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Dropout in Individual Psychotherapy From Adult Male Clients' Perspectives

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DROPOUT IN INDIVIDUAL PSYCHOTHERAPY FROM ADULT MALE CLIENTS' PERSPECTIVES

By

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of the Requirements for the Degree
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MASTER'S THESIS

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Karen Springer

August 5, 2020

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A Thesis
Presented to
The Faculty of
Western Washington University

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Of the Requirements for the Degree
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Abstract

The present study investigated what incidents adult males believed to have led them to drop out of individual, outpatient psychotherapy within the past four years, utilizing the Enhanced Critical Incident Technique with audio-recorded, Skype interviews and Qualtrics. Participants were 18 men from Bellingham, Seattle, Vancouver (Canada), Houston, Austin, Dallas, Indiana, and Tennessee. Critical Incidents and Wish List items were extracted via structured, open-ended questions. The incidents were organized into categories by two research team members and confirmed from feedback provided during follow-up interviews. The finalized categories of why the men dropped out were labeled the following in descending order of strength: Not the Right Interpersonal Fit, Not the Right Approach, Need to Build Trust, Cost, No Longer Needed, and Time Problems. The finalized categories of what would have helped the men stay were the following in descending order of strength: Change the Approach, Building Rapport, Affordability, Client Engages More, More Availability, and Decided if Needed. Not anticipated, the participants yielded a moderately low level of traditional masculinity ideology (M = 2.90, SD = 0.87) according to the Male Role Norms Inventory–Short Form. The categories can aid psychotherapy researchers in designing measures to attend to men's needs in order to help reduce the attrition rate, as well as promote further study on whether certain psychotherapy practices are more suited for men, and aid practicing clinicians by providing a clearer understanding and an awareness of potential risk factors that may signal a client with a greater propensity to drop out.

Keywords: men, counseling, psychotherapy, dropout, ECIT, MRNI-SF

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Dropout in Individual Psychotherapy From Adult Male Clients' Perspectives

Most psychotherapy process and outcome research studies have neglected to differentiate the results between males and females, and most studies include a primarily female sample (Bedi, Young, Davari, Springer, & Kane, 2016). As such, relatively little is known in psychotherapy about the possible differences between males and females, although researchers have begun to investigate gender in therapeutic alliance research more prominently in recent years (e.g., Bedi & Richards, 2011; Richards & Bedi, 2015). Similarly, client dropout research exists, but unlike therapeutic alliance research, studies have yet to begin regularly investigating possible differences between male and female clients. Not every case of early termination in psychotherapy (or *counseling*) is necessarily problematic, as there are many reasons for ending treatment prematurely. However, premature, unilateral termination of psychotherapy (i.e., dropout) often results in negative consequences for clients, such as poorer mental health outcomes and discouragement from seeking future treatment elsewhere (Hamilton, Moore, Crane, & Payne, 2011). Variation in the term used for dropout in research is evident, as terms such as *therapeutic termination*, *attrition*, *unilateral termination*, or *dropout* have been often used, and some researchers have further elaborated its meaning to indicate whether the termination was consensual or not or to indicate whether termination occurred during the beginning or later sessions (Hamilton et al., 2011; Lampropoulos, Schneider, & Spengler, 2009; Self, Oates, Pinnock-Hamilton, & Leach, 2005). However, many studies have failed to give a specific definition of dropout and it is important for researchers to first address this in order to better understand the phenomenon.

Most client dropout in psychotherapy occurs within the early stages of psychotherapy and research has suggested that it is most likely to occur after the second session, followed

by the first session (Bados, Balaguer, & Saldaña, 2007; Wells et al., 2013). There are many variables that have been identified that predict client dropout. Barrett, Chua, Crits-Christoph, Gibbons, and Thompson (2008) reviewed research to determine the variables that have been identified to have a relationship to attrition; these included *client characteristics*, such as age, expectations, beliefs, and ethnicity; *enabling factors*, such as income, treatment cost, level of family involvement, and social support; *need factors*, such as diagnosis, comorbidity, prognosis, and suggested length of treatment; and *environmental factors*, such as treatment accessibility, kind of provider, and treatment setting. Barrett et al. (2008) found that those who were younger (less than 25-30 years of age) tended to have higher rates of dropout and that low socioeconomic status also tended to be associated with more dropout in psychotherapy. However, they found that there were inconsistent findings between age and dropout, though newer studies supported such an association between younger clients and higher dropout rates. In regard to gender and dropout, the most recent study in Barrett et al. (2008) was from 1976 and it did not support such as association between gender and higher dropout rates. Reflecting the results of Barrett et al. (2008), Sharf, Primavera, and Diener (2010) found in their review (in which nine of the 11 studies reported gender distribution and had 60.8% of female participants) that low socioeconomic status and the treatment setting (e.g., inpatient, outpatient, research clinics, and counseling centers) tended to predict dropout and Wells et al. (2013) found that the kind of provider (e.g., psychiatrist, other mental health, general medicine, human services, and complementary and alternative medicine) also tended to predict dropout.

Bados et al. (2007) conducted research with a sample of 203 primarily female participants (72.4%) from a behavioral unit on a university campus. During the study, almost

half of the participants dropped out (43.8%) and most did so within the early stages of treatment. The researchers examined those who dropped out, which was defined as those who stopped treatment prior to 14 sessions (unless a consensus was made with the provider), and found that individual motivation, type of treatment, the level of satisfaction with the psychotherapist, external problems, and an individual's perspective of improvement influenced their decision to drop out. The participants who dropped out also tended to have problems that those who remained in treatment did not tend to have; these included eating disorders, impulsivity problems, and affective disorders. Likewise, Wells et al. (2013) investigated 8,482 individuals across 24 countries who were in a form of mental health treatment, and found that those who were dropouts (31.7%), defined as those who stopped treatment before the provider wanted, were more likely to drop out after the first or second session and that most dropout occurred after the second visit (21.6%). Gender as a predictor variable of dropout was analyzed, but was nonsignificant. Wells and colleagues (2013) also found that dropout was less likely to occur if the client previously had mental health treatment or if the client was being seen by three or four providers (compared to one or two).

Hamilton et al. (2011) investigated whether the variables of profession of provider, psychotherapy modality, and *DSM-IV* diagnosis play an influence in client dropout in psychotherapy using a sample of 293,057 females (59.9%) and 196,592 males (40.1%). The researchers reported that marriage and family therapy (MFT) *providers* had the least amount of dropouts, but that the individual psychotherapy *method* had fewer dropouts than the MFT method, and that those with anxiety and mood disorders tended to have the lowest dropout rates, while those with Schizophrenia, Psychotic, and Substance Use Disorders tended to have the highest dropout rates. Similarly, Fenger, Mortensen, Poulsen, and Lau (2011)

conducted a study of 2,473 non-psychotic clients (83.2% female, 16.8% male) who were receiving psychotherapy and found that "drop-outs" (defined as those who started treatment, but dropped out prematurely) differed from "completers" in that those who were unemployed, under the age of 45 years, had only nine or up to 11 years of education, had no vocational/university education, or had substance abuse were more likely to drop out.

To hone in on the client's level of satisfaction with the psychotherapist as an influential factor of dropout, the *therapeutic alliance*, the working relationship between the client and the psychotherapist, has been found to be a major contributing factor to influence client dropout in psychotherapy (Bados et al., 2007; Bedi, Davis, & Arvay, 2005; Horvath & Bedi (2002); Horvath, Del Re, Fluckiger, & Symonds, 2011; Sharf et al., 2010). Bedi, Davis, and Arvay formally defined the therapeutic alliance, or *counselling alliance*, as "the quality and strength of the reciprocal relationship between a client and a counsellor and [it] includes both the affective elements and the collaborative working elements of this reciprocal relationship" (2005, p. 71). Sharf et al. (2010) reviewed 11 studies and found a "moderately strong," negative relationship between the therapeutic alliance and adult, individual psychotherapy dropout, indicating that those with a weaker therapeutic alliance are more likely to drop out of psychotherapy than those with a stronger therapeutic alliance. Sharf et al. (2010) found the therapeutic alliance to be a greater predictor variable of dropout than the following three client demographic variables: minority racial status, low education, and low socioeconomic status. In addition, though these are exploratory analyses, Sharf and colleagues (2010) found that client educational history, treatment length, and treatment setting moderated this alliance-dropout relationship, in that there was a weaker association when participants had a high school education or more, a stronger association when clients

were in 16 to 40 sessions compared to nine to 16 sessions, and a significantly stronger association when clients were in an inpatient setting compared to a counseling center or a research clinic, though there was a stronger association when clients were in an outpatient clinic than in a counseling center. Goldfried (2012) investigated three "principles of change"—client's treatment expectations, client's motivation to change, and the nature of the therapeutic alliance—and found that all three had an influence on whether clients would drop out of psychotherapy. He pointed out that not only the bond aspect of the therapeutic alliance plays an important factor in an individual's decision to remain in psychological services, but the aspects of agreeing upon the goals of treatment and the tasks chosen to attain those goals also relate to dropout (Goldfried, 2012). He also noted that a good *early* therapeutic alliance in particular tends to be associated with the client staying in treatment and having a positive outcome. Roos and Werbart (2013) reviewed 44 studies that were published from January 2000 to June 2011 in order to examine psychotherapist factors that influence dropout and found that the quality of the therapeutic alliance and low client satisfaction had the largest influence on dropout, as well as whether the psychotherapy process included "pre-therapy preparation" (Roos & Werbart, 2013). The existing psychotherapy research on client dropout is limited in what the client specifically views, without a primed response, as the influential reason for dropping out of treatment. Given the dearth of information on qualitative, client dropout research from the client's perspective that can address the lack of unstructured, free form client responses and the lack of research on *male* client dropout, this study aims to investigate why adult male clients, according to the individual in particular, drop out of individual psychotherapy.

The Enhanced Critical Incident Technique

Given the lack of existing research on male client dropout, in order to research what adult, male clients believe to influence dropout in individual psychotherapy, it may be best to use an exploratory, qualitative research method that examines the subjective factors that are believed to have an influence. The *Critical Incident Technique* (CIT) may be one of the most appropriate measures to use, since it is not only a flexible, exploratory, qualitative research method that can be used to study psychotherapy, but it has also repeatedly shown reliability and validity for this purpose (Andersson & Nilsson, 1964; Flanagan, 1954; Woolsey, 1986). Flanagan (1954) noted that the CIT can be administered in person or via questionnaires, among other procedures, and believed that observation was the best approach. More specifically, according to Flanagan (1954), the CIT should be used to collect human observation of specific behaviors that are perceived as useful to carry out a specified task; these specified, useful behaviors are termed *critical incidents* (CIs). CIs can be either positive or negative, significant contributors to a specified action (Flanagan, 1954). However, Butterfield, Borgen, Maglio, and Amundson (2009) suggested that observation was not always possible and that conducting the CIT through in-person interviews is usually more effective, and was most effective for counseling research due to its inherent advantages, such as building rapport with the participant and being able to probe for clarity or more information on deeply personal material. In fact, researchers have frequently utilized the interview-based CIT to examine the client's perspective related to psychotherapy (e.g., Bedi, Davis, & Williams, 2005; Bedi & Richards, 2011).

The five steps of conducting the CIT are (a) distinguishing the aims of the study, (b) planning and setting specifications, (c) collecting the data, (d) analyzing the data, and (e) correctly interpreting the data and reporting the findings; as noted earlier, observational data

may be collected through interviews, questionnaires, or record forms (Flanagan, 1954). Flanagan (1954) suggested that collecting the data at the same time the behaviors are observed is best, but he also recognized that this is not always possible and that a lot of information obtained in research is based on previously experienced situations. He therefore advised that, since these observations are based on memory, collection should usually be made fairly recently, but dually noted that "in some situations adequate coverage cannot be obtained if only very recent incidents are included" (p. 340). In addition, Flanagan (1954) postulated that reported observations may be deemed accurate based on the level of detail and the amount provided.

In order to increase the methodological reliability of the results of a study that utilizes the CIT method, Butterfield et al. (2009) notably enhanced the traditional CIT research approach and coined the term of the updated version the *Enhanced Critical Incident Technique* (ECIT). The ECIT is primarily different from the CIT in that it added background questions at the start of the interviewing process, *wish list* (WL) items, and nine standardized credibility checks. The added background questions serve to better contextualize and thus help understand the CIT data. WL items are those that participants believe would have been helpful if they had occurred in the experience being studied. The following are the nine credibility checks: *audio-recorded interviews*, *interview fidelity*, *independent extraction of CIs*, *exhaustiveness*, *participation rates*, *placing incidents into categories by an independent judge*, *cross-checking by participants*, *expert opinions*, and *theoretical agreement* (Butterfield et al., 2009).

As with any research method, the (E)CIT does have its limitations. The (E)CIT is a qualitative method; therefore, no causality can be made due to the lack of a randomly

assigned experimental design—the (E)CIT is merely suggestive. As previously mentioned, the collected verbal and nonverbal CIs that are reported to have actually occurred are subjective and based on fallible retrospective recall of the participant's history, though Flanagan (1954) believed more than just recent information should be obtained in order to have satisfactory coverage. Lastly, although the data obtained can be completed through interviewing that allows the participant to be free to state anything, any probing for additional information may pose the threat of the halo effect (i.e., an impression created by a comment may influence the researcher's opinion, or bias, to state a prompt in a similar area), though the credibility checks of the ECIT help to control for this possible confounding variable. In addition, Andersson and Nilsson (1964) checked and found that the CIT can provide reliable and valid results and Butterfield et al. (2009) stated that the ECIT greatly increases the rigor of Flanagan's (1954) original CIT.

Unfortunately, the CIT and ECIT have not been previously used in psychotherapy termination research; however, they have both been used in a similar and an overlapping area—the therapeutic alliance—a variable that predicts dropout well (Bedi, 2006; Bedi, Davis, & Arvay, 2005; Bedi, Davis, & Williams, 2005; Bedi & Richards, 2011; Richards & Bedi, 2015). Bedi, Davis, and Williams (2005) researched what clients conceptualized as forming and strengthening the therapeutic alliance. Bedi, Davis, and Williams (2005) interviewed participants by having them recall their critical incidents, and the interviews were taped and then transcribed. Bedi, Davis, and Williams (2005) found that alliance acts such as making eye contact, smiling, having warm and personalized greetings and farewells, paraphrasing, and identifying client feelings, among others, were believed to have contributed to the strengthening of the therapeutic alliance. The psychotherapists'

characteristics that tended to influence the alliance included attire, age, gender, and others. Lastly, clients believed that the psychotherapy technique used also had an influence on the strengthening of the therapeutic alliance. It could be assumed that the opposite of what was helpful could prove hindering for the development of the therapeutic alliance, and thus contribute to client dropout, but this is an empirical question that was not tested in the current study.

Bedi and Richards (2011) used the 74 CIs identified by participants from the therapeutic alliance research study conducted by Bedi (2006), which sought clients' perception of what forms or strengthens the therapeutic alliance (using multivariate concept mapping techniques). Their study attempted to replicate the Bedi (2006) study, but used an all-male sample, whereas Bedi (2006) had a primarily female sample (77.5%). Among the nine categories that emerged from this study, "Bringing Out the Issues" followed by "Client Responsibility" were the highest-rated categories among the male participants; this finding was different from the study by Bedi (2006), where the primarily female sample had rated "Validation" and "Education" as the highest among the 11 categories that emerged in that study. Therefore, these potential gender differences discovered by Bedi and Richards (2011) support the notion that psychotherapy research should assess rather than assume that psychotherapy process and outcome variables (including dropout) operate equivalently across men and women in an aim to better help these specified populations.

Bedi (2006), Bedi, Davis, and Arvay (2005), Bedi, Davis, and Williams (2005), and Bedi and Richards (2011) investigated what factors clients perceive to form and strengthen the therapeutic alliance, but it was not until Richards and Bedi (2015) conducted an ECIT research study that factors perceived and subjectively experienced by male clients to *hinder*

or *impair* the therapeutic alliance were examined. The 76 adult, male participants in this study were clients who were currently receiving outpatient, individual psychotherapy (or *counseling*) at the time of the study or within the 30 days prior to participating. The researchers used an abbreviated form of the ECIT method and found that, out of the final set of the 56 consensual CIs the male clients believed to be detrimental to their therapeutic alliance, "Not the Right Fit/Approach" was the most frequently experienced category, and therefore considered most detrimental among the seven categories created. It was also found that factors may contribute to hindering the therapeutic alliance *before* treatment begins; these include whether the individual chose to seek the psychotherapy or it was another's decision and "lack of choice" about whom the practitioner is to be seen and what type of treatment is to be received. Factors that may contribute *during* treatment involve whether the client believes there is a "therapeutic match"—how similarly or closely the client, the client's experiences, and the client's believed approach to help his problems match with the practitioner, the practitioner's experiences, and the practitioner's approach.

Richards and Bedi (2015) suggested that adult, male clients currently in individual psychotherapy want to be actively involved in the psychotherapy process and clearly informed about what to expect; they want to decide with the psychotherapist what to discuss and what treatment technique(s) to use. Not doing so would presumably damage the therapeutic alliance and increase the risk of dropout. In addition, the researchers suggested that psychotherapists working with adult, male clients should pay particular attention to whether their treatment approach, interpersonal style, focus, and/or diagnosis are in line (as much as possible) with the client's preferences and beliefs, and also proposed that self-disclosure on the clinician's part, collaborating and being flexible with the client on treatment

planning, and having a clear focus are especially important factors to address. The research study did not conduct direct interviews with participants, but rather administered a condensed CIT questionnaire to obtain the data (Richards & Bedi, 2015). Although conducting a direct, in-person interview is suggested to be the best approach for psychotherapy and counseling research, their study's approach is still regarded as obtaining valid and reliable data due to the numerous credibility checks employed (Butterfield et al., 2009; Richards & Bedi, 2015). One big issue with this study that is pertinent to the current study was that it examined factors that hindered the alliance only. Not all factors that hinder the alliance are severe/significant enough to irreparably rupture the alliance and cause client dropout. What is needed is better understanding the factors that not only result in men experiencing a damaged alliance, but lead to male client dropout.

The aim of this current study is to determine why adult males, according to the client's perspective, drop out of outpatient, individual psychotherapy. For the purposes of this research, *client dropout* is defined as when the client unilaterally decides to terminate psychotherapy (as opposed to a joint decision between the psychotherapist and client). The perspective of those who dropped out of individual psychotherapy—regardless of whether this was completed at the beginning of treatment or after multiple sessions—will be sought to participate. Past psychotherapy research that utilized the CIT or ECIT to obtain participant "retrospective self-report" had mixed timelines of *when* the incident of interest occurred, from having participants recall incidents within the past six months to within the past five years (e.g., Butterfield & Borgen, 2005; Butterfield, Borgen, Amundson, & Erlebach, 2010); therefore, this research study proposes a considerate approach in regard to participants recalling the past event of interest. It would be ideal to capture participants' memories within

a recent six-month framework, but since recruitment of such individuals is anticipated to be limited, individuals who have dropped out within the past four years prior to participation will be allowed. The question still exists of whether there may be a difference between the individuals who dropped out of psychotherapy earlier compared to those who dropped out later in treatment. Therefore, if such differences between those who dropped out early (within the first few sessions after starting treatment) elicit differences during analyses of the collected data from those who dropped out later on in treatment, then the sample will be sub-grouped to reflect these results in a table for clarity (Lampropoulos et al., 2009; Self et al., 2005).

Butera (2006) noted that men today still adhere to making a distinction between the genders by acting "masculine," and some may express *hypermasculinity* (unnatural, forced masculinity; Horrocks, 1994). A previous study found that men with higher ratings of conforming to traditional masculinity norms tended to have greater stigma toward seeking help (McKelley & Rochlen, 2010). Richards and Bedi (2015) found in their sample of men that they did not conform to traditional masculine norms; the researchers suggested that men who remain in psychotherapy may exhibit a moderate nonconformity to traditional masculine norms. Therefore, it is important for this present study to also determine whether an individual's adherence to traditional masculinity ideology may also play a role in adult male client dropout in psychotherapy. The goal of this research is to contribute to the burgeoning literature on adult males in psychotherapy research and shed insight on the possible male-gendered reasons for dropout in individual psychotherapy.

Method

Participants

Adult male clients. As this study is focused on adult male dropout from psychotherapy, those eligible for participation were adult males (18 years of age or older) whose primary language was English and whom dropped out of outpatient, individual psychotherapy (or *counseling*) within the last four years prior to participation. The demographics and other requirements of each individual for participation was not further restricted. Participation was not limited to students or citizens of the immediate communities, and was also not limited to specific clinical diagnoses. The proposed sample size was 60 participants (see Recruitment), but resulted in 18 participants due to exhaustiveness occurring. All 18 participants met the criteria for participating in the study.

The sample of men (N = 18) ranged in age from 18 to 66 years (M = 32.72, Mdn = 29.00, SD = 13.02). The men represented a diverse sample of geographical locations, ethnicities, educational levels, occupations, socioeconomic status, and relationship status. The majority of men were from the US (n = 16, 88.9%), compared to Canada (n = 2, 11.1%); seven were from Bellingham (38.9%), two were from Vancouver (11.1%), two were from Houston (11.1%), two were from Austin (11.1%), two were from Dallas (11.1%), one was from Seattle (5.6%), one was from Indiana (5.6%), and one was from Tennessee (5.6%). Self-reported ethnicities included the following: thirteen identified as Caucasian/Mostly White/White (72.2%), one identified as African American (5.6%), one identified as Asian American (5.6%), one identified as Black and Latinx (5.6%), one identified as Eurasian (5.6%), and one identified as Hispanic (5.6%). For the highest level of education the men completed, six men completed High School or had their GED (33.3%), one had his Occupational/Technical/Vocational degree (5.6%), three had their Associate's degree (16.7%), seven had their Bachelor's degree (38.9%), and one had his Master's degree (5.6%).

Self-reported occupations included the following: Business Owner, Database Administrator, E-Commerce Sales Manager, Electrician, Freelancer, Front Office Manager- Intercontinental Hotels, Full-Time Student, Full-Time Student/Part-Time Lyft/Uber Driver, Health Educator/Patient Navigator, Investor, Landscape and Masonry, Options Trader, Retail, Security Officer, Semi-Retired, Server at a restaurant/Student, Software Testing and Implementation Consultant, and Team Leader for a Non-Profit. Household income of the participants included the following: $14,999 (2, 11.1%), $15,000 - $29,999 (1, 5.6%), $30,000 - $44,999 (4, 22.2%), $45,000 - $59,999 (4, 22.2%), $60,000 - $74,999 (2, 11.1%), $75,000 - $89,999 (3, 16.7%), $90,000 - $104,999 (1, 5.6%), $135,000 - $149,999 (1, 5.6%). Twelve men were Single/Never Married or Partnered (66.7%), five were Married or Partnered (27.8%), and one was Divorced (5.6%). Men were also asked to report their sexual identity; most men identified as heterosexual (12, 66.7%), three identified as homosexual (3, 16.7%), two identified as bisexual (2, 11.1%), and one self-identified as “sexual” (1, 5.6%).

The participants also reported on their mental health care history. The men reported a range of one to “seven or eight” mental health professionals that they received individual counseling/psychotherapy from throughout their life (M = 3.44, Mdn = 3.25, SD = 2.22), though six had just the one counselor/psychotherapist (33.3%) and four had five (22.2%). When asked how many counseling/psychotherapy sessions they had with their most recent mental health professional with whom they dropped out of counseling/psychotherapy with, the men reported a wide range of one session to 30 sessions (M = 8.03, Mdn = 5.50, SD = 8.46), though eight of the men reported having less than four sessions (44.4%). As such, the men reported a wide range of one month to 96 months for the time that they had been with their most recent mental health professional (M = 19.36, Mdn = 3.00, SD = 33.96), though 10

of the participants were with their counselor/psychotherapist for three months or less (55.6%). The men were asked to rate the quality/strength of the working relationship with their former mental health professional (the therapeutic alliance) on a scale of 1 (*extremely negative/weak*) to 6 (*extremely positive/strong*); most of the men reported a negative/weak relationship (four reported a 2, 22.2%, and seven reported a 3, 38.9%), though some did report a positive/strong relationship (six reported a 4, 33.3%, and one reported a 5, 5.6%).

