

1-1-1996

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Stephen M. Saunders

Marquette University, stephen.saunders@marquette.edu

Marquette University

e-Publications@Marquette

Psychology Faculty Research and Publications/College of Arts and Sciences

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APPLICANTS' EXPERIENCE OF SOCIAL SUPPORT IN THE PROCESS OF SEEKING PSYCHOTHERAPY

Stephen M. Saunders
Marquette University;

Acknowledgement

This investigation was partially supported by research grant RO1 MH42901 from the National Institute of Mental Health. The author would like to thank Kenneth I. Howard.

Abstract

This study assessed social support during the process of seeking psychotherapy, conceptualized as four steps: realizing there is a problem; deciding therapy might help; deciding to seek therapy; and contacting the clinic. Psychotherapy applicants completed a questionnaire asking them whether they had talked to anyone about the problem prior to seeking therapy, whether they had help at any of the steps, and from whom they had obtained such help. Results indicated that social support was important across the process. Younger applicants had more help. Males more frequently had help from a spouse or romantic partner than females. Medical professionals were used primarily for referral to the clinic, rather than as sources of help at earlier steps. Implications of the results are discussed.

Introduction

There are two consistent findings generated by epidemiological research into the prevalence and treatment of mental illness. Research indicates that a substantial proportion of the population is presently suffering, has suffered within the past year, or will suffer at some time in their life from a diagnosable psychiatric disorder. For example, the Epidemiologic Catchment Area (ECA) program reported that the one-month prevalence rate of psychiatric disorders was 15.7% and the annual prevalence rate was 28.1% ([Regier, Narrow, Rae, Manderscheid, Locke, & Goodwin, 1993](#)). Similarly, the National Comorbidity Survey (NCS) yielded an annual prevalence rate of 29.5% ([Kessler, McGonagle, Zhao, Nelson, Hughes, Eshleman, Wittchen, & Kendler, 1994](#)). Concerning the treatment of mental illness, research indicates that most individuals suffering psychiatric disorders do not get any professional help and that, of those who do get help, most do not receive it from a mental health professional. The ECA program reported that only 28.5% of respondents with a diagnosable mental illness had obtained any help in the previous 12-month period, and that only 12.7% of these persons had consulted a mental health professional (Kessler et al., 1994).

These figures suggest that a considerable "service gap" ([Stefl & Prospero, 1985](#)) exists between need for help and utilization of mental health services. Although there have been programs aimed at addressing this problem (e.g., [Regier, Hirschfeld, Goodwin, Burke, Lazar, & Lewis, 1988](#)), research indicates that help-seeking behavior is a complex phenomenon. Studies have shown that a positive attitude towards mental health is more likely for certain demographic groups, such as the younger, the better educated, nonminorities, and the relatively wealthy (e.g., [Horgan, 1985](#); [Nickerson, Helms, & Terrell, 1994](#); [Taube, Kessler, & Feuerberg, 1984](#); [Tijhuis, Peters, & Foets, 1990](#); [Veroff et al., 1981](#); [Wells, Manning, Duan, Newhouse, & Ware, 1986](#)), but there is not a clear or simple association between attitude and actual use (e.g., [Leaf, Bruce, & Tischler, 1986](#)). Indeed, [Veroff et al. \(1981\)](#) reported that respondents' hypothetical willingness to use professional services was "only slightly related to indicators of the actual use" (p. 68).

Other research highlights the complexity of help-seeking behavior. In one study, adolescents experiencing suicidal ideation were as likely as their peers to realize that they needed help, but were significantly less likely to obtain such help ([Saunders, Resnick, Hoberman, & Blum, 1994](#)). [Garland and Zigler \(1994\)](#) found that depressive symptoms are associated with negative attitudes towards help-seeking among children and adolescents, but help-seeking behavior in adults has been positively associated with psychiatric symptoms (e.g., [Husaini, Moore, & Cain, 1994](#); [Kessler, 1981](#); [Ware, Manning, Duan, Wells, & Newhouse, 1984](#)). Mental health service utilization has also been found to be related to the stigma of seeking help (e.g., [Farina, 1982](#); [Stefl & Prospero, 1985](#)), treatment fearfulness ([Kushner & Sher, 1991](#)), education, race, urbanization ([Horgan, 1985](#); [Taube, Kessler, & Feuerberg, 1984](#)), and insurance coverage ([Keeler, Wells, Manning, Rumpel, & Hanley, 1986](#)).

