CHAPTER 18

INTERPERSONAL ANALYSIS OF THE HELP-SEEKING PROCESS

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This chapter provides an interpersonal analysis of help-seeking. We view help-seeking behavior as a process with some complexity, involving interactions between characteristics of the help-seeker, the type of help sought, the context, and the potential helper. In this chapter we consider epidemiological evidence, suggest some theoretical issues about the nature of help-seeking, and discuss factors that could help to elucidate different types of help-seeking behavior. The aim is to provide a theoretical framework for help-seeking and to show the linkage to factors that encourage versus discourage help-seeking behavior. The focus is on the types of problems (depression, anxiety, achievement difficulties) typically confronted by mental health professionals.

The chapter begins by considering epidemiologic evidence on help-seeking. Then we present a framework of help-seeking motivation and discuss how it may apply to three kinds of predictive factors: situational, personality, and esteem maintenance. Finally, we consider implications of this formulation for social and clinical psychology.

EPIDEMIOLOGIC EVIDENCE

Correlates of help-seeking behavior have been examined in a number of epidemiological studies (for reviews see DePaulo, 1982; DePaulo, Nadler, & Fisher, 1983; Gourash, 1978; Kadushin, 1969; McKinlay, 1972; Nadler, Fisher, & DePaulo, 1983). To provide a background of evidence on help-seeking we shall discuss epidemiologic findings on sex, age, and other variables. These studies provide basic information about help-seeking as it occurs in naturalistic settings, although they do not always test specific hypotheses about processes in help-seeking.

There are two basic types of studies. A few studies have obtained direct interviews with representative samples of community residents to examine the correlates of self-reported help-seeking. Studies of clinic samples, in contrast, determine factors that differentiate treated patients from controls. Studies with community samples are preferable methodologically because they include persons who have problems but do not seek pro-
fessional help, thus avoiding a potential bias that may be introduced by clinic samples (Link & Dohrenwend, 1980). At the same time a number of studies are retrospective, obtaining data from subjects after help-seeking has occurred; so the effect of a predictor sometimes is not easily disentangled from the effects of the treatment experience and data on stages of help-seeking (Gross & McMullen, 1983; Wills, 1983) are not easily determined. With some exceptions (e.g., Kessler, Brown, & Bowman, 1981; Matthews, Siegel, Kuller, Thompson, & Varat, 1983), longitudinal data are rare.

**Treatment Rates**

A first question concerns the probability that a person with emotional distress will seek professional help. (It is presumed in these studies that the respondents sought help, but there is usually no direct evidence that the help-seeking was entirely voluntary vs. coerced by family or social institutions.) The approach in retrospective studies is to identify a subgroup of individuals with currently high psychological distress and determine what proportion of these ever have received treatment from a person in a formal helping role, such as a psychiatrist, psychologist, social worker, or counselor. Data from a variety of studies indicate that the majority of persons with distress do not seek professional treatment. Studies based on psychiatric screening scales indicate that the median treatment rate is 27% (Neugebauer, Dohrenwend, & Dohrenwend, 1980); that is, among the subgroup of persons with high distress, 73% do not receive professional help. Recent studies indicate that the phenomenon is not attributable simply to financial considerations. For example, in a study conducted in health maintenance organizations, where mental health care was available without extra cost, the 1-year treatment rate for psychological distress was 12% (Ware, Manning, Duan, Wells, & Newhouse, 1984).

While help-seeking from formal sources is relatively low, evidence on help-seeking from informal support sources (spouse, friends, family) suggests a different picture (cf. Cowen, 1982). When data on use of both formal and informal support are available, they indicate a primary reliance on informal support. For example, data from Veroff, Kulka, and Douvan (1981) indicate that for coping with “periods of unhappiness,” 2% of the sample utilized formal help resources, whereas 28% used informal resources. The difference narrows somewhat for coping with specific life events or major life crises, but a 2:1 differential of informal: formal help is typically observed (Norcross & Prochaska, 1986; Wilcox & Birkel, 1983). A combination of help-seeking from formal and informal resources is also a common pattern; for example, Brown (1978) found that 12% of distressed persons used formal help only, 48% used informal help only, and 40% used both formal and informal help (cf. Cross, Sheehan, & Khan, 1980; McCrae, 1984; Veroff, Kulka, & Douvan, 1981). Studies with comparative data consistently find help-seeking from informal sources to be the mechanism most frequently used for coping with psychological distress (McCrae, 1984; Norcross & Prochaska, 1986; Stone & Neale, 1984; Veroff, Kulka, & Douvan, 1981). It is still unclear whether help-seeking should be classified as problem-focused or emotion-focused coping, and both positions have been expressed (see Lazarus & Folkman, 1984; Moos & Billings, 1982; Stone & Neale, 1984).

**Preferred Source of Help**

There are surprisingly few data on people’s preferred sources of help. Scenario studies with college student samples (e.g., Christensen & Magoon, 1974; Tinsley, de St. Aubin, & Brown, 1982) report data on preferred sources and provide an estimate of the preference for help-seeking versus self-help. For personal problems the typical preference ranking is (a) friend or relative, (b) professional or paraprofessional counselor, and (c) instructor or academic advisor. These scenario studies indicate that about 49% of people preferred self-help to talking with a friend, and 66% preferred self-help to professional help. The findings were somewhat different for career decisions, where academic advisors were more likely to be consulted, but self-help was still the majority response.

Veroff, Kulka, and Douvan (1981) obtained data from a community sample on ranking of potential help sources, given different types of problems. The majority preference for coping with worries or unhappiness was informal support (from spouse or friends). For coping with persistent problems, 46% of respondents indicated they would seek some form of professional help, with the ranking of professionals being doctor (28%
of hypothetical utilization), clergy (27%), psychiatrist/psychologist (22%), and other mental health professional (17%). The data on hypothetical help-seeking were somewhat discrepant from data on actual help-seeking, which showed that 26% of respondents had ever sought help, a twofold discrepancy from the hypothetical utilization estimate of 46%. Among respondents who had sought help, the primary sources were clergy (39% of utilization), psychiatrist/psychologist (29%), doctor (21%), and other mental health professional (20%). The shift toward pastoral help was predominately among respondents with less severe problems. Among the 10% of the sample who had ever sought help for "an impending nervous breakdown," the primary sources were doctor (52%), psychiatrist/psychologist (18%), and other mental health professional (10%). These data suggest that use of help sources depends on the severity of the problem, with a relative shift from clergy to psychologists to doctors as the problem becomes more severe.

Sex

Studies with aggregate data have shown that females appear in treatment settings in greater proportions than expected from population proportion. This is true both for medical treatment (Verbrugge, 1976) and for psychiatric treatment (Gourash, 1978). The issue is whether this indicates a higher level of morbidity, a greater tendency of females to seek help, or a greater tendency to label symptoms as requiring help.

Data from the national sample of Veroff, Kulka, and Douvan (1981) indicated some complexity. Overall there were no significant sex differences in use of formal help or in use of spouse as a confidant. For use of multiple, informal help sources there was a sex difference (59% for women compared with 50% for men), apparently because men were more likely to rely on their wives as a primary support source, whereas women engaged more friends and relatives. For use of formal help, men were more likely to use professional help for instrumental problems (work, achievement, financial), whereas women were more likely to seek professional help for interpersonal problems.

Recent studies have controlled for level of morbidity and examined different stages in the process of problem-labeling and help-seeking (Fox, 1984; Kessler, Brown, & Bowman, 1981). Retrospective questions asked whether the respondent was bothered in the last year by a personal problem; if so whether he or she felt the problem was of serious concern; and if so whether he or she sought professional help. Morbidity was indexed by items about current psychiatric symptoms. When morbidity level is controlled by stratifying the sample on severity of symptomatology, it is found that females are more likely to seek help at low levels of symptomatology, but males more likely to seek help at high levels. When age, marital status, and severity of symptoms are controlled, there is actually a significant male differential in help-seeking (Fox, 1984; Leaf & Bruce, 1988). Kessler et al. (1981) considered three stages of the help-seeking process, and suggested that females are more likely to define a problem as serious enough to require help; after this stage, however, there were no significant sex differences in help-seeking behavior.

