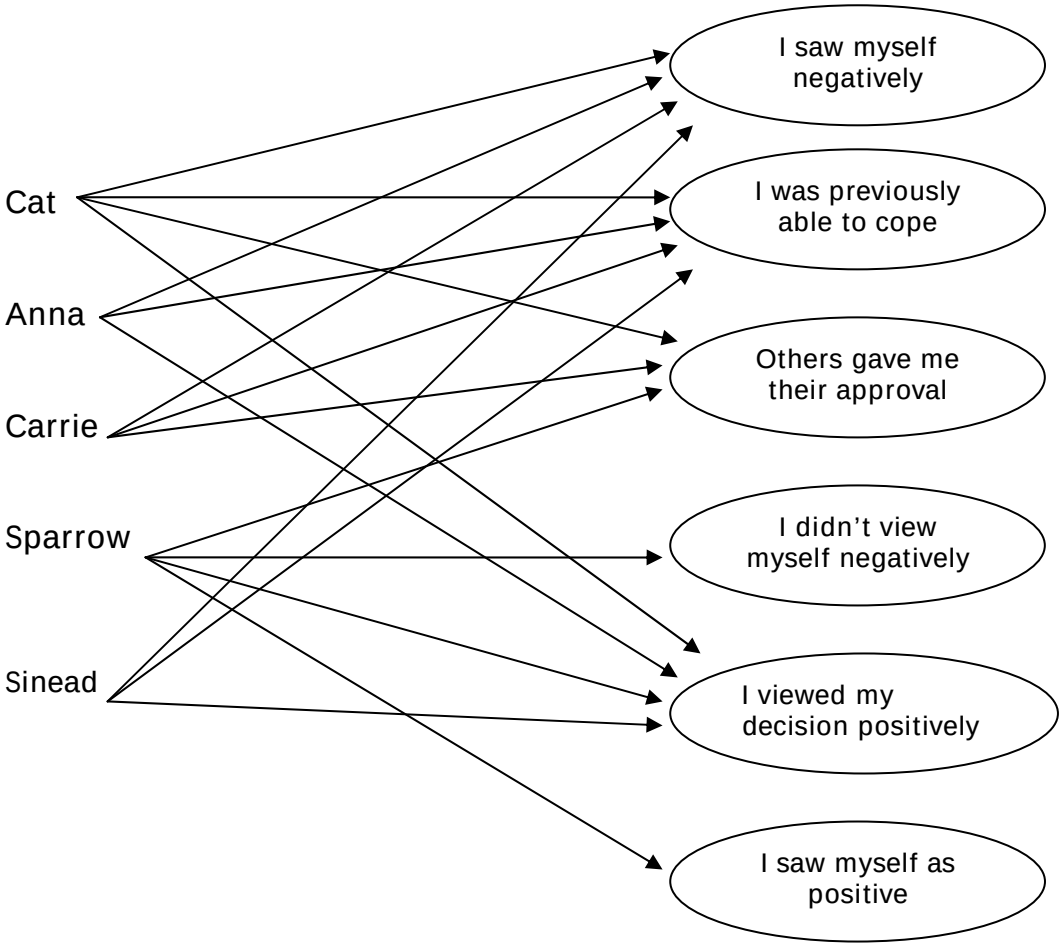
I didn't know where to get information, I would have liked more information.

Make the service more accessible

Seeing a counsellor more quickly.

Appendix I

Example of spider diagram used to determine overlapping themes from discovery sheets.



Appendix J

Provisional Categories

The negative view of others.

No concern about other's thoughts on having counselling.

Concern about being seen entering premises.

No Concern about being seen entering premises.

Signs should be ambiguous.

Advertising should be discreet.

Keeping counsellors details anonymous.

Acknowledging the counsellor in public.

Taking care in revealing having counselling.

Keeping contact with counsellor private.

Keeping counsellors contact details private.

Negative view of self for seeking help.

Positive view of self for seeking help.

Others approval of decision to seek help.

View of decision to seek help positive.

Assumption of other's approval.

View of decision to seek help as positive.

The effect of the counselling room on experience.

Improving the counselling environment.

Counselling in the client's home.

Time taken to see a counsellor.

