

Spring 4-1-2016

Barriers to Treatment and the Connection to Maslow's Hierarchy of Needs

Kelsey James

The College at Brockport, kjame1@brockport.edu

Follow this and additional works at: http://digitalcommons.brockport.edu/edc_capstone



Part of the [Counselor Education Commons](#), and the [Student Counseling and Personnel Services Commons](#)

Recommended Citation

James, Kelsey, "Barriers to Treatment and the Connection to Maslow's Hierarchy of Needs" (2016). *Counselor Education Capstone*. Paper 18.

This Capstone is brought to you for free and open access by the Counselor Education at Digital Commons @Brockport. It has been accepted for inclusion in Counselor Education Capstone by an authorized administrator of Digital Commons @Brockport. For more information, please contact kmyers@brockport.edu.

Barriers to Treatment and the Connection to Maslow's Hierarchy of Needs

Kelsey L. James

The College at Brockport, State University of New York

Acknowledgement

I would like to thank several people for their involvement and support during the completion of this Capstone Research Project. Thank you to the professors of the Counselor Education department at The College at Brockport, SUNY. Each one of you have played a role in my journey, growth, and development as a professional counselor. I appreciated the times you have been supportive and the times you have pushed me to not only be the best counselor I can be but the best person I can be. Thank you to my family who has always provided their support and encouragement. Thank you to my closest friends and wonderful man, Chris. Each of you knows who you are and have been a major support for me throughout this final journey of my graduate degree. I have reached out to so many people during this time for words of encouragement, advice, and at times just a shoulder to lean on. A special thank you to my internship site. Thank you to the entire staff for treating me like staff and a professional counselor. I felt like part of the family during this process and I will always remember that experience as being a crucial point in my career. To my cohort, thank you for being a part of my journey and I am so blessed to have gone through this process with each and every one of you, we did it!

Abstract

Individuals who are engaging in mental health counseling services are demonstrating a lack of engagement in treatment. The purpose of this research study is to demonstrate a relationship between client's perceived barriers to mental health treatment and to human needs as identified through Maslow's hierarchy of needs (1943). This study was conducted through administration of a 27-item survey that consisted of a list of barriers to treatment and basic needs. The development and administration of this survey will be detailed through describing the location of the research site, recruitment process, and collection of data. A total of 22 participants completed the survey. Data analysis showed that 72.27% of participants reported at least one of their barriers to treatment being a basic need as identified by Maslow. The findings are discussed and implications for professional counseling and future research.

Table of Content

Review of the Literature	5
Barriers to Treatment	5
Human Needs	8
Method	12
Setting	12
Procedure	13
Instrument	16
Data Management and Analysis	17
Results	17
Physiological Needs	18
Safety Needs	18
Love Needs	18
Esteem Needs	19
Other Barriers to Treatment	19
Discussion	19
Physiological Needs	20
Safety Needs	21
Love Needs	22
Esteem Needs	23
Other Barriers to Treatment	24
Limitations	25
Implications of Counseling and Research	27
Conclusion	29
References	30
Appendix A	32
Appendix B	33

Barriers to Treatment and the Connection to Maslow's Hierarchy of Needs

Introduction

One in every 25 adults in America are living with a severe mental illness (NAMI). It is evident that the need for mental health services is high, however, individuals are continuing to identify barriers to treatment. Transportation, forgetting appointments, and childcare have been noted in the research as common barriers to mental health treatment (Delaney, 2012; Lacy, Paulman, Reuter, & Lovejoy, 2004). Lack of engagement in an outpatient mental health clinic is still occurring despite attempts at diminishing barriers. These attempts consist of incorporating buss passes for clients who struggle with transportation and integrating reminder calls for clients who struggle remembering their appointments. This poses the question of what else clients perceive as their barriers to mental health treatment. The purpose of this research was to demonstrate that client's barriers to mental health treatment are correlated with clients not attaining their basic needs. Basic needs were identified through Maslow's hierarchy of needs (1943). Maslow's hierarchy of needs consisted of the following groups of needs: Physiological needs, safety needs, love needs, esteem needs, and the need for self-actualization (1943). This study was conducted through an anonymous 27-item survey completed by clients at an outpatient mental health agency.

Review of the Literature

Barriers to Treatment

According to the National Institute of Mental Illness (NAMI), in 2015, nearly 44 million adults were experiencing mental illness. Statistically, one in every 25 adults in America are living with a severe, as defined by NAMI, mental illness (NAMI, 2015). It is apparent that there is a need for mental health treatment services; however, research shows a multitude of barriers to

clients receiving services (Broadbent, Kydd, Sanders, & Vanderpyl, 2008; Delaney, 2012; Grote, Zuckoff, Swartz, Bledsoe, & Geibel, 2007; Lacy, Paulman, Reuter, & Lovejoy, 2004; Rondon, Campbell, Galway, & Leavey, 2014). Research shows that barriers to treatment are multifactorial and not a result of a single decision (Lacy, Paulman, Reuter, & Lovejoy, 2004). These barriers may be within or out of clients' control, based on their perception and situation. Barriers that are reviewed throughout the literature are clients' perceptions and beliefs about their mental health along with concrete barriers such as transportation, child-care, finances, etc.