Age

While there have been few studies of stratified community samples, data typically show a decline in formal help-seeking with age (Brown, 1978; Gurin, Veroff, & Feld, 1960; Veroff, Kulka, & Douvan, 1981). This is in contrast to data on age differences in mental health, which are complex and nonmonotonic but indicate increases in depression during older years (Diener, 1984; Veroff, Douvan, & Kulka, 1981). This may occur because older people are more likely to cope with problems through self-reliance (Pearlin & Schooler, 1978) or support from religious and community organizations (Veroff, Kulka, & Douvan, 1981). Data from treatment settings indicate a marked underrepresentation of elderly in mental health treatment but an overrepresentation in medical treatment settings (e.g., Fox, 1984; Schurman, Kramer, & Mitchell, 1985). It has been suggested that elderly people are more likely to attribute subjective distress to physical illness (Fox, 1984), but there have been no specific tests of this process.

Socioeconomic Status

Early data indicated a strong socioeconomic differential, with persons of higher education and income more likely to receive psychological treatment (Gurin et al., 1960; Srole, Langner, Michael, Opler, & Rennie, 1962). More recent data suggest that this effect still exists, but has been moderated by increased access to health services (Tischler,
Henesz, Myers, & Boswell, 1975). For example, data from Veroff, Kulka, and Douvan (1981) indicated that 22% of lower educated respondents sought no formal or informal help for major problems, compared with 10% for higher educated respondents. While a socioeconomic differential existed, the majority of respondents (73% to 89%) had some combination of formal and informal help. The suggestion has been made that socioeconomic effects are attributable primarily to attitudinal factors because positive attitudes toward psychotherapy are strongly related to higher socioeconomic status (Fischer, Winer, & Abramowitz, 1983; Greenley & Mechanic, 1976). Also consistent with this point is the fact that income and education are related to greater levels of subjective well-being (Diener, 1984; Veroff, Douvan, & Kulka, 1981), but also to higher rates of help-seeking.

Life Stress

Psychological distress is related to adverse life events (Lewinsohn, Hoberman, Teri, & Hautzinger, 1985), and available data indicate that negative events serve as a trigger for help-seeking behavior. Comparisons of clinic cases with controls in college populations indicate that help-seekers have experienced greater intensity of negative events, and fewer positive events, during the previous year (Goodman, Sewell, & Jampol, 1984; Greenley & Mechanic, 1976). Similarly, data on help-seeking decisions among samples of laypersons and professionals (Brown, 1978; Norcross & Prochaska, 1986) indicated that in most cases a help-seeking episode was set off by a severe negative event. In a community study, Dooley and Catalano (1984) found that a measure of recent life events was related to an index of recent help-seeking for emotional problems, either from friends and family (61% of those seeking help) or from doctors, psychotherapists, or self-help groups (39%).

It should be noted that life events also increase seeking of medical treatment (e.g., Pilisuk, Boylan, & Acredolo, 1987; Ostrove & Baum, 1983). For example, Gortmaker, Eckenrode, and Gore (1982) obtained diary data over a period of 28 days and found that the occurrence of an upsetting event on a given day doubled the probability of health care utilization on the subsequent day, even when no physical symptoms were reported. The exact mechanism in the linkage between perceived stress and health care utilization, however, has not been clarified.

Social Context

Data on the relation between social networks and help-seeking are complex, and are discussed in more detail subsequently. Comparisons of clinic cases with controls typically show that people in treatment have lower support. For example, Goodman et al. (1984) obtained data on perceived social support from the Arizona Social Support Interview Schedule from 50 clinic attenders and 50 controls (nonmatched volunteers from introductory psychology classes). These data indicated that the cases (mean = 4.5 support people) scored significantly lower than the controls (mean = 6.0 support people); differences were found for several support dimensions, including instrumental support, advice and guidance, and social participation. These data, then, suggest that a deficiency in supportive relationships may contribute to emotional distress and thus lead to professional help-seeking. The case-control design, however, fails to consider people with high distress who did not seek treatment.

In data from a community sample (Brown, 1978), the level of perceived support was generally high, and among the subsample of people who had experienced negative life events, help-seekers were not strongly differentiated on most of the social support measures. People who sought professional help reported somewhat less activity and intimacy in their informal network, but these people also had a greater severity of negative life events, so there is a confound in these data. Pili- suk et al. (1987) examined the interaction of life stress and social support in predicting medical care utilization in a health maintenance organization (HMO) setting. They found that high support, indexed through marital satisfaction and availability of confidants outside the family, reduced the level of health care utilization primarily among persons who had experienced many life events; that is, this support produced a stress-buffering effect (Cohen & Wills, 1985). These data, then, suggest that low support may contribute to help-seeking because persons with lower support have increased levels of distress and less protection against the adverse effects of negative life events.

In contrast, some data indicate ways in which a large social network may facilitate help-seeking. For example, Horwitz (1977) conducted interviews
with psychiatric outpatients shortly after initiation of treatment, and found that respondents had talked with an average of 4.4 members of their network before seeking professional help (2.1 for men, 6.6 for women). This represented a substantial part of the network, the proportions being .30 to .61 of the intimate network. Network members had been involved in helping define the problem, offering advice, and providing recommendations for professional help. Similarly, Cross et al. (1980) studied patients in outpatient psychiatric treatment over a 3-month period and found that the mean frequency for informal help-seeking increased from 1.3 times per week pretreatment to 2.7 times/week posttreatment. The data suggested that psychotherapy increased the utilization of informal support from friends, spouse, and family. These findings are consistent with data from Taylor, Falke, Shoptaw, & Lichtman (1986) in a study of cancer patients (predominantly female), of whom 60% were participants in self-help groups. Participants in support groups, compared with patients who were nonattenders, had more social support resources of all kinds. They had greater willingness to share cancer-related concerns with friends and spouses, were more likely to have sought help from mental health professionals, and had a higher level of participation in religious and sociocultural groups. These data thus suggest that social network members may play an active role in helping people to define problems and seek treatment when appropriate.

There is one process in which social networks may operate to restrict the type of help-seeking pursued. For example, McKinlay (1973) studied medical service utilization among a sample of low-income families in Aberdeen, Scotland. Measures of network structure were obtained, and subjects were classified as underutilizers versus utilizers of prenatal services. The data showed that underutilizers had social networks of higher density, that is, more kin-centered and with greater interconnection among network members. Similar data from a study of divorced women (Wilcoxon & Birkel, 1983) indicated that persons in high-density networks were less likely to seek professional help for depressive problems, and more likely to seek help from a family member. Other data suggest that larger, more diffuse networks are relevant for facilitating access to needed services (Granovetter, 1973; Henderson, Byrne, Duncan-Jones, Scott, & Adcock, 1980; Miller & Ingham, 1979). The implication is that in high-density networks there is a tendency to keep problems within the network, which in some respects may operate to reduce the use of community help resources.

To summarize, different processes are indicated by between- and within-subject designs. Social support operates to reduce psychological distress, and so may reduce the amount of help-seeking from professionals (Goodman et al., 1984; Pilisuk et al., 1987), possibly by providing an additional source of help or through a buffering effect on life stress. At the same time, several studies have shown ways in which informal networks guide troubled people toward professional help, and may augment the professional treatment process (Cross et al., 1980; Horwitz, 1977; Taylor et al., 1986). There is no necessary contradiction between these findings; if there is any general conclusion, it is that informal networks offer an additional coping resource that may be useful to distressed people in several ways.