It must be concluded, then, that seeking help from the mental health system is a manifold and complex process, and that simply examining whether or not persons "make a mental health visit" oversimplifies the issue. [Saunders \(1993\)](#), expanding on the work of [Kadushin \(1969\)](#), [Mechanic \(e.g., 1976\)](#), and others, proposed a model of the process of seeking psychotherapy that focuses on the many decisions that must be made. The first step in the process is recognizing that a problem exists ([Kadushin, 1969](#); [Meile & Whitt, 1981](#)), and the second step is deciding that seeking mental health services would be an appropriate way to try to solve the problem. That these steps are distinct is supported by [Kessler, Brown, and Broman \(1981\)](#). These researchers re-analyzed data from four surveys and found that about 23% of persons who both recognized the problem and believed that professional help was necessary contacted a mental health professional; in contrast, fewer than 3% of those who did not perceive a need for professional help and less than 1% of those not recognizing a problem made such contact. It is not necessary for the prospective therapy patient to attribute the problem to an emotional disorder, although this increases the likelihood that mental health services will be sought ([Davies, Sieber, & Hunt, 1994](#); [Yokopenic, Clark, & Aneshensel, 1983](#)).

The third step in the process is deciding to obtain professional mental health help. Seeking formal help does not happen automatically after the person has decided that doing so might be appropriate ([Cohen, Barbano, & Locke, 1976](#); [Silverman, Eichler, & Williams, 1987](#)). In an experimental study, [Yates \(1992\)](#) examined attitudes towards actual use of mental health services. Subjects read descriptions of a trauma victim and rated the appropriateness of help seeking behavior. Help-seeking was more likely to be considered improper if the damage suffered was relatively minor. Thus, although generally considered to be appropriate, there appear to be "decision rules" regarding whether one should actually seek professional help. The final step is contacting a professional helper. [Phillips and Fagan \(1981\)](#) reported that almost half of the initial appointments of a counseling center failed to appear (see also [Sue, McKinney, & Allen, 1976](#)). Garfield (1994) reviewed the research on "refusal of therapy" and concluded that there is no adequate explanation for why some persons decide to seek therapy and then fail to come to the intake interview or the first session.

[Saunders \(1993\)](#) explored the difficulty and time needed for therapy applicants to complete these four steps. He found that the initial step—problem recognition—was the most difficult and time-consuming to achieve, but that subsequent steps in the process were accomplished with greater ease and speed. Nonetheless, even later steps—such as making an appointment after deciding that one would seek professional help—were experienced by many therapy applicants as difficult and time-consuming.

Social Support and Help-seeking Behavior

For most persons the process of seeking formal (professional) help often includes seeking informal help, that is, consulting with one's social network of family, friends, and acquaintances, and also with a variety of professionals (such as clergy; see [Larson, Hohmann, Kessler, Meador, Boyd, & McSherry, 1988](#)) who will not actually provide treatment. The ECA program explicitly recognized the "voluntary support network (VSN) of self-help groups, family, and friends" ([Regier et al., 1993](#), p. 89) as a major sector of the mental health service delivery system.

The relationship between informal and formal help is complex, however. Social support ameliorates stress and may reduce the need for formal help ([Birkel & Reppucci, 1983](#); Cohen & Wills, 1985; [Linn & McGranahan, 1980](#)). Many prefer the help obtained from informal resources (e.g., [Husaini et al., 1994](#); [Narikiyo & Kameoka, 1992](#); [Yoder, Shute, & Tryban, 1990](#)). Thus, social support may reduce the likelihood of formal help-seeking for certain people (e.g., Briones, Heller, Chalfant, Roberts, Aguirre-Hauchbaum, & Fair, 1990; [Thoits, 1986](#)).

The social network is also an important resource for determining when formal help is needed and where it can be obtained. The social network helps identify mental problems ([Gourash, 1978](#); [Kadushin, 1969](#)) and provides information about formal resources ([Friedson, 1960](#)). The social network may also transmit attitudes or information that make formal help-seeking less likely, however. For example, [Horwitz \(1977a,b, 1978\)](#) found that family members were more reluctant than friends and coworkers to attribute a problem to mental illness or to refer to a mental health professional. In another study, [Ginsberg and Brown \(1982\)](#) examined why a sample of depressed females did not receive formal help, and they found that the initial consultants (e.g., friends) attributed the depression to life stress and advised against professional intervention.