Research shows that clients' perceptions of their mental health is influential on treatment outcomes and can be a barrier to successful treatment. For example, Rondon, Campbell, Galway, and Leavey (2014) concluded that young males did not want to seek help for fear of being laughed at. Broadbent, Kydd, Sanders, and Vanderpyl (2008) also concluded that a barrier to treatment was participants' perceptions of their mental illness. The research also concluded that participants' perceptions of their mental illness were also influential on the symptoms of their mental illness. Including anxiety, depression, sleep, appetite, etc. (Broadbent, Kydd, Sanders, & Vanderpyl, 2008). Broadbent, Kydd, Sanders, and Vanderpyl (2008) demonstrated that participants' perceptions of their mental illnesses led to an increase in symptoms of mental illness, emotional instability, increase in negative consequences of their mental illness, increase in the symptoms duration, and less manageability of the symptoms. Barriers to treatment may result in individuals not engaging in treatment or dropping out of treatment due to their perceptions of their mental health. According to Mojtabai et al. (2011), the main barrier to treatment were participants identifying that they could handle their mental illness on their own. Mojtabai et al. (2011) reported that if an individual believed that their mental illness would go away on its own, or the individual perceived that they were not in need of clinical help, it limited

the individual's ability to seek counseling for their mental illness. Thus, creating a barrier to treatment. Another study reports that some barriers to treatment may be poor coping skills for the individuals' perception of their mental health (Broadbent, Kydd, Sanders, & Vanderpyl, 2008). An example of this may be that a client perceives his/her anxiety to be so significant that he/she is unable to cope enough with the anxiety to leave the house in order to attend an appointment. This implies that if individuals cannot cope with their perceived mental illness, this may lead to barriers to treatment such as missed appointments and continued decline in mental health. Maladaptive beliefs about the client's mental health may also interfere with success of treatment (Broadbent, Kydd, Sanders, & Vanderpyl, 2008). Maladaptive beliefs may include but are not limited to believing that the mental illness will go away on its own and not wanting to be labeled.

Other barriers to treatment supported through the literature are existential to the clients. Existential barriers are defined as qualities or situations of the clients that are not innate. A study indicated that the main barriers to treatment were delay of appointments, transportation, and child-care (Delaney, 2012; Lacy, Paulman, Reuter, & Lovejoy, 2004). Confidentiality, cost, and scheduling conflicts have also been documented as barriers to mental health treatment (Grote, Zuckoff, Swartz, Bledsoe, & Geibel, 2007). The impact of medication is also seen to influence treatment coherence. Participants who reported a positive experience with their medication reported higher adherence to treatment (Broadbent, Kydd, Sanders, & Vanderpyl, 2008). The above-mentioned barriers all have an impact on clients' abilities to receive mental health services. When clients do not have adequate transportation and/or childcare, it leaves the clients feeling trapped and/or stuck in their home. Client's without health insurance may want to receive counseling for their mental health but may not have the financial ability to do so. Lack of finances may increase the client's anxiety and/or depression. When situations arise when there

were scheduling errors or wait times for appointments, some client's are left feeling discouraged. In return, access to counseling and medications present as a barrier for client's to engage in counseling.

Human Needs

Needs of clients is a necessary assessment that must be considered in order for counselors to provide effective treatment to clients when working towards their mental health. The literature provides evidence of the validity of Abraham Maslow's (1943) hierarchy of human needs and assessment in mental health counseling (Ostman, 2008; Rondon, Campbell, Galway, & Leavey, 2014; Taormina & Gao, 2013; Wennstrom, Berglund, & Lindback, 2010).

Abraham Maslow developed a theory of motivation that focused on a hierarchy of human needs (Maslow, 1943). Maslow (1943) reported that there were different levels of needs. He reported that the level that needed to be met first was physiological needs (Maslow, 1943). Following physiological needs were safety, love, esteem, and the need for self-actualization. Maslow (1943) also reported that individuals' world can become consumed with what needs are not being met. If individuals are hungry, their world revolves around looking for and finding food. If those individuals reach a state of being in which their physiological needs are being met, the need for safety then emerges; "A person who is lacking food, safety, love, and esteem would most probably hunger for food more strongly than for anything else" (Maslow, 1943, p. 373).

According to recent research, Maslow's Hierarchy of needs, motivation theory, is still demonstrating validity. Taormina and Gao (2013) conducted a series of assessment questionnaires to assess six different dimensions, one of them being the hierarchy of five needs defined in their study as: physiological needs, safety-security needs, belongingness needs, esteem needs, and self-actualization needs. Research indicated that as one level of need within the

hierarchy is satisfied, the higher level within the hierarchy will then emerge as a need. When that need emerges, if the lower level need reached full potential, then the next need will have a greater chance at also being successfully met (Taormina & Gao, 2013). For example, if individuals' physiological needs are met to full extent, the individuals' likelihood of successfully receiving their safety-security needs increases. The ability of individuals needs being met is not only dependent on the individuals themselves; individuals' environments can have an influence. Taormina and Gao (2013) concluded that family emotional support and perceived healthiness can be a predictor of satisfaction of physiological needs (Taormina & Gao, 2013).

Wennstrom, Berglund, and Lindback (2010) utilized two needs assessments, Camberwell Assessment of Need (CAN) and Met Needs Index (MNI) to survey 321 clients. The clients surveyed carried a diagnosis of schizophrenia, other psychotic disorders, bipolar disorder, and other clinical disorders. The biggest needs found by the MNI survey were "looking after the home, food accommodations, safety to self, psychotic symptoms, and physical health" (Wennstrom, Berglund, & Lindback, 2010, p. 428). The need domains reported through the MNI survey that were identified to have less importance for clients were "benefits, sexual expression, intimate relationships, drugs, and childcare" (Wennstrom, Berglund, & Lindback, 2010, p. 428). This research supports the importance of Maslow's hierarchy of needs. If individuals' basic needs are not being met, such as shelter and food, they cannot move on to further their interpersonal growth.

When individuals' needs are not being met, it is influential on the outcome of treatment. Broadbent, Kydd, Sanders, and Vanderpyl (2008) conducted research in which participants were randomly selected from existing database of clients who frequently use mental health services. Broadbent, Kydd, Sanders, and Vanderpyl (2008), utilizing the Brief Illness Perception

Questionnaire, defined consequence scores as “how much the client thinks the illness affects their life,” personal control scores as “how much control the client feels they have over their illness,” and concern scores as “how concerned the client is about their illness” (p. 149). This study reports that participants who had greater unmet needs demonstrated “higher consequences scores, lower personal control scores, and higher concern” (Broadbent, Kydd, Sanders, & Vanderpyl, 2008, p. 150). In discussion, this demonstrates that clients whose needs are not being met experience more consequences of their mental health, feelings of no control, and higher concerns.

