Title
Help-seeking

Author
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Publication Date
1987

Peer reviewed|Thesis/dissertation

Help-Seeking: An Avenue for Adult Sexual Development

by

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DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

Human Development and Aging

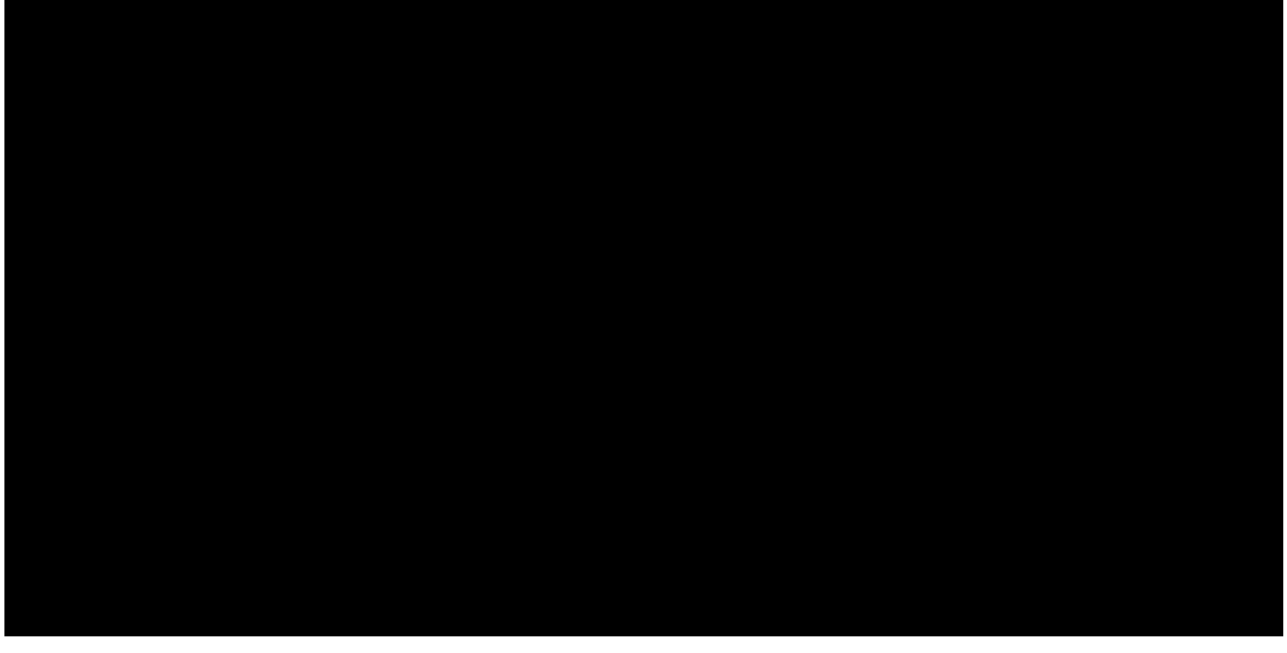
in the

GRADUATE DIVISION

of the

UNIVERSITY OF CALIFORNIA

San Francisco



ACKNOWLEDGEMENTS

I have been fortunate to have so many supporters on the path to this place. I love each of you and dedicate this work to you.

To my parents, Jacob and Hazel, who encouraged me to do whatever would make me happy and gave me my first microscope; now where did I go wrong?

To Robert Handyside and my parents who, nineteen years ago, helped me back from death; what a way to start the day.

To Ben McCready who shared my first research experiences; we faced the terrors of Swanson House and cognitive Dissonance with courage and laughter.

To the three Marys of my life, Marianna Catania, Marianne Steele, and Mary Margaret Dolcini without whom this could never have happened so gracefully. Marianna taught me persistence and the beauty of knowledge. Marianne gave me her love and laughter, her joy of living, encouragement of excellance, and her delight of ideas; the dragons we battled and the love we loved will never be forgotten. Mary Margaret gave me patience, and humor, and listened with judging; we have shared a journey not found in any travel agents files.

To those people who taught me survival: Jacob, Hazel, Robert, Marianna, Marianne, and Mary Margaret.

To John Jacob Catania, I owe a special thanks for opening my eyes to the world and its wonderous mysteries.