In conclusion, the social network acts as both an important resource for the easing of emotional distress and as a facilitator of the process of seeking professional help. Obviously, the two processes or functions of social support are not mutually exclusive, and both were investigated in the present study.

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Method

Dependent Variables: Social Support during the Process of Seeking Therapy

The Process of Seeking Therapy Questionnaire (PSTQ) assessed therapy applicants' experience of seeking therapy. After a short paragraph describing the four-step process, respondents were asked how long the problem had existed. Three questions were asked about each of the four steps. First, respondents were asked to indicate how long it took to achieve the step (e.g., "How long was it between when the problem started and when you realized it existed?"), with possible responses ranging from "right away" to "more than a year." They were then asked how difficult it was to achieve the step (e.g., "How hard was it to decide actually to seek psychotherapy?"), with responses ranging from "extremely hard" to "extremely easy." (See [Saunders, 1993](#), for a report on these variables.) Respondents were then asked whether anyone helped them accomplish the particular steps (e.g., "Was there anyone who helped you decide therapy might help?") A checklist of various social support members followed, and respondents indicated who—if anyone—helped. Since at the fourth step, calling for an appointment, such a question is meaningless, respondents were asked who referred them to the clinic.

To assess general social support regarding the problem, respondents were asked: "After you realized there was a problem and before you came to this clinic, did you talk to anyone about the problem?" They then indicated to whom they talked and what the other person(s) did.

Three general categories of helpers or social support were examined in terms of whether or not the applicant consulted them. One of these categories combined boss and coworker into "workplace" help source. A second category combined the subcategories of family member, spouse or romantic partner, and friends. Within this category, family member included parent, sibling, child, or any "other relative." The third category concerned professional help and combined the subcategories of medical professionals (nonpsychiatrist physicians, nurses, or clinics), mental health professionals (psychologists, psychiatrists, social workers, counselor, etc.), clergy, and teachers.

To assess whether therapy applicants achieved any of the steps at the suggestion of the helper, respondents were asked "Who's idea was it" to achieve the step, with possible responses being "my idea," "both my and someone else's idea," and "someone else's idea."

Independent Variables: Therapy Applicants' Characteristics

PSTQs were completed by 315 persons applying for treatment at Northwestern University's Institute of Psychiatry outpatient program. The Institute is a community mental health center (CMHC), and the outpatient program's overriding therapy model is long-term, psychodynamically-oriented psychotherapy.

The majority of psychotherapy applicants were female (72.9%), and the majority had previous psychotherapy experience (58.9%). Respondents' age ranged from 18-62, with a mean age of 32.1 ($SD = 8.8$) and a median age of 29. For purposes of data analysis, we recategorized age into four groups: 18-24 (13.1%); 25-34 (56.7%); 35-44 (19.9%); and 45-62 (10.3%). This group tended to be well educated: high school or less (10.3%); some college (23.0%); college degree (33.3%); and some professional or graduate school or more (33.3%). Gender, age, and previous therapy experience were used as independent variables, contrasted to social support.

The other independent variable was emotional distress. Therapy applicants completed a symptom checklist, adapted from Derogatis (1977), indicating to what extent 61 "problems and complaints" had been bothering them, with responses ranging on a 5-point scale ranging from "not at all" (1) through "extremely" (5). The mean item endorsement was 2.7 ($SD = 0.8$). The therapy applicants were subgrouped into four categories (quartiles) according to their score on the symptom checklist.

Procedure

Data collection. As part of the Institute's usual clinic policy, therapy applicants were screened via phone interview. If they were judged to be suitable for long-term psychotherapy, an intake interview was conducted. Research questionnaires were mailed to clients but became part of their clinic file only upon subsequent informed consent. Applicants completed the PSTQ at the clinic, prior to the intake interview, that is, at the very end of the process of seeking psychotherapy.

Statistical analyses. Preliminary chi-square analyses examining relationships among the independent variables were conducted, and one statistically significant relationship emerged. Age and education were significantly associated, $\chi^2 (9, N = 315) = 27.77, p = .008$. Examining the frequency table indicated that the youngest applicants (age 18-24) tended to be less likely to have achieved the higher levels of education, which is obviously an artifact of age. None of the other relationships were statistically significant.