Another study researched needs among older adults from ages 58-92 who have been diagnosed with depression (Houtjes, Meijel, Deeg, & Beekman, 2010). The met needs of the 99 participants were identified as physical needs consisting of physical health, household skills, and psychological distress (Houtjes, Meijel, Deeg, & Beekman, 2010). Social needs showed to be the highest percentage of unmet needs including psychological distress, daytime activities, and intimate relationships (Houtjes, Meijel, Deeg, & Beekman, 2010). In this particular population, Maslow's hierarchy of needs (1943) is demonstrated through the participants' basic physiological needs being met but lack of social interactions and relationships are not being met. This results in continued depression and decrease in quality of life for the older adult population (Houtjes, Meijel, Deeg, & Beekman, 2010; Wiersma, 2006).

Maslow (1943) states that if individuals are not meeting interpersonal/love needs, their self-esteem and self-actualization needs will not be met. This is supported through a qualitative research study conducted by Ostman (2008) assessing the quality of sexuality among six clients and four identified partners of the clients. Through in-depth interviews, research concluded that individuals with mental illness experience impacts on their sexuality. Participants reported still

having a sexual desire, but feeling powerless to act upon their desires (Ostman, 2008). This identified powerlessness impacts the quality of interpersonal relationship with their partners (Ostman, 2008). Partners, in return, reported that they suppressed their expectations for sexual intercourse due to not wanting to force their partners into sexual intercourse (Ostman, 2008). In respect to Maslow's hierarchy of needs (1943), self-esteem and self-actualization cannot be met if the need for love remains unmet. Individuals who are struggling with mental illness are reporting unmet needs in the domains of sexuality and intimate relationships. The need for sexuality and intimate relationships is defined by Maslow as the need for love (1943). According to Maslow (1943), individuals will not be able to move towards mental wellness until their need for love is met. Ostman (2008) argues that sexuality and intimate relationships impact the physical, psychological, and relationship needs.

Rondon, Campbell, Galway, and Leavey, (2014) also conducted a series of in-depth interviews with 27 young males ranging from ages 14-16. The lack of needs in this study/population can be related to Maslow's hierarchy of needs (1943). Drugs and alcohol are replacing interpersonal relationships and crime and violence replaced boredom/sense of self worth (Rondon, Campbell, Galway, & Leavey (2014). The participants also identified need for school and work as an area that was not being met (Rondon, Campbell, Galway, & Leavey (2014).

Conclusion

It is prevalent that individuals are experiencing a multitude of barriers in receiving adequate treatment/care. Lacy, Paulman, Reuter, and Lovejoy (2004) conclude that barriers to treatment are multifactorial and not result of a single decision. Research indicates that these barriers may include: transportation, remembering appointments, effective coping skills, denial

of mental illness, and low income (Delaney, 2012; Grote, Zuckoff, Swartz, Bledsoe, & Geibel, 2007; Mojtabai et al., 2011). It is imperative that agencies become aware of what their clientele identifies as being the common barriers to treatment at that specific agency. In theory, this would open up access for clients and increase client engagement.

In exploration of clients' needs, Abraham Maslow's (1943) hierarchy of human needs is explored. The validity of Maslow's (1943) hierarchy of human needs and assessment in mental health counseling is demonstrated through an array of literature (Ostman, 2008; Rondon, Campbell, Galway, & Leavey, 2014; Taormina & Gao, 2013; Wennstrom, Berglund, & Lindback, 2010). It is important to be aware of what clients' needs are to make sure that their basic needs are being met. If the clients' basic needs are not being met, clients will not be able to work towards their mental health, and in return, creating another barrier to effective treatment.

The goal of this research is to explore the relationship between client's barriers to treatment and basic needs as defined by Abraham Maslow. The developed research question is what is the correlation between client's perceived barriers to treatment in an outpatient mental health setting and Maslow's hierarchy of needs (1943). It is hypothesized that there will be a significant relationship between the identified client barriers to treatment and basic needs. This research will enhance the existing literature by demonstrating the need of counselors to focus on client's needs first, in order to gain self-growth and actualization.

The next section discusses the methods of the research study. Within the methods includes discussion of setting, population, participants, attainment of Institutional Review Board (IRB) approval, procedures, discussion of the instrument used, and analysis of the data.

Method

Setting

The research took place at an urban outpatient, not for profit, mental health clinic located in Rochester, New York. The agency is located on the second floor of a building in downtown Rochester. Within this building, other services are available to clients such as immigration and refugee assistance. The outpatient clinic was composed of one director, two supervisors, two psychiatrists, two psychiatric nurses, a registered nurse, and registration staff. The clinician's degrees consisted of Licensed Mental Health Counselor (LMHC), Licensed Mental Health Counselor-Permit (LMHC-P), and Licensed Master Social Worker (LMSW). The population served is generally from a low socioeconomic status. This data was gathered based on a majority of the clients who received services also received assistance through the Department of Human Services. The population served also had a variety of cultural and ethnic backgrounds. The agency is able to work with clients with a variety of primary languages with the utilization of interpretative services.

Population

All participants were 18 years of age or above and due to the nature of the study, participants' other demographics were not collected to ensure participants' confidentiality. The Barriers to Treatment Survey was anonymous. The population that was researched were individuals that struggled with engagement in mental health treatment. Participants in this study had a history of not showing to two appointments within a 45-day span that led to a walk-in service referral. The other participants had completed the offered walk-in service and continued to not show for their appointments and were referred to the five-week engagement group. Clients that were not referred to walk-in service or the engagement group were excluded from the study due to that percentage of the population actively attending their scheduled appointments.