Most of the men had at least one past or present psychological diagnosis (11, 61.1%); self-reported past or present diagnoses included the following: Anxiety Disorder Not Further Specified (1, 5.6%), Anxiety, Bipolar, Depression, and ADHD (1, 5.6%), Bipolar II (1, 5.6%), Clinical Depression (1, 5.6%), Depression (2, 11.1%), Depression and methamphetamine substance abuse (1, 5.6%), Depression and Anxiety (1, 5.6%), MDD and Anxiety (1, 5.6%), past Depression (1, 5.6%), and past ADHD and Depression (1, 5.6%). Likewise, most of the men had at least one psychological diagnoses at the time of their last counseling/psychotherapy session (11, 61.1%); self-reported diagnoses at the time of their last session included the following: Anxiety, Bipolar, Depression, and ADHD (1, 5.6%), Bipolar “unofficial” (1, 5.6%), Bipolar II (1, 5.6%), Clinical Depression and Anxiety Disorder (1, 5.6%), Depression (2, 11.1%), Depression and methamphetamine substance abuse (1, 5.6%), Depression and Anxiety (1, 5.6%), Depression and PTSD (1, 5.6%), MDD and Anxiety (1, 5.6%), and “possible ADD behaviors indicated according to counselor: (1, 5.6%). Half of the men endorsed taking a prescription medication for at least one past or present psychological diagnosis (9, 50.0%); self-reported past or present prescription medication for any past or present diagnoses included the following: Celexa, Effexor, Wellbutrin, and Zoloft (1, 5.6%), “forgot name” (1, 5.6%), Lamictal and Gabapentin (1,

5.6%), Paxil and Fluoxetine (1, 5.6%), Pristiq and Clonazepam (1, 5.6%), Prozac (1, 5.6%), Suboxone, Aripiprazole, Buspirone HCL, Bupropion HCL ER, and Gabapentin (1, 5.6%), Wellbutrin, Zoloft, Pamelor, and Sandoz (1, 5.6%), and Zoloft (1, 5.6%). One-third of the men endorsed taking a prescription medication at the time of their last counseling/psychotherapy session (6, 33.3%); self-reported prescription medication at the time of their last session included the following: Lamictal and Gabapentin (1, 5.6%), Paxil and Fluoxetine (1, 5.6%), Pristiq and Clonazepam (1, 5.6%), Suboxone, Aripiprazole, Buspirone HCL, Bupropion HCL ER, and Gabapentin (1, 5.6%), and Zoloft (2, 11.1%).

Most of the men received counseling/psychotherapy with a male mental health professional than a female (77.8%, 22.2%). When asked what their most recent mental health professional's highest level of education was, some of the men did not know (6, 33.3%), and the rest reported the following: LMHC (2, 11.1%), Master's degree (e.g., M.A./M.Ed./M.Sc./M.S.W.; 4, 22.2%), M.D. (2, 11.0%), Ph.D. (1, 5.6%), and Psy.D. (3, 16.7%). When asked what their most recent mental health professional's profession was, the men reported the following: Counselor (7, 38.9%), Psychiatrist (5, 27.8%), Psychologist (5, 27.8%), and Social Worker (1, 5.6%). With their most recent mental health professional, six men received free services (33.3%), five self-paid full cost (27.8%), five men had full coverage by their healthcare plan (27.8%), one man had partial coverage by his healthcare plan (5.6%), and one man had automatic coverage by self-paid student services fees (5.6%). Counseling/psychotherapy was most received by the men at a private practitioner's office (12, 66.7%), two at a community agency (2, 11.1%), one at a university/college clinic or counseling center (1, 5.6%), one at a hospital (1, 5.6%), one self-reported as "employer benefits" (1, 5.6%), and one self-reported at a mental health center (1, 5.6%). Most of the

men reported that they primarily sought counseling/psychotherapy with their most recent counselor/psychotherapist for depression (7, 38.9%), while others were for anxiety or stress (3, 16.7%), alcohol/drug use (3, 16.7%), relationship issues (1, 5.6%), trauma (1, 5.6%), or another reason (3, 16.7%; self-reported "hesitant on taking prescription medication," "wanted… ongoing talk therapy," and "identity and general well-being"). Though a couple reported that they did not know (2, 11.0%), the rest of the men self-reported the following type/style/theory of counseling/psychotherapy they most recently received: CBT (2, 11.1%), CBT and conversation (1, 5.6%), counseling (1, 5.6%), general therapy (1, 5.6%), depression diagnosis and medical and physical analysis (1, 5.6%), detached and medication oriented (1, 5.6%), medication-assisted treatment (1, 5.6%), one-on-one in-person counseling (1, 5.6%), one-on-one one-hour session (1, 5.6%), over the telephone (1, 5.6%), talk therapy (3, 16.7%), talk therapy and group dynamic therapy (1, 5.6%), traditional (1, 5.6%).

Research team. The primary author of this study trained during a period of no more than 12 weeks for approximately 18 total hours on how to conduct the interviews by running through the interview protocol with a research assistant in the exact manner that was done with a participant. The interview protocols consist of how to conduct the initial interview and the interviews that later follow as part of the credibility checks in order to have standardization across interviews. Additional research team members included the primary investigator's advisor (Dr. Robinder Bedi,[2] who has experience and published research utilizing the CIT), an interview fidelity checker (Kayla Christiani), and one research assistant (Brenda Ulinski), who was used as the independent checker of the data (see *interview fidelity* and *CIs and WL items category placement by an independent judge*). Lastly, Dr. Robinder Bedi (a knowledgeable member of the male psychotherapy research field) was utilized as the

expert whose post hoc examination of the created categories enhanced the trustworthiness of this research.

Measures

Enhanced Critical Incident Technique (ECIT). The interview-based ECIT was utilized because it is an appropriate, exploratory, qualitative research design that is well-suited for answering the stated research question; it was administered in a direct interview format via Skype and participants' demographics were collected within the appropriately constructed ECIT. The direct interview approach takes precedence over collecting the data via telephone or through questionnaires because Butterfield et al. (2009) suggested this technique was the most effective method of gathering CI data. Lastly, these interviews were doubly audio-recorded to increase the trustworthiness of the answered questions, which is part of the nine credibility checks that enhance the original CIT. However, if the possible problem of recruiting participation was limited due to having direct participation via Skype, there was also another avenue to extend flexibility to, in that those eligible yet not able or willing to participate via Skype may be offered to participate over the telephone, which can still be recorded; all participants interviewed via Skype and no one needed to use this telephone interview option. Further detail of this method follows.

Adhering to the ECIT for this study generally entailed a combination of the CIT measures outlined by Bedi, Davis, and Williams (2005), Butterfield et al. (2009), Flanagan (1954), and Richards and Bedi (2015), as well as some of the questions used by Bedi and Richards (2011). The interview protocol was similar to that provided in Appendix A of Butterfield et al. (2009); it included a demographics questionnaire at the beginning in order to obtain information regarding age, ethnicity, relationship status, educational history,

occupation, socioeconomic status, medical diagnoses, psychological diagnoses (primary and/or comorbidity), prescribed medications, etc. Other questions that were asked of each participant included information regarding beliefs about psychotherapy, expectations of psychotherapy, reason(s) for entering psychotherapy, reported reason(s) for leaving psychotherapy, whether the clinician was their first-time psychotherapist or not, the gender of their psychotherapist, the treatment's environmental setting, therapy modality/the therapeutic technique used (if known), treatment cost, level of family involvement, social support, prognosis, suggested length of treatment, treatment accessibility, profession of provider, and so forth. A copy of the demographic questionnaire is provided in Appendix I. In addition to the background information questions, the ECIT in this study included WL items questions to capture what the client believes would have enabled him to remain in his psychotherapy treatment. The primary focus of this ECIT was elicited through questions regarding what the participant believes to have led him to drop out of psychotherapy prematurely. The provided operationalized definition of CIs in this study was addressed by the question, "what was the most important thing that ultimately led you to drop out of psychotherapy," and included not just overt behaviors or occurrences, but also what the individual subjectively experienced as a whole. The interviewer followed the interview suggestions outlined by Butterfield et al. (2009), including being attentive as to not rush the interview, giving the interviewee one's full and undivided attention, and allowing the participant to tell his story in a way that allows him to feel like he is being understood (e.g., "using basic empathy along with other active listening skills and being curious while also being respectful," p. 270). Participants were permitted to report as many factors as they believed were critical to their decision to drop out of psychotherapy after the primary factor. The follow-up interview was conducted over e-

mail and the telephone and involved the same participants (who consented to the second interview) checking that the extracted CIs were consistent with their intended answers, checking that the created categories for the CIs appropriately represented their experiences (and expressing any opinions about potential improvements of the categories), and answering any questions (that may arise during interview data analysis) regarding the initial interview; more information about this follows.

Male Role Norms Inventory–Short Form (MRNI-SF). Levant and colleagues (2007) pointed out that men abiding to traditional gender role norms tend to have aversive psychological consequences, such as anxiety, depression, and low self-esteem, due to the gender role strain that is created. Levant (1990) also noted that treatments geared toward working specifically with men is lacking. Therefore, matching a male's endorsement of *traditional masculinity ideology* (defined as "beliefs about the importance of men adhering to traditional norms for male behavior"; Levant, Stefanov, et al., 2013, p. 393) to psychotherapy practices is important in order to improve understanding of how to better serve men seeking help and to create gender-sensitive treatments. Furthermore, it was suggested that understanding what men believe they "should think, feel, or do" may direct attention toward that which should be addressed in order to understand and change the traditional masculinity norms hindering men's treatment (Levant, Stefanov, et al., 2013). The traditional masculinity ideology of each participant was measured using the *Male Role Norms Inventory–Short Form* (MRNI-SF),[3] as it assesses traditional male role norms and its items relate to statements "manly men" are concerned with (Levant et al. 2007; Levant, Hall, & Rankin, 2013; see Appendix K). Richards and Bedi (2015) utilized the Conformity to Masculine Norms Inventory (CMNI) to measure conformity to masculine norms. The MRNI-SF was utilized in

this research to measure adherence to traditional male role norms (traditional masculinity ideology). Though the two constructs are related, there is a slight difference, there are pros and cons to both, and Levant et al. (2015) found discriminant validity between the two (there are subtle differences between conformity and norms). The MRNI-SF was utilized instead of the CMNI for the following reasons mentioned in Levant et al. (2010):

> The MRNI measures an individual's internalization of cultural belief systems and attitudes toward masculinity and men's roles, whereas the CMNI measures the individual's personal conformity to those norms; a man could endorse the societal norm of restrictive emotionality as the expectation for boys and men, believing that they should conform to certain socially sanctioned masculine behaviors and to avoid certain proscribed behaviors, but not be able to conform to these expectations himself; hence, there is a need for an instrument to assess masculinity ideology in which multiple norms are supported by factor analysis and for which there is evidence of reliability and validity (26-27).

In addition, behavioral forecasting research suggests that we are not good at predicting our actions in given circumstances (Diekmann, Tenbrunsel, & Galinsky, 2003; Osberg & Shrauger, 1986). Therefore, the MRNI-SF appears to be more appropriate for this research instead of the CMNI because the MRNI-SF asks about ideology instead of asking how one would conform in a given situation as the CMNI does. The MRNI-SF includes 21 items on a 7-point Likert scale that capture seven subscales of traditional masculinity: Avoidance of Femininity, Negativity Toward Sexual Minorities, Self-Reliance Through Mechanical Skills, Toughness, Dominance, Importance of Sex, and Restrictive Emotionality. Higher scores on the MRNI-SF indicate more endorsement of traditional masculinity

ideology (for corresponding items of the seven factors, see Table 2 in Levant, Hall, et al., 2013). The MRNI-SF also allows the researcher to describe the global masculinity level of the sample, which will allow the researcher to know if highly masculine men (who are the ones supposedly who drop out the most) were recruited for the study. The MRNI-Revised (MRNI-R) has greater reliability and construct validity than the original MRNI, as the MRNI had outdated statements and needed some items to better fit the subscale it represented, and the MRNI-SF takes precedence over the MRNI-R, as the MRNI-SF can be completed in less time (Levant et al., 2007; Levant et al., 2010; Levant, Hall, et al., 2013). In addition, the MRNI-SF has construct validity in the general traditional masculinity ideology factor and specific factors; however, further research is needed for investigating the construct validity of three specific factors (Levant, Hall, Weigold, & McCurdy, 2016). Levant et al. (2016) found that the seven subscales representing the dimensions of traditional masculine norms have construct validity in the Negativity Toward Sexual Minorities, Importance of Sex, Restrictive Emotionality, and Toughness factors, but further testing is needed for the Dominance, Avoidance of Femininity, and Self-Reliance through Mechanical Skills factors, as Dominance did not show construct validity in their testing and the other two specific factors were not tested, as those two subscales were not comparable to the subscales on the multidimensional masculinity measures used.

Procedure

Recruitment. Participants were originally recruited from the cities of Bellingham, Seattle, Vancouver, and Houston via Craigslist, accessible college and university campuses, and the general Whatcom county area community, but later recruited from Austin, Dallas, Huntsville, and Galveston in order to achieve more participation due to a slow recruitment

rate (see Appendices A, B, and C). Recruitment took place in more than one city for greater diversity of the sample, as Levant, Hall, et al. (2013) suggested future research should do, and in different regions for greater generalizability of the results. Recruitment consisted of posting flyers in approved public locations, Craigslist for each of the cities, and participating community partners within the cities whom have given their written consent to advertise this research study (see Acknowledgments). Levant, Stefanov, et al. (2013) recruited 654 men from one university and several community websites; of the community-dwelling participants online, the researchers ultimately obtained the most from Craigslist. More participants from this present study were recruited due to the snowball effect, and the men whom were recruited that way stated that they saw the flyer on private men's groups via Facebook; those men were from Indiana and Tennessee.

Those who inquired more about participation were screened using the Initial Contact and Screening Telephone Call Protocol (Appendix D). In addition to the requirements mentioned previously, the male participants needed to be at least 18 years of age and a diagnosis of psychopathology did not exclude participation. According to ethics, participants from Vancouver needed to be at least 19 years of age and those from Tennessee needed to be at least 21 years of age to be considered adults; all men from these locations met that requirement. Although some researchers have found that individuals with certain, varying psychopathology tend to have a higher dropout rate than those without such diagnoses (e.g., Bados et al., 2007; Fenger et al., 2011; Hamilton et al., 2011), individuals were still eligible to participate if they did have any psychopathology diagnosis. Such possible differences within the analyses were taken into consideration, but were ultimately not parsed since it was not appropriate or applicable.

Approved men who met the requirements for participation were scheduled and reminded of their appointment the day before the interview and provided with directions (e.g., participant Skype account username and password) for participating via Skype (see Appendix E). Each participant was requested to provide the approximate date of their last psychotherapy session, which consisted of them contacting their former psychotherapist/counselor and providing that information to the primary researcher (see Appendix F). Informed consent was required for participation and required the participant's electronic signature and interview date, which was obtained by following the Research Interview Protocol (see Appendices G and H). Having a large sample size increases generalizability of the data. Nevertheless, there was a limit on the timeline of when an individual dropped out (four years). Although the proposed sample size was originally 60 total participants, part of the ECIT's credibility checks deems that participation is sufficient once exhaustion occurs. More information on "exhaustiveness" follows. The total participation was indeed less as there were 18 total participants due to exhaustiveness, and it was not more than the proposed sample size. Butera (2006) pointed out that men may only want to participate in research that further affirms their masculinity, and also noted that having a male author on one's study may help offset any potential gender bias toward participating in a research study with a female as the primary researcher. Not only were three men overseeing this research, but their names were included on any recruitment documentation. Butera (2006) suggested that men will be appealed for participation by a monetary incentive (see Footnote 1) and knowledge of the men involved in the research (see Appendix B), in addition to the flexibility and speed regarding the time taken to participate. Participation for this study was sufficient given everything mentioned above.

Data collection. The initial interview consisted of three questionnaires that were administered by the primary author directly with participants via Skype (see Appendices I, J, and K). Initial interviews took approximately 1 hour in length as expected and were doubly audio-recorded with the software application Callnote Premium and a LiveScribe pencast, and the one research assistant transcribed them for validity purposes, as part of the ECIT's credibility checks (Butterfield et al., 2009). As previously noted, the option for telephone interviewing with Qualtrics in lieu of online interviewing via Skype was provided to account for the possibility of insufficient recruitment of participation. Federal law permits the use of recording devices of telephone conversations so long as there is consent (this is called the one-party consent law). Therefore, if participants had chosen the telephone interview with Qualtrics, they would have given both verbal and written consent and the telephone conversation would have been recorded using the Google Voice application for calls made within the US and Boldbeast Call Recorder for calls made within Canada. However, telephone interviewing was not needed after all, as all men who participated were interviewed via Skype.

According to Deakin and Wakefield (2013) and Janghorban, Roudsari, and Taghipour (2014), Skype interviewing does offer its advantages in qualitative research, as synchronous, or "real-time," online interviewing provides researchers the opportunity to not only reach a higher volume of participation, due to the *free* communication service allowing people to be wherever they are and at more convenient times, but also provides the same direct probing interaction with the presence of nonverbal communication as onsite interviewing. Skype interviewing may also be the preferred method of participation over direct in-person interviewing for men because one study found that the number one reason why men stated

they did *not* participate in a research study was due to time constraints (Butera, 2006). It is anticipated that men with lower traditional masculinity ideology ratings among the sample may report a reason other than the anticipated possible CI of "time" as the primary reason for dropping out, since hypermasculine men may report time as the primary reason (Butera, 2006). In addition, Hanna (2012) pointed out that both the researcher and the participant may be given “neutral” ground during the interviewing process, allowing both parties to maintain personal space, which may provide more ease for the participant. Participants were fully aware and provided informed consent to the use of audio—not video—recording for Skype interviewing. However, such online communication does have its limitations. A “head shot” is usually only seen during such video communications and may not provide the researcher with the nonverbal cues of the individual’s full body; to take this into account, participants were directed to be just far enough away from the camera to elicit a full, upper body shot in order to mimic the same view face-to-face interviewing at a desk provides. Another limitation of utilizing Skype is the location of the participant being interviewed. For example, the external environment may pose the risk of distractions or, as Deakin and Wakefield (2013) pointed out, participants might not feel comfortable being interviewed inside their home. Therefore, participants were also directed to choose a location that is not disruptive by the external environment, is free of personal items in view, and is approved of beforehand; this included the silencing of telephones (unless notified of potential emergencies in advance) and the preparedness of one’s self (which is addressed and stated in the Appointment Reminder Telephone Call Protocol/E-Mail Script, which was provided to the participant the day the appointment was scheduled and the day before the scheduled interview; see Appendix E). Janghorban, Roudsari, and Taghipour (2014) also noted that using Skype *can*

have higher rates of absentees and rescheduled interviews than direct in-person interviews due to the face-to-face relationship nature, but the cost of such an occurrence outweighs the costs of the additional finances and time spent of cancelled in-person interviews, and the benefit of increasing participation outweighs the possible cost of building a better rapport with direct in-person interviewees, especially since those whom choose to be interviewed via Skype may have not otherwise been reached.

In addition, a questionnaire—the Male Role Norms Inventory–Short Form (MRNI-SF)—was administered during the Skype interview via Qualtrics in order to measure each participant's adherence to traditional masculinity ideology. According to Levant et al. (2007), masculinity plays a role in male psychotherapy. A relationship may be found between dropout in psychotherapy and one complying with traditional masculine norms. The MRNI-SF helps to determine each male's personal perception of what he believes to be the norms of the male role by what he endorses. One's strain to fit the traditional male ideology may count for part of why males tend to drop out of psychotherapy, which itself may not be as good of a fit for serving males as it may be for females.

Participants were debriefed following the interview and provided a copy of the debriefing statements; additional contact information was obtained in order to have greater probability of reaching willing participants later for the follow-up interview (see Appendix L). Compensation[1] of $15 via PayPal was given for completion of the initial interview. If a participant withdrew from the initial interview before its completion, but he completed at least an hour of the interview, then he would have received $10 for his time (see Appendices L and M); however, this never occurred. All participants completed the interview. Participation from Western Washington University students were compensated the same way

in lieu of assigning SONA credit in order to control for the potential confound of not having participants recruited with the same incentive. In addition, participants received a list of mental health resources (see Appendix N).

Data analysis. The primary author and the research assistant tracked the emergence of categories and individually created categories for the CI and WL items (see Appendices O, P, and Q). The researchers then met via telephone to come to a consensus of the categories for the CI and WL items (see Appendix R). The analysis of the collected data followed the directions instructed by Butterfield and colleagues (2009) and is outlined below.

***Data organization*.** The raw data was organized into a modified version of Butterfield and colleagues' (2009) suggestion; instead of a being put into a physical binder, the transcribed interviews were typed in a Word document, labeled with the participant number, and placed into a Dropbox folder, and the primary investigator created a color scheme for highlighting the interview components, such as the CIs and WL items (see Appendices O, P, and Q). Butterfield et al. (2009) also suggested using a qualitative research data analysis program (e.g., NVIVO; ATLAS TI). However, the suggested programs are very expensive and access to them was unavailable; therefore, a revised version of Butterfield's manual organization method was utilized upon initial organizing of the data.

***CIs and WL items extraction*.** As recommended by Butterfield et al. (2009), the CIs and WL items were extracted in groups of three transcribed interviews by the primary investigator sorting each item into piles based on similarity. CIs were first identified and highlighted; these were any words and supporting statements that appeared to describe a CI and the impact it made on the individual or its level of importance. Items that appeared to be CIs, but that did not elicit such support through statements of importance or impact were

highlighted a different color and asked during the follow-up interview to clarify whether it was a CI or not. Only items that the participant agreed was a CI and had supporting statements or examples were used in the final data analysis. The process was repeated for WL items as well.

***Categories creation*.** The categories of the CIs and WL items were created through an inductive reasoning process by the primary investigator. The items from the first transcribed interview selected was extracted and placed into an electronic document that organizes the participant number (in parentheses) with the corresponding CIs and WL items into a table (see Appendices O, P, and Q). As an example, Butterfield and colleagues' (2009) sample of this table can be viewed in Appendix B of their research (see Table O). Similarities and themes among the items were noted and tentative categories were formed. The second and third transcribed interviews selected followed the same process and the categories were updated accordingly. When deciding whether to divide a category or merge two together, Butterfield et al. (2009) suggested asking "will the change make it easier or harder to use the data for its intended purpose?" (p. 273). The categories underwent this process with the addition of the remaining transcribed interviews until all of the extracted CIs and WL items from 90% of the interviews had been appropriately categorized; at this point, no new categories were likely to emerge. Butterfield et al. pointed out that Borgen and Amundson (1984) considered a category to be credible if there is at least a 25% participation rate. Category titles and operational definitions were then determined, and the CIs and WL items from the remaining 10% of the interviews were categorized into the created categories. The credibility checks follow this step of the ECIT.

Data interpretation. The interpretation of the data and the results to be reported also followed the ECIT's outlined directions instructed by Butterfield et al. (2009). The information that follows addresses the remaining eight of the ECIT's nine credibility checks, as the first one (*audio-record interviews* to avoid reliance on interviewer memory and the fallibility of on-the-spot note-taking) was addressed above.

***Interview fidelity*.** Part of this second credibility check was making sure that the protocols of this enhanced CIT method and the interview guide were being strictly followed and that each participant was not being asked leading questions or prompted in any way by the interviewer during the interviewing process; the remaining part of this credibility check was ensuring these were being followed by having the interview fidelity checker, Kayla Christiani, listen to every fifth audio-recorded interview and provide feedback. The checker needed to be and was very well-informed about the CIT method in order to provide feedback to the interviewer, which was done prior to the next interview to be conducted.

***CIs and WL items extraction by an independent research assistant*.** The research assistant extracted CIs and WL items from 25% of the transcribed interviews; the primary investigator randomly selected these and gave them to the independent research assistant. The primary investigator then compared the independently extracted items with those (that the primary investigator) extracted earlier and calculated the percentage of agreement. Discrepant items were resolved by having the primary investigator and independent research assistant come to a consensus with the discrepancies. Items that were not resolved were removed from analysis, as only a 100% concordance rate between the extracted items would be and were used.