Appendix K

Refined Categories/Sub-Themes

Category/Sub-theme:	My perception of other people's views of my need to have counselling.
Rule of inclusion:	Other people will have differing views on client's need to have counselling/psychotherapy some will be positive, whilst others will be negative.
Category/Sub-theme:	The location of the counsellor's practice.
Rule of inclusion:	The location of the counsellor/psychotherapist's practice is important because other people may see client's entering and view them negatively.
Category/Sub-theme:	Advertising the counsellor's practice.
Rule of inclusion:	Advertising is important because signs outside counsellor's practices risks identifying clients-something clients may not wish others to know. Advertising should be discreet so that people can find a counsellor without other people knowing.
Category/Sub-theme:	Maintaining the confidentiality of the counselling relationship.
Rule of inclusion:	Keeping the counsellor/psychotherapists details anonymous means that no-one can accidentally find out that clients are seeing a counsellor and clients can acknowledge their practitioner in public because other people may not know they are having counselling/psychotherapy
Category/Sub-theme:	The effect of the counselling room on my experience.
Rule of inclusion:	The environment of the counselling/psychotherapy room can have a positive or negative impact on the client's experience of counselling/psychotherapy.

Category/Sub-theme:	How my counselling environment could have been improved.
Rule of inclusion:	Changes that could have been made that would have improved client's experience of counselling/psychotherapy or would improve it if they chose to have counselling/psychotherapy again.
Category/Sub-theme:	Counselling in the participant's own home.
Rule of inclusion:	People's homes may not always be a suitable location to have counselling/psychotherapy due to interruptions and client's preference to keep counselling/psychotherapy separate from their home-life.
Category/Sub-theme:	The time taken to secure an appointment with a counsellor.
Rule of inclusion:	People do not want to have to wait too long to see a counsellor. By the time they have made their mind up to see a counsellor/psychotherapist they want to see one as soon as possible.
Category/Sub-theme:	Keeping telephone contact with my counsellor private from my family.
Rule of inclusion:	Clients may keep telephone contact with their counsellor/psychotherapist private from their family, even if their family are aware they are having counselling/psychotherapy.
Category/Sub-theme:	Keeping my counsellor's contact details private from my family and others.
Rule of inclusion:	Despite their family knowing they are having counselling/psychotherapy, clients may still keep their practitioner's contact details private.
Category/Sub-theme:	The view of self having decided to have counselling.
Rule of inclusion:	Clients perceptions that they have coped in the past may lead them to believe that their need to have counselling/psychotherapy is weak, although mitigating factors may prevent this or make them view their actions as positive.

Appendix L

Final Category Revisions

'Umbrella' Category/Theme: Experiences of Attitudinal Barriers.

Rules of inclusion: Society's generally negative attitude towards people who seek and secure counselling/psychotherapy may negatively affect the way they view themselves and act as a barrier to seeking help, unless they can keep their involvement with counselling/psychotherapy private and confidential. Furthermore, the individual's attitude towards the counselling environment can act as a further barrier to help-seeking.

Main Theme: Public Stigma.

Rule of Inclusion: The client/potential client's perception that the public will view their need for help negatively makes them concerned about being associated with counselling/psychotherapy, leading them to take steps to avoid public stigmatisation which they feel counsellors/psychotherapists could help them achieve through ambiguous advertising.

Sub Theme: My perception of other people's views of my need to have counselling.

Sub Theme: The location of the counsellor's practice.

Sub Theme: Advertising the counsellor/psychotherapist's practice.

Sub Theme: Maintaining the confidentiality of the counselling relationship.

'Umbrella' Category/Theme: Experiences of Attitudinal Barriers.

Main theme: Self-Stigma.

Rule of Inclusion: People may view themselves negatively as a result of admitting they need counselling/psychotherapy, unless mitigating factors prevent the development or mediate the effects of this 'self-stigma'.

Sub-theme: The view of self having decided to have counselling.

‘Umbrella’ Category/Theme: Experiences of Attitudinal Barriers.

Main Theme: The Counselling/Psychotherapeutic Environment.

Rule of Inclusion: The counselling/psychotherapeutic environment can positively or negatively affect the client’s experience and there are improvements which could be made to ensure this experience is positive, although this may not include offering counselling/psychotherapy in the client’s own home.

Sub Theme: The effect of the counselling room on my experience.

Sub Theme: How my counselling environment could have been improved.

Sub Theme: Counselling/psychotherapy in the participant’s home.

‘Umbrella’ Category/Theme: Experiences of Attitudinal Barriers.

Main Theme: Privacy/Confidentiality from family.

Rule of Inclusion: Although other family members may be aware the client is having counselling/psychotherapy, clients prefer to keep the therapeutic relationship private.

Sub Theme: Keeping telephone contact with my counsellor private from my family.

Sub Theme: Keeping my counsellor’s contact details private from my family.

‘Umbrella’ Category/Theme: Experiences of Structural Barriers.

Rules of Inclusion: People may find that accessing counselling/psychotherapy is more difficult than expected because the way such services are structured can lead to waiting times longer than help-seekers would like.

Theme: The time taken to secure an appointment with a counsellor.