Help-Seeking in Medical Settings

In recent years, evidence has developed concerning help-seeking for psychological distress in medical settings. While one would expect medical illness to cause some elevation of distress, the extent to which observed distress levels exceed population values has led to efforts to identify the true prevalence of psychiatric versus medical problems in primary care populations. One current explanation is that a proportion of patients visit physician and hospital practices as a means of help-seeking to deal with implicit or explicit psychological distress. For example, Tessler, Mechanic, and Dimond (1976) conducted interviews with adults enrolled in an HMO program, and medical records for 1 year subsequent to the interview were coded to index medical service utilization. Prospective analyses showed that a composite index of psychological distress (perceived stress, worry, and neuroticism) was related to greater medical utilization, with control for health status at baseline. These data suggested that some proportion of health care visits were related to mental health concerns, whether or not labeled as such by the patient.

Subsequent studies with diagnostic interviews, such as the Epidemiological Catchment Area (ECA) study, have shown that there is a high pre-
valence of mental disorder among patients in primary care settings and that mental health problems produce a considerable increment in medical visits (Cleary, Goldberg, Kessler, & Nycz, 1982; Kessler et al., 1987; Von Korff et al., 1987). For example, Shapiro et al. (1984) found that the average number of health provider visits in the previous 6 months was 4.6 among persons with any Diagnostic Interview Schedule (DIS) disorder compared with 2.6 in the general population, a 74% increase. The 6-month rate of hospital admissions for physical conditions was 24.7 per 100 among persons with any DIS disorder compared with 18.2 per 100 in the general population, representing a 36% increase. Of health provider visits made explicitly for mental health reasons, data showed that across sites, 41% to 63% of these visits were made to general medical practitioners. Similarly, Schurman, Kramer, and Mitchell (1985) analyzed data on visits to outpatient practitioners and found that 47% of all medical office visits resulting in a diagnosis of mental disorder were to nonpsychiatrists; these were primarily general practitioners, family practitioners, and internists. The initial visit typically had a physical symptom as the presenting complaint.

Another aspect of the ECA data is that medical service users were asked whether they had discussed emotional problems with the practitioner (Kessler et al., 1987). These questions showed that across sites, 30% of persons with a current DIS diagnosis reported talking with a practitioner about emotional problems, compared with about 15% among those without a current diagnosis. The appreciable rate among nondistressed persons is striking, but the data still indicate that the majority of persons with current mental disorder do not discuss emotional problems directly with the practitioner. What kind of treatment they do receive remains unclear.

Summary and Conclusions

The existing data are based on large and representative samples, thus provide a good source of basic findings about help-seeking behavior. Although there are some limitations on the available data base, there seems to be a sequence of help-seeking efforts. The first stage is based on conversations with informal support sources (spouse, friends, family); seeking help from clergy or general medical practitioners is the second stage; and this may result, in the third stage, in help from a mental health specialist. The indications are that this is a pyramidal process, with the majority of help-seeking conducted within informal networks, a substantial proportion directed to medical or religious professionals, and the minority of help-seeking directed to psychologists or psychiatrists.

A second conclusion is that a stress-coping model seems useful for understanding the broad outlines of the help-seeking process. Help-seeking from both informal and formal sources clearly is primed by negative events. It is apparent that distressed people use a variety of resources, including informal support, formal help, and other nonsocial coping mechanisms, in active attempts to deal with their situations. It is less clear whether seeking of professional help is attributable to deficiencies in informal support, but it is clear that social network members can provide assistance that is complementary to professional helping efforts.

A third conclusion is that a good deal of formal help for emotional distress is provided by people who are not mental health specialists. With some variation across studies and problem types, studies show that primary-care physicians and ministers are major sources of service provision. Whether this derives from a labeling of emotional distress as a physical problem, a form of disguised help-seeking based on concerns about stigmatization, or whether distressed people perceive medical and religious professionals as more accessible than psychotherapists is not well understood at present.

Conclusions about individual differences in help-seeking tendencies are more qualified. While there is a female differential in treatment rates for both medical and psychological problems, sex differences seem to occur primarily at early stages of problem definition, not at the stage of help-seeking behavior. Socioeconomic differences, to the extent that they still exist, seem more attributable to attitudinal factors, and demographic effects are moderated by type of problem (instrumental vs. emotional). Age differences are not well understood; while elderly people are markedly underrepresented in treatment, this may occur because elderly people are more likely to define problems as physical, or to conduct help-seeking within informal community and religious sources. The only general conclusion is that help-seeking behavior
is most predictable from the interaction of demographics and problem type.

**THEORETICAL FRAMEWORK**

For a theoretical perspective, we consider help-seeking from the standpoint of a coping mechanism. Our postulate is that evaluation of help-seeking is determined by how it is construed from a coping standpoint. In some cases, seeking help may be construed as a form of direct-action coping, used in concert with other coping mechanisms, such as information-seeking and problem-solving, which are aimed at resolution of the problem. In certain other cases the help-seeking may be dependency based, used in a context where other coping mechanisms are perceived as unavailable or ineffective, or where requests for help are part of self-presentation concerns, used as a way of eliciting sympathy from others.

Our basic prediction is that the probability of help-seeking behavior in a given situation, and the reactions of the recipient to receiving help, are determined by this aspect of the help-seeking process. Responses construed as direct action are more consistent with a positive self-image and favorable social comparisons (cf. Nelson-Le Gall, Gumerman, & Scott-Jones, 1983; Wills, 1983). In contrast, help-seeking construed as dependency based may pose a threat to a person's self-image, because it could lead to unfavorable social comparisons or continued dependency (cf. Ames, 1983a; Fisher, Nadler, & Whitcher-Alagna, 1982). In general, we expect individuals to be more likely to seek help, and to react favorably to a helping interaction, when the interaction is perceived as likely to increase competence in the long term. A corollary is that when help-seeking is linked to use of other coping mechanisms such as problem-solving, there will be greater likelihood of increased competence, so this should be perceived more favorably. There is in fact some evidence that self-change efforts that involve use of multiple coping strategies, including both social and nonsocial coping, are more effective in the long term (Perri, 1985).

The perceived distinction between the two types of help-seeking may be influenced by several factors. Distinctions may be situationally guided, influenced by situational cues that emphasize coping versus dependency-related aspects of the help-seeking interaction. Distinctions also may be guided by dispositional factors, because personality attributes and belief systems may determine how various types of help-seeking are perceived and evaluated. The social context of help-seeking also may exert a considerable impact on how help-seeking is perceived and implemented. Finally, esteem-maintenance factors may operate to influence help-seeking perceptions and decisions. In the following sections, we consider how these factors may apply to the process of help-seeking.

**SITUATIONAL FACTORS**

**Visibility of Help-Seeking**

The act of seeking help can be an admission of inferiority, inadequacy, or dependency. It is probably for this reason that willingness to ask for help increases as the act of seeking help becomes less visible and more private (cf. Nadler & Porat, 1978; Shapiro, 1978). Often people will choose impersonal sources of help, such as self-help tapes, over the more personal touch of talking to a counselor on the telephone (Hill & Harmon, 1976). When help-seeking from impersonal sources is not an option, then help-seeking increases as the number of observers of the help request decreases (Williams & Williams, 1983).

The help request itself is not the only potentially embarrassing aspect of helping interactions. The problem or need that potentially motivates the help request can also be a source of embarrassment (Shapiro, 1983). The needy individual contemplating seeking help must weigh the embarrassment of asking for help against the prospect of continued failure or dependency (Wallston, 1976). When it is clear that potential helpers are already aware of the problem or deficiency, the probability that the needy individual will ask for help increases (Nadler & Fux, 1984). As Shapiro (1978) has demonstrated, help-seeking is especially likely to occur when the act of seeking help is private but the problem that necessitates the help is public. Although the needy may be more willing to seek help when their problems are visible to others than when they are invisible, they also may find that they are less likely to need to request help explicitly in order to obtain the desired support. This factor may help to explain the high prevalence of help-seeking within informal social networks, where network members are
likely to be aware of problems, and help can be provided in a more private setting.