Procedure

Prior to beginning research the researcher needed to obtain permission from the outpatient mental health agency. The researcher submitted a proposal that consisted of research vision and projected outcomes to the agencies director for approval. After the researcher received the agencies approval, the next step was obtaining Institution Review Board (IRB) approval. The researcher submitted an application to the IRB and gained approval on 12/16/2015. On 12/18/2015 the researcher presented at the agency staff meeting about the purpose of the research study after obtaining approval from the agency and the IRB. On 12/18/2015, the first set of recruitment letters were mailed out to the clients for the engagement group. The recruitment letters consisted of the researcher explaining the purpose of the group, reasoning for why the client was recommended, dates and time of the group, and contact information for the group facilitator. On 12/22/2015 the Barriers to Treatment Surveys were administered to all walk-in service clients and on 1/4/2016 the first engagement group began with the second group beginning on 02/15/16. Clients that were referred to the engagement group were administered the barriers to treatment survey upon arrival to their first group session. The researcher collected all completed surveys at the end of the first group session.

Participants who were asked to complete the Barriers to Treatment Survey were individuals who met one of two sets of criteria. The first set of criteria included a group of participants who were referred by their primary clinicians to complete "walk-in service" due to missing two appointments with their clinician. Walk-in service was a twenty to thirty-minute appointment in which clients met with a clinician to discuss their barriers to treatment and reasons for missing their scheduled appointments. Walk-in service was offered on Tuesday, Wednesday, and Thursdays from 9:00AM-11:00AM. Individuals were asked to arrive during these hours to meet with a clinician about their engagement in treatment. Once the individuals

arrived at the clinic to complete walk-ins, they were provided an informational cover letter, informed consent, and the Barriers to Treatment Survey. If the individuals chose to sign the informed consent and complete the Barriers to Treatment Survey the clinician on duty placed the informed consent and Barriers to Treatment Survey in a folder that was in a locked drawer in the medical record office.

The second set of criteria was individuals that already completed walk-in service but continued to miss appointments. These individuals were referred to a five-week engagement group that met one time a week for five weeks. Once individuals were referred to the group, they were provided education on the research study and what was included in the Barriers to Treatment Survey. Group members that provided informed consent were asked to complete the Barriers to Treatment Survey. Recruitment for the engagement group was based on clinicians' referrals to the group based on their client's engagement. The researcher was the facilitator for the engagement group. The researcher sent out letters to all group members referred to the engagement group introducing herself, stating the purpose of the referral, and the dates and times of the engagement group. Once members attended their first group session, they were provided time to read the informed consent and ask the researcher any questions. Participants were provided time to complete the Barriers to Treatment Survey and were asked to hand them into the researcher face down.

The researcher intended for approximately 130 participants to be reached through the survey. This number was gathered through projecting that approximately 10 clients per week will be seen for the walk in service. This research was in process for 13 total weeks. The number of participants that were reached was 22. The researcher suspects that there is a high dissonance between participants projected and participants obtained based on weeks that only one to two

clients were seen for walk-in services as opposed to the projected 10. All participants that were approached to complete the Barriers to Treatment survey completed and no participants denied consent.

Minimum risk of time to complete the Barriers to Treatment survey was approximately five minutes. Regardless of this research study, the clients were still required to complete the group and/or the walk-in service due to the attendance policy at the outpatient clinic. There were no incentives or compensations for this study.

Instrument

The researcher developed the Barriers to Treatment Survey. The researcher formulated the list of barriers based on previous interactions with clients and based on Maslow's Hierarchy of needs (1943). The researcher identified barriers to be indicative of the different levels of basic needs. The barriers that were coded as physiological needs were: lack of food, lack of water, fatigue, and health complications. Safety need barriers were a lack of safety, inadequate housing, lack of feeling secure, and lack of protection. The identified love need barrier was a limited support system. Lastly, esteem needs barriers were low self-esteem and low confidence. The researcher formulated the other barriers to treatment by listening to what clients expressed as barriers and incorporated them into the barriers list. The researcher randomly selected the order of the barriers to include Maslow's basic needs to be listed intermittently. The barriers list was complete with 27 identified barriers including free space and opportunity for clients to list their own barriers (see Appendix A).

The Barriers to Treatment Survey was given to each qualified participant. The Barriers to Treatment Survey was a one-page survey that asked participants to place an "X" or check next to each barrier that they identified as being a barrier to them attending their mental health

appointments.

Data Management and Analysis

Clinicians and other staff members continuously collected participants' surveys until the researcher informed them that data collection was completed. The clinicians and staff members placed each survey in a designated folder in a locked drawer within the agencies medical record room. The medical record room was locked in the evening. All clinicians and staff had access to the medical record room during operating hours. Once the clinic closed, only the director and office manager had keys to access the medical record room. The researcher implemented all data while on agency property and was able to keep all data surveys within the locked drawer.

Once the surveys were no longer being distributed to clients, the researcher began the collection of the Barriers to Treatment Surveys. The researcher labeled each survey one through 22 in order to decrease human error while entering in the survey data. The researcher utilized the statistically programming, SPSS. The researcher labeled each barrier within the survey to be a variable. The data for each variable was coded as "1" for a "yes" response and "2" for a "no" response. The researcher inputted all 27 barriers, coded as "yes" or "no," for every survey into SPSS. After data was inputted, the researcher computed descriptive statistics. The descriptive statistics utilized were percentages and frequencies of each reported barrier. The researcher received a table for each barrier that provided the total number of participants and the percentage of participants that reported this variable as a barrier to treatment.

Results

The participants in this research study received the barriers to treatment survey when they attended a walk-in service appointment or attended the engagement group. Participants only had

to complete the survey once and the survey was open to participants for a total of 13 weeks. The recruitment process for this research study was based on clinicians' referrals for walk-in service or to the engagement group.

The researcher completed survey distribution after 13 weeks. A total of 22 surveys were collected. The researcher then collected the surveys and implemented the data into SPSS and calculated descriptive statistics. The survey was coded to include 11 barriers that were organized according to Maslow's hierarchy of needs (physiological needs, safety needs, love needs, and esteem needs) and 16 barriers as identified through client reports. The following results are based on the analysis of SPSS and implementation of the data from 22 Barriers to Treatment Surveys.

Physiological Needs

Fatigue, lack of water, lack of food, and health complications were representative of physiological needs. Out of 22 responding participants, 22.7% reported fatigue as being a barrier to treatment and 36.4% reported health complications as being a barrier to treatment. No clients reported lack of water or lack of food as being a barrier to attending appointments.