Exhaustiveness. Exhaustiveness refers to the point at which no new CIs or WL items are created after three consecutive interviews, and is therefore the time when no new participation is needed, according to Flanagan's (1954) application of the CIT. Butterfield and colleagues (2009) stated that further participation may continue for the ECIT, though it is up to the researcher. Due to the low rate at which participants were being recruited in this present study and exhaustiveness had occurred, more participation was no longer necessary (see Table O). The example table in Appendix B of the Butterfield et al. (2009) study also provides the tracking for exhaustiveness and these procedures are followed here.

Participation rates. Butterfield et al. (2009) suggested calculating the participation rates by utilizing the form in Appendix O (which provides the participant number next to each CI and WL item) and summing the number of different participant numbers in each created category and dividing by the total number of participants. As noted earlier, each created category would need to have at least a 25% participation rate, as a category would not be considered credible if the percentage is less (Borgen & Amundson, 1984; Butterfield et al., 2009). The participation rates were calculated and are provided in the Results.

CIs and WL items category placement by an independent judge. The primary investigator randomly selected 25% of the CIs and WL items in each created category and the research assistant placed those extracted CIs and WL items into the categories that were created by the primary investigator. Operational definitions of each created category were also provided to the independent judge. A match rate between the placement by the independent judge and that of the primary investigator was calculated by the primary investigator. As Butterfield et al. (2009) pointed out, Andersson and Nilsson (1964) recommended having an 80% or greater match rate, which was met in this study.

Discrepancies were handled by coming to a consensus and ultimately utilizing the follow-up interview responses for the final decision on category revision.

***Cross-check by participants*.** After the CIs and WL items were categorized and a consensus of the categories was made, participants who gave their consent in the initial interview to participate in the follow-up interview were contacted to provide feedback on the created categories. All 18 participants consented to the follow-up interview and were contacted via telephone for the interview (see Appendix S). The follow-up interview was conducted over the telephone and e-mail and the primary researcher read the information in the follow-up interview protocol aloud (see Appendix S). Participants completed the follow-up interview to check that the extracted CIs and WL items accurately represented *their* answers and experiences, check that the created categories for the CIs and WL items also accurately represented *their* experiences and express feedback for potentially improving the created categories, check that the CIs and WL items had been appropriately placed into the created categories, and provide answers for any potential questions that arose during the analysis of the initial interview responses. The participants were read the extracted CIs and WL items listed, as well as a list of the created categories with the CIs and WL items placed into them. Five men did not answer after three telephone call attempts were made and were therefore contacted via e-mail with the same information noted above; this was to ensure accuracy (and any potential clarification) of the interview responses, which would then be and was returned to the researcher via e-mail. Two of the five men contacted via e-mail gave their follow-up interview responses and the remaining three were addressed in the finalization of the created categories by the primary researcher and the research assistant. Each participant was asked whether the CIs and WL items were accurate, whether any were

missing, whether any needed to be altered, and whether he would have liked to provide additional comments. The protocol for clarification of a listed item followed that of Butterfield et al. (2009): Each participant was asked whether the created categories for the CIs and WL items were easily understood or unclear, whether the categories accurately represented his experiences, and whether he believed any of the listed CIs and WL items fell under a corresponding category that should have fallen under another (and if so, which other category). The final part of the follow-up interview involved asking participants about any possible questions that potentially arose during analysis of the initial interview responses. The collaboration with the participants enhances the accuracy of the collected data.

The participant was debriefed at the end of the follow-up interview (see Appendix T). The primary researcher and the research assistant then implemented the follow-up participants' feedback and noted how the finalization of the categorization consensus came to be (see Appendices U, V, and W).

Confirmation by expert opinions. Dr. Bedi, an expert of the male alliance and psychotherapy field, was utilized to provide feedback about the created categories. Butterfield et al. (2009) suggested that this expert should answer whether the created categories are perceived as "useful," whether any of the categories seemed surprising, and whether anything may be missing that is not captured by the categories. The opinions serve to enhance the credibility of the research by providing such feedback. Butterfield et al. (2009) suggested having two expert opinions, but this study only utilized one just as Richards and Bedi (2015) had this limitation.

Theoretical agreement. The agreement of the emergent categories with research theories were checked and any categories that may not have such theoretical agreement may

only indicate that it may be a potential variable to study in future research, rather than a variable that is not theoretically sound, as Butterfield et al. (2009) stated that such use of the ECIT method is for the purpose of exploratory research. Some theories that were used to cross-reference the resulting emergent categories included those suggested from Bedi and Richards (2011), Butera (2006), and Richards and Bedi (2015), and are discussed in greater detail below. Part of the final step of Flanagan's (1954) CIT follows.

Results

Recruitment took place and information was collected from August 2019 to March 2020 for the initial interview. Information was collected in March 2020 for the follow-up interview. As expected, the majority of men were recruited from Craigslist (*n* = 13, 72.2%), followed by flyers posted at Western Washington University (*n* = 2, 11.1%), Facebook private groups from the snowball effect (*n* = 2, 11.1%), and the Co-Op downtown on 4th Street in Bellingham (*n* = 1, 5.6%). The collected data was checked for errors in the IBM SPSS Statistics 26.0 dataset prior to conducting analyses.

Individual Categorization Structures

The primary investigator individually extracted 26 CIs and 25 WL items in batches of three interviews, and individually completed the original creation of the CI and WL item categories.

Credibility of Data

All nine credibility checks of the ECIT (Butterfield et al., 2009) were utilized, though only one expert opinion was used instead of the recommended two, as had been done in a similar study (Richards and Bedi, 2015).

Audio-recorded interviews. All 18 of the Skype interviews were doubly audio-recorded (using Callnote Premium and LiveScribe pencast) and transcribed by Brenda Ulinski, the research assistant.

Interview fidelity. Kayla Christiani listened to every fifth interview to make sure the ECIT method was being followed, the interview protocols were being followed, and that the primary investigator did not make any leading questions with participants. Kayla Christiani provided feedback to the primary investigator before the next interview with a participant.

CIs and WL items extraction by an independent research assistant. After the primary investigator extracted all of the CIs and WL items and completed the creation of the categories, the primary investigator then gave the independent research assistant a random selection of 25% of the transcripts to extract CIs and WL items. The primary investigator then computed the percentage of agreement. The percentage of agreement between the extracted CIs and WL items from the primary investigator and the independent research assistant was 85.71%, as the research assistant extracted 12 of the 14 same CIs and WL items. The primary investigator and the independent research assistant discussed CI and WL items that did not match and resolved differences; any items that were not able to be resolved were not used in further analysis. The concordance rate after discrepancies were resolved was 100%.

Exhaustiveness. The emergence of new CIs and WL items originally ceased after the 15th participant. However, after consensus of the categories by the independent judge and feedback from the follow-up interviews, the emergence of new CIs ceased after the 7th participant and the emergence of new WL items ceased after the 12th participant (see Table

O). Appendix P provides the original categories with their descriptions and the finalized changes made.

CIs and WL items category placement by an independent judge. The primary investigator randomly selected 25% of the CIs and WL items from each created category and gave it to the research assistant. The research assistant placed each CI and WL item into the category of their choosing and the primary investigator then compared the research assistant's placements with the primary investigator's placements (see Tables Q1 and Q2). The primary investigator calculated the match rate between their placements. The recommended match rate of 80% or greater was met; the match rate was 80.95%, as the research assistant placed 17 of the given 21 CIs and WL items into their corresponding categories. All of the placements were the same except for three CIs and one WL item. The discrepancies were resolved by coming to a consensus and ultimately utilizing participant feedback in the follow-up interviews, as suggested by Butterfield et al. (2009; see Table R).

Cross-check by participants. All but three of the participants completed the follow-up interview ($N = 15$). The follow-up participants' feedback on the CIs and WL items categorization structure and how the follow-up participant feedback on incidents and categories was addressed were recorded (see Table U1). The notes and decisions on the final categorization consensus structure with the remaining three participants are provided (see Table U2).

Participation rates. The participation rates for all of the primary and secondary CIs and WL items before finalization are presented in Table U3. Before finalization, the following categories of the CIs are in descending order of strength (with their participation rate): Not the Right Approach (34.62%), Not the Right Fit (26.92%), Cost (11.54%), Need to Build

Trust (7.69%), No Longer Needed (7.69%), Time Problems (7.69%), and Client Not Engaging (3.85%). The following categories of the WL items before finalization are in descending order of strength (with their participation rate): Change the Approach (32.00%), Building Rapport (20.00%), Affordability (12.00%), Client Engages More (12.00%), More Availability (12.00%), Building Trust (4.00%), Decided if Needed (4.00%), and Counselor/Psychotherapist Recommendation (4.00%). The expert opinion feedback integration notes and participation rates for the finalized CI and WL item categories for all primary CIs and WL items with the expert opinion feedback are presented in Table U4 and Table U5, respectively. The finalized categories only include credible, primary CIs and WL items in order for secondary CIs and WL items to not carry equal weight. As it was noted earlier, created categories need to have a participation rate of at least 25% in order to be considered a credible category according to Borgen and Amundson (1984), though all finalized categories regardless of their participation rate are listed here in order to provide more insight. It is important to note that some researchers have pointed out that having a low participation rate does not necessarily make the category less important or invalidates it, but rather that it is not as uniform of an experience across the men as those with a higher participation rate—it is as equally important to the man who experienced it (Andersson & Nilsson, 1964; Bedi, Davis, Williams, 2005). The strength of each category is also determined by the participation rate. The following finalized categories of the CIs are in descending order of strength: Not the Right Interpersonal Fit (33.33%), Not the Right Approach (27.78%), Need to Build Trust (11.11%), Cost (11.11%), No Longer Needed (11.11%), and Time Problems (5.56%). The CI category Not the Right Interpersonal Fit has the highest participation rate out of all of the CI categories, as six of the 18 men provided

incidents for this category. The following finalized categories of the WL items are in descending order of strength: Change the Approach (35.29%), Building Rapport (29.41%), Affordability (11.77%), Client Engages More (11.77%), More Availability (5.88%), and Decided if Needed (5.88%). The WL item category Change the Approach has the highest participation rate out of all of the WL item categories, as six of the 17 men provided credible items for this category. There were only 17 credible WL items, as one participant's response was not considered a credible WL item as his only "wish" that would have helped him to stay was "nothing" and he only wanted his former counselor/psychotherapist to give him a recommendation for another counselor/psychotherapist.

Confirmation by expert opinions. The one expert, Dr. Robinder Bedi, independently reviewed the finalized CI and WL item categories. This credibility check was met, even though Butterfield et al. (2009) suggested having two expert opinions, as Richards and Bedi (2015) also had one expert. Dr. Bedi answered "yes" as to whether the created categories are perceived as "useful," but added a few exceptions (Time Problems, Client Not Engaging, and Client Engages More) that can be viewed in Table U4. When asked whether any of the categories seemed surprising, Dr. Bedi answered "no." Lastly, when asked whether anything may be missing that is not captured by the categories, Dr. Bedi responded by stating that "nothing comes to mind immediately as the single most important reason for drop out." Dr. Bedi made additional comments in regard to the created categories and asked to have his feedback presented verbatim (see Table U4).

One question that arose and was addressed was whether some of the created categories should be the same as similar studies for consistency across research. It is important for the present study to have its own category names, as there needs to be clarity

kept of the participants' CIs in this present study, as well as distinction kept of the focus of this study verses others for its intended purpose in research. Although there is overlap with previous research studies, such as "Time Problems" being the same CI category name as in Richards and Bedi (2015), this was to be expected, as those with a weakened therapeutic alliance are more likely to drop out (Bados et al., 2007; Bedi, Davis, & Arvay, 2005; Horvath & Bedi (2002); Horvath, Del Re, Fluckiger, & Symonds, 2011; Sharf et al., 2010); their category descriptions are different, though, as they reflect the distinct CIs that they are in these separate studies.

Critical Incident and Wish List Item Categories

As noted earlier, the participants were given the chance to share possible secondary reasons after their primary reason for dropping out of counseling/psychotherapy in the interview. The 18 men reported a total of 26 CIs and 25 WL items representing seven CI categories and eight WL item categories for all primary and secondary reasons for dropping out of counseling/psychotherapy and wishes of what would have helped them stay in sessions before finalization. The finalized six CI categories and six WL item categories below show only the primary reasons for dropping out in order for secondary reasons to not hold equal weight for the participation rate. The participant whose WL item and corresponding category were not deemed as credible were also removed from the finalized categories. Therefore, the 18 men reported a total of 18 credible, primary CIs and 17 credible, primary WL items that appropriately represented the six CI and six WL item categories. The characteristics of the finalized categories are described in detail below. The frequency of the occurrence of CI and WL item categories is provided in descending order of participation rate strength.

Critical Incident Category Not the Right Interpersonal Fit. This CI category was most frequent among the men's CI responses. The operational definition of this CI category is that the client "didn't connect with the therapist." This CI category most closely describes the therapeutic alliance. Some of the responses that the men in this category stated are the following: "I didn't really feel heard. Him and I didn't have a strong enough relationship for me to feel secure and like communicating issues with him;" "I felt like we weren't clicking. I felt like he wasn't seeing my issues as serious as I did. I didn't feel comfortable opening up furthermore;" "I felt like I wasn't being heard. I felt like… my professional was being close-minded about my circumstances;" and "We just weren't jelling or vibing… it just wasn't gonna fit." As expected, the men in this category had a moderately low therapeutic alliance strength with their mental health provider (n = 6, M = 3.00, SD = 0.00).

Critical Incident Category Not the Right Approach. This CI category describes the men who "didn't want to or no longer wanted to take suggested medication, didn't agree with diagnosis, or needed a different counseling approach." Some of the men whose CI responses fit this category are the following: "We had a disagreement about… the use of medication… and I didn't feel comfortable about that. I have nothing bad to say about him. It's just that I don't believe in change through chemicals;" "I was told that I was bipolar and I did not believe such a thing is applicable. The tendency of my psychotherapist to adhere to textbook standards and complete a fast diagnosis;" and "The counseling seemed to be too open-ended…. I didn't really understand the direction it was taking… I didn't know what I was supposed to get out of it…."

Critical Incident Category Need to Build Trust. The operational definition of this CI category is that the client "didn't trust the therapist." One of the responses for this CI

category was the following: “Loss of trust. It had to be someone who I thought was sympathetic and was easy for me to talk to… and this event made me think that this guy was definitely not.” One question that arose between the primary investigator and independent research assistant was whether this category should merge with Not the Right Interpersonal Fit; when the corresponding participants were asked this and about their response in the follow-up interview, they believed that it was not a connection issue, but just a trust issue—that a lack of trust is different from a lack of a connection. Therefore, their answers and category were kept as is to reflect this difference between the two reasons for dropping out.

Critical Incident Category Cost. The description for this CI category is “insurance no longer covered or no longer able to continue due to life change.” The men’s CI responses in this category are the following: “Due to restructuring of the mental health practice, counseling was no longer covered under my insurance. The price was no longer covered by my insurance;” and “It was just cost prohibitive for me at that time.”

Critical Incident Category No Longer Needed. This CI category’s description is “thought no longer needed/was in a good state.” The experiences listed here describe men who either were in a manic state and believed in that state of mind that they no longer needed to attend sessions, or believed they were doing well in general and no longer needed counseling/psychotherapy. Their responses are as follows: “I thought I was in a good state and didn’t need help. I’m bipolar and I guess at the time I was in a manic state where I felt really good and… I kind of stopped using my medications and started using some drugs and… I had just decided that I was delusional in my head and thought I was in a good place and decided I did not need therapy anymore;” and “I felt that I was at a place in my life where I was doing better than I previously was.”

Critical Incident Category Time Problems. This final CI category's operational definition is "time constraints such as the way time was not spent constructively in sessions or having lack of time to attend sessions." A man's CI response in this category is as follows: "Time to attend sessions was probably the biggest eliminating factor for me. Lack of time on account of many moving parts in my personal and professional life." This CI category's description highlights a secondary CI response from another man before finalization; his CI response is the following: "It became very odd, especially because I was paying out-of-pocket to go and have an hour meeting with somebody that talked for 45 minutes while I talked for 20." The description was kept this way in order to provide richer content about why the men dropped out of counseling/psychotherapy.

Wish List Item Category Change the Approach. This WL item category was most frequent among men's WL item responses. The operational definition of this WL item category is "the counselor/psychotherapist changes the approach to accommodate the client's needs." Some of the men's WL item responses in this category are as follows: "If there was a framework, a little bit of guidance before going into the session, it would have given me some guidance about what I was going to be talking about;" "…if there was just more discussion… around ground rules or an outline of what we wanted therapy to be or what I wanted therapy to be and what he provided;" and "…a little bit more assertion and direction on her part. …maybe less time… doing the get to know you part and understand the character. But also at the same time, use that information to… complete the diagnosis."

Wish List Item Category Building Rapport. The men in this study believed that this WL item category would have also helped them to want to stay in their psychotherapy. The description reads that "the counselor/psychotherapist and client work on building a

strong therapeutic alliance." Some of the men's WL item responses in this category are the following: "The mental professional could be more compassionate and taken me more seriously, that could have helped me. …just feeling that bond. …maybe even him giving more examples in his own life that he went through similarly… to strengthen the bond…;" "Finding common ground to help understand each other. I think that having that connection with your counselor… to understand you… the experience you are having… would have been more beneficial than remaining silent throughout the duration of the counseling sessions;" and "My mental health professional… listened to me more and not been as close-minded."

Wish List Item Category Affordability. The operational definition of this WL item category is that "the counseling/psychotherapy sessions are able to be covered by insurance or the client has the finances to afford it." The men's WL item responses in this category are the following: "…if I had the finances to cover continuing with the mental health professional. (And… I'd appreciated if it had been more notice for its changes.);" and "Have the counseling be more affordable for myself."

Wish List Item Category Client Engages More. This WL item category's description is that "the client takes more action in his counseling/psychotherapy sessions." The men's WL item responses in this category are as follows: "…managing my medication and being honest with the professional. …to be more honest and open and to be willing to actually… open up to the counselor. Just not being afraid to say what I'm thinking;" and "…if maybe I had discussed maybe what my friend had told me [about the negative side effects of the medication] it would have made things a lot different. It would have cleared up a lot of things for me. …the fact that I didn't disclose that to the practitioner, the fact that he

could have done even more…. If I had taken my time and did my homework, my research, really looked into it, more than what I did (I was hardheaded) I think I would have been further down the road. I think I'd be a lot better off." This WL item category shows the client taking responsibility for his part in counseling/psychotherapy.

Wish List Item Category More Availability. The description of this category is "a better time for the client to have a session with his counselor/psychotherapist." The man's WL item response in this category is the following: "If our schedules aligned, if time stopped working as a limiting factor, my life at least and probably others as well, that would definitely help to continue help me work with the mental health professional."

Wish List Item Category Decided if Needed. The operational definition of this final WL item category is "the client decides he needs it." The WL item response in this category is the following: "…if we had been deciding that it was something that we needed. …if I… felt that I needed it…." This WL item category may be controversial due to the category not necessarily representing a "wish." However, this WL item category was kept as is due to the participant believing that this was his primary need to want to remain in sessions with his former mental health professional. Although this WL item category is not necessarily deemed as credible according to the participation rate and "wish" description, it is still noted as important and there may be other men who have dropped out who feel the same way as this man.

Theoretical agreement. Suggested theories from Bedi and Richards (2011), Butera (2006), and Richards and Bedi (2015) support the majority of the created CI and WL item categories. As noted earlier, if an emergent category is not supported by one of the theories, it is important to remember that the ECIT is exploratory.

Male Role Norms Inventory–Short Form (MRNI-SF)

The MRNI-SF has good internal consistency reliability, Cronbach's alpha = .894. Scores range from 1 (*strongly disagree*) to 7 (*strongly agree*); higher scores indicate greater endorsement of traditional masculinity ideology. One participant answered *strongly disagree* for all questions on his MRNI-SF; results without his response are shown in further corresponding analyses to adjust for skewness (see Table 1). Not as anticipated, the average total score of men endorsing traditional masculinity ideology was $M = 2.90$, $SD = 0.87$, indicating that the men in the present study did *not* yield a higher than average endorsement of traditional masculinity ideology. The average scores of each of the seven subscales of traditional masculinity ideology are as follows: Avoidance of Femininity $M = 2.59$, $SD = 1.46$, Negativity Toward Sexual Minorities $M = 1.84$, $SD = 1.25$, Self-Reliance Through Mechanical Skills $M = 5.02$, $SD = 1.27$, Toughness $M = 4.08$, $SD = 1.40$, Dominance $M = 1.69$, $SD = 0.69$, Importance of Sex $M = 2.61$, $SD = 1.66$, and Restrictive Emotionality $M = 2.49$, $SD = 1.25$. As Levant, Hall, and Rankin (2013) noted, men (and women) tend to have higher scores on the Self-Reliance Through Mechanical Skills and Toughness subscales, as was evident in this study.

Subsample Comparisons

It was anticipated that older men may have greater adherence to endorsing higher traditional masculinity ideology on the MRNI-SF than younger men. However, there was not a statistically significant correlation between age and MRNI-SF scores, $r(15) = .385$, $p = .127$. When taking sexual identity into consideration, there was still not a statistically significant correlation between age and MRNI-SF scores of heterosexual men only, $r(10) = .568$, $p = .054$, though the data is trending. Although these results are nonsignificant, it may

be due to a small sample size. Butera (2006) found that the older men she conversed with were more likely to push an image of masculinity than men from a younger generation. Echoing Butera (2006), it was anticipated that older participants would likely have statistically significant, higher ratings of traditional masculinity ideology than the younger participants, reflecting a decrease in change between generations in Western society's norm of expecting men to conform to traditional masculinity. Congruent with the results from Butera (2006), when dividing the sample in half in terms of the median age of 42, the older men (43-66 years; $n = 3$, $M = 3.87$, $SD = 0.29$) showed a statistically significant difference in greater adherence to traditional masculinity ideology than the younger men (18-42 years; $n = 9$, $M = 2.83$, $SD = 0.61$) in the (heterosexual only) sample, $t(10) = -2.806$, $p = .019$, though it is important to note that this is a small sample size and their scores are still considered to be a moderate nonconformity to traditional masculinity ideology.

It was hypothesized that men with lower traditional masculinity ideology ratings among the sample may report a reason other than the anticipated possible CI of "time" as the primary reason for dropping out, as hypermasculine men may report time as the primary reason (Butera, 2006). There is only one man whose primary CI category was Time Problems in this present study, and therefore it is not appropriate to compare his adherence to traditional masculinity ideology with the rest of the sixteen men due to the small sample size.

In comparing participants' primary CI category of why they dropped out of individual psychotherapy with their overall MRNI-SF score, a one-way between subjects ANOVA found no statistically significant effect of primary reason for dropping out on overall MRNI-SF scores, $F(5, 11) = 2.55$, $MSE = .510$, $p = .091$ (see Table 2 for means and standard

deviations). Due to the low sample size, further analysis into these relationships is not appropriate.

As noted earlier, it was hypothesized that there may be a statistically significant difference between men who dropped out early on in their psychotherapy treatment compared to men who dropped out later, as most dropout usually occurs after the second visit (Lampropoulos et al., 2009; Self et al., 2005). The men who dropped out prior to four sessions (n = 7, M = 2.57, SD = 0.76) did not show a statistically significant difference in overall endorsement of traditional masculinity ideology than the men who dropped out after four sessions (n = 10, M = 3.13, SD = 0.90), $t(15) = -1.343$, $p = .199$, though it is important to note the small sample size. No association was found between early versus later dropout and primary reason for dropping out of counseling/psychotherapy, $X^2(5, N = 17) = 5.072$, $p = .413$. Lastly, men who dropped out prior to four sessions (n = 7, M = 3.00, SD = 0.82) did not yield a statistically significant difference in therapeutic alliance strength than the men who dropped out after four sessions (n = 10, M = 3.40, SD = 0.97), $t(15) = -.893$, $p = .386$.