**Controllability of the Problem**

Are people more likely to be willing to ask for help if they view their problems as controllable or uncontrollable? At first blush, the evidence appears contradictory. For example, alcoholics are more willing to seek help if they believe that people have little control over whether they develop a drinking problem (Hingson, Mangione, Meyers, & Scotch, 1982). Research also indicates that helpers are more positive toward needy individuals whose problems are beyond their control than toward persons whose problems are within their control (Ickes & Kidd, 1976; Meyer & Mulherin, 1980; Wills, 1978). Thus, perceptions of the problem as uncontrollable seem to increase help-seeking. This may occur because the perception of the problem as outside one's control reduces the element of esteem-threat that deters help-seeking. The impact of this factor would in theory be most likely when previous failure has occurred.

On the other hand, research in achievement contexts indicates that students who do poorly on an exam will seek help to improve their performance on the next exam if they believe that performance is under their control; that is, they believe that they can do better if they try harder and do not blame their previous failure on uncontrollable factors such as task difficulty or teacher biases (Ames, 1983a; Ames & Lau, 1982; Testa & Major, in press). In their important statement on helping and coping, Brickman et al. (1982) posed a distinction that suggests a resolution to this puzzle—the distinction between control over the cause of the problem and control over the solution to the problem. It is the latter type of control that should predict willingness to seek certain kinds of help. Alcoholics who believe that the development of a drinking problem is not under their control are describing a belief about the origins of their problem; but students who believe that if they study harder they can do better in the future are instead making a statement about the solution to their problem. The distinction is also useful in illuminating the inclination of victims to blame themselves for their victimization, an attribution that others often find baffling. By assuming blame, victims also can assume responsibility and control, which can help them feel that they can avoid future victimization (Janoff-Bulman, Madden, & Timko, 1983). Seeking help to deal with the victimization and to learn how to avoid future victimizations might be part of the exercise of control.

In general, then, people who see the solutions to their problems as under their control may be more willing to seek the sort of help that will allow them to remedy their problems and facilitate their self-sufficiency. The distinction between control over the origin of the problem and control over the solution for the problem is also an important one for helpers to make. Brickman et al. (1982) suggest that often the most helpful perspective is one in which helpers see the origins of people's problems as beyond their control (thus justifying the rendering of aid), but the solution to problems as within their control.

The seeking and receiving of help are fraught with difficulties for people who hope eventually to be free of the need for help. The mere fact of receiving help could undermine people's independence by depriving them of opportunities to learn to succeed on their own (Skinner, 1976), or by generating self-perceptions of helplessness and inferiority (Coates, Renzaglia, & Embree, 1983; Langer & Benevento, 1978)—perceptions that also may be shared by others who view them in the recipient role (e.g., Wills, 1978). It may be possible, though, for people to seek and receive help in ways that preserve their sense of autonomy and augment their motivation to improve. For example, rather than seeking help that directly solves their problem (such as the answers to troublesome problems for students in a math class, or money for food and shelter for the impoverished), the needy might instead seek the kind of help that allows them to develop new skills so that they can then help themselves (DePaulo, Brown, & Greenberg, 1983; Nadler, in press). Gartner and Riessman (1977) argue that the potency of self-help groups stems in part from the fact that members give help as well as receive it.

Short of becoming a helper as well as a recipient of help, there are other ways that people can seek and receive help that are likely to render the aid more effective in the long run. For example, clients who are offered a choice among different types of treatment benefit more from help than do those who are not offered this type of control (Miller, 1985). A sense of control over the duration of the help also can be important (Harris, Tessler, & Pot-
ter, 1977). In fact, uncertainty about this very factor may deter many people from beginning psychotherapy and from soliciting other types of help as well.

**Prior Success with the Task**

Sometimes help-seeking is used strategically—for example, as a way of ingratiating (Jones, 1964; Nadler, Shapiro, & Ben-Itzhak, 1982). Other times it is used as a way of further developing and enhancing skills and talents (Fisher, Goff, Nadler, & Chinsky, 1989). More often, however, it is prompted by some perceived failure or need (e.g., Ames & Lau, 1982). Whether the experience of failure will motivate people to ask for help may depend in part on their history of successes and failures with the task. If their previous experiences were primarily positive, they may feel that future outcomes are under their control and that they need simply to redouble their efforts to succeed on their own (cf. Nadler & Fisher, 1986; Wortman & Brehm, 1975).

Prior successes, however, do not guarantee invulnerability to failure, nor do they necessarily predict reluctance to ask for help. For instance, while working on a type of problem that they have solved successfully in every prior attempt, students might notice something about it that they do not understand. This could undermine their confidence (Bandura, 1982), and motivate them to seek help. There are other subtle ways, too, that dependency can be induced in people who have a history of successes. Langer and Benevento (1978) suggest that people who are assigned a label that implies inferiority to another person (e.g., help-recipient, as opposed to helper), or who allow others to do things for them that they could have done themselves, may erroneously infer that they are incompetent. As a result, they may be likely to seek help.

**Threat Appraisal**

Folkman and Lazarus (1980) have described three categories of stressful life events. Challenges are events that afford opportunities for personal mastery, growth, or gain. Harms and losses are events in which damage to one’s health, relationships, or self-esteem has already occurred, and threats are events in which harm or loss is anticipated, though it has not yet occurred. McCrae (1984) studied the patterns of help-seeking in response to all three types of stressful events, and found more help-seeking by people dealing with threats and challenges than by those dealing with harms or losses. Similarly, in their study of college students’ ways of coping with exams, Folkman and Lazarus (1985) found that students sought more social support before the exam (when they were experiencing threat, and perhaps challenge) than after the exam was over and the grades were posted (and any harm or loss had already occurred). There was some support-seeking after the grades were posted; this occurred primarily among the students who had done most poorly on the exam and may represent a form of social comparison behavior (Wills, 1983).

In a subsequent study, Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen (1986) divided threats into threats to self-esteem (e.g., appearing incompetent, losing one’s self-respect or the approval of a significant other) and threats to a loved one’s well-being, and found that when threat to self-esteem was high (compared with when it was low), people were especially unlikely to seek social support. Unfortunately, in most studies of coping, measures of social support mix different kinds of support, such as informational support and emotional support. The distinction between the two could be important. For example, the support sought by students prior to taking an exam may well be primarily informational; in contrast, after the exam is over and they learn that they did poorly, they may seek primarily emotional support.

**Helper’s Abilities**

Intuitively, one might expect needy individuals to seek competent help provided by talented helpers who are especially skilled at dealing with the problem in question. In fact, there is evidence that potential help recipients value expertise in professional helpers and trustworthiness in professionals and friends (Corrigan, 1978). Further, therapists who are skilled at communicating empathy and a desire to help, and who avoid hostility and moralizing, are especially successful at influencing clients to enter and continue with treatment, and to experience successful outcomes (Miller, 1985; Wills, 1982). However, there are some data indicating that the helper’s ability often is not as powerful a predictor of choice of helper, or satisfaction with help, as one might expect. In organizational settings, workers often prefer to
seek help from coworkers than from higher status helpers who are more competent (Blau, 1955; Rosen, 1983). Such findings have been linked to social comparison processes, with the suggestion that people are sensitive to whether help-seeking will affect the status differential between the self and the potential helper (cf. DePaulo, 1978a; Druian & DePaulo, 1977).

Further, even when recipients have no choice of helpers and are instead assigned to a particular helper, they do not always show greater benefit from the most competent helpers. For example, in a peer tutoring study, second- and fourth-grade students were paired with tutors in the same grade as themselves or two grades ahead (DePaulo, Tang, Webb, Hoover, Marsh, & Litowitz, 1989). Presumably, the older tutors were the more talented helpers, yet, as predicted by social comparison theory, some students (fourth-graders who were especially competent themselves) performed much better when tutored by smart tutors from the same grade rather than two grades ahead. These effects seem to occur because social comparison concerns are maximized (cf. Tesser, in press; Wills, 1983).