To Hanna Palm, who provided love, money, and two new suits for this journey.

To Don McCready whose collection of psychology books turned

me on and to Dennis Conway whose mind opened a universe of possibilities.

To Dave Bullard who helped me recover my balance during difficult times.

To my colleagues whose heads, hands and hearts helped bake this cake: Louanne Cole, Lois McDermott, Lance Pollack, Sara Qualls, Susan Kegeles, Anne Weinstein, Heather Turner, Mel Lerner, Dave Bullard, Bill Hargreaves, Evalyn Gendel, David Chiriboga, Larry Fisher, Maria Flaherty, Mary Rodocker, Bob Badame, and Linda Alperstein.

To all of you whose lives have touched this process: Tom Coates, Harry Harlow, Steve Suomi, Andy Michner, Dale Jaffe, Ellie Miller, Pete Grossman, Lou Seiden, Sherry Spitzer, Joanne Duffy, Joanna Fanos, Jeff Lazarus, John Loss, Linda Kachel, Jennifer James, Chris Beard, Colonel Ralph Balloon, T. R. Scott, Kathy Harris, Kathy Marinnari, Nancy Bliewise-Gourash, Charles White, Charles McConnel, Betsy DeBaufer, Dave Wilber, Carmen Catania, Meribeth Catania, Beth Catania, Tony Catania, Mario Catania, Ben Catania, Tim Catania, Sam B. Brown, Kugel, Tootsie, Lorena Steele, Bob Pierce, Blossom Young, Julian Davidson, Mitch, Steve Buban, Nancy Buban, Dave Burkepile, Jacob Oberman and the Rolling Stones.

Help-Seeking: An Avenue For Adult Sexual Development

Joseph Anthony Catania

Abstract

This dissertation examined psychosocial conditions hypothesized to effect the help-seeking activities of people reporting sexual problems. In community settings, respondents N = 503) were assessed on self-administered measures immediately prior to being offered the opportunity to privately request referrals to psychotherapists Those requesting referrals were later contacted, provided referrals, and efforts were made to validate attendance at therapy. Retrospective reports of self-help and informal help-seeking were also obtained. In predicting help-seeking behavior, a motivation model was employed to organize relevant helper characteristics, problem context components, emotional distress, and other developmental and psychosocial conditions of the help-seeker.

Major findings include the following: a) A significant increase in dyadic sexual problems over early adulthood was evidenced; this shift did not influence help-seeking behavior, b) contrary to past views, psychotherapeutic help-seekers exhibited a relatively high degree of self-efficacy, c) the importance of examining psychotherapeutic help-seeking as a process, and the differential impact of psychosocial conditions on this process were documented, d) in opposition to social network theory, help-seeking from intimates evidenced a central role in successful help-seeking from other informal contacts and psychotherapists,

e) a "normative" sequence to help-seeking behaviors was identified, and f) the role of help-seeking in sexual development was suggested to be one of funneling people towards particular types of change.

Although the proposed motivation model was not substantiated, suggestions for further study were made, and several basic features of current middle range theories of help-seeking were clarified. Also discussed was the present work's relevance to research on interventions directed towards reducing HIV (Human Immunodeficency Virus) transmission by facilitating reduction in "high risk" sexual behaviors.

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CHAPTER I

INTRODUCTION

Specific Aims

The benefits we derive from others when faced with troublesome situations, and the willingness of people to come to our aid have been the object of considerable study in the areas of social support and help-giving (see for reviews, House, 1981; Antonucci & Depner, 1982; Moos & Mitchell, 1982, on social support, and Rushton, 1980; Staub, 1978; 1979, on help-giving). This corpus of data has helped identify how people profit from advice and assistance, and under what conditions help will be offered. Yet, to some extent, researchers have neglected two basic questions. What factors determine whether or not people will consult others in troublesome situations, and what factors influence their choice of helpers? These questions form the basis of the present investigation.