Safety Needs

The listed barriers of inadequate housing, lack of feeling secure, lack of protection, and lack of safety represented safety needs. Out of 22 responding participants, 18.2% identified inadequate housing, 13.6% identified lack of feeling secure, and 13.6% reported lack of protection as being a barrier to treatment. The least reported was lack of safety (9.1%).

Love Needs

Limited support system was the barrier representative of love needs. Only 9.1% of participants identified with a limited support system as being a barrier to them attending appointments.

Esteem Needs

Low self-esteem and low confidence were representative of esteem needs in the Barriers to Treatment Survey. Of 22 responding participants, 45.5% identified with low self-esteem and 18.2% identified with low confidence as being barriers to treatment.

Other Barriers to Treatment

The researcher included other barriers to treatment into the survey based on clients self-reports. Participants identified low motivation as being the biggest barrier to treatment with 77.3% of individuals reporting this barrier. 68.2% of participants reported transportation and 68.2% reported forgetting appointments as barriers to treatment. Conflicts in schedule were reported 27.3% by participants. Finances, no childcare, and time management were each reported 22.7% by participants. Participants also identified with the following barriers: instability in mental health (18.2%), instability in life (13.6%), lack of clothing, no connection with counselor, negative attitude towards counselor, medication is not working, and lack of adequate coping skills (9.1%), alcohol/drug use and no medications (4.5%).

Discussion

The researcher hypothesized that there was a relationship between client's perceived barriers to treatment and Maslow's hierarchy of basic needs. Past literature has failed to make the connection between barriers to treatment and Maslow's hierarchy of needs. The literature has reported the most common barriers to treatment (transportation and remembering appointments) along with the importance of addressing human needs (Delaney, 2012; Ostman, 2008; Rondon, Campbell, Galway, & Leavey, 2014; Taormina & Gao, 2013; Wennstrom, Berglund, & Lindback, 2010). This research aimed to prove the relationship between barriers to treatment and Maslow's hierarchy of needs. The findings indicated that 72.27% of responding participants

struggled with basic needs (as identified according to Maslow) as being a barrier to treatment. This was demonstrated through participants reporting at least one barrier to treatment that was previously coded to be indicative of a basic need. This concludes that about three-fourths of responding participants report that some of their basic needs are not being met, and as a result of this, are experiencing barriers to engagement in treatment. Overall, 21 participants out of 22 reported more than one barrier to treatment, validating previous literature that discusses barriers to treatment as being multifactorial (Lacy, Paulman, Reuter, & Lovejoy, 2004).

Physiological Needs

In respect to Maslow's hierarchy of human needs (1943), physiological needs are the foundation of the pyramid. If the needs in this area are not met, individuals will present with difficulty in the next level of needs, safety. Out of a total of 22 responding participants, the findings indicated that 22.7% of participants reported fatigue as being a barrier to treatment, meaning, approximately one out of every four people seen for treatment struggle with sleep. Sleep deprivation can have a significant influence on mental health symptoms, i.e., increase in anxiety, increase in ability to manage emotions, decrease process time (Orzel-Gryglewska, 2010). This presents as a barrier for services in multiple ways. One, clients that do not get enough sleep do not attend their appointments and do not receive the needed counseling services. Two, clients that identified with low amounts of sleep but have attended appointments, may be demonstrating an increase in mental health symptoms that are indicative of sleep deprivation, not mental health. If sleep was not assessed, clients may have received inaccurate diagnosis or treatment. Orzel-Gryglewska (2010) researched sleep deprivation and stated findings of participants who had 50 hours of sleep deprivation reported an increase in the perception of affective symptoms of anxiety, depression, mania, and insanity.

Approximately one out of every three participants (36.4%) reported health complications as being a barrier to treatment. Health complications influence clients' perceptions of attainments of their physiological needs (Taormina & Gao, 2013). Mental health symptoms at times may mimic health complications such as difficulty breathing, chest pain, heart palpitations, increase in heart rate/blood pressure, nausea, diarrhea, etc. In return, health complications may increase mental health symptoms (Ai, Kabba, and Kathy, 2014). No clients reported lack of water or lack of food as being a barrier to attending appointments. These findings indicated that clients' basic needs of food and water were met.

Furthermore, the findings conclude that clients' mental health concerns and diagnoses may be overlooked if they have experienced difficulty in obtainment of their physiological needs. This is a barrier to treatment because clients' physiological needs are presenting as the primary concern for treatment. Indicating that clients' physiological needs have to be met before other need areas of the clients can be addressed. These findings support Maslow's theory of hierarchy of needs (1943). It is important for professional counselors to assess clients for their physiological needs such as amount of sleep and any pre-existing health complications in order to accurately treat and assess the clients.

Safety Needs

Safety needs are identified as the second most important area of needs in Maslow's hierarchy of needs (1943). Safety needs in the Barriers to Treatment Survey were inadequate housing, lack of feeling secure, lack of protection, and lack of safety. Out of a total of 22 responding participants 18.2% identified inadequate housing as a barrier to treatment. The findings concluded that about one out of every five clients are living in a situation where their living environment is not conducive to their needs. Living in unsupportive housing is creating a

barrier to these individuals attending their appointments. 13.6% of participants identified lack of feeling secure, 13.6% reported lack of protection, and 9.1% reported lack of safety as being a barrier to treatment. These statistics indicated that approximately one out of every eight clients that received treatment did not feel secure or protected and that one out of every 11 clients did not feel safe. Although safety was least reported in the assessment of safety needs, when discussing client safety in an agency that treats nearly 1,000 clients, that would indicate that approximately 91 clients did not feel safe on a daily basis (ratio of one to 11 is equivalent to 91 out of 1000).