On the other hand, various factors not clearly relevant to the instrumental quality of aid have been shown to affect the positivity of recipients’ reactions to help, and are likely to predict willingness to seek help as well. These include the helper’s physical attractiveness (Nadler, 1980; Nadler et al., 1982; Stokes & Bickman, 1974); the recipients’ liking for the helper (DePaulo, 1978a; Stapleton, Nacci, & Tedeschi, 1973); the helper’s (DeMatteo, Hays, & Prince, 1986; Whitcher-Alagna, 1983) and the help-seeker’s (DePaulo & Fisher, 1981) nonverbal communication skills; whether the helper is a friend or a stranger (Nadler, Fisher, & Ben-Itzhak, 1983; Nadler, Fisher, & Streufert, 1974; Shapiro, 1980); the amount of imposition on the helper (DePaulo & Fisher, 1980; DePaulo, Leiphart, & Dull, 1984); the amount and appropriateness of the help that the helper provided (e.g., DePaulo, Brittingham, & Kaiser, 1983); and whether the helper provided the help voluntarily or involuntarily (Goranson & Berkowitz, 1966; Greenberg & Frisch, 1972).

Other Coping Attempts Employed for the Problem

Because the proportion of needy individuals who seek help is often low, it would not be surprising to find that people often engage in a variety of other ways of coping before deciding to seek help. In fact, people typically utilize a variety of coping mechanisms to deal with a stressful event; in over 90% of such events, they employ both problem-focused and emotion-focused coping strategies as well as social coping (Folkman & Lazarus, 1980, 1985; Perri, 1985). Among people experiencing symptoms that could be indicative of heart disease, some used a variety of strategies for appraising their symptoms, such as discussing them with others; those people were slower to seek help from physicians (Matthews et al., 1983; see also Safer, Tharps, Jackson, & Leventhal, 1979).

Even when people do seek help, they often do not begin by seeking help directly from the most appropriate helpers. They might begin, for example, by trying some implicit, disguised attempts to solicit help (e.g., Blau, 1955; Glidewell, Tucker, Todt, & Cox, 1983). They might then progress to the use of direct requests for help, but from helpers who are not necessarily the most competent to deal with their problems. For instance, as noted previously, psychological problems are often presented first to friends, clergy, or physicians, and only later (if at all) to helpers trained in psychology. This may indicate that people begin by seeking help for one type of problem (e.g., instrumental or physical) and then progress to discussions about other types of problems (e.g., interpersonal or emotional).

PERSONALITY FACTORS

Self-Esteem and Achievement Motivation

A psychologically troublesome aspect of seeking help is that it can feel like an admission of inadequacy and dependency. It might seem reasonable to expect that this threatening aspect of seeking help would be especially daunting to people with low self-esteem, who perhaps would be most vulnerable to such an acknowledgment of ineptitude. Yet, a number of studies have found low, rather than high, self-esteem people most willing to seek help (Nadler, 1986). Alcoholics with low self-esteem, for example, are more likely to seek treatment (Charalampous, Ford, & Skinner, 1976; Miller, 1985) and to agree to more extensive treatment (Corotto, 1963) than are those with high self-esteem. Women who blame themselves for being mistreated, or who are low in self-acceptance, are more likely to join women's coun-
saling groups (Frieze, 1979; Gross, Fisher, Nadler, Stiglitz, & Craig, 1979). In organizational settings, too, self-esteem predicts help-seeking, with low self-esteem employees more likely to seek needed advice (Burke & Weir, 1976). For undergraduates in the laboratory, too, low self-esteem predicts willingness to ask for help (e.g., Harris et al., 1977; Nadler & Fux, 1984).

In all of these instances, it is the people with high self-esteem who are more resistant to seeking help, perhaps because they believe that they should be able to succeed at the task by themselves. In fact, in one study in which half of the participants were made to feel inadequate by learning that most other participants in their situation had done much better (and that, by implication, they should have, too), those participants were more likely than the others (who were told that their performance, though deficient, was better than most others in their situation) to resist seeking help (Morris & Rosen, 1973).

In situations that are especially threatening to self-esteem, people may try to avoid seeking help (Folkman et al., 1986), but this sensitivity to threat seems to characterize people with high self-esteem even more than those with low self-esteem. For example, if performance at a task is described as indicative of intelligence or creativity, people with high self-esteem are even more reluctant than lows to seek help at the task (Tessler & Schwartz, 1972). Their reluctance is further exacerbated if the person from whom help is to be sought is similar to themselves, thus making them appear even more incompetent in comparison (Nadler, 1987). People with high self-esteem also are especially reluctant to seek help when they anticipate no opportunity to reciprocate the help (Nadler, Mayseless, Peri, & Tchemenski, 1985). In addition, traditional males with high self-esteem are especially resistant to seeking help on stereotypically masculine tasks (Wallston, 1976), probably because they feel that they should be able to succeed at those tasks by themselves.

In some instances, it may be appropriate for people with low self-esteem to be especially receptive to help, and there is evidence that people with low self-esteem profit from their willingness to seek advice. In work settings, for example, lows succeed more often than highs on tasks that require cooperation and consultation (Weiss & Knight, 1980). But there can also be hazards to seeking help for people who are low in self-esteem. To the extent that they feel incapable of improving, they might respond to the receipt of help with feelings of dependence and with impaired performance, rather than with persistence and enhanced performance as often shown by highs (e.g., DePaulo, Brown, Ishii, & Fisher, 1981; Miller, 1985; Nadler & Fisher, 1986). In the study of battered women, for example, those who blamed themselves were more likely to seek therapy than those who blamed their husbands, but they also were less likely to regard their therapy as successful (Frieze, 1979).

In situations that are threatening to self-esteem, is it possible for people to seek help and still avoid feeling demoralized by their need for help? Ames and Lau (1982) addressed this question in a study of students' willingness to attend an academic help session in preparation for a second exam after learning the results of their performance on the first exam. In this context it is, of course, the students who failed the first exam who are likely to feel most vulnerable. Ames and Lau (1982) predicted, and found, that of the students who had failed the first test, those who would be most likely to take the constructive step of attending the help sessions were those who made help-relevant attributions. Such students do not feel that their overall ability has been called into question by their performance on the first test, nor do they blame their performance on external forces; instead, they decide they did not try hard enough the first time, and that if they try harder the second time, they will succeed. They are, in essence, compartmentalizing their failure and construing it as a very specific (rather than global) deficit that can be remedied (Weiner, 1979). The results of the Ames and Lau (1982) research are consistent with Nadler and Fisher's (1986) threat to self-esteem model of reactions to help. Students who had failed the first test were motivated by the potential threat to their self-esteem to improve their performance; those who also made self-relevant attributions believed that the potential for improved performance was under their control—that is, that they could do better if they tried. Together, these two factors—motivation to improve and belief in one's control over the potential for improvement—predicted instrumental help-seeking.

A process analogous to the psychological compartmentalizing performed by the Ames and Lau (1982) help-seekers may be what allows certain paraplegics to be more open than others to seeking help (Nadler, in press). Paraplegics who are especially reluctant to seek help are those who
regard their disability as central to their lives. For example, they see it as interfering with many important activities and they feel that they would be better people if they were not disabled. In contrast, those who see their disabilities as specific limitations in circumscribed domains that do not threaten their worth as a person are more open to seeking and receiving help from others (Nadler, Sheinberg, & Jaffe, 1981; cf. Nadler, Lewinstein, & Rahav, in press).

We have argued that asking for help can be threatening to self-esteem, and it is largely this threat that deters people with high self-esteem from seeking needed aid. But continuing to fail also can be threatening to self-esteem. Thus, in situations in which the embarrassment inherent in persistent failure supersedes the embarrassment of admitting the need for help, people with high self-esteem may be even more willing than people with low self-esteem to ask for help.