Examination of the relationships between the independent and dependent variables was conducted via chi-square analyses. In particular, gender, age, distress, and previous psychotherapy experience were contrasted with whether the applicant had help at that particular step, what was the source of that help, and who's idea it was to achieve the step.

Results

General Social Support

"Did you talk to anyone?" Therapy applicants were asked: "After you realized there was a problem and before you came to this clinic, did you talk to anyone about the problem?" As seen in [Table 1](#), most of the therapy applicants did so. Of those who talked to someone, over nine-tenths talked to either a family member, spouse/romantic partner, or friend. Less frequent sources of support were a professional or someone at work.

TABLE 1. To Whom Did You Talk about the Problem? ($n = 281$)

	n (%) ^a
Family, spouse/partner, friend	258 (91.8)
Family member (excluding spouse)	165 (58.7)
Mother	97 (34.8)
Father	50 (17.9)
Sister	82 (29.2)
Brother	34 (12.1)
Son/daughter/other relative	31 (11.0)
Spouse/romantic partner	128 (45.5)
Friend	197 (70.1)
Workplace	56 (19.9)
Coworker	46 (16.4)
Boss	20 (7.1)
Professional ^b	85 (30.2)
Medical professional	39 (13.9)
Mental health professional (MHP)	31 (11.0)
Teacher	6 (2.1)
Clergy	9 (3.2)

Note. Respondents were asked to endorse as many helpers as appropriate and %s add to above 100.

^a Percent of those respondents who indicated they had talked to someone

Whether or not the applicants talked to anyone was unrelated to the independent variables. Among those who did talk to someone, to whom they talked was related to the independent variables. Whether applicants talked to a family member, spouse/romantic partner, or a friend was associated with age: only 61.5% of the oldest (45-62) applicants did so compared to over 90% of all other age applicants, $\chi^2(0, N = 252) = 36.63, p < .001$. At the subcategory level, there was an inverse, linear relationship between consulting one's family and age: 18-24 (65.6% consulted family), 25-34 (64.8%), 35-44 (46.2%), 45-62 (38.5%), $\chi^2(3, N = 315) = 10.53, p = .02$.

Gender was also related to whether or not a family member was consulted as 63.0% of females did so in contrast to only 47.9% of males, $\chi^2(1, N = 260) = 4.84, p = .03$. None of the other independent variables were significantly related to the source of support.

"*What did they do?*" There were 281 applicants who stated that they had talked to another person. These were asked to also indicate, via checklist, what the other person (to whom they talked) did, and the results are summarized in [Table 2](#). At the two extremes, "listened to me" was the most common response, whereas few respondents indicated that their social support did "nothing in particular."

Table 2. What did Confident(s) Do

	n	(%)
Listened to me	248	(88.3)
Suggested I seek therapy	149	(53.0)
Talked things out with me	141	(50.2)
Gave me advice	138	(49.1)
Cheered or comforted me	111	
Showed me a new way to look at things	71	(25.3)
Helped me take action to solve problem	68	(24.2)

Helped me keep my mind off the problem	33	(11.7)
Told me who else to see	30	(10.7)
Nothing in particular	15	(5.3)

Percentages based on the subset of applicants (n = 281) who talked to someone about the problem.

What the other person(s) did was contrasted to the demographic characteristics of the applicants, and a few significant associations emerged. The oldest applicants were less likely than other age applicants to say that the other person "listened to me": 69.2% of the oldest endorsed this compared to 90.3% of all other age applicants, $\chi^2(3, N = 252) = 11.12, p = .01$. The eldest were also less likely to report that the other "cheered or comforted me" (15.4% of the eldest vs. 42.5% of the other age applicants), $\chi^2(3, N = 252) = 7.61, p = .05$. Only one of the eldest applicants (3.8%) reported that the helper "showed me a new way to look at things"; in contrast, 28.8% of the other age applicants reported experiencing this, $\chi^2(3, N = 252) = 8.02, p = .05$. Age was associated with "gave advice" as well, as younger applicants were more likely to experience this: 18-24 (68.8% experienced this), 25-34 (48.6%), 35-44 (46.2%), 45-62 (26.9%), $\chi^2(3, N = 252) = 10.22, p = .02$.

The only other significant difference was that females (56.3%) were more likely than males (34.0%) to endorse "helped me take action," $\chi^2(1, N = 259) = 7.21, p = .007$.