The barrier to treatment of lack of safety may be a result of a history of abuse and/or trauma. Clients that have experienced trauma within their communities may experience difficulty leaving the safety of their home due to fear of recurrent trauma. If a client is unable to leave their home due to a history of abuse and/or trauma, the client is unable to receive the mental health services that they need. A severe struggle in treatment presents when clients do not report feeling safe to be in their community but also do not have a safe place to live in. These clients may be living in shelters or abandoned places. The data concludes that when clients' safety needs are not being met, it presents as a barrier to clients attending their appointments due to fear of leaving their own homes, affecting clients to not be receiving the counseling services that they need for their mental health.

Love Needs

Love needs are the third most pertinent area of needs according to Maslow's hierarchy of needs (1943). Limited support system was the barrier within the Barriers to Treatment Survey that represented love needs. Only 9.1% of participants identified with a limited support system as being a barrier to them attending appointments. This concluded that approximately one out of

every 11 clients reported that lack of their love needs being met is a barrier to them engaging in treatment. The researcher concludes that although it may not be interfering highly with their engagement in treatment, it could be presenting as a barrier to clients being able to achieve self-actualization. Unmet needs, such as unmet love needs, are indicative of a lower quality of life (Houtjes, Meijel, Deeg, & Beekman, 2010; Wiersma, 2006). The ultimate goal of counseling is for clients to achieve self-actualization. Clients that report their love needs are not being met will have difficulty in obtaining self-actualization and have a lower quality of life (Houtjes, Meijel, Deeg, & Beekman, 2010; Maslow, 1943; Wiersma, 2006).

Esteem Needs

Esteem needs are the level of needs right below achievement of self-actualization (Maslow, 1943). Low self-esteem and low confidence were representative of esteem needs in the Barriers to Treatment Survey. Almost half of the participants (45.5%) identified with low self-esteem and about one-fifth (18.2%) identified with low confidence as being barriers to treatment. The findings indicated that clients are more confident in their abilities of achievement than their ability to self-love or have self-acceptance. Maslow (1943) stated that in order for an individual to achieve self-actualization, all the previous discussed areas of needs must be met. It is the researchers belief that the ultimate goal of counseling is to help clients achieve self-actualization. If half of the clients reported having low self-esteem, then at least half of the clients will not be able to achieve self-actualization.

A second area to discuss about the findings would be why participants reported lower frequencies in need for confidence than in need for self-esteem. The findings indicated that participants' confidence levels are higher than their esteem levels. This is important because the researcher determined that the findings indicated that participants' perceptions of their mental

health were influential of the data (Mojtabai et al., 2011). For example, if a client is in a state of denial and not wanting to accept that they struggle with mental health they may have been superficial in their confidence ratings. In return, clients may have experienced difficulty with self-esteem due to stigma of mental health or not wanting to accept their mental illness. To conclude, clients may be confident in their ability to have a high quality of life but may struggle with accepting the presence of mental health. This supports the literature that clients' perceptions of their mental health can present as a barrier to treatment (Broadbent, Kydd, Sanders, & Vanderpyl, 2008; Mojtabai et al., 2011; Rondon, Campbell, Galway, & Leavey, 2014). For example, clients that perceive their mental health to be stable may not reach out to counseling services, thus creating a barrier to treatment

Other Barriers to Treatment

The researcher included other barriers to treatment into the survey based on clients self-reports. Some of these barriers were transportation, finances, lack of childcare, and lack of clothing. 68.2% of participants reported transportation as barriers to treatment. Finances and no childcare were reported 22.7% by participants. Lack of clothing was reported by 9.1% of participants.

Through analysis of the findings, socioeconomic status (SES) revealed as a barrier to treatment for the urban population. Specifically transportation, finances, lack of childcare, and lack of clothing are some barriers that may suggest SES as a barrier to treatment. Transportation as a barrier to treatment suggests lack of finances or accessibility to a vehicle and/or inability to afford bus passes. Finances in general, if applied to the population at large, impacts approximately 227 (ratio of 22.7% to approximately 1,000 clients) clients. These findings indicate the need for an increase in services for the urban population in order to afford/receive

mental health counseling services. Inadequate resources were also revealed through the data.

9.1% of participants reported lack of clothing as a barrier to treatment, demonstrating a need for counselors to advocate for clients to obtain resources such as clothing closets or a care manager.

Limitations

Within this research study were limitations that may have influenced the overall data. The first limitation is the researchers availability. Due to the researchers scheduled hours, the researcher was only present on-site one time a week during the scheduled walk-in service days. If the researcher were available all days of walk-in service, more clients may have been reached. To address this limitation, the researcher could have trained other staff members to be co-researchers or been present for all walk-in service scheduled days and times. It is important for future researchers to increase the number of researchers because it will allow for an increase in researcher availability and increase the likelihood of a larger sample size. A larger sample size will allow for an increase in generalizability.

A second limitation was the short time frame the research study was conducted. Due to restrictions from having to meet semester guidelines and pending IRB approval, the distribution of the Barriers to Treatment Survey was limited to 13 weeks. This created a small sample size of only 22 participants. Another limitation that may have influenced the sample size was the distribution of the Barriers to Treatment Surveys over the course of the winter season. Due to this attendance rates in general decrease at the outpatient mental health clinic. Participants reported barriers may have also been skewed based on the weather season. Clients' needs in the winter are different than clients' needs in the summer months. For example, transportation presents as a bigger concern in the winter at the agency due to most of the population walking to their appointments. Clients' housing needs are also different from winter to summer months.

Client's who identified as homeless are in bigger need of supportive housing in the winter as opposed to the summer. To address this limitation, the researcher recommends extending the barriers to treatment survey over a longer period of time to incorporate more seasons along with a bigger sample size. It is important to extend the Barriers to Treatment Survey over a longer period of time to eliminate weather and climate as being a variable that impacted data. A larger sample size will allow for more data and an increase in generalizability to the populations across agencies. If the data is able to be generalizable to a larger population, agencies may be more willing to adapt styles of counseling to incorporate assessment of client's needs.