In particular, this dissertation prospectively examines social psychological conditions expected to influence psychotherapeutic help-seeking by people with sexual problems. Psychotherapeutic help-seeking has, in general, been a relatively underexplored area (Gourash, 1978). This topic is particulalry interesting since a majority of people with psychological problems never seek psychotherapy, though they might benefit greatly from doing so (Bergin, 1971; Cowen, 1982; Gottlieb, 1976; Gurin, Veroff, & Feld, 1960; Veroff, Kulka & Douvan, 1981). Although investigators have been concerned with psychotherapetic help-seeking for psychosocial problems (Veroff et al., 1981; see

Fischer et al., 1983; Gourash, 1978, for reviews), they have not examined service utilization patterns of people evidencing sexual difficulties (Seagraves, et al., 1982; Martin, 1975; Frank et al., 1978). Since the prevalence of sexual problems may be quite high (50-70%; Frank et al., 1978), it is important to gain an understanding of those factors preventing people from obtaining the benefits of professional help. This topic is also an important area of inquiry since sexual dysfunctions may contribute to low self-esteem (Hudson et al., 1981), divorce (Thurnher et al., 1983), and death (e.g., behavioral "problems" related to Human Immunodeficency Virus transmission).

Also examined are retrospective assessments of self-help and informal help-seeking activities. Though these activities are extensively utilized in coping with a variety of different problems (Brown, 1978; Cowen, 1982), there have been few studies focusing on the determinants of or extent to which people with sexual problems employ self-help and informal help-seeking (Cowen, 1982; De Amici et al., 1984). Self-help and informal help-seeking efforts are also important to consider as determinants of psychotherapeutic help-seeking (Gourash, 1978; Brown, 1979; Fisher, Winer, & Abramowitz, 1983; Gross & McMullen, 1983; De Amici et al., 1984).

Chapter I: Overview & Organization

Within this first chapter the focus will be placed on reviewing background literature and development of a conceptual framework for the present study. Chapter I is broken into twelve sections. Section 1.01 describes the role help-seeking plays in

the process of adult development in general, and sexual development specifically. This section highlights the fact that adult development and help-seeking are new fields of investigation with correspondingly fundamental research objectives.

Help-seeking, in particular, is an area whose conceptual integration reflects the recency of its origins; reasons for its slow emergence will be discussed in a brief historical review (Section 1.02). This review includes discussion of the limitations of past work, and summarizes how the present study addresses those limitations (see also Chapter II, section 2.05). Lastly, section 1.02 will present an overview of the help-seeking model developed for this study. This overview will provide the reader with a framework for organizing the more detailed discussion and development of the proposed model over sections 1.03 - 1.12.

Sections 1.03 to 1.06 present a conceptual integration of past findings; the conceptual building blocks derived from this discussion concern helper characteristics, the problem context, and problem distress. These building blocks form important components of a proposed model (see section 1.12). Current help-seeking models, their contributions to present understandings of the help-seeking process and conceptual limitations, are discussed in sections 1.09 to 1.11. Finally, building on the material presented in sections 1.03 - 1.11, a motivation model is proposed that integrates current help-seeking models within a

unifying framework (section 1.12). This unifying model assumes that emotional states interact with cognitive, social and resource conditions to influence help-seeking behavior.

SECTION 1.01

ADULT DEVELOPMENT & HELP-SEEKING

The Study of Change

Baltes et al. (1980) have described a movement away from the common view of adult development as stage sequential, universal, and unidirectional. This shift emphasizes the study of ontogenetic change over adulthood, and has an implied taxonomic purpose. That is, there is the suggestion that meaningful principles of development may emerge from a "taxonomy of change", an approach with roots in diverse disciplines. For instance, biological taxonomies, based on descriptions of physiological systems, have guided research questions and yielded developmental and evolutionary principles. Geology has, for example, achieved the ability to predict oil deposits based on a taxonomy of the earth's crust. For adult developmental psychologists, the construction of developmental principles, and achievement of useful predictions may, in a similar fashion, best be derived from detailed study and organization of change processes into a taxonomy of change.

Adult Sexual Development, Help-Seeking & Change

In general, help-seeking is viewed here as a class of behaviors that may facilitate, though not unequivocally, the onset of a change process. That is, in reaching out for help, people

attempt to move from a problem to a problem free state. Given a psychosocial problem, then by definiton the process initiated by seeking help has potential for altering psychological and social elements of the help-seeker. Thus, help-seeking and conditions which influence it are important constituents of adult sexual development.