As previously mentioned, parsing subsamples for comparisons would be made if statistically significant differences were found between the men recruited for this study based on their possible psychopathology diagnosis, such as affective disorders or substance use disorder (according to *DSM-5*). The men who endorsed having a diagnosis at the time of their last counseling/psychotherapy session (n = 10, M = 2.77, SD = 0.93) did not show a statistically significant difference in general adherence to traditional masculinity ideology compared to the men who did not have a diagnosis at the time of their last counseling/psychotherapy session (n = 7, M = 3.10, SD = 0.81), $t(15) = .756$, $p = .461$. No association was found between men who had a diagnosis or not at the time of their last

counseling/psychotherapy session and primary reason for dropping out of counseling/psychotherapy, $X^2(5, N = 17) = 4.614$, $p = .465$. Lastly, men who endorsed having a diagnosis at the time of their last counseling/psychotherapy session did not yield a statistically significant difference in therapeutic alliance strength ($n = 10$, $M = 3.10$, $SD = 0.74$) than the men who did not have a diagnosis at the time of their last counseling/psychotherapy session ($n = 7$, $M = 3.43$, $SD = 1.13$), $t(15) = .727$, $p = .478$. Further analyses did not need to be made.

Discussion

The present study adds to the burgeoning literature on men in psychotherapy research and male-gendered reasons for dropout. The current study sheds light on why men drop out of individual, outpatient counseling/psychotherapy, according to their perspective, as well as what would have helped them to stay. In addition, this present study reveals whether adherence to traditional masculinity ideology plays a role in adult male client dropout in psychotherapy for the participants in this study.

As anticipated, most of the men who dropped out of counseling/psychotherapy had a weakened therapeutic alliance. Thus, it is sensible as to why the CI category Not the Right Interpersonal Fit was most salient among the CI categories. Besides Not the Right [Interpersonal] Fit, it was also expected that men would likely report Not the Right Approach, Time [Problems], and/or Didn't Need Outside Help (No Longer Needed) as a reason for dropping out, as previous studies suggested (Bedi and Richards, 2011; Butera, 2006; and Richards and Bedi, 2015). This study suggests that men are most likely to drop out of counseling/psychotherapy if they don't have the right interpersonal fit—a strong therapeutic alliance—with their mental health professional (specifically the bond component

of the therapeutic alliance) or if they do not have the right approach to fit their personal needs and/or beliefs. Overall, this study suggests the following CIs that are organized in the following six categories that can lead to attrition with men in counseling/psychotherapy: Not the Right Interpersonal Fit, Not the Right Approach, Need to Build Trust, Cost, No Longer Needed, and Time Problems.

The men's WL items can aid counselors/psychotherapists in helping their adult male clients to stay in treatment. The present study suggests that men who are headed toward dropping out are more likely to remain in counseling/psychotherapy if the approach being used is changed if it does not meet their needs and/or beliefs, or if they work on building a stronger therapeutic alliance with their mental health professional. Overall, this study suggests the following WL items that are organized in the following six categories that may help men to remain in counseling/psychotherapy if they are leading to drop out: Change the Approach, Building Rapport, Affordability, Client Engages More, More Availability, and Decided if Needed.

Not hypothesized, the average overall score of the men's MRNI-SF ratings did not yield greater endorsement of traditional masculinity ideology. Therefore, with the combined results from Richards and Bedi (2015), men who go to treatment at all—even if they drop out—exhibit a moderate nonadherence to traditional masculinity ideology. Men who do not attend therapy at all may be those who have greater endorsement of traditional masculinity ideology, as McKelley and Rochlen (2010) found that men who tended to have greater stigma toward seeking help had higher ratings of conforming to traditional masculinity *norms*. A future study can address if men who do not enter counseling/psychotherapy have higher than average adherence to traditional masculinity *ideology* utilizing the MRNI-SF, as

it is expected. It may be that the majority of the men in the present study endorsed a moderate nonadherence to traditional masculinity ideology because men with a lower endorsement of traditional masculinity ideology are more likely to participate in research than men who have greater adherence to traditional masculinity ideology. There may be men outside of the study who exhibit greater endorsement, but who did not want to participate in research. If such men with greater endorsement of traditional masculinity ideology had participated in this research, their results may had been similar, as two of the men in the present study had a MRNI-SF score greater than 4 (4.14 and 4.29).

There was no association found between the men's age and their adherence to traditional masculinity ideology, but the data was trending when taking sexual identity into consideration and only looking at the heterosexual men; a future study with a larger sample size may reveal a strong positive correlation between age and MRNI-SF scores. However, when the sample was divided in half by age (*Mdn* = 42.00), there *was* a statistically significant difference in the men's adherence to traditional masculinity ideology, in that the older men did have greater adherence than the younger men in the sample, as previous research suggested (Butera, 2006), though the present study has a small sample size.

In addition, greater adherence to traditional masculinity ideology does not have an effect on the primary reason for dropping out of counseling/psychotherapy in the current study—the men's primary reason for dropping out was not statistically significantly different from the men's general adherence to traditional masculinity ideology.

Further, the men who dropped out prior to four sessions did not yield statistically significant differences between the men who dropped out later in terms of their adherence to traditional masculinity ideology or therapeutic alliance strength, and no association was

found with primary reason for dropping out. Finally, the men who had a psychopathology diagnosis at the time of their last counseling/psychotherapy session did not yield statistically significant differences between the men who did not have a diagnosis in terms of their adherence to traditional masculinity ideology or therapeutic alliance strength, and no association was found with primary reason for dropping out, though it is important to note the small sample size.

Former Research

As previously mentioned, some of the results of this study mimic results from past research. One example is the Richards and Bedi (2015) study that investigated CIs that hindered or impaired the therapeutic alliance, according to men. Not the Right Interpersonal Fit and Not the Right Approach in the current study is similar to their CI category Not the Right Fit/Approach; their CI category was highest-rated among their results, as was anticipated and evident in the present study, therefore offering more support that men are most likely to drop out of counseling/psychotherapy if they do not have a strong therapeutic alliance with their clinician or if they are not utilizing the right therapeutic approach to meet their needs and/or beliefs. Likewise, Need to Build Trust is similar to their CI category Client Uncertain or Untrusting, which offers more support that men are also more likely to drop out of counseling/psychotherapy if they do not trust their clinician. Lastly, Time Problems is similar to their Time/Timing Problems CI category and offers more support that men are also more likely to drop out of counseling/psychotherapy if there are time constraints, such as the way time was not handled constructively in sessions or having a lack of time to attend sessions.

Butera (2006) suggested that men in particular would report time as a limiting factor for not participating in research; this study revealed the CI category Time Problems, though men did participate in the research and most of the men who participated did not yield great adherence to traditional masculinity ideology. Therefore, time may be a factor for both hypermasculine men and men who do not have great adherence to traditional masculinity ideology.

Bedi and Richards (2011) suggested that men are most concerned with "Bringing Out the Issues" for what forms or strengthens the therapeutic alliance with their mental health professional. Bringing Out the Issues was the highest-rated category in their study and is linked to the present study's highest-rated WL items category Change the Approach, as the most highly rated variables for Bringing Out the Issues were "the psychotherapist asked questions," "the psychotherapist made encouraging comments," and "the psychotherapist listened to my truthful negative personal reactions to him/her," which are approach-related techniques for therapy; this adds support to the notion that men are more likely to remain in their counseling/psychotherapy sessions if the approach being utilized meets their needs.

When comparing results of past research that utilized a primarily female sample with the results of this all-male study, one can see that the primarily female sample (72.4%) in Bados et al. (2007) dropped out due to low motivation and/or low satisfaction with the treatment type or therapist (46.7%), external problems (transportation, moving, time, illness, new responsibilities, etc.; 40.0%), and because they believed that they had improved (13.3%), whereas the all-male sample in this present study dropped out due to the following CI categories: Not the Right Interpersonal Fit, Not the Right Approach, Need to Build Trust, Cost, No Longer Needed, and Time Problems. What is most evident is that the reasons of the

present all-male study are similar to the primarily female study in that the highest-rated categories include the therapeutic alliance and the treatment approach, but differs in that low motivation was not evident in the present all-male study as a primary reason for dropping out. Motivation is similar to the secondary CI category Client Not Engaging, but this was not present among the primary CI categories. Therefore, what is relatively unique is that the primarily dominated female sample rated low motivation as one of the highest variables for dropping out, whereas this was not evident in this present all-male study—it was merely a secondary reason for dropping out for one individual. Bados et al. (2007) did not break down the three groups of reasons for dropping out further as this present study did. A future study can determine why women drop out of counseling/psychotherapy utilizing the ECIT and a clearer comparison can be made with the present study's all-male sample, though one should keep in mind that the results would be suggestive as the ECIT is exploratory.

Dr. Robinder Bedi noted that former research studies utilizing the ECIT have not used different CI and WL item categories. However, the present study's results yielded different CI and WL item categories. Butterfield et al. (2009) did not specify that CI and WL item categories should be different or the same. What was found in the present study was that sometimes a participant's CI category had the direct opposite WL item category (e.g., the CI category Not the Right Approach and the WL item category Change the Approach), but also sometimes a participant's CI category was not the direct opposite WL item category (e.g., the CI category Not the Right Interpersonal Fit and the WL item category Change the Approach). In fact, not all of the CI categories have an exact opposite WL item category (e.g., the CI category Need to Build Trust and the WL item category Client Engages More),

though most of them do. Therefore, future research should be sure to not assume that CI and WL item categories should be the same—it will depend on the aim of the study.

Application

Given that this research suggests that men are most likely to drop out of counseling/psychotherapy if they do not have a strong therapeutic alliance with their mental health professional or if they do not have the right treatment approach to meet their needs and/or beliefs, it may be beneficial to implement steps that previous research has suggested for the start of treatment to help put the treatment course on the right path from the beginning. Therefore, past research suggests tailoring the following six practice strategies to each client's need to prevent dropout from occurring (Roos & Werbart, 2013; Swift, Greenberg, Whipple, & Kominiak, 2012): provide clients with education prior to therapy about treatment duration and timing of progress/change, provide clients with role expectations for client and therapist behaviors in order to prepare them for the therapy, incorporate client therapy preferences, strengthen hope early of how treatment will help to overcome client problems, foster the therapeutic alliance, and continuously monitor and discuss treatment progress.

Although the men in the present study overall had a moderately low adherence to traditional masculinity ideology, there may be men who have dropped out of counseling/psychotherapy who have greater adherence to traditional masculinity ideology and did not participate in the research. Kivari (2014) found the following helped men who were socialized to be traditionally masculine to remain engaged in group psychotherapy, and most of these incidents may help mental health professionals who work with men in individual psychotherapy to foster a better treatment approach and a stronger therapeutic

alliance, which are suggested from the present study to be most important in helping men to remain in treatment: having a safe environment that is free from judgment and advice given by having established rules, moving at a speed that matches men's readiness to change (which helps men feel respected and competent), utilizing guidelines to take turns talking about experiences and feelings (which helps men to not feel alone), expressing affection for another (e.g., expressed anger for another's experience), being effective by coming across as a humane individual instead of as a therapist, working as a collaborative team, having the men know externally that the therapy is highly effective, and having a straightforward and "to-the-point" style of working through the therapy. When working with traditionally masculine men, Kivari (2014) honed in the importance of the therapist to relate similarities with the men clientele, allow the men to be self-governing in order to feel competent and respected, and consider working with men in group therapy instead of individual therapy alone, as psychotherapy research is suggesting that men work better in groups (Kiselica & Englar-Carlson, 2010; Maccoby, 2002).

Due to the present study's most prominent CI category of Not the Right Interpersonal Fit, it is sensible to also reflect on the application suggestions of the Richards and Bedi (2015) study, as they sought what hindered the therapeutic alliance. As noted earlier, they suggested that men in counseling/psychotherapy want to be involved in the process and informed about expectations. Men want to decide together with their clinician what to talk about and what approach to utilize. Clinicians working with men should pay attention to whether the client's preferences and beliefs are in line with their treatment approach, interpersonal style, focus, and/or diagnosis. Self-disclosure from the clinician, collaborating with the client on their treatment plan, and having a clear focus are important to address.

Unlike past research, this research may suggest steps to prevent a potential *dropout* situation from occurring with *men* in *individual* psychotherapy. The suggestions are the most frequent WL items the men believed would have helped them continue working with their mental health professional. The following are present implications of appropriate steps to prevent dropout with men: discuss the approach being utilized and whether the client suggests a different method (as the most frequent WL item category was Change the Approach); address the therapeutic alliance with the client in an effort to build a stronger relationship (as Building Rapport was the second-most frequent WL item category); and address whether there is any concern with the cost and avenues of relief (Affordability), whether the client feels he may be disengaging and what you could do to help (Client Engages More), whether there are better times for the client to come in and how he would like to spend time in sessions (More Availability), and whether the client feels he needs help—if he believes he needs to be there—and ask what his goals for treatment are (Decided if Needed).

Limitations

As noted in the Method, no causality can be made with the (E)CIT due to the lack of a randomly assigned experimental design—as a qualitative method, it is merely suggestive. The collected verbal and nonverbal CIs that are reported to have actually occurred are subjective and based on fallible retrospective recall of the participant's history. As noted earlier, Flanagan (1954) suggested that reported observations may be accepted as accurate if the participants give a lot of detailed descriptions of their former experience. All 18 men in the study gave large amounts of detailed descriptions of their experience. However, past research has shown that even if an individual is confident in their memory, it does not

necessarily mean that their memory is completely accurate. Therefore, as mentioned earlier, the results of ECIT data are merely suggestive. Although the data obtained was completed through interviewing that allowed the participant to be free to state anything, probing for additional information may have posed the threat of the halo effect—an impression created by a comment may have influenced the researcher's opinion, or bias, to state a prompt in a similar area—though the credibility checks of the ECIT helped to control for this possible confounding variable. Only one expert opinion was utilized in this study instead of the recommended two experts, though this had been done before (Butterfield et al., 2009; Richards and Bedi, 2015). The CIT and ECIT have not been previously used in psychotherapy termination research; what may remain unknown is whether the men in this study would have truly remained in their psychotherapy/counseling if their WL items were met. Finally, although exhaustiveness had occurred (twice) in the present study, it is important to note the small sample size when evaluating the quantitative statistical analyses.

Future Research

A future research study may determine whether the WL items that were found in this research help men who continue psychotherapy to remain in psychotherapy by asking men who have remained in psychotherapy what they like most about their psychotherapy, and then compare those CIs with this present study's WL items, but note that they may not necessarily be the exact same, as the ECIT is exploratory and the results are merely suggestive. The same study can investigate (and likely support) whether adult males who are currently remaining in individual, outpatient psychotherapy have a general nonadherence to traditional masculinity *ideology* by utilizing the MRNI-SF and compare it with the men's

ratings in this study, as it is anticipated that they would be similar, as the Richards and Bedi (2015) study yielded a general nonconformity to traditional masculine *norms*.

One reason why an individual with a diagnosis of schizophrenia or psychosis may drop out of psychotherapy or may not seek help is due to if the individual has the sometimes-accompanied psychological symptom termed *anosognosia*, which is when an individual's neurology prevents the individual from having an awareness of their mental disorder. Thus, why would an individual want to attend psychotherapy if one does not see a reason to go? This reason is an important concept to understand for men, as schizophrenia adversely affects men more than women (Saha, Chant, Welham, & McGrath, 2005).

Another future study could address whether men who do not enter counseling/psychotherapy state time problems as one of the primary reasons for not seeking mental health care, as this was the CI category with the least participation rate in this present study and the men had a general nonadherence to tradition masculinity *ideology*, whereas men who do not seek counseling/psychotherapy have shown to conform to traditional masculine *norms* (McKelley & Rochlen, 2010). Men who adhere to traditional masculinity ideology may not want to seek counseling/psychotherapy for reasons of "pride" (adult male Apple employee, personal communication, 2015). Similarly, men adhering to traditional masculine norms are taught to always be in control and self-reliant (Kivari, 2014; Mahalik et al., 2003). Perhaps the study can investigate explicit ratings of pride in comparison to implicit ratings of pride if such a scale exists; if not, future research can create one.

There is research that measured men's explicit masculine self-concept, and there was a measure recently developed to assess implicit masculine self-concept (see Burkley, Wong, & Bell, 2016, and Wong, Burkley, Bell, Wang, & Klann, 2017); perhaps future research can

expand on this particular study by asking participants what they think their subjective masculinity is, as well as assess men's implicit masculine self-concept.

What is evident is that there is a need for mental health resources for adult males. Talk therapy can be viewed as emasculating; perhaps research can create a better type of treatment geared toward men who endorse greater traditional masculinity ideology.

The results of the present study suggest that psychotherapists/counselors working with men may be able to utilize the information to help their adult, male clients remain in session until an appropriate time when help is no longer needed. The research may improve therapy techniques used with men, specifically. In addition, clinical supervisors, course instructors, and researchers can benefit from the results of this study on men who drop out in counseling/psychotherapy.

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Footnotes

[1]The primary researcher self-paid participants as a donation to this research.

[2]Dr. Robinder P. Bedi was the primary research advisor prior to teaching at the University of British Columbia and remained an active committee member until completion.

[3]Dr. Ronald F. Levant from The University of Akron granted permission to use his Male Role Norms Inventory–Short Form (MRNI-SF).

Table 1

Men's MRNI-SF Scores

	All Participants		Adjusted	
Scale	*M*	*SD*	*M*	*SD*
Overall	2.80	0.96	2.90	0.87
Avoidance of Femininity	2.50	1.47	2.59	1.46
Negativity Toward Sexual Minorities	1.80	1.23	1.84	1.25
Self-Reliance Through Mechanical Skills	4.80	1.56	5.02	1.27
Toughness	3.91	1.54	4.08	1.40
Dominance	1.65	0.69	1.69	0.69
Importance of Sex	2.52	1.65	2.61	1.66
Restrictive Emotionality	2.41	1.27	2.49	1.25

Note. The Male Role Norms Inventory–Short Form is from Levant, Hall, and Rankin (2013). Scores range from 1 (*strongly disagree*) to 7 (*strongly agree*); higher scores indicate greater endorsement of traditional masculinity ideology. One participant answered *strongly disagree* for all questions on his MRNI-SF; results with and without his response are shown to adjust for skewness.

Table 2

Men's Primary CI Category and Overall MRNI-SF Score

CI Category	*n*	*M*	*SD*
Not the Right Interpersonal Fit	5	2.42	0.90
Not the Right Approach	5	3.44	0.71
Need to Build Trust	2	2.69	0.37
Cost	2	2.19	0.34
No Longer Needed	2	4.00	0.40
Time Problems	1	2.29	

Note. A one-way between subjects ANOVA found no statistically significant effect of primary reason for dropping out on overall MRNI-SF scores, F (5, 11) = 2.55, MSE = .510, p = .091.

Appendix A

Recruitment Distribution Letter

Department of Psychology
Academic Instruction Center,434
516 High Street
Bellingham, WA 98225

[Month] 2019

[Name]
[Address]

Dear [Name],

Our research team from the Department of Psychology at Western Washington University is currently investigating client dropout in psychotherapy. As part of the recruitment for this study, we respectfully request your assistance. **In particular, we hope that you are willing to share recruitment information about this study with your male clientele (see attached flyer)**. Participants will be asked to describe an incident they believe to have been the primary reason for dropping out of their (most recent) individual psychotherapy treatment with their psychotherapist.

This thesis research study is being led by Karen Springer under the supervision of Dr. Jeff King, Department of Psychology, at Western Washington University. Should you have any questions about this study, please contact the primary investigator at springk3@wwu.edu.

We sincerely hope you are able and willing to share this information with your previous male clients without much inconvenience. Thank you for your time and help- we appreciate it.

Sincerely,

Karen Springer
Experimental Psychology Graduate Student Researcher
Department of Psychology
Western Washington University

Appendix B

Recruitment Distribution Flyer

Men,
Get Paid to Speak Your Mind!

Have you experienced psychotherapy/counseling and terminated services early?
We want to hear from you!

To be eligible, you must:
1) be 18 years of age or older (19 if in Vancouver),
2) have had an appointment with a psychotherapist/counselor (other than an initial consultation) and dropped out within the past four years, and
3) have access to the Internet and the software application Skype in an uninterrupted environment of your choice OR the Internet and a telephone.

You will be interviewed and asked to complete three questionnaires that take approximately one hour and will be paid $15 for completing the study. There are no anticipated risks with your involvement; however, your participation will potentially contribute to the wellbeing of men who seek counseling.

To participate or for more information, contact the primary investigator directly:
springk3@wwu.edu

Please include in your message that you are writing about the "men's dropout study."

This thesis research study is being led by Karen Springer under the supervision of Dr. Robinder P. Bedi, University of British Columbia, Dr. Jeff King, and Dr. Aaron Smith, Department of Psychology, at Western Washington University.

Appendix C

List of Recruitment Locations

Bellingham, WA
- Craigslist
- Western Washington University: message boards in Artzen, Miller, Old Main 100 and 200 levels, SMATE, Viking Union Building (2001 Bill McDonald Pkwy. and 516 High St., Bellingham, WA 98225, 360-650-3400 and 360-650-3000)
- Everett Community College (2000 Tower St, Everett, WA 98201)
- Coffee Junction (401 Harris Ave., 98225, 360-733-3172)
- Community Food Co-Op Downtown (1220 Forest St., 98225, 360-734-8158)
- Fred Meyer (800 Lakeway Dr., 98229 360-676-1102)
- Haggen: Sehome (210 36th St., 98225, 360-676-1996)
- Haggen: Fairhaven (1401 12th St., 98225, 360-733-4370)
- The Woods Coffee (470 Bayview Dr., Bellingham)
- The Woods Coffee (1135 Railroad Ave., Bellingham)
- Wally's Barbershop (314 E Holly St., 98225, 360-647-0807)

Seattle, WA
- Craigslist

Vancouver, BC
- Craigslist
- The University of British Columbia, Psi Chi: November Newsletter (2329 West Mall, Vancouver, BC V6T 1Z4, Canada)

Houston, TX
- Craigslist
- The University of Houston (Main Campus), Psi Chi: President sent to members (4800 Calhoun Rd, Houston, TX 77004)
- Starbucks: 445 North Loop West, 217 Heights Blvd., and 2050 West Gray St.

Austin, TX
- Craigslist

Huntsville, TX
- Craigslist

Dallas, TX
- Craigslist

Denton, TX
- Craigslist

Galveston, TX

- Craigslist

Appendix D

Initial Contact and Screening Telephone Call Protocol

Interview Screening Date: _____

Hi_____ **(Potential Participant's Name)**,

Thank you for contacting us for more information about our men's psychotherapy/counseling dropout research study.

Where did you hear about our study?

_____

This study is being conducted through the Department of Psychology at Western Washington University. We are interested in finding out why men who participated in psychotherapy or counseling dropped out before treatment was completed, as well as what they believe would have helped them to continue working with their clinician.

If you choose to participate, you will be asked to complete an interview via Skype with the primary investigator. A Skype account name and password will be provided to use for the interview. The interview will only be audio-recorded (not video-recorded), and only the research team has access to the audio recording. The interview will consist of three short questionnaires that you will complete on Qualtrics during the Skype interview. The questionnaires address your demographics, why you dropped out and what you believe would have helped you stay, and your beliefs about what masculinity means in our Western society. The interview may take an hour of your time and you will be compensated $15 via PayPal. The compensation is also to thank you for your support of this much-needed research. Any information we collect from you today will be kept confidential in a password-encrypted folder that is only accessible by our research team. If you choose to participate in our study and meet the following requirements, you will be assigned a participant number for your confidentiality.

Please answer the following questions with either a "yes" or "no":

- ☐ Is English your primary language?
- ☐ Are you 18 years of age or older (19 if in Vancouver)?
- ☐ Do you identify yourself as male?
- ☐ Did you drop out of psychotherapy or counseling within the past four years?
- ☐ Do you have access to the Internet in a private location of your choice?
- ☐ Do you have Skype or are able and willing to download it to your computer? (If no, you may participate over the telephone.)

Thank you for your responses.

If participant answered "yes" to ***all*** *questions*:
If we schedule an appointment with you, we'll ask you to complete an e-mailed form with your electronic signature to have you contact your former clinician to verify your last appointment date. Will you verify your last appointment date?

→*If "****yes****"*: Thank you. You are eligible to participate in our research study. When would be a good time for you to participate? (*Complete the form below, add the scheduled time in the Google calendar, and e-mail the participant his scheduled appointment time and "*Date of Last Counseling/Psychotherapy Session Form*" document.*)

→*If "****no****"*: Thank you for your time. Unfortunately not all of the requirements are met for you to be able to participate in our study. If you know of someone who would be a likely candidate, please feel free to share our contact information with him. Thank you very much.