Social Support During the Process of Seeking Psychotherapy

Step 1: Problem realization. As seen in [Table 3](#), 57.5% of the therapy applicants had someone help them achieve the first step in the process of seeking psychotherapy, realizing that there is a problem. Of those who talked to someone, over 90% talked to either a family member, to their spouse or romantic partner, or to a friend. [Table 4](#) shows that the helping source within families tended to be female, that is, either mother or sister. About one in five applicants had assistance from a professional at this step. This was equally likely to be a mental health professional or a medical professional, but the clergy also helped many of the applicants at this step. Finally, about one in ten applicants had help from someone at work, and this was about twice as likely to be a coworker than a boss.

TABLE 3. Social Support Throughout the Process: "The following people helped me achieve the step:"

	Realize there is a problem n (%)	Decide therapy might help n(%)	Decide to seek therapy n(%)	"Did anyone refer you?" n(%)
Anyone ^a	181 (57.5)	201 (63.8)	170 (54.0)	224 (71.1)
Family, friend, spouse/partner	169 (93.4)	168 (83.6)	140 (82.4)	53 (23.7)
Family member	91 (50.3)	87 (43.3)	66 (38.8)	16 (7.1)
Friend	103 (56.9)	88 (43.8)	70 (41.4)	31 (10.0)
Spouse/partner	70 (38.7)	52 (25.9)	48 (28.2)	9 (4.0)
Professional	39 (21.5)	52 (25.9)	47 (27.6)	140 (62.5)
Medical profession.	14 (7.7)	34 (16.9)	29 (17.1)	120 (53.6)
MHP	14 (7.7)	11 (5.5)	13 (7.6)	24 (10.7)
Teacher	7 (3.9)	6 (3.0)	3 (1.8)	0 (0.0)
Clergy	11 (6.1)	8 (4.0)	7 (4.1)	0 (0.0)
Workplace	22 (12.2)	15 (7.5)	12 (7.1)	6 (2.7)
Coworker	16 (8.8)	11 (5.5)	8 (4.7)	4 (1.8)
Boss	10 (5.5)	6 (3.0)	5 (2.9)	2 (0.1)

^a Percentages base don all n = 315) respondents; all other percentages are base don those who indicated that they talked to someone at the step.

Table 4. Family Support Throughout the Process

	Realize there is a problem n (%)	Decide therapy might help n(%)	Decide to seek therapy n(%)	“Did anyone refer you?” n(%)
Family member	91 (50.3)	87 (43.3)	66 (38.8)	16 (7.1)
Mother	50 (27.6)	41 (20.4)	34 (20.1)	7 (3.1)
Father	27 (14.9)	18 (9.0)	15 (8.9)	3 (1.3)
Sister	31 (17.1)	37 (18.4)	21 (12.4)	3 (1.3)
Brother	17 (9.4)	9 (4.5)	8 (4.7)	2 (0.9)
Other relative	19 (10.5)	13 (6.5)	8 (4.7)	3 (1.3)

Whether or not the applicants had help at this step was related to age and previous therapy experience. Respondents who had previous therapy (51.7%) were less likely than those with no such experience (66.4%) to have help, $\chi^2 (1, N = 296) = 6.33, p = .01$. There was an inverse, linear relationship between age and having help realizing there is a problem: 18-24 (78.4% had help), 25-34 (57.9%), 35-44 (50.0%), 45-62 (41.4%), $\chi^2 (3, N = 281) = 10.0, p = .01$. None of the other independent variables were related to such help.

Among those who did have help at this step, gender was related to whether such help came from a family member. Females (56.3%) were more likely than males (34.0%) to have a family member help, $\chi^2 (1, N = 166) = 6.68, p = .01$. Females were less likely than males, however, to have their spouse or romantic partner help them at this step (32.8% vs. 53.2%), $\chi^2 (1, N = 166) = 5.93, p = .01$.

Age was related to whether or not a friend helped at this step. Only one of the twelve of the oldest applicants experienced such help, whereas 62% of the other age applicants had such help, $\chi^2 (3, N = 161) = 17.62, p < .001$. None of the other independent variables were related to the source of the help.

Therapy applicants who had help achieving this step were asked "Did you approach them with the problem or did they bring it up without you ever mentioning it?" [Table 5](#) shows that most applicants stated that it was at least partly their idea that there might be a problem (note that this number is much larger if those who did not have help at this step are included). Less than one-fifth of those who had help stated that another person brought the problem to their attention. The independent variables were unrelated to who's idea it was that there might be a problem.