With any self-reported data, a limitation is created based on participants' perceptions of the barriers on the survey. The Barriers to Treatment Survey was created by the researcher. This limited the knowledge of validity and reliability because the survey has not been used in a prior research study. To ensure validity, future researchers could distribute a different assessment tool along with the barriers to treatment survey and compare responses. An example of this would be to utilize a previous survey created by Delaney (2010) that assessed clients' obstacles to treatment (Appendix B). Future researchers could distribute both surveys and compare results. If both surveys reveal approximately the same results, then the Barriers to Research Survey increases in validity indicating that the Barriers to Treatment Survey is measuring what it is supposed to measure. To gain reliability, researchers could distribute the Barriers to Treatment Survey multiple times to the same participants. It is important for a survey to have reliability because future researchers will want to ensure that the Barriers to Treatment Survey is accurate. If the Barriers to Treatment Survey were distributed multiple times, the results should be the same for each client. The Barriers to Treatment Survey also did not allow for a range of responses. Participants were forced to respond "yes" or "no" to each listed barrier. It is

recommended that future researchers utilize a Likert Scale. Each barrier listed within the survey would be accompanied with a scale from one through five. One indicating "Never," two indicating "Almost Never," three indicating "Neutral," Four indicating "Almost Always", and five indicating "Always." If a likert scale would have been implemented, participants may have been more willing to respond "almost never" or "almost always" as opposed to the limiting variables of a yes or no response. The importance of a likert scale is that it provides participants with a range of responses as opposed to only two options. The researcher suspects that some participants may have been unwilling to check off a barrier to treatment if they did not experience this as barrier consistently.

Another limitation is that only clients at one outpatient mental health clinic in the Rochester area participated in the barriers to treatment survey. The researcher limited the population of participants to be at one outpatient mental health clinic based on the accessibility of clients at this agency. Due to the survey not being distributed among all clients in the Rochester area, the findings are limited to only be generalizable to the population at the outpatient mental health clinic in which the study was conducted. To address this limitation, participants from several agencies within the region would be asked to complete the Barriers to Treatment Survey. This could be accomplished through mailing the surveys to multiple agencies in the area and providing return envelopes with prepaid postage. Through distribution of the Barriers to Treatment Survey among all outpatient mental health clinics in the area, the increase in findings would allow for an increase in sample size and generalizability across populations. Therefore, allowing agencies to advocate for the population at large.

Implications of Counseling and Research

Low motivation was the highest reported at 77.3%. This indicates a need for counselors

to discuss motivation with clients. Motivational interviewing is a therapeutic technique developed by Miller and Rollnick (2002). Motivational interviewing works to help instill motivation for change in clients utilizing a variety of techniques and principles: “express empathy, develop discrepancy, roll with resistance, and support self-efficacy” (Miller & Rollnick, 2012, p. 36). The goals of motivational interviewing are to elicit “change talk” in clients and have clients gain internal motivation. Motivational interviewing has primarily been utilized in addiction counseling but the benefit in mental health counseling is clearly indicated by 77.3% reporting low motivation for treatment as a barrier. The literature also supports the positive improvement in treatment that motivational interviewing has on clients (Lundahl & Burke, 2009).

Exploration of needs would be the next important implication for counseling. It is clear that participants identify with a need for support in certain need areas. Counselors should be asking their clients what they identify as their most immediate needs. If a client's needs are shelter or to be connected with other services, the counselor could utilize a care manager referral early on in treatment to help assist the client. Utilizing a care management referral early in counseling will allow the counselor to work with the client on their presenting issues to counseling (anxiety, depression, trauma) as opposed to finding housing, difficulties with the Department of Human Services, etc. A care manager also provides clients with an additional support system and advocate.

For future research, it is recommended that the Barriers to Treatment Survey be distributed over a longer period of time. The Barriers to Treatment Survey should also be adjusted to include more barriers that reflect each pyramid level of Maslow's hierarchy of needs (1943). Researchers may incorporate at least five barriers per level of Maslow's hierarchy. For

example, five barriers that would identify with physiological needs, five barriers that would identify with safety needs, five barriers for love needs, five barriers for esteem needs, and five barriers for self-actualization. The researcher also concluded that in the developing research area of the relationship between barriers to treatment and Maslow's hierarchy of needs, a qualitative approach might be more beneficial. Through interviews with clients, a researcher may be able to gain a better understanding and perspective on the complexity of why individuals are struggling to make it to their appointments.

Conclusion

One in every 25 adults in America are living with a severe mental illness (NAMI), however, there is a lack of engagement in mental health counseling services. This research aimed to discover what clients in an urban outpatient mental health agency perceived as their barriers to treatment. The researcher hypothesized that there is a relationship to client's perceived barriers to treatment and human needs as described by Maslow's hierarchy of basic needs (1943). The data supported a relationship due to 72.27% of responding participants reporting at least one of their barriers to treatment being a basic need. Low motivation was the barrier that was most reported, indicating a need for motivation to be a topic of conversation between clients and clinicians. For future research, it is recommended that the research is conducted over the span of a full calendar year and provide more room for clients' thoughts.

References

- Ai, A. L., Kabbaj, M., & Kathy, L. L. (2014). Body affects mind? Preoperative behavioral and biological predictors for postoperative symptoms in mental health. *Journal of Behavioral Medicine, 37*(2), 289-299.
- Broadbent, E., Kydd, Br., Sanders, D., Vanderpyl, J. (2008). Unmet needs and treatment seeking in high users of mental health services: Role of illness perceptions. *Australian and New Zealand Journal of Psychiatry, 42*, 147-153.
- Delaney, N. M. (2012). Obstacles to attending treatment in an urban mental health clinic: A client's perspective approach to identifying factors influencing treatment attendance. *The College at Brockport, 125*.
- Grote, N. K., Zuckoff, A., Swartz, H., Bledsoe, S. E., Geibel, S. (2007). Engaging women who are depressed and economically disadvantaged in mental health treatment. *Social Work, 52*, 295-308.
- Houtjes, W., Meijel, B. V., Deeg, D. J. H., Beekman, A. T. F. (2010). Major depressive disorder in late life: A multifocus perspective on care needs. *Aging & Mental Health, 14*, 874-880. doi:10.1080/13607861003801029
- Lacy, A. L., Paulman, A., Reuter, M. D., Lovejoy, B. (2004). Why we don't come: Patient perceptions on no-shows. *Annals of Family Medicine, 2*, 541-545. doi:10.1370/afm.123
- Lundahl, B., & Burke, B. L. (2009). The effectiveness and applicability of motivational interviewing: A practice-friendly review of four meta-analyses. *Journal of Clinical Psychology: In Session, 65*, 1232-1245. doi:10.1002/jclp.20638

Maslow, A. H. (1943). A theory of human motivation. *Psychological Review*, 50, 370-396.