RA: _____
Participant Name: _____
Participant ID #: _____
Participant E-mail Address: _____
Participant Telephone #: _____
Participant Mailing Address: _____
Appointment Date: _____
Appointment Time: _____

Thank you for scheduling your appointment. We'll now e-mail you a confirmation of your appointment time and the document to obtain the date of your last appointment with your clinician. Please check now to confirm you received the e-mail, complete the form with your electronic signature, and go ahead and e-mail it back to us. (If you are unable to do so now, we will check back tomorrow if we haven't received it.) (*Open his completed form and check that he filled in all of the appropriate information.*)

Thank you. We will contact you again before your appointment to remind you of it.

Appendix E

Appointment Reminder Telephone Call Protocol/E-Mail Script

PLEASE E-MAIL IMMEDIATELY AFTER HIS APPOINTMENT IS SCHEDULED
PLEASE CALL/E-MAIL AGAIN>24 HOURS OF HIS SCHEDULED APPOINTMENT

Dear Mr. _____ (Surname),

This e-mail is a* reminder *of your scheduled appointment to participate in our *Dropout in Individual Psychotherapy From Adult Male Clients' Perspectives* ***study in the approved location of your choice [on _____day/tomorrow], [Month] [Day], 2019, at [Hour]:[Minute] [a/p]m. The study will take approximately 1 hour.***

Completing the Skype OR telephone interview:
As a reminder, there are some things that we need to ask you to do to ensure that the data we collect from you is valid:

1. ***Please confirm the chosen location of your interview before your session.***
2. ***Please try to eliminate all potential distractions from your environment.***
3. ***Please turn your cell phone on silent if you are participating in the Skype interview (unless otherwise notified of a potential emergency beforehand) OR turn your cell phone on if you are participating in the telephone interview.***
4. ***Please make sure and confirm with us that your Internet connection and Skype application (if applicable) are working properly before your interview.***
5. ***Please be sure to remove personal belongings from the scope of the interview session window if participating in the Skype interview.***
6. ***Please be sure there is enough room available to see a full upper-body visual of yourself if participating in the Skype interview (this is to ensure we get the same view as we would seated at a desk with an in-person interview).***

If you need to contact us before your appointment, call us at (360) 603-9627 or e-mail us at springk3@wwu.edu.

(If applicable:) The participant Skype account username is Participant.167.
Your unique (single-use) password is _[ENTER UNIQUE PASSWORD]_.
Note: Your unique password will be changed after completion of the study.

I look forward to meeting you. Have a great day!

Karen Springer
Experimental Psychology Graduate Student Researcher
Department of Psychology
Western Washington University
springk3@wwu.edu

WESTERN
WASHINGTON UNIVERSITY

Appendix F

Date of Last Counseling/Psychotherapy Session Form

COVER PAGE

To: Karen Springer, Department of Psychology, Western Washington University

Recipient E-mail Address: springk3@wwu.edu

From: _____

Sender E-mail Address: _____

****

CONFIDENTIAL E-MAIL

The following e-mail contains **confidential** information; its contents should be viewed **only by the intended recipient**. If you are not the intended recipient, please deliver to the intended recipient without reading its contents. If you believe this e-mail has reached you in error, please contact the sender at (360) 603-9627.

Date of Last Counseling/Psychotherapy Session Form

Please contact your former counselor/psychotherapist for the counseling/psychotherapy session **date that you were last seen** and e-mail the requested information to Karen Springer of the Psychology Department of Western Washington University at springk3@wwu.edu.

Thank you.

Client Name: _____

Date of Request: _____

Mental Health Care Provider's Name: _____

Mental Health Care Provider's Agency: _____

Appendix G
Research Interview Protocol

Research Interview Protocol

Participant ID #: _____ Participant Initials: _____

Participant Telephone #: _____ Date: _____

RA Initials: _____ Interview Start Time:_____

Arrive in interview room>30 minutes before the scheduled appointment to set up the interview, sign in to the Skype account, check voicemail and e-mail, and answer the telephone in case the participant calls for help with the Skype directions or to inform you of tardiness.

Interview Checklist

Items for Skype interview:

- ☐ 1 Research Interview Protocol (hard copy or open on desktop)
- ☐ Watch/Clock
- ☐ 1 White Noise Machine (***turned on & next to the interview room door on the floor if not in private area***)
- ☐ Callnote Premium (***up & ready if Skype interview***)
- ☐ 1 Livescribe Pen (***charged & ready to be turned on***)
- ☐ Google Voice ready (***if telephone interview in the US***)
- ☐ Boldbeast Call Recorder ready (***if telephone interview in Canada***)
- ☐ 1 Laptop computer with charger plugged in [***Skype up & running, if applicable***]
    - RA Skype Account
        - Username: **wwu.ra167**
        - Password: **lab167**
    - Participant Skype Account
        - Username: **Participant.167**
        - Password: **167lab** (***change after every Skype interview***)
- ☐ 1 Interview Consent Form (***sent via e-mail & participant saves a copy to his desktop after signing with electronic signature***)
- ☐ 1 Participant Former Counseling/Psychotherapy Information and Demographics Questionnaire [Questionnaire 1: Participant Information] (***on Qualtrics***)
- ☐ 1 Enhanced Critical Incident Interview [Questionnaire 2] (***on Qualtrics***)
- ☐ 1 Male Role Norms Inventory–Short Form (MRNI-SF) (***up & ready with participant ID on Qualtrics & link sent via Skype's Messenger; DOUBLE-CHECK ALL QUESTIONS ANSWERED***)
- ☐ 1 Debrief and Contact Information document (***sent via e-mail & participant saves a copy to his desktop***)

☐ 1 Participant Compensation Form: Skype Interview document (***sent via e-mail & participant completes & e-mails it; send via e-mail if needed***)
☐ 1 Resources document (***sent via e-mail & participant saves a copy to his desktop***)

Give the participant his ID number to type in at the start of opening the Qualtrics link. Read each document's instructions aloud and have the participant follow along. Have the participant read and complete the Demographics questionnaire and MRNI-SF on his own. Check that all of the questions were answered after he completes it on Qualtrics. (If anything was not answered, ask him what he would have put and note it under "Notes" below and integrate it with his other responses in SPSS.)

Notes (If Applicable)

_____

_____

_____

_____

(If Skype:) After the participant completes the interview and logs out of the Skype account, change the Skype password and note it for the next interview.

Update the Google calendar of the "COMPLETED" interview.

Make sure all files are in the study's secure Dropbox folder.

Appendix H

Interview Consent Form

INTERVIEW CONSENT FORM

Western Washington University
Study: **Dropout in Individual Psychotherapy From Adult Male Clients' Perspectives**
Primary Researcher: **Karen Springer, springk3@wwu.edu, (360) 603-9627**
Faculty Advisor: **Dr. Jeff King, jeff.king@wwu.edu, (360) 650-3574**

We are asking you to be in a research study. Participation is voluntary. The purpose of this form is to give you the information you will need to help you decide whether to participate. Please read the form carefully. You may ask questions about anything that is not clear. When we have answered all of your questions, you can decide if you want to be in the study or not. This process is called "informed consent."

Purpose and Benefit:
This study will help people learn about what can lead an adult male client to drop out of psychotherapy/counseling. We want to learn from men who dropped out what the primary deciding factors were that led them to drop out before appropriate completion. It is important to study what contributed to provoke men to drop out because it will help mental health professionals to prevent dropout and be able to help the men. Finding out why men drop out of treatment will help professionals and men to have a more successful treatment outcome. Approximately 60 participants will be recruited.

I UNDERSTAND THAT:

1) To take part in this study, you must identify yourself as a male, you must be at least 18 years of age (or 19 if in Vancouver), English must be your primary language, and you must have dropped out of psychotherapy/counseling within the past four years prior to participating in this research study.
2) This research study will involve completing three questionnaires via online interview. It is estimated that the questionnaires will take approximately one hour.
3) There is minimal risk/discomfort anticipated with participation in this study. These risks/discomforts include the time required to complete the questionnaires. Another risk is that you may not like discussing why you decided to drop out of sessions with your mental health professional.
4) Possible benefits to your participation include learning more about what is important to you in counseling or psychotherapy and helping others to learn what is important to men in psychotherapy/counseling.
5) In exchange for your participation, you will be paid $15 via PayPal; this amount is to thank you for your time.
6) Being a part of this study is your choice. You can choose not to complete any particular item on the questionnaires if answering that item would be upsetting to you. If you decide to be part of this study, you may decide to stop at any time without telling anyone why. If you do decide to stop and you completed at least an hour, you

will be paid $10 for the hour you participated. If you decide to stop being part of the study, the answers you give will not be used for this study or any other study.

7) All of the information you give will be kept confidential. Your signed consent form will be kept in a password-encrypted folder separate from the questionnaires and other information. Your name will be separated from the answers you give. The researchers will put an ID number on your questionnaires to help them know the questionnaires all came from the same person. Only the researcher in charge and research assistants will be allowed to see your answers and forms with your name on them. We take every precaution to protect your information, though no guarantee of security can be absolute. We believe the chances of you being identified are low due to the protections in place for your privacy.

8) All of the information you share about what led you to end sessions with your psychotherapist/counselor will be summarized in one sentence. If the experience you describe is very similar to what other men have experienced, all of your experiences may be described in one sentence. Men in the first part of this study will be asked if they want to help with the second part of the study. Each of the men, on his own, will look at the sentences describing the experiences of all the men in the study and determine whether the group the researchers categorized them in accurately describe what they have in common. No names and no information that could let people know who they are about will be in the sentences.

9) The results of this study will probably be shared in these ways: they may be published in an article, presented at a meeting or conference, and used in classes to teach counselors or psychotherapists. If you or another participant would like to see a short description of the results, that person can let the researcher know at his appointment or contact the researcher to let them know. Any man in the study who asks to see a short description of the results will be sent one after the study is completed.

If you have questions or comments regarding this study, please contact Karen Springer, the primary researcher in charge. You can contact her by e-mail at springk3@wwu.edu or by telephone at (360) 603-9627. If you have questions about your rights as a research participant, you can contact the WWU Research Compliance Officer at (360) 650-2146 or by e-mail at compliance@wwu.edu. If you are hurt or experience problems while taking part in this study or because you were a part of this study, please let the researcher in charge of the study know or tell the WWU Research Compliance Officer. Please retain a copy of this consent form for your records.

****

By signing below, you are saying that you have read this form, you have had your questions answered, you understand the tasks involved, and you volunteer to take part in this research.

_____ _____

Participant's Signature Date

_____

Participant's Printed Name

We will be conducting follow-up interviews to help make sure the researchers honestly and clearly represent the experiences shared by men in this study. They will be asked for their feedback on sentences describing men's experiences in counseling or psychotherapy. It should only take about ten minutes on the phone to answer these questions. No money will be paid for the phone interview, but we will be very grateful for your help.
May we call you for a brief follow-up interview? (insert "x") __Yes __No

Are you interested in being contacted about future studies? (insert "x") __Yes __No

I agree that the answers I give today may be used in future research studies if the researchers do not use my name with my answers and take out any information that could let someone know who gave those answers. _____
(initial here)

NOTE: Please sign with your electronic signature and retain a copy for your records.

Appendix I

Participant Former Counseling/Psychotherapy Information and Demographics Questionnaire

Questionnaire 1: Participant Information

To ensure confidentiality, please do not type your name on this questionnaire. For each question below, you will be asked to select an answer and/or fill in a blank. Please take your time and answer each question completely. Please check your typing for errors. If you have any questions or comments while completing this questionnaire, please let the researcher know.

I. Former Counseling/Psychotherapy Information

1. How did you find out about this research study? (Please only select **one**.)
   - □ From my former mental health professional
   - □ Through a posted flyer or other (please specify where): _____

2. Approximately how many counseling/psychotherapy sessions have you had with your most recent mental health professional? **_____ sessions**

3. How did your most recent counseling/psychotherapy end?
   In your own words: _____
   _____
   _____

4. On a scale of 1 to 6, please rate the quality/strength of the working relationship between you and your former mental health professional (please only select **one** number):

Extremely Negative/Weak					Extremely Positive/Strong
1	**2**	**3**	**4**	**5**	**6**

II. Demographics

5. Please indicate your gender:
   □ Male □ Female □ Other (please specify): _____

6. Please indicate your sexual identity:
   □ Heterosexual □ Homosexual □ Bisexual □ Other (please specify): _____

7. What is your birth date? ___/___/_____

8. Please indicate your current partnership status: □ Single/Never Married or Partnered
   □ Married or Partnered □ Divorced or Separated □ Widowed

9. Please indicate the highest level of education that you have **completed**:
- ☐ Elementary School
- ☐ Junior High School
- ☐ High School or GED
- ☐ Occupational/Technical/Vocational degree
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Ph.D., M.D., or equivalent doctoral degree

10. Please indicate your current occupation (includes full-time student): _____

11. Please indicate your household income:
- ☐ < $14,999
- ☐ $15,000 - $29,999
- ☐ $30,000 - $44,999
- ☐ $45,000 - $59,999
- ☐ $60,000 - $74,999
- ☐ $75,000 - $89,999
- ☐ $90,000 - $104,999
- ☐ $105,000 - $119,999
- ☐ $120,000 - $134,999
- ☐ $135,000 - $149,999
- ☐ > $150,000

12. How would you describe your ethnicity? _____

13. How long have you lived in the US and/or Canada? **US: ___ years; Canada: ___ years**

14. Do you have any past or present psychological diagnoses?
- ☐ No
- ☐ Yes (please specify any diagnoses): _____

15. Did you have any psychological diagnoses at the time of your last counseling/psychotherapy session?
- ☐ No
- ☐ Yes (please specify any diagnoses): _____

16. Have you taken prescription medication for any past or present psychological diagnoses?
- ☐ No
- ☐ Yes (please specify medications): _____

17. Were you taking any prescription medication at the time of your last counseling/psychotherapy session?

☐ No
☐ Yes (please specify medications): _____

III. Characteristics of Your Counseling/Psychotherapy

18. How many mental health professionals have you received individual counseling/psychotherapy from throughout your life (including the former one)? _____

19. With your most recent mental health professional, how long had you been receiving counseling/psychotherapy? **_____ years and _____ months**

20. With your most recent mental health professional, how were you paying for services?
- □ Services were free
- □ Automatic coverage by self-paid student services fees
- □ Self-paid full cost
- □ Full coverage by healthcare plan
- □ Partial coverage by healthcare plan

21. Where did you most recently receive counseling/psychotherapy? (Please only select **one**.)
- □ Private practitioner's office
- □ Community agency
- □ University/College clinic or counseling center
- □ Hospital
- □ Other (please specify): _____

22. What is your most recent mental health professional's highest education level?
- □ Not sure
- □ Diploma/Certificate
- □ Bachelor's degree (e.g., B.A./B.Ed./B.Sc./B.S.W.)
- □ Master's degree (e.g., M.A./M.Ed./M.Sc./M.S.W.)
- □ Ph.D.
- □ M.D.
- □ Psy.D.

23. What is your most recent mental health professional's profession?
- □ Counselor
- □ Social worker
- □ Psychologist
- □ Psychiatric nurse
- □ Psychiatrist
- □ Other (please specify): _____

24. What is your most recent mental health professional's gender?
□ Male □ Female □ Other (please specify):_____

25. Please select the **one** answer that best describes the single, most important reason that you most recently sought counseling/psychotherapy (please only select **one**):

□ Anxiety or stress □ Self-esteem □ Trauma □ Depression
□ Relationship issues □ Alcohol/Drug use □ Anger management
□ Career concerns □ Educational concerns
□ Other (please specify): _____

26. What type/style/theory of counseling/psychotherapy did you most recently receive?

_____

Appendix J

Enhanced Critical Incident Interview

Questionnaire 2

I. Factor(s) that Led to Dropout

Please think back over the sessions you had with your former mental health professional, paying particular attention to the primary factor that was enabling you to think about not returning for more sessions. (Please take a few moments to remember this clearly and put your thoughts in context.) *What was the single most important thing that led you to drop out?* We are most interested in specific behaviors and other observable things. This can be something that either you or the professional did, something you did together, or something else that happened within or outside the sessions. *Please describe the behavior or event completely and in as much detail as possible. Please take your time.*

Before answering, **please remember that we are asking about factors that led *you* to want to discontinue working with the mental health professional.** Please only mention something that led you to want to drop out. If you are unsure about anything, please discuss this with the interviewer.

Q1. What was the **most** important thing that ultimately led you to drop out of counseling/psychotherapy? Please describe it completely and in as much detail as possible. (Please include any possible additional factors after the primary factor.)

_____

_____

_____

_____

_____

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_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

For all subsequent questions in this section (Qs 2 – 20), refer to your response to Q1.

Q2. Was this something that you did, that the mental health professional did, that you did together, or something else that occurred within or outside of the sessions?

- □ Something I did
- □ Something the professional did
- □ Something we did together
- □ Something else from within the session
- □ Something else from outside the session

Please note that not all of the following questions will apply to what you mentioned. Please only answer those questions that are relevant, and put "N/A" if a question does not apply to your situation.

Q3. If this was something the mental health professional did, what were you doing at the time?

_____

_____

Q4. If this was something you did, what was the mental health professional doing at the time?

_____

_____

Q5. Approximately, in what session did this occur or first occur? (e.g., **1st, 2nd, 3rd, etc.**)

_____

Q6. In the particular session in which it did occur, did it happen early in the session, in the middle of the session, or near the end of the session?

- □ Early in the session
- □ Middle of the session
- □ Late in the session
- □ Not applicable

Q7. In only **one** sentence, please summarize what happened that led to you wanting to drop out of sessions with your mental health professional.

_____

_____

Q8. If someone were secretly watching when this happened, what would they see and hear?

_____

_____

Q9. What led up to this and/or happened right before?

_____

_____

Q10. What happened after this?

_____

_____

Q11. Please describe how you were feeling after this happened.

_____

Q12. How many times did this occur?_____

Q13. For how long did this occur?_____

Q14. In what percentage (%) of sessions did this occur? (0% to 100%) _____**%**

Q15. How would you feel or react if this happened again the next session?

_____

Q16. What would you be thinking if it happened again the next session?

Q17. If this stopped happening, how would you feel and react, and what would you be thinking?

Q18. How did this hinder in forming or strengthening the working relationship with the mental health professional?

Q19. Why did this hinder in forming or strengthening the working relationship with the mental health professional?

Q20. Instead of this, what else could you or the professional do to weaken or hurt the working relationship?

II. Factor(s) That Would Have Helped You Stay (Wish List Items)

Now please let us know the single most important thing that you believe would have helped you to stay in counseling/psychotherapy, followed by any other additional factors. We are most interested in specific behaviors and other observable things. This can be something that either you or the professional could have done, something you could have done together, or something else that could have happened within or outside the sessions. *Please describe the behavior or event you wish could have happened completely and in as much detail as possible. Please take your time.*

Before answering, **please remember that we are asking about factors that you wish could have occurred to have helped you want to continue working with the mental health professional.** Please only mention something that you wish could have happened. If you are unsure about something, please discuss this with the interviewer.

Q1. What is the **most** important thing that would have helped you want to continue working in your counseling/psychotherapy sessions? Please describe it completely and in as much detail as possible. (Please include any possible additional factors after the primary factor.)

_____

_____

_____

_____

_____

_____

_____

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_____

_____

_____

_____

_____

_____

_____

For all subsequent questions in this section (Qs 2 – 20) refer to your response to Q1.*

Q2. Was this something that you could do, that the mental health professional could do, that you could do together, or something else that could occur within or outside of the sessions?

- □ Something I could do
- □ Something the professional could do
- □ Something we could do together
- □ Something else that could occur from within the session
- □ Something else that could occur from outside the session

Please note that not all of the following questions will apply to what you mentioned. Please only answer those questions that are relevant, and put "N/A" if a question does not apply to your situation.*

Q3. If this was something the mental health professional could do, what do you think you would be doing at the time?

_____

_____

Q4. If this was something you were to do, what do you think the mental health professional would be doing at the time?

_____

_____

Q5. Approximately, in what session would you want for this to first occur? (e.g., **1st, 2nd, 3rd, etc.**)

_____

Q6. In the particular session in which it were to occur, would it happen early in the session, in the middle of the session, or near the end of the session?

- □ Early in the session

□ Middle of the session
□ Late in the session
□ Not applicable

Q7. In only **one** sentence, please summarize what could have happened to help you to continue working with the mental health professional.

_____

_____

Q8. If someone were secretly watching when this would have happened, what would they see and hear?

_____

_____

Q9. What do you think would lead up to this and/or happen right before?

_____

_____

Q10. What do you think would have happened after this happened?

_____

_____

Q11. Please describe how you think you would feel after this.

_____

Q12. How many times would you want for this to occur? _____

Q13. For how long would you want for this to occur? _____

Q14. In what percentage (%) of sessions would you want this to occur? (0% to 100%) ___**%**

Q15. How would you feel or react if this were to happen again the next session?

_____

_____

Q16. What would you be thinking if it were to happen again the next session?

_____

_____

Q17. If this were to stop happening, how do you think you would feel and react, and what would you be thinking?

_____

_____

Q18. How do you think this would help you want to continue working with the mental health professional?

_____

_____

Q19. Why do you think this would help you want to continue working with the mental health professional?

_____

_____

Q20. Instead of this, what else do you think you or the professional could do to help you want to continue?

_____

_____

Appendix K

Male Role Norms Inventory–Short Form (MRNI-SF)

Please complete the questionnaire by choosing* the number which indicates your level of agreement or disagreement with each statement. Give only one answer for each statement.

Strongly Disagree	Disagree	Slightly Disagree	No Opinion	Slightly Agree	Agree	Strongly Agree
1	**2**	**3**	**4**	**5**	**6**	**7**

1. Homosexuals should never marry.
1 2 3 4 5 6 7

2. The President of the US should always be a man.
1 2 3 4 5 6 7

3. Men should be the leader in any group.
1 2 3 4 5 6 7

4. Men should watch football games instead of soap operas.
1 2 3 4 5 6 7

5. All homosexual bars should be closed down.
1 2 3 4 5 6 7

6. Men should have home improvement skills.
1 2 3 4 5 6 7

7. Men should be able to fix most things around the house.
1 2 3 4 5 6 7

8. A man should prefer watching action movies to reading romantic novels.
1 2 3 4 5 6 7

9. Men should always like to have sex.
1 2 3 4 5 6 7

10. Boys should prefer to play with trucks rather than dolls.
1 2 3 4 5 6 7

11. A man should not turn down sex.

1 2 3 4 5 6 7

12. A man should always be the boss.

1 2 3 4 5 6 7

13. Homosexuals should never kiss in public.

1 2 3 4 5 6 7

14. A man should know how to repair his car if it should break down.

1 2 3 4 5 6 7

15. A man should never admit when others hurt his feelings.

1 2 3 4 5 6 7

16. Men should be detached in emotionally charged situations.

1 2 3 4 5 6 7

17. It is important for a man to take risks, even if he might get hurt.

1 2 3 4 5 6 7

18. A man should always be ready for sex.

1 2 3 4 5 6 7

19. When the going gets tough, men should get tough.

1 2 3 4 5 6 7

20. I think a young man should try to be physically tough, even if he's not big.

1 2 3 4 5 6 7

21. Men should not be too quick to tell others that they care about them.

1 2 3 4 5 6 7

*****The word "circling" was replaced with "choosing" for technicality.

MRNI-SF Scoring:

A. **Specific Traditional Masculinity Ideology Factors (Subscales).** To obtain subscale scores compute the means of the items for that scale. These are designated below by the number as they appear on the instrument.

Avoidance of Femininity = (4+8+10)/3
Negativity Toward Sexual Minorities = (1+5+13)/3
Self-Reliance Through Mechanical Skills = (6+7+14)/3
Toughness = (17+19+20)/3
Dominance = (2+3+12)/3
Importance of Sex = (9+11+18)/3
Restrictive Emotionality = (15+16+21)/3

B. **General Traditional Masculinity Ideology Factor (Total Scale).** To obtain Total Scale, take the mean of all of the items.