There is still another set of conditions under which people with high self-esteem may be willing to avail themselves of needed help. When seeking help is cast as an instrumental behavior that is likely to facilitate effective task performance, people with high self-esteem may be more willing than those with low self-esteem to utilize the available helpful resources. Esteem threats become essentially irrelevant, and the focus is instead on effective routes to the attainment of important goals (e.g., DePaulo, Brown, & Greenberg, 1983). Ames (1983b) has found, for example, that teachers who value being competent are especially willing to make use of a variety of sources of help.

The foregoing analysis does not necessarily imply that people who have a high motivation to achieve will be more willing to seek help than low-need achievers (Nadler, 1983). Achievement-oriented people may have the goal of mastering tasks completely independently (DePaulo, Brown, & Greenberg, 1983), or of using their level of performance at a task as an index of their own ability level (Trope, 1983). In either case, help-seeking would interfere with their goal.

Both self-esteem and achievement motivation were measured in the Tesser and Schwartz (1972) study. The two constructs were positively correlated (r = .40), and both independently predicted reluctance to seek help. That is, even after controlling for the fact that people with high self-esteem were somewhat more resistant to seeking help, it was still found that people highly in need for achievement were significantly less likely to seek help than were people low in need for achievement.

Shyness

One of the most reliable findings about people who are shy is that they are low in self-esteem (Cheek, Melchior, & Carpentieri, 1986). Typical correlations are quite robust, hovering around -.50. In that people with low self-esteem are often more willing to seek help than are people with high self-esteem, it might be expected that shy people also will be willing to ask for help. However, shyness is more than simply low self-esteem. Rather, it is a decidedly interpersonal syndrome. For people who are shy, social interactions are fraught with danger. Shy people would like very much to make a good impression on others, but doubt that they can do so (Leary, 1983). They feel anxious and act inhibited in the presence of other people (Cheek & Buss, 1981; DePaulo, Epstein, & LeMay, 1989), and they sometimes try to avoid social interactions altogether. Because help-seeking often involves initiating a social interaction, then, it can be quite problematic for people who are shy.

By their own self-reports, shy people concur with the conclusion that asking for help is hard for them. They acknowledge they have a smaller percentage of people in their social networks to whom they can turn for help and in whom they can confide. They also see others as offering less support, and they feel less satisfied with the support that they do receive (Jones & Carpenter, 1986). In educational contexts, they seek help less frequently from advisors (Friedman, 1980) and make fewer attempts to seek information from others about careers that interest them (Bruch, Giordano, & Pearl, 1986; Phillips & Bruch, 1988). Although about one in every four shy people indicates a willingness to seek help to overcome their shyness (Pilkonis, 1977), many also note that it would be difficult to do so, in part because they fear that others do not take shyness very seriously (Harris, 1984). On the basis of extensive questionnaires and interviews with people who are shy, Zimbardo (1977) concluded that the reluctance to ask for help is one of the most serious consequences of being shy.

In one of the few studies of shyness in which behavioral measures of help-seeking were collected (DePaulo, Dull, Greenberg, & Swaim, 1989), subjects attempted to do an impossible task in the presence of another person who was
said to have just successfully completed the task. Shy subjects were not any less likely overall than were subjects who were not shy to seek help from the other person; however, they were less likely to seek help when the other person was a member of the opposite sex. In a second study, subjects were required to call strangers and ask them if they would be willing to complete a questionnaire. All respondents agreed to do so. However, when the subjects placing the calls were shy (compared with when they were not shy), and the respondents were of the opposite sex, the questionnaires actually were less likely to be returned (DePaulo et al., 1989).

Self-Disclosure

When people ask for help, even in the most perfunctory way, the mere fact of seeking the help can be a sort of self-disclosure; it can reveal, for instance, the help-seeker’s dependence and need for help. Many help-requests, though, are not barren. Rather, the help-seeker, in requesting aid, often discloses something about the feelings or problems that are the basis of the need for assistance. It should follow, then, that people who are dispositionally more self-disclosing should also be more willing to ask for help. The evidence for this hypothesis is mostly indirect. For example, Fischer and Turner (1970) developed a scale of attitudes toward seeking professional help that successfully postdicts contacts with therapists. One of the four subscales was “interpersonal openness,” a measure of willingness to disclose intimate facts and feelings. Also relevant to the hypothesized link between disclosure and help-seeking are studies showing that people who are interested in hearing feedback about themselves are particularly likely to seek psychological help (Snyder, Ingram, & Newburg, 1982); one way to solicit feedback is, of course, to self-disclose.

There is evidence that people who are high self-disclosers are more likely to form supportive relationships (Cohen, Sherrod, & Clark, 1986), to feel that social support is available to them (Burke, Weir, & Harrison, 1976), and to receive needed help (Burke, Weir, & Duncan, 1976). The effectiveness of self-disclosure in eliciting help may lie in the fact that in describing their distress, self-disclosers also are providing potential helpers with a cue to offer help and with information about the type of help that might be most appropriate and most appreciated (Coates & Winston, 1987). In many instances, perhaps particularly in interac-

tions with close friends and family members, self-disclosures may function as implicit requests for help. The mere fact of having mentioned one’s distress may be sufficient to elicit an offer of help from people with whom one enjoys a communal relationship. And in fact, if it is necessary explicitly to request help in those relationships, the relationships may be troubled ones (cf. Pearl & Schooler, 1978).

There are risks, though, to the persistent disclosure of distress. After a certain point, network members may become less helpful, rather than more helpful, as implicit demands for help continue unremittingly (Coates & Winston, 1987). Conversely, both network members and professionals, in providing help, may make demands for continued self-disclosure from the help recipient, which can breed resentment and suppress future requests for help (cf. Merton, Merton, & Barber, 1983).

Belief System

People’s beliefs about themselves, about helpers and the helping process, and about others’ views of psychological problems are important predictors of their willingness to seek help. Three of the subscales of the Fischer and Turner (1970) measure of attitudes toward professional help are measures of such beliefs. Specifically, people with more positive attitudes toward professional help are those who believe that it is important and useful to seek help for psychological problems, who have confidence in mental health practitioners, and who are unconcerned with the potential stigma involved in seeking professional help.

Fischer and Turner (1970) also found that people with an internal locus of control (i.e., those who believe that they can control important outcomes in their lives) reported more positive attitudes toward professional help than did externals, who believe that their own outcomes are in the hands of fate, luck, or powerful other people. In medical contexts, too, internals are more likely to seek help, in that they search for more information relevant to their physical disorders. It is likely that internals preferentially seek the kinds of help that allow them some control over the helping process and outcomes. For example, they are more successful in self-directed and nondirective forms of treatment than in structured and directive forms (Miller, 1985).

People’s beliefs about the nature of their problems are also important. For example, students
who had been taught a disease model of mental illness, compared with those who were taught a social learning approach, were less likely to report that they would take active steps to deal with their own emotional problems, such as seeking help from a mental health center (Fisher & Farina, 1979), and more likely to say that they would resort to drugs and alcohol instead.

**SOCIAL CONTEXT**

One of the striking findings in the help-seeking literature is the preference for seeking help from friends rather than strangers. This has been demonstrated in laboratory studies (Corrigan, 1978; DePaulo, 1978a; DePaulo & Fisher, 1980; Shapiro, 1980; Tausig & Michello, 1988) showing that the probability of help-seeking increases markedly when the potential helper is a friend. Epidemiological studies also are notably consistent in showing that most help-seeking occurs within the informal network.

Several factors can be noted that would be relevant in naturalistic settings. One is that friends and family are easily accessible compared with professionals, who are physically distant. Another is that help from informal networks is less costly in terms of effort, time, and money. While these factors are probably relevant, however, we do not think that they are the sufficient factors for predicting help-seeking, because the major findings about help-seeking remain when these factors are controlled in laboratory and field studies. What other processes, then, may be relevant for help-seeking and social networks?