Miller, W. R., Rollnick, S. (2002). *Motivational interviewing: Preparing people for change*. New York, NY: The Guilford Press.

Mojtabai, R., Olfson, M., Sampson, N. A., Jin, R., Druss, B., Wang, P. S., Wells, K. B., Pincus, H. A., Kessler, R. C. (2011). Barriers to mental health treatment: Results from the national comorbidity survey replication (ncs-r). *Psychol Med*, 41, 1751-1761.
doi:10.1017/S0033291710002291

Orzel-Gryglewska, J. (2010). Consequences of sleep deprivation. *International Journal Of Occupational Medicine And Environmental Health*, 23(1), 95-114. doi:10.2478/v10001-010-0004-9

Ostman, M. (2008). Severe depression and relationships: The effect of mental illness on sexuality. *Sexual and Relationship Therapy*, 23, 355-363.
doi:10.1080/14681990802419266

Rondon, J., Campbell, J., Galway, K., Leavey, G. (2014). Exploring the needs of socially excluded young men. *Children & Society*, 28, 104-115. doi:10.1111/j.1099-0860.2012.00457.x

Taormina, R. J., Gao, J. H. (2013). Maslow and the motivation hierarchy: Measuring satisfaction of the needs. *American Journal of Psychology*, 126, 155-177.

Wennstrom, E., Berglund, L., Lindback, J. (2010). The met needs index: A new metric for outcome assessment in mental health services. *Springer*, 45, 425-432.
doi:10.1007/s00127-009-0080-y

Wiersma, D. (2006). Needs of people with severe mental illness. *Acta Psychiatrica Scandinavica*, 113, 115-119. doi:10.1111/j.1600-0447.2005.0728.x

Appendix A

Date: _____

Please check the following that you consider creates a barrier/makes it difficult for you to attend your counseling appointments.

- _____ Transportation
- _____ Finances
- _____ No Child Care
- _____ Lack of Safety
- _____ Lack of Food
- _____ Lack of Water
- _____ Inadequate Housing
- _____ Fatigue
- _____ Low Motivation
- _____ Instability in Mental Health
- _____ Instability in Life
- _____ Lack of feeling Secure
- _____ Lack of Protection
- _____ Forgetting Appointments
- _____ Time Management
- _____ Conflicts in Schedule
- _____ Low Self-Esteem
- _____ Limited Support System
- _____ Lack of Clothing
- _____ Health Complications
- _____ No Connection with counselor
- _____ Negative Attitude Towards Counselor
- _____ Low Confidence
- _____ Alcohol/Drug Use
- _____ Medication is not working
- _____ No Medications

_____ Lack of adequate coping skills

Other:_____ Other:_____

Other:_____ Other:_____

Appendix B

Adult Survey

This survey is meant to be a way to help us find out what makes it hard to attend appointments. So please let us know how we could be of help.

For the following questions, please indicate on a scale from 1-4 how much each of the following affect your ability to make your appointments at the clinic. A response of 1 meaning "Never prevents me from making my appointments" and 4 meaning "Always prevents me from making my appointments."

1 _____ 2 _____ 3 _____ 4 _____

Never Occasionally Most the Time Always

1. Getting a ride/catching the bus is a problem for me.

1 _____ 2 _____ 3 _____ 4 _____

Never Occasionally Most the Time Always

1a. How could the clinic help you with transportation? _____

2. Getting bus passes from my insurance provider is a problem for me.

1 _____ 2 _____ 3 _____ 4 _____

Never Occasionally Most the Time Always

2a. How could the clinic help you get your bus passes from your provider? _____

3. A family illness affects my attendance at my appointments.

1 _____ 2 _____ 3 _____ 4 _____

Never Occasionally Most the Time Always

3a. How could the clinic help you when your family is affected by an illness? _____

4. The amount of people around when entering and waiting at the clinic is a problem for me.
1 _____ 2 _____ 3 _____ 4 _____
Never Occasionally Most the Time Always

4a. How could the clinic make it easier for you to arrive and wait for you appointments?

5. A problem I have not yet told my clinician makes me not want to attend my appointments.
1 _____ 2 _____ 3 _____ 4 _____
Never Occasionally Most the Time Always

5a. How could your clinician help you to share this information? _____

6. A person in my life makes it hard for me to make all of my appointments.
1 _____ 2 _____ 3 _____ 4 _____
Never Occasionally Most the Time Always

6a. How can the clinic, or your clinician help you this person/these people? _____

7. I have a hard time remembering when my appointments are.
1 _____ 2 _____ 3 _____ 4 _____
Never Occasionally Most the Time Always

7a. How can the clinic help you to remember your appointments? _____

8. If you have ever missed an appointment and did not call to cancel it beforehand, what if any of the following played a part in your not calling. *Please circle all that apply*

- (Embarrassed) (Emergency) (Forgot to call)
- (No access to a phone) (Didn't think it was expected) (The counseling isn't helping)
- (Other _____)
- (No minutes on cell phone) (Forgot my appointment) (Phone anxiety)

9. Is there anything else the clinic can do to help you attend your appointments? _____

Please answer questions 10-12 by circling the response that best describes you.

10. What is your age?
(18-24) (25-34) (35-44) (45-54) (55-60) (61+)

11. What is your gender?
(Male) (Female) (Transgender)

12. Who is your insurance provider/payer? Check all that apply.

(Medicaid) (Monroe Plan/Blue Choice Option) (MVP Option)
(Fidelis Care) (Medicare) (Other Insurance _____)
(None/Self Pay)