Appendix L

Debrief and Contact Information

DEBRIEF AND CONTACT INFORMATION

Thank you for participating in the *Dropout in Individual Psychotherapy From Adult Male Clients' Perspectives* research study. The information you provided today will better enable us to understand why adult males drop out of psychotherapy. None of the information shared today will be available to anyone except the research team. In addition, we will contact you to take part in the follow-up interview; are you willing to participate in the follow-up interview to ensure the accuracy of participant responses? **Y__ N__**

It is important that the contact information we have for you is accurate and we ask that you also provide an additional contact should we not be able to reach you. (*Read him the telephone number(s), e-mail, and mailing address we have for his contact information.*)
Contact information verified by the participant? Y__ N__
If not, put the corrected contact information here:

_____ (telephone)

_____ (e-mail)

What additional contact information would you be "ok" with us having in case we are unable to reach you? (*Put the additional contact name and information below.*)
Additional contact name and information:
_____ (name)

_____ (telephone)

_____ (e-mail)

Thank you for helping us to ensure we are able to reach you if we have any questions regarding the accuracy of your responses. A copy of the debriefing statements will be sent to you now to save on your desktop (*send the participant the debriefing statements document*).

We will now send you your compensation via PayPal and the Compensation Form (*send the participant his compensation and the "*Participant Compensation Form: Skype Interview*" document*). After you receive the $15 (or $10 if completed an hour, but did not complete the interview), please complete the compensation form via electronic signature on the document that we will e-mail you right now and e-mail it back to us. (*E-mail the participant RIGHT NOW and VERIFY HE RECEIVED THE E-MAIL with the attached "*Participant Compensation Form: Skype Interview*" document. If it was not received, confirm his e-mail address and do it again.*) Please note: if we do not receive your reply e-mail with your completed compensation form now, we will assume the $15 (or $10) was received and no further contact will be made.

In addition, we will now send you a list of Resources that we give to every participant (*verify that he received it*). Thank you again for your participation. Have a great day!

Research Interviewer Initials: _____ Date: ___/___/2019
Interview End Time: ___:___a/pm CST Length of Interview: _____

Appendix M

Participant Compensation Form: Skype Interview

PARTICIPANT COMPENSATION FORM: SKYPE INTERVIEW

Dropout in Individual Psychotherapy From Adult Male Clients' Perspectives

Principal Investigator: Karen Springer
Department of Psychology
Western Washington University

I hereby confirm via electronic signature that I received **$____** for the participation in the above-mentioned research study on the date noted below.

Participant Name: _____

Participant Signature: _____ Date _____

Witness Name: _____

Witness Signature: _____ Date_____

If the participant withdraws early from the research study, please note the length of time he participated: _____ hour(s) and ____ min(s). (*If the participant withdrew, but completed an hour of participation, he will still receive $10 for that hour.*)

The participant should be provided with **$15** for a completed interview. After the participant receives the appropriate compensation amount for his participation via PayPal, have him complete this form. *BE SURE TO SIGN AND DATE THE DOCUMENT. E-mail the participant and CC this study's Gmail account for the receipt. (PLEASE CHECK TO VERIFY THAT HE COMPLETED AND E-MAILED THIS DOCUMENT.*)

Appendix N

Resources

RESOURCES

24-hour Western Washington Crisis Line: 1-800-584-3578

24-hour Suicide Prevention Lifeline: 1-800-SUICIDE (1-800-784-2433)

24-hour National Suicide Lifeline: 1-800-273-TALK (1-800-273-8255)

National Alliance on Mental Illness (NAMI): 1-800-950-NAMI (1-800-950-6264)
http://www.nami.org/
NAMI Air App:
http://www.nami.org/Find-Support/Breathe-Easy-with-Air
NAMI Whatcom: 360-671-4950
http://www.namiwhatcom.org
NAMI Greater Seattle: 206-783-9264
http://www.nami-greaterseattle.org
NAMI Greater Houston: 713-970-4419
http://www.namigreaterhouston.org
P.O. Box 66270 77266
Education, support, advocacy

Alcoholics Anonymous:
http://www.aa.org
Alcoholics Anonymous- Whatcom County: 360-734-1688
http://whatcomaa.org
Alcoholics Anonymous- Greater Seattle Intergroup: 206-587-2838
http://www.seattleaa.org
Alcoholics Anonymous- Greater Vancouver Intergroup Society: 604-615-2911; 604-434-3933
http://www.vancouveraa.ca
Alcoholics Anonymous- Houston Intergroup Association, Inc.: 713-686-6300
http://www.aahouston.org

Narcotics Anonymous:
http://www.na.org/
Narcotics Anonymous- Northwest Washington Area: 360-647-3234
http://www.nwwana.org/
Narcotics Anonymous- Seattle Area: 206-790-8888
http://www.seattlena.org/
Narcotics Anonymous- Vancouver Area: 604-873-1018
http://www.vascna.ca/
Narcotics Anonymous- Houston Area: 713-661-4200

http://www.hascona.com/

Treatment Center Search:
https://treatment.psychologytoday.com/rms/

American Psychiatric Association:
http://www.psychiatry.org/patients-families

National Institute of Mental Health:
http://www.nimh.nih.gov/index.shtml

Bellingham/Whatcom County Area(Agencies/Clinics/Counselors):
Those listed **may** be able to provide services for a reduced fee **or** on a sliding scale basis.

Whatcom Counseling & Psychiatric Clinic: 360-676-2220
"Counsel Program": 360-752-4542
Low-Cost Counseling Services
Call Diane & ask about the "Counsel Program"

WWU Counselor Training Clinic: 360-650-3184
Low-Cost Counseling Services

Interfaith Community Health Center: 360-676-6177
Ask about low-cost counseling program. Must be a medical patient there, but if not & qualify as low income, you can apply to a program called "Access to Mental Health Services." If this is the case, call 1-888-693-7200 to get approved; the program will contact Interfaith & Interfaith will then call you to set up a psychiatric evaluation (which must be done before counseling can start).

Northwest Behavioral: 360-392-2838
Individuals, couples, families

Northwest Youth Services: 360-734-9862
Children, adolescents, families

Sea-Mar Community Health Center (Outpatient Behavioral Health Clinic):
360-734-5458
Children, adults

Domestic Violence and Sexual Assault Services (DVSAS): 360-715-1563 (24 hours)
dvsasemail@dvsas.org

Rainbow Recovery Center: 360-752-2577
209 W Holly Street
Bellingham, WA 98225

Anyone with a mental illness & >18 years old

Brigid Collins Family Support Center: 360-734-4616, 8:00-4:30 M-F
1231 N Garden St., #200
http://www.brigidcollins.org/

Washington State Mental Health Division: 1-800-446-0259

Washington Recovery Help Line: 1-866-789-1511
http://warecoveryhelpline.org/
24-hour help for mental health, substance abuse, & problem gambling

Lauren Davies: 360-647-7905
Individuals, families, couples

Peg Davies: 360-734-2668
Individuals, couples, families

Stephanie Druckman: 360-483-8824
Individual adults (18+; chemical dependency, PTSD)

Freedman & Assoc.
Jordan Feigal: 360-734-2664, ext. 21
Individuals (children, adolescents, adults), families, couples

Lisa Harmon: 360-820-9469
Individuals, couples, general postpartum (Mon. & Fri. only)

Laurel Holmes: 360-920-0009
Individuals, couples

Northwest Behavioral
Marcia Joye: 360-318-3966
Individuals, couples (18+)

Karen King: 360-927-7262
Individuals (children, adolescents, adults), families, couples

Claire Mannino: 360-224-5334
Individuals, couples, family (LGBTQ, queer, gender counseling)

Marlene Sexton: 360-758-4295
Individuals, marriage, family

Seattle:

Harborview Psychiatric Walk-In Emergency Services: 206-744-3000
325 9th Ave.
Seattle, WA 98014

Crisis Line: 206-461-3222 (24 hours)

Washington Recovery Help Line: 1-866-789-1511
http://warecoveryhelpline.org/
24-hour help for mental health, substance abuse, & problem gambling

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Vancouver:

BC Crisis Line: 310-6789 (do not add 604, 778, or 250 before the number; 24 hours)

BC Partners for Mental Health and Addictions Information:
www.heretohelp.bc.ca

Canadian Mental Health Association, BC Division: 1-800-555-8222 (toll-free in BC);
604-688-3234 (in Greater Vancouver)
www.cmha.bc.ca

Houston:

The Council on Recovery- Outpatient Treatment:
303 Jackson Hill St.
Houston, TX 77007
Call Mrs. Cheryl Kalinec
281-784-3318

The Harris Center for Mental Health and IDD:
http://www.mhmraharris.org

Low-Cost Mental Health Resources in Greater Houston and Harris County:
http://www.mhahouston.org/find-help/

Gateway To Care Navigators:
3611 Ennis St. 77004
713-783-4616
Helps connect to healthcare services

Attention Deficit Disorders Association:
12345 Jones Rd., Ste. 287-7 77070
281-894-4932

Education, support groups

Baylor Psychiatry Clinic:
1977 Butler Blvd., Ste. E4.400 77030
713-798-4857
Psychiatric & psychological services

Bo's Place:
10050 Buffalo Speedway 77054
713-942-8339
Information & referral services, grief support groups, community education

Catholic Charities of the Archdiocese of Galveston-Houston (multiple locations):
713-526-4611
Individual, couples, family counseling
(*Appointments*) 713-874-6590

The Center for Creative Resources:
816 Hawthorne St. 77006
713-461-7599
Counseling by supervised interns

Crisis Intervention of Houston, Inc.:
3701 Kirby Dr., Ste. 540 77098
(*Hotline*) 713-468-5463
Crisis services, crisis intervention, suicide prevention

Denver Harbor Family Clinic:
424 Hahlo St. 77020
713-674-3326
Medical & mental health services

Depression and Bipolar Support Alliance:
3800 Buffalo Speedway, Ste. 350 77098
713-600-1131
Information & referral services, self-help support groups

Family Services of Greater Houston (multiple locations):
4625 Lillian St. 77007
(*Appointments*) 713-861-4849
Various counseling programs, education

Harris Health Behavioral Health (multiple locations):
(*Eligibility*) 713-566-6509
Therapy, psychiatry, medical services
(*Appointments*) 713-526-4243

Ben Taub General Hospital:
1504 Taub Loop 77030
713-873-2000
Crisis services, psychiatric & medical hospital

Hope and Healing Center:
717 Sage Rd. 77056
713-871-1004
Education programs, support groups

Houston Area Community Services (multiple locations):
713-426-0027
Medical & mental health services

Houston Galveston Institute:
3316 Mount Vernon St. 77006
713-526-8390
Individual, family & group counseling, walk-in clinic

Innovative Alternatives:
1335 Regents Park Dr., Ste. 240 77058
832-864-6000
Individual, family counseling, anger management, trauma
(*Alternate phone*) 713-222-2525
Victims support group, free victim services

Interface-Samaritan Counseling Center (multiple locations):
4803 San Felipe St. 77056
713-626-7990
Individual, couples, family counseling

Jewish Family Service:
4131 South Braeswood Blvd. 77025
713-667-9336
Information & referral services, counseling, employment services

Krist Samaritan Center:
17555 El Camino Real 77058
281-480-7554
Individual, family, marriage counseling , psych. testing, speech & social communication therapy

Legacy Community Health Services (multiple locations):
1415 California St. 77006
832-548-5000
Individual, group, family, couples therapy, psych. services

MHMRA (multiple locations):
713-970-7070
Mental health services, psychiatry

Eligibility Determination Center:
3630 West Dallas St. 77019
713-970-4444
Financial & clinical eligibility for services

NeuroPsychiatric Center:
1502 Taub Loop 77030
713-970-7070
Crisis services, emergency psychiatric treatment

Riverside General Hospital:
3204 Ennis St. 77004
713-526-2441
Psychiatric hospital

St. Joseph House:
3307 Austin St. 77004
713-523-5958
Psychosocial rehabilitation

The Gathering Place:
5310 South Willow Dr. 77035
713-729-3799
Psychosocial rehabilitation

University of Houston Clear Lake:
2700 Bay Area Blvd., Box 83 77058
281-283-3330
Counseling by Master-level trainees

UH Psychology Research & Services Center:
4505 Cullen Blvd., Entrance 8 77004
713-743-8600
Individual & group therapy, psychological assessments

UT Harris County Psychiatric Center:
2800 South MacGregor Way 77021
713-741-5000
Involuntary commitment, inpatient psychiatric hospital

Appendix O

Record of Emerging Critical Incident (CI) and Wish List (WL) Categories Form

Description (raw CI #); **CI Category Name**

1. We had a disagreement about… the use of medication… and I didn't feel comfortable about that. I have nothing bad to say about him. It's just that I don't believe in change through chemicals. (CI 1); **Not the Right Approach**

2. I did not think therapy and meds did not do anything for me after all these years I'd been taking them. (CI 2.1); **Not the Right Approach**
I'd say… [I had] lack of interest. I lost interest because I didn't think my counselor/psychotherapist was focusing on me. We didn't connect. (CI 2.2); **Not the Right Fit**
…didn't want to have to drive to the facility so many times. It was a motivation factor. (CI 2.2); **Client Not Engaging**

3. I was told that I was bipolar and I did not believe such a thing is applicable. The tendency of my psychotherapist to adhere to textbook standards and complete a fast diagnosis. (CI 4); **Not the Right Approach**

4. I felt like we weren't clicking. I felt like he wasn't seeing my issues as serious as I did. I didn't feel comfortable opening up furthermore. (CI 5); **Not the Right Fit**

5. Due to restructuring of the mental health practice, counseling was no longer covered under my insurance. The price was no longer covered by my insurance. (CI 7); **Cost**

6. Loss of trust. It had to be someone who I thought was sympathetic and was easy for me to talk to… and this event made me think that this guy was definitely not. (CI 8); **Need to Build Trust**

7. I thought I was in a good state and didn't need help. I'm bipolar and I guess at the time I was in a manic state where I felt really good and… I kind of stopped using my medications and started using some drugs and… I had just decided that I was delusional in my head and thought I was in a good place and decided I did not need therapy anymore. (CI 3); **No Longer Needed**

8. My mental health professional was unresponsive to my needs. His mannerisms… he was very professional, but he didn't feel very engaging. He felt rather detached. He… looked at me the whole time and I didn't really feel like I was being led in a particular direction… it's just like, talk it out. (CI 6); **Not the Right Fit**

9. We failed to connect. We never really connected, he seemed very detached from the get go and I… had trouble opening up to him. (CI 9); **Need to Build Trust**

10. I felt like I wasn't being heard. I felt like… my professional was being close-minded about my circumstances …. (CI 12.1); **Not the Right Fit**
…my professional… had like a one-way approach of how he wanted to treat this. (CI 12.2); **Not the Right Approach**

11. It was just cost prohibitive for me at that time. (CI 13); **Cost**

12. I felt that I was at a place in my life where I was doing better than I previously was. (CI 10.1); **No Longer Needed**
Cost and there are other therapeutic things you can do. (CI 10.2); **Cost**

13. I didn't really feel heard. Him and I didn't have a strong enough relationship for me to feel secure and like communicating issues with him. (CI 11.1); **Not the Right Fit**
It became very odd, especially because I was paying out-of-pocket to go and have an hour meeting with somebody that talked for 45 minutes while I talked for 20. (CI 11.2); **Time Problems**

14. Time to attend sessions was probably the biggest eliminating factor for me. Lack of time on account of many moving parts in my personal and professional life. (CI 14.1); **Time Problems**
…I still have some misgivings about whether or not that is the right thought or diagnosis…. (CI 14.2); **Not the Right Approach**

15. Conflict of interest between myself and the provider… that therapist was a provider in the clinic that I work in. (CI 15.1); **Not the Right Fit**
Lack of cultural competency or experience. (CI 15.2); **Not the Right Approach**

16. We just weren't jelling or vibing… it just wasn't gonna fit. (CI 16.1); **Not the Right Fit**
…it just wasn't gonna fit. You know, his methods and my way. (CI 16.2); **Not the Right Approach**

17. A friend of mine… spoke to me… and he told me that… the medication… he had a bad reaction from that… he actually did worse by taking the medication and that kind of scared me a little bit and I didn't go back. Once my friend started telling me the symptoms… it made me feel leery. I'm thinking it was gonna affect me in that way, too. (CI 17); **Not the Right Approach**

18. The counseling seemed to be too open-ended.... I didn't really understand the direction it was taking… I didn't know what I was supposed to get out of it…. (CI 18); **Not the Right Approach**

Description (raw WL #); WL Category Name
1. I agree to take the medication… or he would drop the idea. Either I modify or compromise my philosophy or he continues and tries to treat me based on the principals that I listed. (WL 1); **Change the Approach**

2. …first appointment to affirm me if I had any episodes or situations…. I would like… the therapy to be like… AA- you get a sponsor. …he'll call you, check in with you, you'll call him and check in with him at any time. That would have helped when things started going rather than wait 'til things culminate…. …certain trust and all that. I would be nice to have a friend to confide in. (WL 2.1); **Change the Approach**
I could call him any time or text what my situation is or I could talk to him. (WL 2.2) **More Availability**
3. The mental health professional could have utilized a perspective which accepted more possibilities that include the unknown. …have a more… spirit-oriented perspective… a more willing acceptance, and… more of an ability to take everything with a grain of salt…. Just a more spiritual perspective. (WL 4); **Change the Approach**

4. The mental professional could be more compassionate and taken me more seriously, that could have helped me. …just feeling that bond. …maybe even him giving more examples in his own life that he went through similarly… to strengthen the bond…. (WL 5); **Building Rapport**

5. …if I had the finances to cover continuing with the mental health professional. (And… I'd appreciated if it had been more notice for its changes.) (WL 7); **Affordability**

6. (Nothing.) I would have wanted him to follow-up about giving me the recommendation of another counselor/psychotherapist. (WL 8.1) **Counselor/Psychotherapist Recommendation**
…just to feel… I was on good terms with the counselor…. I got the impression [that he disliked me]…. More compassion. …he needs to work on how he words responses. Some communication… basically. I was really looking to establish… a relationship with someone I trusted. (WL 8.2); **Building Trust**

7. …managing my medication and being honest with the professional. …to be more honest and open and to be willing to actually… open up to the counselor. Just not being afraid to say what I'm thinking. (WL 3); **Client Engages More**

8. If there was a framework, a little bit of guidance before going into the session, it would have given me some guidance about what I was going to be talking about. (WL 6.1); **Change the Approach**
…if him or any other mental health professional was available outside 8-5…. (WL 6.2); **More Availability**

9. …it would be to incorporate my social work session progress… with my mental health and physical health sort of like treating them all together. I… had a really good working relationship with my social worker… and if she were able to attend my sessions with me and… provide… like a mediator… that would have been really helpful. …aside from being

more warm and less like cold and like clinical. That would have been the main big thing if I had been able to incorporate my… social worker into my mental health sessions…. (WL 9); **Building Rapport**

10. My mental health professional… listened to me more and not been as close-minded. (WL 12.1); **Building Rapport**
My mental health professional… maybe come up with an alternative approach to treating me other than what he thought was the one right answer. (WL 12.2); **Change the Approach**

11. Have the counseling be more affordable for myself. (WL 13); **Affordability**

12. …if we had been deciding that it was something that we needed. …if I… felt that I needed it…. (WL 10.1); **Decided if Needed**
…part of it was the cost, I felt like paying someone to talk to me was you know, maybe not as effective as talking to someone…. (WL 10.2); **Affordability**

13. Finding common ground to help understand each other. I think that having that connection with your counselor… to understand you… the experience you are having… would have been more beneficial than remaining silent throughout the duration of the counseling sessions. (WL 11.1); **Building Rapport**
…that I let my guard down enough to feel comfortable enough to tell him what I was truly feeling about the sessions rather than just going through the motions with him. If I would have verbalized how I was truly feeling rather than keeping it to myself. (WL 11.2); **Client Engages More**

14. If our schedules aligned, if time stopped working as a limiting factor, my life at least and probably others as well, that would definitely help to continue help me work with the mental health professional. (WL 14); **More Availability**

15. …safety planning around my… conflict of interest. (WL 15.1); **Building Rapport**
…offering referrals to providers that shared my identity issue. (WL 15.2); **Change the Approach**

16. …if there was just more discussion… around ground rules or an outline of what we wanted therapy to be or what I wanted therapy to be and what he provided. (WL 16); **Change the Approach**

17. …if maybe I had discussed maybe what my friend had told me [about the negative side effects of the medication] it would have made things a lot different. It would have cleared up a lot of things for me. …the fact that I didn't disclose that to the practitioner, the fact that he could have done even more…. If I had taken my time and did my homework, my research, really looked into it, more than what I did (I was hardheaded) I think I would have been further down the road. I think I'd be a lot better off. (WL 17); **Client Engages More**

18. …a little bit more assertion and direction on her part. …maybe less time… doing the get to know you part and understand the character. But also at the same time, use that information to… complete the diagnosis. (WL 18); **Change the Approach**

Table O

Tracking the Emergence of New Categories as Suggested by Butterfield et al. (2009)

Date of CI or WL item extraction	Participant no.	Date categorized	New categories emerged?
August 26	16701	September 30	All new categories emerged
August 27	16702	September 30	2 new CI categories emerged; 1 new WL item category emerged
September 24	16704	September 30	No new categories emerged
September 25	16705	October 16	1 new CI category emerged; 1 new WL item category emerged
October 11	16707	October 16	1 new CI category emerged; 1 new WL item category emerged
October 11	16708	October 16	1 new CI category emerged; no new WL item categories emerged
October 21	16703	November 4	1 new CI category emerged; 1 new WL item category emerged
October 23	16706	November 4	No new CI categories emerged; 1 new WL item category emerged
October 29	16709	November 4	No new categories emerged
November 25	16712	December 30	No new categories emerged
December 7	16713	December 30	No new categories emerged
December 21	16710	December 30	No new CI categories emerged; 1 new WL item category emerged
December 31	16711	February 18	No new categories emerged
January 29	16714	February 18	No new categories emerged
February 4	16715	February 18	[a]No new categories emerged
February 26	16716	March 11	No new categories emerged
March 2	16717	March 11	No new categories emerged
March 8	16718	March 11	No new categories emerged

Note. CI = critical incident; WL = wish list.

[a]The emergence of new CIs and WL items originally ceased after the 15th interview, but changed after consensus of the categories by an independent judge and feedback from the follow-up interviews.

Appendix P

Description of Critical Incident (CI) and Wish List (WL) Item Categories Form

CI Category Name: **Not the [Interpersonal] Right Fit**
CI Category Description: Didn't connect with the therapist

CI Category Name: **Not the Right Approach**
CI Category Description: Didn't want to or no longer wanted to take suggested medication, didn't agree with diagnosis, or needed a different counseling approach

CI Category Name: **Need to Build Trust**
CI Category Description: Didn't trust the therapist

CI Category Name: **Cost**
CI Category Description: Insurance no longer covered or no longer able to continue due to life change

CI Category Name: **No Longer Needed**
CI Category Description: Thought no longer needed/was in a good state

CI Category Name: **Time Problems**
CI Category Description: Time constraints [such as the way time was not spent constructively in sessions or having lack of time to attend sessions]

~~CI Category Name: **Client Not Engaging**~~
~~CI Category Description: Client began to withdrawal or not engage~~

WL Category Name: **Change the Approach**
WL Category Description: The counselor/psychotherapist changes the approach to accommodate the client's needs

WL Category Name: **Building Rapport**
WL Category Description: The counselor/psychotherapist and client work on building a strong therapeutic alliance

WL Category Name: **Affordability**
WL Category Description: The counseling/psychotherapy sessions are able to be covered by insurance or the client has the finances to afford it

WL Category Name: **Client Engages More**
WL Category Description: The client takes more action in his counseling/psychotherapy sessions

WL Category Name: **More Availability**
WL Category Description: A better time for the client to have a session with his counselor/psychotherapist

WL Category Name: **Decided if Needed**
WL Category Description: The client decides he needs it

~~WL Category Name: **Building Trust**~~
~~WL Category Description: Building and having trust with the counselor/psychotherapist~~

~~WL Category Name: **Counselor/Psychotherapist Recommendation**~~
~~WL Category Description: The counselor/psychotherapist provides the client with a recommendation for another counselor/psychotherapist~~

Appendix Q

Researchers' Categorization Sorting

Table Q1

Researcher A Response Content

Category		
Name	Description	CI or WL item
Not the Right Fit	Didn't connect with the therapist	CI 5 I felt like we weren't clicking. I felt like he wasn't seeing my issues as serious as I did. I didn't feel comfortable opening up furthermore. CI 6 My mental health professional was unresponsive to my needs. His mannerisms… he was very professional, but he didn't feel very engaging. He felt rather detached. He… looked at me the whole time and I didn't really feel like I was being led in a particular direction… it's just like, talk it out. CI 9 We failed to connect. We never really connected, he seemed very detached from the get go and I… had trouble opening up to him. CI 11.1 I didn't really feel heard. Him and I didn't have a strong enough relationship for me to feel secure and like communicating issues with him. CI 12.1 I felt like I wasn't being heard. I felt like… my professional was being close-minded about my circumstances…. CI 15.1 Conflict of interest between myself and the

		provider… that therapist was a provider in the clinic that I work in. CI 16.1 We just weren't jelling or vibing… it just wasn't gonna fit.
Need to Build Trust	Didn't trust the therapist	CI 8 Loss of trust. It had to be someone who I thought was sympathetic and was easy for me to talk to… and this event made me think that this guy was definitely not.
Not the Right Approach	Didn't want to or no longer wanted to take suggested medication, didn't agree with diagnosis, or needed a different counseling approach	CI 1 We had a disagreement about… the use of medication… and I didn't feel comfortable about that. CI 2.2 I did not think therapy and meds… did not do anything for me after all these years I'd been taking them. CI 4 I was told that I was bipolar and I did not believe such a thing is applicable. The tendency of my psychotherapist to adhere to textbook standards and complete a fast diagnosis. CI 12.2 …my professional… had like a one-way approach of how he wanted to treat this. CI 14.2 …I still have some misgivings about whether or not that is the right thought or diagnosis…. CI 15.2 Lack of cultural competency or experience. CI 16.2 … it just wasn't gonna fit. You know, his methods and my way.