Table 5. “Who’s idea was it to (achieve step)?”

	Realize there is a problem n(%)	Decide therapy might help n(%)	Decide to seek therapy n(%)
Who's idea was it to . . . ?			
My idea	42 (23.2)	39 (19.4)	31 (19.0)
Both mine and someone else's idea	104 (57.5)	120 (59.7)	106 (65.0)
Someone else's idea	35 (19.3)	42 (20.9)	26 (16.0)

Step 2: Deciding therapy might help. Tables 3 and 4 shows that most applicants who had someone help them decide therapy might help talked to either a family member, spouse or romantic partner, or friend. Mother and sister were again the most common family member consulted. About one in four applicants had assistance from

a professional at this step, most frequently a medical professional. Few had help from someone at work, and this was again more frequently a coworker rather than a boss.

Whether or not the applicants had help at this step was related to previous therapy experience. Respondents who had previous therapy (57.8%) were less likely than those with no such experience (78.8%) to have help at this step, $\chi^2(1, N = 291) = 13.86, p < .001$. None of the other independent variables were related to such help.

Among those who did have help at this step, applicants' characteristics were related to the help source. There was an inverse, linear relationship between age and having help from a family member, spouse or romantic partner, or friend at this step: 18-24 (96.3% had such help), 25-34 (86.5%), 35-44 (69.7%), 45-62 (56.3%), $\chi^2(3, N = 180) = 15.91, p = .001$. The youngest applicants (63.0%) were much more likely to have a family member help them make this decision than the other age applicants (average 37.9%), $\chi^2(3, N = 180) = 9.29, p = .03$. In contrast, the oldest applicants (12.5%) were less likely to have a friend help them at this step than the other age applicants (average 46.3%), $\chi^2(3, N = 180) = 8.74, p = .03$.

Males were more likely than females to have a family member, friend, or spouse/partner help them decide therapy might help (93.3% vs. 79.3%), $\chi^2(1, N = 185) = 4.70, p = .03$. Females were less likely than males to have their spouse or romantic partner help them at this step (20.4% vs. 42.4%), $\chi^2(1, N = 131) = 6.23, p = .01$. Females were more likely than males to have a professional help them achieve this step (31.4% vs. 8.9%), $\chi^2(1, N = 185) = 9.00, p = .003$. None of the other independent variables were related to the source of the help.

As shown in [Table 5](#), only about one in five of those who had help at this step stated that the idea that therapy might help solve the problem was only someone else's idea; most applicants stated that it was at least partly their idea. The independent variables were unrelated to who's idea it was that therapy might help.

Step 3: Deciding to seek therapy. Tables 3 and 4 show that most of the therapy applicants had someone help them decide to seek therapy, and that this was most commonly a family member (usually mother or sister), a spouse or romantic partner, or a friend. Over one in five applicants had assistance from a professional at this step, usually a medical professional. Few had such help from someone at work.

Whether someone helped the applicants decide to seek therapy was related to previous therapy experience. As at the prior steps, respondents who had previous therapy were less likely than respondents with no such experience to have any help at this step (50.6% vs. 64.7%), $\chi^2(1, N = 291) = 5.71, p = .02$. None of the other independent variables were related to such help.

Among those who had help deciding to seek therapy, applicants' age and gender were related to the help source. There was an inverse, linear relationship between age and having help from a family member, spouse or romantic partner, or friend at this step: 18-24 (92.3% had such help), 25-34 (86.9%), 35-44 (70.0%), 45-62 (53.8%), $\chi^2(3, N = 153) = 12.97, p = .005$. The oldest applicants (69.2%) were significantly more likely to have a professional help them decide to seek therapy than the other age applicants (average 24.3%), $\chi^2(3, N = 153) = 13.55, p = .004$.

Females were more likely than males to have a family member, spouse or romantic partner, or a friend help them decide to seek therapy (44.7% vs. 22.7%), $\chi^2(1, N = 158) = 6.49, p = .01$. Females were also more likely than males to have a professional help them achieve this step (34.2% vs. 11.4%), $\chi^2(1, N = 158) = 8.25, p = .004$. As at the previous steps, females were less likely than males to have their spouse or romantic partner help them at this step (22.6% vs. 40.6%), $\chi^2(1, N = 116) = 3.76, p = .05$. None of the other independent variables were related to the source of the help.