**Emotional Support and Self-Disclosure**

One consideration derives from a functional analysis of social support and help-seeking (Wills, 1985, 1987). This suggests that the major supportive function sought from social networks is emotional support, namely reassurance of self-worth, ability to talk about worries and negative feelings, and affirmation of acceptance by another person. There is little direct evidence about the desired functions from informal support, but a variety of studies suggest that emotional support is a major function of informal networks (see Cohen & Wills, 1985; Wills, in press).

This type of support involves self-disclosure, talking sometimes about negative aspects of the self, performances that have been negatively evaluated, or worries that might seem unfounded. The ability to self-disclose depends on the existence of a relationship where intimacy is possible. It is perhaps trivial to note that self-disclosure is facilitated by a close relationship, but a number of studies have demonstrated the importance of this process (e.g., Berg, 1984; Cohen, Sherrod, & Clark, 1986; Reis, Sanchak, & Solomon, 1985). The crucial aspect of informal networks is that there is a history of self-disclosure where people learn that they are accepted despite negative aspects.

**Reciprocal Comparison Process**

Another aspect of informal networks is that they involve enduring relationships where reciprocal helping is possible. Helping interactions in which the recipient is unable to reciprocate the help received are perceived as aversive, whereas interactions in which some type of repayment is possible are perceived more positively (see Greenberg & Westcott, 1983). Such reciprocation is unlikely in relationships with strangers, but more likely in continuing relationships.

Social comparison is another relevant process. When a person receives help on a dimension central for self-definition, an unfavorable comparison is produced relative to the helper (Wills, 1983). The unfavorable comparison process could, in principle, present a source of strain to relationships where help-seeking occurs. The unfavorable comparison may be ameliorated, however, if the focal person has a subsequent opportunity to provide help to the other on a different task, perhaps a task that is central to the other's self-esteem. Tesser has shown that a kind of balancing of favorable and unfavorable comparisons seems to occur in close relationships, so that each participant has a source of comparisons that is favorable to central dimensions of his or her self-esteem (see Tesser, in press). Ideally, each participant in the network could be supportive to others in ways that would provide reciprocal enhancement of the individuals' self-esteem; for example, receiving support on emotional dimensions and giving support on instrumental dimensions. In everyday settings, behavior that has sometimes been construed as "disguised help-seeking" (Glidewell et al., 1983) may be based on this kind of process. Interactions focused on instrumental problems help to build a history of acceptance that promotes further help-seeking. A series of interac-
tions of this type also may be constructive because it helps to build competence and hence reduces the prospect of dependence in future situations.

There are many unanswered questions. Do network members tend to minimize the seriousness of problems, as some have suggested (Sanders, 1982; cf. Timko, 1987; Turk, Litt, Salovey, & Walker, 1985)? Do they tend to make physical attributions for problems, which would tend to steer distressed persons toward medical practitioners (Tessler & Mechanic, 1978)? Or do they tend to accept simple solutions rather than encouraging more effortful problem-solving (Toro, Rappaport, & Seidman, 1987; Wahlert, 1990). Currently there is little understanding of how network members actually respond to presentations of mild or severe problems and how this affects their help-seeking recommendations.

SELF-PROCESSES

There is reason to consider help-seeking behavior within the context of self-esteem maintenance. There is a general tendency for people to maintain self-esteem in the face of possible threats by processes such as social comparison (Wills, 1981), changes in self-perception (Tesser, in press), or information selection (Pyszczynski, Greenberg, & LaPrelle, 1985). Aspects of help-seeking that can present a potential threat to self-esteem include admission of inability to accomplish a goal (see Rosen, 1983), unfavorable comparison with others (Wills, 1983), and the prospect of continued dependence on others (Nadler & Fisher, 1986). Conditions that produce high levels of these factors should minimize help-seeking, whereas conditions that serve to reduce the salience of these factors should increase help-seeking. The question is, What conditions operate to reduce self-esteem concerns in help-seeking?

Labeling of Behavior

One cognitive mechanism for dealing with potential esteem issues is the labeling of the help-seeking behavior. Through cognitive mechanisms, people may construe help-seeking behavior as representing instrumental rather than emotional difficulties, and esteem concerns may be reduced. The source chosen for initial help efforts may be guided by a labeling process. For example, consulting a medical practitioner suggests that difficulties are physical, not emotional. This would occur both because the practitioner customarily treats physical illness and because the context of initial interaction is focused on discussion of physical symptoms. What is known about the typical course of help-seeking suggests that consultations with medical practitioners may reflect this type of labeling process. In the development of a medical consultation the patient may introduce some emotional concerns, with the expectation that some attention may be obtained and a relatively noncostly treatment (e.g., tranquilizers) will be provided. When the problem is extremely severe, the patient can go to a physician with reports of imminent mental breakdown, with the expectation that appropriate referral of supportive treatment can be obtained.

One way in which persons may deal with esteem concerns is to decrease the perceived centrality of a dimension on which esteem is threatened (Tesser & Campbell, 1983). This approach seems less available in the case of help-seeking because the person must decide to seek help specifically for the problematic dimension, which would emphasize rather than minimize its importance. Hence relabeling of the behavior may be easier than altering the perceived importance of the dimension.

Attributions for Help-Seeking

The implications of different types of attributions for a problem present a double-edged sword. If the problem is attributed to dispositional factors, then seeking help would presumably be more likely; but if this kind of personal attribution is made, then the corresponding degree of self-esteem threat would be increased. Laboratory studies are consistent with this, showing help-seeking to be decreased when performance problems are attributed to internal factors (Tesser & Schwartz, 1972; Morris & Rosen, 1973).

Evidence on the role of attributional processes in naturalistic help-seeking is lacking. We could predict that people will be more likely to seek professional help if an external attribution for their problem is available (e.g., stress). Retrospective studies with clinic samples show that the clients are virtually unanimous in attributing their problems to dispositional factors (Calhoun, Dawes, & Lewis, 1972; Robbins, 1981), but because the samples are highly selected and have been influenced by participation in treatment, these data are difficult to interpret.
Help-seeking may also be influenced if people make physical rather than psychological attributions for problems. Seeking treatment for stomach pain would, presumably, evoke fewer esteem issues than seeking treatment for neuroticism. The difficulty with this hypothesis is the lack of a determination of whether people really tend to confuse psychological distress and physical symptomatology. There are several studies showing that global ratings of perceived health status are significantly correlated with measures of psychological distress (Tessler & Mechanic, 1978; Garrity, Somes, & Marx, 1978). But because one would expect and find a correlation between poor health and depression (e.g., Frerichs, Aneshensel, Yokopenic, & Clark, 1982), it is hard to know what interpretation to make of this. There are few data on how attributions influence selection into treatment.

Consensus and Comparison Information

Perceptions of social consensus for behavior may be quite relevant for help-seeking. Studies of what has been termed the false consensus effect show a general tendency to perceive that one’s own behavior and opinions are also characteristic of others (Marks & Miller, 1987). There is also a tendency to enhance social comparisons through perceptions that one’s desirable attributes are relatively infrequent in the population (Marks, 1984; Campbell, 1986) and that one’s undesirable attributes are relatively common (Suls & Wan, 1987).

Experimental studies have suggested that help-seeking is increased when perceived consensus is high (Gross et al., 1979; Nadler & Porat, 1978). These may be reflecting the operation of self-processes: If information provided to the subjects suggests that consensus for help-seeking is high, then esteem implications are reduced. Snyder and Ingram (1983) manipulated consensus information and showed that among symptomatic people, high-consensus information increased the tendency to seek help, apparently because it reduced the esteem threat of help-seeking; there was a reversed effect among nonsymptomatic people. Medical help-seeking, being a relatively frequent occurrence, may also be influenced by consensus perceptions; if people perceive this type of help-seeking as prevalent, they may regard it as more normative.