		CI 17 A friend of mine… spoke to me… and he told me that… the medication… he had a bad reaction from that… he actually did worse by taking the medication and that kind of scared me a little bit and I didn't go back. Once my friend started telling me the symptoms… it made me feel leery. I'm thinking it was gonna affect me in that way, too. CI 18 The counseling seemed to be too open-ended.... I didn't really understand the direction it was taking… I didn't know what I was supposed to get out of it….
Cost	Insurance no longer covered or no longer able to continue due to life change	CI 7 Due to restructuring of the mental health practice, counseling was no longer covered under my insurance. The price was no longer covered by my insurance. CI 13 It was just cost prohibitive for me at that time.
No Longer Needed	Thought no longer needed/was in a good state	CI 3 I thought I was in a good state and didn't need help. I'm bipolar and I guess at the time I was in a manic state where I felt really good and… I kind of stopped using my medications and started using some drugs and… I had just decided that I was delusional in my head and thought I was in a good place and decided I did not need therapy anymore. CI 10 I felt that I was at a place in my life where I was doing better than I previously was.
Time Problems	Time constraints	CI 2.2 …didn't want to have to drive to the facility so many times.

		CI 11.2 It became very odd, especially because I was paying out-of-pocket to go and have an hour meeting with somebody that talked for 45 minutes while I talked for 20. CI 14 Time to attend sessions was probably the biggest eliminating factor for me. Lack of time on account of many moving parts in my personal and professional life.
Client Not Engaging	Client began to withdrawal or not engage	CI [2.1 I'd say… [I had a] lack of interest.]
Building Rapport	The counselor/psychotherapist and client work on building a strong therapeutic alliance	WL 5 The mental professional could be more compassionate and taken me more seriously, that could have helped me. …just feeling that bond. …maybe even him giving more examples in his own life that he went through similarly… to strengthen the bond…. WL 9 …it would be to incorporate my social work session progress… with my mental health and physical health sort of like treating them all together. I… had a really good working relationship with my social worker… and if she were able to attend my sessions with me me and… provide… like a mediator… that would have been really helpful. …aside from being more warm and less like cold and like clinical. That would have been the main big thing if I had been able to incorporate my… social worker into my mental health sessions….

		WL 11.1 Finding common ground to help understand each other. I think that having that connection with your counselor… to understand you… the experience you are having… would have been more beneficial than remaining silent throughout the duration of the counseling sessions. WL 12.1 My mental health professional… listened to me more and not been as close-minded. 15.1 …safety planning around my… conflict of interest.
Change the Approach	The counselor/psychotherapist changes the approach to accommodate the client's needs	WL 1 I agree to take the medication… or he would drop the idea. Either I modify or compromise my philosophy or he… tries to treat me based on the principals that I listed. WL 2.1 …first appointment to affirm me if I had any episodes or situations… I could call him any time or text what my situation is or I could talk to him. I would like… the therapy to be like… AA- you get a sponsor. …he'll call you, check in with you, you'll call him and check in with him at any time. That would have helped when things started going rather than wait 'til things culminate…. WL 4 The mental health professional could have utilized a perspective which accepted more possibilities that include the unknown. …have a more… spirit-oriented perspective… a more willing acceptance, and… more of an ability to take everything with a

		grain of salt…. Just a more spiritual perspective. WL 6.1 If there was a framework, a little bit of guidance before going into the session, it would have given me some guidance about what I was going to be talking about. WL 12.2 My mental health professional… maybe come up with an alternative approach to treating me other than what he thought was the one right answer. WL 15.2 …offering referrals to providers that shared my identity issue. WL 16 …if there was just more discussion… around ground rules or an outline of what we wanted therapy to be or what I wanted therapy to be and what he provided. WL 18 …a little bit more assertion and direction on her part. …maybe less time… doing the get to know you part and understand the character. But also at the same time, use that information to… complete the diagnosis.
Building Trust	Building and having trust with the counselor/psychotherapist	WL 2.2 …certain trust and all that. It would be nice to have a friend to confide in. WL 8 …just to feel… I was on good terms with the counselor…. I got the impression [that he disliked me]…. More compassion. …he needs to work on how he words responses. Some communication… basically. I was

		really looking to establish… a relationship with someone I trusted.
Affordability	The counseling/psychotherapy sessions were able to be covered by insurance or the client has the finances to afford it	WL 7 …if I had the finances to cover continuing with the mental health professional. (And… I'd appreciated if it had been more notice for its changes.) WL 10.2 …part of it was the cost, I felt like paying someone to talk to me was you know, maybe not as effective as talking to someone…. WL 13 Have the counseling be more affordable for myself.
Client Engages More	The client takes more action in his counseling/psychotherapy sessions	WL 3 …managing my medication and being honest with the professional. …to be more honest and open and to be willing to actually… open up to the counselor. Just not being afraid to say what I'm thinking. WL 11.2 …that I let my guard down enough to feel comfortable enough to tell him what I was truly feeling about the sessions rather than just going through the motions with him. If I would have verbalized how I was truly feeling rather than keeping it to myself. WL 17 …if maybe I had discussed maybe what my friend had told me [about the negative side effects of the medication] it would have made things a lot different. It would have cleared up a lot of things for me. …the fact that I didn't disclose that to the practitioner, the fact that he could have done even more…. If I had

		taken my time and did my homework, my research, really looked into it, more than what I did (I was hardheaded) I think I would have been further down the road. I think I'd be a lot better off.
More Availability	A better time for the client to have a session with his counselor/psychotherapist	WL 6.2 …if him or any other mental health professional was available outside 8-5… WL 14 If our schedules aligned, if time stopped working as a limiting factor, my life at least and probably others as well, that would definitely help to continue help me work with the mental health professional.
Decided if Needed	The client decides he needs it	WL 10.1 …if we had been deciding that it was something that we needed. …if I… felt that I needed it….

Note. CI = critical incident; WL = wish list.

Table Q2

Researcher B Response Content

Category		
Name	Description	CI or WL item
Not the Right Fit	Didn't connect with the therapist	CI 1 We had a disagreement about… the use of medication… and I didn't feel comfortable about that…. CI 9 We failed to connect. We never really connected, he seemed very detached from the get go and I… had trouble opening up to him. CI 16.2 … it just wasn't gonna fit. You know, his methods and my way.
Need to Build Trust	Didn't trust the therapist	CI 8 Loss of trust. It had to be someone who I thought was sympathetic and was easy for me to talk to… and this event made me think that this guy was definitely not.
Not the Right Approach	Didn't want to or no longer wanted to take suggested medication, didn't agree with diagnosis, or needed a different counseling approach	CI 12.1 I felt like I wasn't being heard. I felt like… my professional was being close-minded about my circumstances…. CI 15.2 Lack of cultural competency or experience.
Cost	Insurance no longer covered or no longer able to continue due to life change	CI 7 Due to restructuring of the mental health practice, counseling was no longer covered under my insurance. The price was no longer covered by my insurance.
No Longer Needed	Thought no longer needed/was in a good state	CI 10 I felt that I was at a place in my life where I was doing better than I previously was.

Time Problems	Time constraints	CI 14 Time to attend sessions was probably the biggest eliminating factor for me. Lack of time on account of many moving parts in my personal and professional life.
Client Not Engaging	Client began to withdrawal or not engage	CI 2.1 I'd say… [I had a] lack of interest.
Building Rapport	The counselor/psychotherapist and client work on building a strong therapeutic alliance	WL 5 The mental professional could be more compassionate and taken me more seriously, that could have helped me. …just feeling that bond. …maybe even him giving more examples in his own life that he went through similarly… to strengthen the bond…. WL 11.1 Finding common ground to help understand each other. I think that having that connection with your counselor… to understand you… the experience you are having… would have been more beneficial than remaining silent throughout the duration of the counseling sessions.
Change the Approach	The counselor/psychotherapist changes the approach to accommodate the client's needs	WL 6.1 If there was a framework, a little bit of guidance before going into the session, it would have given me some guidance about what I was going to be talking about. WL 12.2 My mental health professional… maybe come up with an alternative approach to treating me other than what he thought was the one right answer. WL 15.2 …offering referrals to providers that shared my identity issue.

Building Trust	Building and having trust with the counselor/psychotherapist	WL 2.2 …certain trust and all that. It would be nice to have a friend to confide in.
Affordability	The counseling/psychotherapy sessions were able to be covered by insurance or the client has the finances to afford it	WL 10.2 …part of it was the cost, I felt like paying someone to talk to me was you know, maybe not as effective as talking to someone….
Client Engages More	The client takes more action in his counseling/psychotherapy sessions	WL 1 I agree to take the medication… or he would drop the idea. Either I modify or compromise my philosophy or he… tries to treat me based on the principals that I listed. WL 17 …if maybe I had discussed maybe what my friend had told me [about the negative side effects of the medication] it would have made things a lot different. It would have cleared up a lot of things for me. …the fact that I didn't disclose that to the practitioner, the fact that he could have done even more…. If I had taken my time and did my homework, my research, really looked into it, more than what I did (I was hardheaded) I think I would have been further down the road. I think I'd be a lot better off.
More Availability	A better time for the client to have a session with his counselor/psychotherapist	WL 6.2 …if him or any other mental health professional was available outside 8-5…
Decided if Needed	The client decides he needs it	WL 10.1 …if we had been deciding that it was something that we needed. …if I… felt that I needed it….

Note. CI = critical incident; WL = wish list.

Appendix R

Notes on Researchers' Categorization Consensus Decisions

Table R

Notes on Researchers' Categorization Consensus Decisions

Statement no.	CI or WL item statement	Decision	Reasoning
		[e.g., Put in category… (over other potential category…).]	
CI 1	We had a disagreement about… the use of medication… and I didn't feel comfortable about that….	Keep in category Not the Right Approach (over Not the Right Fit)	This CI fits in this category better since the participant stated an approach and not a connection/rapport issue.
CI 12.1	CI 12.1 I felt like I wasn't being heard. I felt like… my professional was being close-minded about my circumstances….	Keep in category Not the Right Fit (over Not the Right Approach)	This CI fits in this category better since the participant is describing the counselor/psychotherapist relationship and not the approach. However, this may fit under Counselor/Psychotherapist Characteristics, so we will ultimately utilize the follow-up feedback response from the participant.
CI 16.2	CI 16.2 … it just wasn't gonna fit. You know, his methods and my way.	Keep in category Not the Right Approach (over Not the Right Fit)	This CI fits in this category better since the participant is describing the fit of the approach and not the counselor/psychotherapist.
WL 1	WL 1 I agree to take	Keep in category Change	This WL item fits in this

	the medication… or he would drop the idea. Either I modify or compromise my philosophy or he… tries to treat me based on the principals that I listed.	the Approach (over Client Engages More)	category better since his CI response is an approach issue. However, we will utilize the participant feedback in the follow-up interview to see whether to separate his WL item response into two and put half in this category and the other half in Client Engages More.

Note. CI = critical incident; WL = wish list.

Appendix S

Follow-Up Interview Protocol

FOLLOW-UP INTERVIEW PROTOCOL

Participant ID #: _____ Participant Name: _____
Date of 1st Call: ____/____/_____ Message Left (circle one): Y / N
Date of 2nd Call: ____/____/_____ Message Left (circle one): Y / N
Date of 3rd Call: ____/____/_____ Message Left (circle one): Y / N

Participant's CI:

_____
_____

Category Containing Participant's CI:_____

Participant's WL Item:

_____
_____

Category Containing Participant's WL Item:_____

Call participant to let him know he's been selected to participate in a follow-up interview.

Hello __Mr. (*Surname*)__, my name is _____. I'm calling from the Psychology Department's psychotherapy research lab at Western Washington University to follow up on the information you provided in the study on what former, adult male clients in counseling or psychotherapy believe to have led them to withdrawal from continuing to see their mental health professional. I'm going to share with you the words we used to summarize your experience and how it was sorted into a category with other similar incidents. I'd like to get your feedback on how well this reflects your experience. Do you have a few minutes to complete this now?

*If **not**, say*:

When would be a better time for me to call you back?

_____

*If **yes**, say*:

Now I'll read to you a single sentence we used to describe what you stated during the interview; these words may only describe what *you* stated, or may describe what you *and others who had similar experiences* stated.

*Read CI/WL item to participant, then ask the following questions. Record answers **verbatim**.*

1. Does this accurately describe what happened that led you to withdrawal from continuing to see your psychotherapist? **Y / N**

Comments: _____
_____
_____

2. In the sentence describing your experience, is anything missing? **Y / N**
Comments: _____
_____
_____

3. In the sentence describing your experience, is there anything that needs to be changed?
Y / N Comments: _____
_____
_____

4. Do you have any other comments? **Y / N**

_____
_____
_____

Read to participant:

The experience that you stated and the experiences that other participants stated have been sorted into groups; this is to show different ways that those experiences led men to drop out of their psychotherapy. Each group, called a *category*, has been given its own name to describe what kinds of experiences are in that category.

*Read list of **category names** to participant*.

5. Do the category names make sense to you? **Y / N** (If they don't, include explanation.)
Comments: _____
_____
_____

Tell participant:

The sentence describing your experience was sorted into the category named:
_____.

6. Does the name of the category that your experience was sorted into capture your experience and the meaning it had for you? **Y / N**
Comments: _____
_____
_____

7. If your experience does not seem to fit in this category, in which other category do you think it belongs? (*You may need to reread the list of category names to the participant*).

_____

Read to participant:

Thank you for your time. We will use your feedback to help make sure we've honestly and clearly represented your experience and the experiences of other men in this study.

Appendix T

Follow-Up Interview Debrief

FOLLOW-UP INTERVIEW DEBRIEF

Thank you for participating in the follow-up interview of the Dropout in Individual Psychotherapy From Adult Male Clients' Perspectives research study. The information you provided today will better enable us to understand why adult males drop out of psychotherapy. None of the information shared today will be available to anyone except the interviewer and members of the research team. Thank you again for your participation. Have a great day!

Research Interviewer Initials: _KS_ Date: _3/__/2020_

Appendix U

Table U1

Participant Follow-Up Feedback Integration Notes

Statement no.	CI or WL item statement	Notes
		(e.g., The participant wanted to change the CI statement to "…," but we did not. This would have… and would therefore not….)
CI 1	We had a disagreement about… the use of medication… and I didn't feel comfortable about that.	The participant wanted us to add in "I have nothing bad to say about him. It's just that I don't believe in change through chemicals." We honored his request to reflect how it wasn't a CI regarding a characteristic with the counselor/psychotherapist. He wants us to keep his CI in Not the Right Approach.
WL 1	I agree to take the medication… or he would drop the idea. Either I modify or compromise my philosophy or he continues and tries to treat me based on the principals that I listed.	The participant wants us to keep his WL item in Change the Approach and don't split into two categories, such as Client Engages More.
CI 2.1	I'd say… [I had] lack of interest.	Participant wants us to remove this from Client Not Engaging because he said he felt that his *counselor/psychotherapist* was not focusing on *him*. He wants us to add in the statement to now read as "I'd say… [I had] lack of interest. I lost interest because I didn't think my counselor/psychotherapist was focusing on me. We didn't connect." and put this under Not the Right Fit, and change it to a secondary reason, so it will now read as CI 2.2 under Not the Right Fit.

CI 2.2	I did not think therapy and meds did not do anything for me after all these years I'd been taking them.	Participant wants us to make this his primary factor and keep in Not the Right Approach, so it will now read as CI 2.1.
CI 2.2	…didn't want to have to drive to the facility so many times.	Participant wants us to remove this from Time Problems and put this under Client Not Engaging and have it read "…didn't want to have to drive to the facility so many times. It was a motivation factor."
WL 2.1	…first appointment to affirm me if I had any episodes or situations… I could call him any time or text what my situation is or I could talk to him. I would like… the therapy to be like… AA- you get a sponsor. …he'll call you, check in with you, you'll call him and check in with him at any time. That would have helped when things started going rather than wait 'til things culminate….	Participant wants us to keep this as is and under Change the Approach, just add in so it reads "WL 2.1 …first appointment to affirm me if I had any episodes or situations…. I would like… the therapy to be like… AA- you get a sponsor. …he'll call you, check in with you, you'll call him and check in with him at any time. That would have helped when things started going rather than wait 'til things culminate…. …certain trust and all that. I would be nice to have a friend to confide in."
WL 2.2	…certain trust and all that. It would be nice to have a friend to confide in.	Participant wants us to delete this WL under Building Trust and add this WL 2.2 under More Availability and have it read "I could call him any time or text what my situation is or I could talk to him."
CI 4	I was told that I was bipolar and I did not believe such a thing is applicable. The tendency of my psychotherapist to adhere to textbook standards and complete a fast diagnosis.	Participant stated to keep his CI as is and keep under Not the Right Approach.
WL 4	The mental health	Participant sated to keep his WL item

	professional could have utilized a perspective which accepted more possibilities that include the unknown. …have a more… spirit-oriented perspective… a more willing acceptance, and… more of an ability to take everything with a grain of salt…. Just a more spiritual perspective.	as is and under Change the Approach.
CI 5	I felt like we weren't clicking. I felt like he wasn't seeing my issues as serious as I did. I didn't feel comfortable opening up furthermore.	The participant wants us to keep his CI in Not the Right Fit and not put it in Need to Build Trust.
WL 5	The mental professional could be more compassionate and taken me more seriously, that could have helped me. …just feeling that bond. …maybe even him giving more examples in his own life that he went through similarly… to strengthen the bond….	The participant wants us to keep his WL item in Building Rapport and not split his answer to put half in this category and the other half in Change the Approach.
CI 6	My mental health professional was unresponsive to my needs. His mannerisms… he was very professional, but he didn't feel very engaging. He felt rather detached. He… looked at me the whole time and I didn't really feel like I was being led in a particular direction… it's just like, talk it out.	The participant wants us to keep his CI under Not the Right Fit and not move it under Counselor/Psychotherapist Characteristics or Not the Right Approach.

WL 6.1	If there was a framework, a little bit of guidance before going into the session, it would have given me some guidance about what I was going to be talking about.	The participant wants us to keep this WL item under their Change the Approach. He also confirmed that this was his primary WL item.
WL 6.2	…if him or any other mental health professional was available outside 8-5….	The participant wants us to keep this second WL item under More Availability.
CI 7	Due to restructuring of the mental health practice, counseling was no longer covered under my insurance. The price was no longer covered by my insurance.	Participant wanted to keep his CI statement as is and keep it under Cost.
WL 7	…if I had the finances to cover continuing with the mental health professional. (And… I'd appreciated if it had been more notice for its changes.)	Participant wanted to keep his WL item statement as is and keep it under Affordability.
CI 8	Loss of trust. It had to be someone who I thought was sympathetic and was easy for me to talk to… and this event made me think that this guy was definitely not.	The participant wants us to keep his CI under Needs to Build Trust.
WL 8.1	(Nothing.) I would have wanted him to follow-up about giving me the recommendation of another counselor/psychotherapist.	The participant asked us to change his WL item to have an added primary response (WL 8.1) of him having his counselor/psychotherapist follow-up with giving him the recommendation of another counselor/psychotherapist. We will add the category of Counselor/Psychotherapist Recommendation.

WL 8.2	…just to feel… I was on good terms with the counselor…. I got the impression [that he disliked me]…. More compassion. …he needs to work on how he words responses. Some communication… basically. I was really looking to establish… a relationship with someone I trusted.	The participant asked us to make this WL item his second, so it will change from WL 8 to read as WL 8.2 under Building Trust.
CI 9	We failed to connect. We never really connected, he seemed very detached from the get go and I… had trouble opening up to him.	Participant wanted us to keep his CI as is and change it from Not the Right Fit category to Need to Build Trust.
WL 9	…it would be to incorporate my social work session progress… with my mental health and physical health sort of like treating them all together. I… had a really good working relationship with my social worker… and if she were able to attend my sessions with me and… provide… like a mediator… that would have been really helpful. …aside from being more warm and less like cold and like clinical. That would have been the main big thing if I had been able to incorporate my… social worker into my mental health sessions….	Participant wanted us to keep his WL item as is and keep it under Building Rapport instead of putting it under another category (e.g., Change the Approach).
CI 10.1	I felt that I was at a place	Participant wanted us to keep his CI

	in my life where I was doing better than I previously was.	as is and keep under No Longer Needed.
CI 10.2	Cost and there are other therapeutic things you can do.	Participant wanted us to add a secondary CI (CI 10.2) and put under Cost.
WL 10.1	…if we had been deciding that it was something that we needed. …if I… felt that I needed it….	Participant wanted us to keep his primary WL item as is and keep it under Decided if Needed.
WL 10.2	…part of it was the cost, I felt like paying someone to talk to me was you know, maybe not as effective as talking to someone….	Participant wanted us to keep his secondary WL item as is and keep it under Affordability.
CI 11.1	I didn't really feel heard. Him and I didn't have a strong enough relationship for me to feel secure and like communicating issues with him.	Participant wants to keep this CI as is under Not the Right Fit.
CI 11.2	It became very odd, especially because I was paying out-of-pocket to go and have an hour meeting with somebody that talked for 45 minutes while I talked for 20.	Participant stated to keep this as a CI and keep it under Time Problems and not Cost.
WL 11.1	Finding common ground to help understand each other. I think that having that connection with your counselor… to understand you… the experience you are having… would have been more beneficial than remaining silent throughout the duration of the counseling sessions.	Participant stated to keep this primary WL item as is and under Building Rapport.