As shown in [Table 5](#), only a minority of those who had help at this step stated that the decision to seek therapy was only someone else's idea. The independent variables were unrelated to who's idea it was to seek therapy.

Step 4: Calling for an appointment. At this step, applicants were asked whether anyone referred them to the Institute, and [Table 3](#) shows the results. Most indicated that someone had referred them to the clinic. In contrast to the three previous steps, only a minority were referred by a family member, spouse or romantic partner, or friend. Likewise, few were referred by someone at work. Of those referred by someone, most were referred by a professional, most frequently a medical professional. Whether or not someone obtained a referral to the Institute was related to previous therapy experience, as those with such experience were less likely to get a referral than those without previous therapy experience (20.5% vs. 31.4%), $X^2(1, N = 294) = 4.32, p = .04$. None of the other independent variables were related to such help.

Although only nine applicants indicated that they were referred by their spouse or partner, they were more likely to be male than female (9.4% vs. 2.0%), $x^2(1, N = 206) = 5.89, p = .02$. Age was related to referral source as well. The oldest applicants were more likely than the other age applicants to be referred by a professional (81.8% vs. 59.4%), $x^2(1, N = 202) = 4.14, p = .04$. None of the other independent variables were related to the source of the help.

Social support across the process of seeking psychotherapy. To determine the experience of social support across the steps, at how many steps the applicants had help was computed. (Complete data on all steps was available for 303 subjects.) Consistent with the findings of general social support, only 29 (9.6%) respondents did not have help at any of the four steps. Fifty-five (18.2%) respondents had help at only one of the steps, 50 (16.5%) had help at two of the steps, and 77 (25.4%) had help at three. Finally, 92 (30.4%) of the respondents had help at all four of the steps in the process of seeking psychotherapy.

Discussion

This study assessed the experience of social support by persons who are in the process of seeking psychotherapy. The social network encompasses two roles. Informal help ameliorates stress and reduces the incidence and intensity of emotional distress ([Thoits, 1986](#)). Research has also shown that informal support is an important source of referrals to formal helping agents ([Horwitz, 1977a](#)). The results of this study suggest that these two functions are closely interconnected. They also suggest that social support is not a one-time event or a unique step (cf. [Kadushin, 1969](#)), but rather is important throughout the process. This study suggests that persons consult with their social network many times in the process—when they are attempting to decide whether a problem exists, when they are struggling with whether therapy would help and should be sought, and when they are looking for a particular provider. Almost three-fourths of all respondents had help with at least two of the four steps, and almost one-third had help at all four.

The primary limitation of any interpretations of these results is that this was a study of persons who had successfully negotiated the process of seeking therapy. When these persons completed the PSTQ, they had reached the final step and were about to meet with the assigned mental health professional. In contrast, most persons with diagnosable mental illnesses do not get any help. It is nonetheless argued that assessing the experience of those who complete the process will enhance our understanding of it and may provide some insight into how to address the difficulties and barriers being experienced by others.

This study is also limited in generalizability by the subject sample. All respondents were seeking therapy from one CMHC in Chicago, which was oriented towards long-term, psychodynamically-oriented psychotherapy. Most had had previous psychotherapy, and comparing their demographic characteristics to a more representative (randomly selected) sample, this study sample tended to have more females and to be better educated (cf. [Vessey & Howard, 1993](#)). It seems likely that the experience of these therapy seekers might differ from therapy seekers as a whole. Given these limitations, certain conclusions and speculations are offered.

Having previous psychotherapy experience reduced the likelihood that the applicant had help at the steps. In the previous report, [Saunders \(1993\)](#) found that previous experience was not related to difficulty achieving or time needed to achieve the steps. Combining the results of these two reports, it appears that previous therapy experience makes one less needful of informal advice as to whether a problem exists and what to do about it; at the same time, however, such experience does not make such decisions easier. This suggests that the "barriers" to seeking psychotherapy (such as money concerns, stigma of mental illness, etc.) may be operating even among those with previous therapy experience. This may be a worthwhile point to discuss with persons who are re-entering therapy, rather than perhaps assuming that such concerns have been dealt with previously.

Age was inversely related to having help in the process. Younger therapy applicants were more likely to have help achieving the steps, especially from a family member or a friend. In contrast, the oldest applicants were the least likely to have help. Applicants age 45 and older were the least likely to consult talk to a family member, spouse or romantic partner, or friend about the problem. They were also the least likely to have help at the three initial steps, and were the most likely to have a professional refer them to the clinic (see also [Husaini et al., 1994](#)).