IMPLICATIONS FOR SOCIAL/CLINICAL PSYCHOLOGY

In this chapter we have presented descriptive data on help-seeking in community settings, and discussed evidence on processes in help-seeking behavior. From this discussion one should emerge with several conclusions. One is that the study of help-seeking is an important area for social and clinical psychology because there seem to be situations in which people could seek help, but do not. Understanding the factors that create reluctance to seek help would have bearing on a number of questions in the theory of coping and service utilization. Another conclusion is that a body of knowledge is available on factors in help-seeking behavior and suggests some predictable aspects of help-seeking. Our suggestion is that help-seeking is guided by concerns of dependence versus independence, and that this framework may serve to illuminate some basic issues in help-seeking research. At the same time, we suggest that many important questions in this area currently do not have definitive answers. In the following section, we suggest some general issues and directions for further research.

Sequence of Help-Seeking

From studies in community settings it is apparent that there may be a consistent progression in help-seeking. It is evident that of persons with significant psychological problems, many receive some kind of help within informal social networks but relatively few receive professional help. The suggestion is that there is a pyramidal process, such that (a) relatively minor problems and worries are dealt with through emotional and cognitive support from family and friends, (b) more persistent problems are taken to first-line helping agents such as clergy and general medical practitioners, and (c) serious problems are referred to appropriate specialists. While this model of help-seeking is logical and plausible, it is largely inferential and there is little direct evidence on stages of help-seeking. There is a need for studies that follow a general population or a high-risk subsample over time and try to delineate, through repeated measures, what types of help-seeking actions are pursued at different points in time.

Another reason for such studies is that there is little understanding of the consequences of assistance provided by various help resources. For
example, one can find evidence suggesting that informal helpers may discourage medical help-seeking when it is in fact appropriate (see Matthews et al., 1983; McKinlay, 1973), or may sometimes have negative rather than positive effects on health behaviors (Baranowski & Nader, 1985; Wills, 1990, in press-a). Other studies suggests that some types of helping arouse negative affect in the short term but increase competence in the long term (e.g., DePaulo et al., 1989). The examples suggest caution about a straightforward generalization that if people receive informal help, then the help is necessarily appropriate or effective. Such issues indicate a need for detailed information on how help from informal networks affects efficacy and coping ability.

Finally, research on informal help-seeking suggests an issue for evaluation of professional help resources. Literature on professional psychotherapy shows evidence that it produces improved outcomes for most clients (e.g., Smith, Glass, & Miller, 1980), but community studies indicate that only a small minority of troubled people seek professional help; so the suggestion is that psychotherapy research is conducted on a highly selected sample of people. Additionally, there is reason to believe that participation in psychotherapy increases utilization of informal help resources (Cross et al., 1980; Veroff, Kulka, & Douvan, 1981), which introduces a possible confound in evaluation of formal psychotherapy. These considerations suggest a need for research on the interaction between formal and informal help resources.

**Typology of Help-Seeking**

Our analysis also suggests that help-seeking comprises a number of dimensions, hence, simply determining whether a person sought help provides limited information. The preceding discussion has suggested several dimensions that may be used to form a typology of help-seeking. These include (a) the type of helper (e.g., formal vs. informal), (b) the type of problem (e.g., instrumental vs. emotional), (c) the severity of the problem (e.g., minor vs. serious), (d) the relation to other coping efforts (e.g., none vs. many). We think that these dimensions may relate to an overall perception of the goal of help-seeking; that is, whether it will result in dependency versus increased competence in the long run. Another cross-cutting dimension is the type of relationship, such that people may react very differently to dependence in the context of a close relationship, where dependence may be necessary and perhaps desirable, than they would in the context of a casual or exchange-oriented relationship (cf. Clark, 1983).

Our point is similar to that made by Stone and Neale (1984) about coping behavior in general; that is, a particular occurrence of a behavior may involve potentially different functions, and the person’s goal in help-seeking could be a part of a typology. As we have noted previously, a given occurrence of a request for help may be based on functions such as an attempt at ingratiation with another person, an attempt to reduce dependence in the long term, or a response of helplessness with no perception that self-improvement will occur. Obviously these are very different functions that must have quite different consequences for coping and adjustment in the long run, yet without trying to elicit the person’s perceived intent in the help-seeking, it could be difficult to tell these apart. At a minimum, one could get a subject’s perception of how efficacy would be affected by a helping interaction, and how this would affect their feelings of intrinsic motivation and their perception of dependency on the helper (cf. Deci & Ryan, 1985).

This aspect remains somewhat ambiguous in laboratory studies. While present studies have provided tight control over situational variables that influence the probability of a help-seeking act, there is currently little information about the effects of help-seeking on the recipient, and in most cases there is little knowledge about how help-seekers perceive and construe their actions. What is surprising about data from laboratory studies is the low level of help-seeking in settings where one would think subjects would have little ego-investment, suggesting that even in a limited interaction with a stranger, people experience some conflict over esteem concerns and possible dependency. Obtaining more specific data on these types of variables may be an issue for further laboratory research.

**Increasing Appropriate Utilization of Services**

In applying the present model to help-seeking in community settings, considerations at both the institutional and individual levels are relevant. Con-
sidering institution-level factors, one suggestion is to find ways to routinize the process of help-seeking (Nelson, 1980) and to increase the ease of transitions between stages of help-seeking. For example, various types of resources (financial aid, academic advising, routine medical services, personal counseling) could be provided in the same physical location. In this setting, it would be easier for persons to enter the help-seeking area (e.g., for treatment of sexually transmitted diseases) because they would not be labeled by presenting for a particular type of treatment. It would be easier for people to make transitions from one type of help-seeking to another (e.g., from financial aid to personal counseling) because the referral process could be routinely suggested by staff members to all participants and would be physically convenient. Such a setting also might reduce administrative barriers to help-seeking, such as making appointments and determining the location of appropriate services.

With regard to individual-level factors, there is an issue about increasing choice about type of help. While practical considerations may be a limiting factor, in theory it seems desirable to offer potential clients a choice between several modalities (e.g., trained psychotherapist, group interaction, or self-help materials). Current research on reactions to help suggests that peer counselors may be a nonpreferred type of help (e.g., Nadler & Fisher, 1986); this issue deserves more research in professional help settings.

Also, there are approaches that could be used to advertise available helping services. One would be to provide consensus information, that is, data on the frequency of help-seeking among the relevant population. Another would be to provide information about the benefits of professional help so that people would be more aware of the potential benefits. Also, advertising material could emphasize the function of limited professional help for increasing independence (cf. Nelson & Barbaro, 1985). If attempting to increase utilization by underserved groups (e.g., older people, people of lower socioeconomic status), advertising material could provide examples of appropriate role models who have benefited from services.

**Decreasing Inappropriate Utilization of Services**

Psychological processes in help-seeking might create some situations that could be undesirable from a policy standpoint. For example, there are indications that a significant part of medical service utilization is attributable to mental health problems. From the standpoint of the individual, this may be a rational coping mechanism, although there is a question whether the typical outcome (drug treatment) is optimally matched to the person's needs (e.g., Caplan et al., 1984). From the standpoint of medical service provision, however, mental health treatment is time intensive, and presentation of psychological problems in medical clinics may result in less efficient treatment of medical patients. How could the concerns of the individual and the institution best be reconciled?

One suggestion is to screen patients for psychological distress and provide psychological services for people who appear to be most appropriate for psychological treatment. This is probably not a straightforward solution, first because utilization of psychological services is low even under optimal conditions (cf. Ware et al., 1984), and second because it directly counters the probable reason that the patients sought medical help in the first place (i.e., because they did not view psychological treatment as necessary). One suggestion is to develop educational approaches for teaching clients to discriminate better between physical and psychological conditions, perhaps, using terminology that is less esteem involving (e.g., reactions to stress) rather than stigmatizing (e.g., psychiatric condition). Another possibility is development of self-help material that is appropriate for particular populations (e.g., the elderly) and could be used in conjunction with established institutions (e.g., community centers). Finally, more research in medical settings is needed to understand the dynamics of this important issue.

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