WL 11.2	…that I let my guard down enough to feel comfortable enough to tell him what I was truly feeling about the sessions rather than just going through the motions with him. If I would have verbalized how I was truly feeling rather than keeping it to myself.	Participant stated to keep this WL item as is as well and to keep it under Client Engages More.
CI 13	It was just cost prohibitive for me at that time.	Participant wants us to keep his CI as is and keep it under the CI category Cost.
WL 13	Have the counseling be more affordable for myself.	Participant wants us to keep his WL item as is and keep it under the WL item category Affordability.
CI 14.1	Time to attend sessions was probably the biggest eliminating factor for me. Lack of time on account of many moving parts in my personal and professional life.	The participant wanted to keep his primary CI statement as is and keep it under Time Problems.
CI 14.2	…I still have some misgivings about whether or not that is the right thought or diagnosis….	The participant wanted to keep this secondary CI statement, keep as is, and keep under the CI Category Not the Right Approach.
WL 14	If our schedules aligned, if time stopped working as a limiting factor, my life at least and probably others as well, that would definitely help to continue help me work with the mental health professional.	The participant wanted to keep his WL item as is and keep it under More Availability.
CI 15.1	Conflict of interest between myself and the	Participant wanted to keep his primary CI as is and keep it under Not

	provider… that therapist was a provider in the clinic that I work in.	the Right Fit, as he stated it was a connection issue. I asked if he wanted to add in anything about the connection issue and he said no and to leave his statement as is. He did not want it under another potential category (e.g., Conflict of Interest).
CI 15.2	Lack of cultural competency or experience.	Participant wanted to keep his secondary CI as is and keep it under Not the Right Approach. He didn't think it needed a separate category as we asked if "Counselor/Psychotherapist Characteristics" fit better, and he said no.
WL 15.1	…safety planning around my… conflict of interest.	Participant wanted to keep his primary WL item as is and keep it under Building Rapport because he stated it would have helped to work on building a better rapport. He did not want to add to his statement. He did not want it under another potential category (e.g., Avoiding Conflicts of Interest).
WL 15.2	…offering referrals to providers that shared my identity issue.	Participant wanted to keep his secondary WL item as is and keep it under Change the Approach.
CI 16.1	We just weren't jelling or vibing… it just wasn't gonna fit.	Participant stated to keep this CI as his primary reason for dropping out and keep it in this CI category Not the Right Fit.
CI 16.2	…it just wasn't gonna fit. You know, his methods and my way.	Participant stated to keep this CI as his secondary reason for dropping out and keep it in this CI category Not the Right Approach.
WL 16	…if there was just more discussion… around ground rules or an outline of what we wanted therapy to be or what I	Participant stated to keep this WL item as his primary and only wish list item and keep it in the WL item category Change the Approach.

	wanted therapy to be and what he provided.	
CI 17	A friend of mine… spoke to me… and he told me that… the medication… he had a bad reaction from that… he actually did worse by taking the medication and that kind of scared me a little bit and I didn't go back. Once my friend started telling me the symptoms… it made me feel leery. I'm thinking it was gonna affect me in that way, too.	Participant stated to keep everything as it is under Not the Right Approach.
WL 17	…if maybe I had discussed maybe what my friend had told me [about the negative side effects of the medication] it would have made things a lot different. It would have cleared up a lot of things for me. …the fact that I didn't disclose that to the practitioner, the fact that he could have done even more…. If I had taken my time and did my homework, my research, really looked into it, more than what I did (I was hardheaded) I think I would have been further down the road. I think I'd be a lot better off.	Participant stated to keep his WL item as it is and under the Client Engages More category.

Note. CI = critical incident; WL = wish list.

Table U2

Notes on Final Categorization Consensus Decisions

Statement no.	CI or WL item statement	Decision	Reasoning
		[e.g., Put in category… (over other potential category…).]	
CI 3	I thought I was in a good state and didn't need help. I'm bipolar and I guess at the time I was in a manic state where I felt really good and… I kind of stopped using my medications and started using some drugs and… I had just decided that I was delusional in my head and thought I was in a good place and decided I did not need therapy anymore.	Keep in category No Longer Needed	The participant didn't answer three follow-up interview phone calls or respond via e-mail. We didn't see any questions arise from his statements or categories.
WL 3	…managing my medication and being honest with the professional. …to be more honest and open and to be willing to actually… open up to the counselor. Just not being afraid to say what I'm thinking.	Keep in category Client Engages More	The participant didn't answer three follow-up interview phone calls or respond via e-mail. We didn't see any questions arise from his statements or categories.
CI 12.1	I felt like I wasn't being heard. I felt like… my professional was being close-minded about my circumstances….	Keep in category Not the Right Fit	The participant didn't answer three follow-up interview phone calls or respond via e-mail. We decided to keep his primary CI in Not the Right Fit since he is

			describing his counselor/psychotherapist relationship. We decided not to put it under the potential category Counselor/Psychotherapist Characteristics and we removed this category.
CI 12.2	…my professional… had like a one-way approach of how he wanted to treat this.	Keep in category Not the Right Approach	The participant didn't answer three follow-up interview phone calls or respond via e-mail. We didn't see any questions arise from this CI statement or its category.
WL 12.1	My mental health professional… listened to me more and not been as close-minded.	Keep in category Building Rapport	The participant didn't answer three follow-up interview phone calls or respond via e-mail. We decided to keep his primary WL item in Building Rapport since he is describing his counselor/psychotherapist relationship. We decided not to put it under the potential category Counselor/Psychotherapist Characteristic Competency and we removed this category.
WL 12.2	My mental health professional… maybe come up with an alternative approach to treating me other than what he thought was the one right answer.	Keep in category Change the Approach	The participant didn't answer three follow-up interview phone calls or respond via e-mail. We didn't see any questions arise from this WL item statement or its category.
CI 18	The counseling seemed to be too open-ended.... I didn't really understand the	Keep in category Not the Right Approach	The participant didn't answer three follow-up interview phone calls or respond via e-mail. We

	direction it was taking… I didn't know what I was supposed to get out of it….		didn't see any questions arise from this CI statement or its category.
WL 18	…a little bit more assertion and direction on her part. …maybe less time… doing the get to know you part and understand the character. But also at the same time, use that information to… complete the diagnosis.	Keep in category Change the Approach	The participant didn't answer three follow-up interview phone calls or respond via e-mail. We didn't see any questions arise from this WL item statement or its category.

Note. CI = critical incident; WL = wish list.

Table U3

All Categorization Consensus Content

Category			
Name	Description	Participation rate (%)	CI or WL item
Not the Right Approach	Didn't want to or no longer wanted to take suggested medication, didn't agree with diagnosis, or needed a different counseling approach	34.62%	CI 1 We had a disagreement about… the use of medication… and I didn't feel comfortable about that. I have nothing bad to say about him. It's just that I don't believe in change through chemicals. CI 2.1 I did not think therapy and meds… did not do anything for me after all these years I'd been taking them. CI 4 I was told that I was bipolar and I did not believe such a thing is applicable. The tendency of my psychotherapist to adhere to textbook standards and complete a fast diagnosis. CI 12.2 …my professional… had like a one-way approach of how he wanted to treat this. CI 14.2 …I still have some misgivings about whether or not that is the right thought or diagnosis…. CI 15.2 Lack of cultural competency or experience. CI 16.2 … it just wasn't gonna fit. You know, his methods and my way. CI 17 A friend of mine… spoke to me… and he told me

			that… the medication… he had a bad reaction from that… he actually did worse by taking the medication and that kind of scared me a little bit and I didn't go back. Once my friend started telling me the symptoms… it made me feel leery. I'm thinking it was gonna affect me in that way, too. CI 18 The counseling seemed to be too open-ended.... I didn't really understand the direction it was taking… I didn't know what I was supposed to get out of it….
Not the Right Fit	Didn't connect with the therapist	26.92%	CI 2.2 I'd say… [I had] lack of interest. I lost interest because I didn't think my counselor/psychotherapist was focusing on me. We didn't connect." CI 5 I felt like we weren't clicking. I felt like he wasn't seeing my issues as serious as I did. I didn't feel comfortable opening up furthermore. CI 6 My mental health professional was unresponsive to my needs. His mannerisms… he was very professional, but he didn't feel very engaging. He felt rather detached. He… looked at me the whole time and I didn't really feel like I was being led in a particular direction… it's just like, talk it out. CI 11 I didn't really feel heard. Him and I didn't have a

			strong enough relationship for me to feel secure and like communicating issues with him. CI 12.1 I felt like I wasn't being heard. I felt like… my professional was being close-minded about my circumstances…. CI 15.1 Conflict of interest between myself and the provider… that therapist was a provider in the clinic that I work in. CI 16.1 We just weren't jelling or vibing… it just wasn't gonna fit.
Cost	Insurance no longer covered or no longer able to continue due to life change	11.54%	CI 7 Due to restructuring of the mental health practice, counseling was no longer covered under my insurance. The price was no longer covered by my insurance. CI 10.2 Cost and there are other therapeutic things you can do. CI 13 It was just cost prohibitive for me at that time.
Need to Build Trust	Didn't trust the therapist	7.69%	CI 8 Loss of trust. It had to be someone who I thought was sympathetic and was easy for me to talk to… and this event made me think that this guy was definitely not. CI 9 We failed to connect. We never really connected, he seemed very detached from the get go and I… had trouble

			opening up to him.
No Longer Needed	Thought no longer needed/was in a good state	7.69%	CI 3 I thought I was in a good state and didn't need help. I'm bipolar and I guess at the time I was in a manic state where I felt really good and… I kind of stopped using my medications and started using some drugs and… I had just decided that I was delusional in my head and thought I was in a good place and decided I did not need therapy anymore. CI 10.1 I felt that I was at a place in my life where I was doing better than I previously was.
Time Problems	Time constraints	7.69%	CI 11.2 It became very odd, especially because I was paying out-of-pocket to go and have an hour meeting with somebody that talked for 45 minutes while I talked for 20. CI 14 Time to attend sessions was probably the biggest eliminating factor for me. Lack of time on account of many moving parts in my personal and professional life.
Client Not Engaging	Client began to withdrawal or not engage	3.85%	CI 2.2 …didn't want to have to drive to the facility so many times. It was a motivation factor.
Change the Approach	The counselor/psychotherapist changes the approach to accommodate the	32.00%	WL 1 I agree to take the medication… or he would drop the idea. Either I modify or compromise my philosophy or he… tries to treat me based

	client's needs	on the principals that I listed. WL 2.1 …first appointment to affirm me if I had any episodes or situations…. I would like… the therapy to be like… AA- you get a sponsor. …he'll call you, check in with you, you'll call him and check in with him at any time. That would have helped when things started going rather than wait 'til things culminate…. …certain trust and all that. I would be nice to have a friend to confide in. WL 4 The mental health professional could have utilized a perspective which accepted more possibilities that include the unknown. …have a more… spirit-oriented perspective… a more willing acceptance, and… more of an ability to take everything with a grain of salt…. Just a more spiritual perspective. WL 6.1 If there was a framework, a little bit of guidance before going into the session, it would have given me some guidance about what I was going to be talking about. WL 12.2 My mental health professional… maybe come up with an alternative approach to treating me other than what he thought was the one right answer. WL 15.2 …offering referrals

			to providers that shared my identity issue. WL 16 …if there was just more discussion… around ground rules or an outline of what we wanted therapy to be or what I wanted therapy to be and what he provided. WL 18 …a little bit more assertion and direction on her part. …maybe less time… doing the get to know you part and understand the character. But also at the same time, use that information to… complete the diagnosis.
Building Rapport	The counselor/psychotherapist and client work on building a strong therapeutic alliance	20.00%	WL 5 The mental professional could be more compassionate and taken me more seriously, that could have helped me. …just feeling that bond. …maybe even him giving more examples in his own life that he went through similarly… to strengthen the bond…. WL 9 …it would be to incorporate my social work session progress… with my mental health and physical health sort of like treating them all together. I… had a really good working relationship with my social worker… and if she were able to attend my sessions with me me and… provide… like a mediator… that would have been really helpful. …aside from being more warm and less like cold and like clinical. That would have been the

			main big thing if I had been able to incorporate my… social worker into my mental health sessions…. WL 11.1 Finding common ground to help understand each other. I think that having that connection with your counselor… to understand you… the experience you are having… would have been more beneficial than remaining silent throughout the duration of the counseling sessions. WL 12.1 My mental health professional… listened to me more and not been as close-minded. WL 15.1 …safety planning around my… conflict of interest.
Affordability	The counseling/psycho therapy sessions were able to be covered by insurance or the client has the finances to afford it	12.00%	WL 7 …if I had the finances to cover continuing with the mental health professional. (And… I'd appreciated if it had been more notice for its changes.) WL 10.2 …part of it was the cost, I felt like paying someone to talk to me was you know, maybe not as effective as talking to someone…. WL 13 Have the counseling be more affordable for myself.
Client Engages More	The client takes more action in his counseling/psycho	12.00%	WL 3 …managing my medication and being honest with the professional. …to be

	therapy sessions		more honest and open and to be willing to actually… open up to the counselor. Just not being afraid to say what I'm thinking. WL 11.2 …that I let my guard down enough to feel comfortable enough to tell him what I was truly feeling about the sessions rather than just going through the motions with him. If I would have verbalized how I was truly feeling rather than keeping it to myself. WL 17 …if maybe I had discussed maybe what my friend had told me [about the negative side effects of the medication] it would have made things a lot different. It would have cleared up a lot of things for me. …the fact that I didn't disclose that to the practitioner, the fact that he could have done even more…. If I had taken my time and did my homework, my research, really looked into it, more than what I did (I was hardheaded) I think I would have been further down the road. I think I'd be a lot better off.
More Availability	A better time for the client to have a session with his counselor/psychotherapist	12.00%	WL 2.2 I could call him any time or text what my situation is or I could talk to him. WL 6.2 …if him or any other mental health professional was available outside 8-5… WL 14 If our schedules

			aligned, if time stopped working as a limiting factor, my life at least and probably others as well, that would definitely help to continue help me work with the mental health professional.
Building Trust	Building and having trust with the counselor/psychotherapist	4.00%	WL 8.2 …just to feel… I was on good terms with the counselor…. I got the impression [that he disliked me]…. More compassion. …he needs to work on how he words responses. Some communication… basically. I was really looking to establish… a relationship with someone I trusted.
Decided if Needed	The client decides he needs it	4.00%	WL 10.1 …if we had been deciding that it was something that we needed. …if I… felt that I needed it….
Counselor/Psychotherapist Recommendation	The counselor/psychotherapist provides the client with a recommendation for another counselor/psychotherapist	4.00%	WL 8.1 (Nothing.) I would have wanted him to follow-up about giving me the recommendation of another counselor/psychotherapist.

Note. CI = critical incident; WL = wish list. Participation rate is the percentage of participants who contributed a CI or WL item to a given category. This table presents the CIs and WL items of all participants; WL 8.1 is not considered a credible WL item response and is removed in Table U5. The participation rate includes both primary and secondary CIs and WL items.

Table U4

Expert Opinion Feedback Integration Notes

Statement	CI or WL item category	Decision and reasoning
…except "Time Problems" – this category title is too general and lacking specificity. In addition, the two sentence description "time constraints" is also so unclear and brief that I still don't understand what you mean. Please revise both so they can be read clearly and lead to usefulness.	Time Problems	The primary researcher decided to keep the category name as is, but elaborated on the description to now read the following: Time constraints such as the way time was not spent constructively in sessions or having lack of time to attend sessions.
"Not the right fit" – your definition specifically refers to the relationship/interpersonal nature but "not the right fit" sounds pretty general and could include fit on many dimensions, including therapeutic approach/strategies (which is your second category). Perhaps a more precise title specifying more clearly that this CI refers to Interpersonal fit (try to choose a word/descriptor/adjective that came directly from a client if possible and it does not sacrifice clarity).	Not the Right Fit	The primary researcher decided to change this CI category name to "Not the Right Interpersonal Fit" as it captures the "connection" (the therapeutic alliance) the participants were discussing, and enhances the category name for greater clarity and distinction from Not the Right Approach.
I am also unsure about the category "Client not engaging" defined as "client began to withdraw or not engage". In part, this seems to overlap with the outcome (dropping out) and perhaps could be seen as part of the process of dropping out rather than as the reason for dropping out. I could be wrong as I don't have the context and answers myself but be sure that the client is referring to this as the case for them dropping out. On the other hand, the client could say that I ended up dropping out because I noticed myself withdrawing. However, again, what was the reason for the withdrawal? Was it "not	Client Not Engaging	The primary researcher checked the CI of this category and saw that the participant truly believed it was a "motivation factor" for himself as a reason to not attend sessions. It is also important to note that this CI is a secondary CI, so it will not be included within the finalized categories. Therefore, this qualitative data will be kept in the research for the richer content it provides, but it

the right fit", "not the right approach", the need to build trust etc. In other words, could this category be explained or related to or caused by the other categories? For example, does the therapist not providing the right therapeutic approach lead the client to withdraw? If so, then that is more reason that the CIs/client comments that lead you to create this category. Client not engaging seems to the result of something. Why did the client withdraw? What happened that led them to withdraw? This is the only category I have significant difficulty with.		will ultimately be removed from the final, legitimate category names.
For the WL: client engages more. See my comment in (b) as the point is the same here and this category may need to be revised/deleted etc.	Client Engages More	The primary researcher decided to leave this category as is. There were three participants whom each stated that they should have put in more work in hindsight—that they weren't doing their part to help themselves have a more successful treatment outcome. It appeared that these participants had reflected on what happened and ended up taking ownership of their part in therapy. This seemed sensible to the primary researcher; it shows that there are CIs and WL items that the counselor/psychotherapist can address to help on their part, but that there may be clients who just simply are not engaging on their part to help with the treatment outcome.
WL: Counselling/psychotherapist recommendation: This category seems inappropriate. If the WL question was	Counseling/ Psychotherapist Recommendation	The primary researcher decided to keep this category as is before the

about what the client needed to stay in therapy and avoid drop out, how could "giving a referral/recommendation of another counsellor" help the client stay in therapy with the therapist?	ultimate finalization of the created categories as it provides a situation where it is important to note that there may be some men out there who are absolutely unwilling to stay in sessions with their mental health professional—that there would not be a wish list item that would have helped them want to continue working with their mental health professional. The participant who was adamant that "nothing" would have helped him to stay and that he simply wanted his therapist to follow through with providing a recommendation to another counselor/psychotherapist is a valid response. However, as it is not a true WL item according to its very definition, this participant's WL item will be removed from further data analyses and noted in the Results.

Note. CI = critical incident; WL = wish list.

Table U5

Final Categorization Consensus Content

Category			
Name	Description	Participation rate (%)	CI or WL item
Not the Interpersonal Right Fit	Didn't connect with the therapist	33.33%	CI 5 I felt like we weren't clicking. I felt like he wasn't seeing my issues as serious as I did. I didn't feel comfortable opening up furthermore. CI 6 My mental health professional was unresponsive to my needs. His mannerisms… he was very professional, but he didn't feel very engaging. He felt rather detached. He… looked at me the whole time and I didn't really feel like I was being led in a particular direction… it's just like, talk it out. CI 11 I didn't really feel heard. Him and I didn't have a strong enough relationship for me to feel secure and like communicating issues with him. CI 12.1 I felt like I wasn't being heard. I felt like… my professional was being close-minded about my circumstances…. CI 15.1 Conflict of interest between myself and the provider… that therapist was a provider in the clinic that I work in. CI 16.1 We just weren't jelling or vibing… it just

			wasn't gonna fit.
Not the Right Approach	Didn't want to or no longer wanted to take suggested medication, didn't agree with diagnosis, or needed a different counseling approach	27.78%	CI 1 We had a disagreement about… the use of medication… and I didn't feel comfortable about that. I have nothing bad to say about him. It's just that I don't believe in change through chemicals. CI 2.1 I did not think therapy and meds… did not do anything for me after all these years I'd been taking them. CI 4 I was told that I was bipolar and I did not believe such a thing is applicable. The tendency of my psychotherapist to adhere to textbook standards and complete a fast diagnosis. CI 17 A friend of mine… spoke to me… and he told me that… the medication… he had a bad reaction from that… he actually did worse by taking the medication and that kind of scared me a little bit and I didn't go back. Once my friend started telling me the symptoms… it made me feel leery. I'm thinking it was gonna affect me in that way, too. CI 18 The counseling seemed to be too open-ended…. I didn't really understand the direction it was taking… I didn't know what I was supposed to get out of it….
Need to Build Trust	Didn't trust the therapist	11.11%	CI 8 Loss of trust. It had to be someone who I thought was

			sympathetic and was easy for me to talk to… and this event made me think that this guy was definitely not. CI 9 We failed to connect. We never really connected, he seemed very detached from the get go and I… had trouble opening up to him.
Cost	Insurance no longer covered or no longer able to continue due to life change	11.11%	CI 7 Due to restructuring of the mental health practice, counseling was no longer covered under my insurance. The price was no longer covered by my insurance. CI 13 It was just cost prohibitive for me at that time.
No Longer Needed	Thought no longer needed/was in a good state	11.11%	CI 3 I thought I was in a good state and didn't need help. I'm bipolar and I guess at the time I was in a manic state where I felt really good and… I kind of stopped using my medications and started using some drugs and… I had just decided that I was delusional in my head and thought I was in a good place and decided I did not need therapy anymore. CI 10.1 I felt that I was at a place in my life where I was doing better than I previously was.
Time Problems	Time constraints such as the way time was not spent constructively in sessions or having lack of time to attend sessions	5.56%	CI 14 Time to attend sessions was probably the biggest eliminating factor for me. Lack of time on account of many moving parts in my personal and professional life.

Change the Approach	The counselor/psychotherapist changes the approach to accommodate the client's needs	35.29%	WL 1 I agree to take the medication… or he would drop the idea. Either I modify or compromise my philosophy or he… tries to treat me based on the principals that I listed. WL 2.1 …first appointment to affirm me if I had any episodes or situations…. I would like… the therapy to be like… AA- you get a sponsor. …he'll call you, check in with you, you'll call him and check in with him at any time. That would have helped when things started going rather than wait 'til things culminate…. …certain trust and all that. I would be nice to have a friend to confide in. WL 4 The mental health professional could have utilized a perspective which accepted more possibilities that include the unknown. …have a more… spirit-oriented perspective… a more willing acceptance, and… more of an ability to take everything with a grain of salt…. Just a more spiritual perspective. WL 6.1 If there was a framework, a little bit of guidance before going into the session, it would have given me some guidance about what I was going to be talking about. WL 16 …if there was just more discussion… around

			ground rules or an outline of what we wanted therapy to be or what I wanted therapy to be and what he provided. WL 18 …a little bit more assertion and direction on her part. …maybe less time… doing the get to know you part and understand the character. But also at the same time, use that information to… complete the diagnosis.
Building Rapport	The counselor/psychotherapist and client work on building a strong therapeutic alliance	29.41%	WL 5 The mental professional could be more compassionate and taken me more seriously, that could have helped me. …just feeling that bond. …maybe even him giving more examples in his own life that he went through similarly… to strengthen the bond…. WL 9 …it would be to incorporate my social work session progress… with my mental health and physical health sort of like treating them all together. I… had a really good working relationship with my social worker… and if she were able to attend my sessions with me me and… provide… like a mediator… that would have been really helpful. …aside from being more warm and less like cold and like clinical. That would have been the main big thing if I had been able to incorporate my… social worker into my mental health sessions….

			WL 11.1 Finding common ground to help understand each other. I think that having that connection with your counselor… to understand you… the experience you are having… would have been more beneficial than remaining silent throughout the duration of the counseling sessions. WL 12.1 My mental health professional… listened to me more and not been as close-minded. WL 15.1 …safety planning around my… conflict of interest.
Affordability	The counseling/psycho therapy sessions were able to be covered by insurance or the client has the finances to afford it	11.77%	WL 7 …if I had the finances to cover continuing with the mental health professional. (And… I'd appreciated if it had been more notice for its changes.) WL 13 Have the counseling be more affordable for myself.
Client Engages More	The client takes more action in his counseling/psycho therapy sessions	11.77%	WL 3 …managing my medication and being honest with the professional. …to be more honest and open and to be willing to actually… open up to the counselor. Just not being afraid to say what I'm thinking. WL 17 …if maybe I had discussed maybe what my friend had told me [about the negative side effects of the medication] it would have made things a lot different. It

			would have cleared up a lot of things for me. …the fact that I didn't disclose that to the practitioner, the fact that he could have done even more…. If I had taken my time and did my homework, my research, really looked into it, more than what I did (I was hardheaded) I think I would have been further down the road. I think I'd be a lot better off.
More Availability	A better time for the client to have a session with his counselor/psychotherapist	5.88%	WL 14 If our schedules aligned, if time stopped working as a limiting factor, my life at least and probably others as well, that would definitely help to continue help me work with the mental health professional.
Decided if Needed	The client decides he needs it	5.88%	WL 10.1 …if we had been deciding that it was something that we needed. …if I… felt that I needed it….

Note. CI = critical incident; WL = wish list. Participation rate is the percentage of participants who contributed a CI or WL item to a given category. WL 8.1 was removed, as it was determined to not be a credible WL item. This finalized table only lists the *primary* CIs and WL items. Thus, the participation rate only includes the primary CIs and WL items.