There are a number of interpretations of the relationship between age and social support in the help-seeking process. One explanation is that age and problem chronicity or severity are confounded (i.e., older respondents have problems that are more severe or of longer duration). Problem chronicity and severity might, in turn, affect capacity to develop or maintain a supportive social network. Post-hoc analyses of the associations between age and self-rated problem duration ($X^2(15, N = 282) = 10.85, p > .10$) and problem severity ($\chi^2(9, N = 282) = 4.60, p > .10$) indicated that these variables were not significantly associated, however (see also [Saunders, 1993](#)). Alternatively, older respondents may simply have a smaller or less available support network, causing the perception, in this study, that they utilize the network less. Another explanation of the association between social support and formal help-seeking is that discussing emotional distress and the need for professional intervention is less difficult for younger persons. Younger respondents may be discussing distress and its treatment with their family and friends more readily than older peers. To investigate these alternatives more fully, future research should document the severity and chronicity of the presenting problem, and also measure and account for the available social network. For example, [Phillips and Murrell \(1994\)](#) found that older adults who sought formal help had less social support available to them.

Other research has shown that positive attitudes towards and utilization of mental health services are less common among the elderly (e.g., [Davies et al., 1994](#); [Waxman, Carner, & Klein, 1984](#)). [Phillips and Murrell \(1994\)](#) reported that older adults preferred seeking formal help from a medical doctor (as opposed to a mental health professional), and that those who sought formal help had more psychological distress, more physical problems, and more unpleasant stressful events. The experience of informal and formal help among the elderly clearly requires further scrutiny.

Gender was not related to whether or not help was obtained in the process of seeking psychotherapy, but it was related to the source of that help. For example, at the level of general help or support, females and males were equally likely to consult with someone about the problem; however, females were more likely than males to talk to a family member. This pattern emerged at the individual steps in the process as well. Females were more likely than males to have a family member help them recognize the problem, and they were also more likely to have a professional help them decide that therapy might help and to seek therapy. In contrast, males were significantly more likely than females to have help from their spouse or romantic partner at all of the steps in the process. [Horwitz \(1977b\)](#) noted that males must rely on spouses or partners for information about emotional distress and its treatment because they have smaller social networks that they utilize less. Less likely to obtain information, males would then be more likely either not to obtain treatment or to obtain it in more

severe distress. It also suggests, as others have found (e.g., [Good, Dell, & Mintz, 1989](#)), that males have more difficulty admitting or confronting emotional distress and will do so only if the help source is relatively safe.

The source of help differed greatly across the steps. At the first three steps, the help source tended to be a family member or friend. In contrast, when seeking a referral, therapy applicants tended to turn to a medical doctor. In other words, these results suggest that primary care doctors are not consulted early in the process when the person is trying to decide whether a problem exists and what to do about it. Rather, the therapy applicants seek a referral from the physician, after concluding these earlier steps. This might lead one to wonder whether physicians were not consulted at all at earlier steps, or whether they simply did not promote specialty mental health services when consulted.

Research has established that primary care professionals frequently miss or misdiagnose emotional disorders (e.g., [Gerber, Barret, Manheimer, Whiting, & Smith, 1989](#); [Popkin & Callies, 1987](#)). Despite this, the 1993 guidelines from the Agency for Health Care Policy and Research recommend that pharmacotherapy prescribed by primary care physicians be the first line of treatment for depression (see Munoz, Hollon, McGrath, Rehn, & VandenBos, 1994, for a critique of these guidelines). One might be concerned that primary care physicians have not formerly utilized mental health care professionals in adequate fashion, and that they are not currently being encouraged to do so.

Seeking support from one's social network is an important response to emotional distress that leads to reduction of such distress and to dissemination of information about possible solutions. Whether or not a person had help-in the steps of the process, and from whom that help was obtained, were examined in detail. Such informal help might be construed as a proxy for a measure of the stigma associated with mental illness and seeking psychotherapy. Interpreted in this light, the present study suggests that older adults and males are particularly hesitant to discuss issues related to mental illness. Unfortunately, these results also suggest that although they do provide referrals to mental health clinics, medical practitioners may not play a significant role in helping to recognize emotional illness and referring to appropriate helping resources.

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