Psychological Aspects. Conditions eliciting change in sexual cognitions, affect, and behavior, related change processes, and process outcomes fall under the purview of adult sexual development. In this context, sexual problems (pathogenesis) represent an opportunity for initiating ontogenetic change; help-seeking provides one route by which this process takes place. That is, help-seeking may initiate processes that affect sexual beliefs, feelings and behavior.

Social Aspects. Help-seeking is also of import to sexual development from the perspective of socialization. That is help-seeking can be viewed as a process that facilitates contacts with formal and informal socialization agents (e.g., therapists, educators, friends, relatives). In addition, as a self-initiated act, help-seeking may also be conceptualized in terms of self-socialization. In short, help-seeking represents a major social mechanism for developing adult sexual relationships. That is, adult help-seeking fills the gaps left by our society's inadequate formal (Kirby et al., 1979) and informal (Spanier, 1976) sources of pre-adult sexual knowledge.

SECTION 1.02

HELP-SEEKING: A BRIEF HISTORY

Overview

Help-seeking and help-giving represent complementary functions of a social relationship whose purpose is problem solving. Until the late 1970s, most research dealing with helping relationships focused only on variables that facilitate or inhibit the actions of potential helpers (Gross & McMullen, 1983; see Rushton, 1980; Staub, 1978; 1979, for reviews of the literature on help-giving), or influence the outcomes of helping relationships (e.g., House, 1981; Antonucci & Depner, 1982; Moos & Mitchell, 1982).

In part, it may be that so little research effort has been devoted to the help-seeker because it was assumed that helpers and those in need would somehow automatically contact each other (Gross & McMullen, 1983). However progress in this area may also have been hampered by the lower value placed on help-seeking relative to self-reliant behavior in our culture (DePaulo; 1983; Weber, 1930; Merton, 1968). For instance, Graf, Freer, and Plaizier (1979) found Americans evaluated a help-seeker less favorably than they did an individual who was said to maintain self-reliance in the same situation. Moreover, in our society it is still more blessed to give than to receive. Thus, help-seeking does not possess the halo of social acceptability that surrounds help-giving (DePaulo, 1983). However, help-seeking is in fact a pervasive feature of everyday problem solving and skill acquisition over the life span. Development of help-seeking behavior is necessitated (a) during infancy in acquiring

locomotion and mastery of the immediate physical environment (Sears, 1972; Nelson-Le Gall et al., 1983), (b) in early adulthood for development of career skills, and (c) in old age in coping with declining health.

A Growing, But Fragmented Field

Despite the greater research emphasis on social support and help-giving, past work has not entirely neglected the role of the help-seeker (see McKinlay, 1972; Fischer, Winer & Abramowitz, 1983; Gourash, 1978, for reviews). Recent efforts at consolidating the help-seeking literature indicate research has been conducted in a variety of related fields (DePaulo, Nadler, & Fisher, 1983; Nadler, Fisher & DePaulo, 1983). These fields include studies of help-seeking from medical professionals (see McKinlay, 1972; Ostrove & Baum, 1983, for reviews), psychotherapists (see Gourash, 1978; Fischer et al., 1983), social service agencies (e.g., Pettigrew, 1983; Nelson, 1980), legal and protection services (e.g., Greenberg, Ruback, & Westcott, 1983), and informal helpers (e.g., friends, spouse, parents; see Gourash, 1978; Nelson-Le Gall, et al., 1983; Nadler, 1983; Clark, 1983; Wilcox & Birkel, 1983, for relevant reviews).

Although past research settings have been quite diverse, this diversity does not address the question of how much work has been conducted. However, the present dissertation, with it's limited focus, cites over 50 primary publications and 17 review papers or chapters. Ostrove and Baum (1983), in their recent overview of medical help-seeking, cite over 40 primary sources not referenced here. At a superficial level, it would seem then

that considerable work has been accumulating on the topic of help-seeking. One limitation of this accumulated work is that a majority of studies have focused on people who seek help in a direct way (Gross & McMullen, 1983; DePaulo, 1983). With minor exceptions, past investigators have ignored help-seeking that occurs indirectly through, for instance, story telling (Blau, 1955). Nevertheless, the problems with the help-seeking field are not so much based on the lack of research or an over emphasis on direct help-seeking, rather the major difficulties are those posed by a conceptually fragmented literature based on limited reserach designs (Fischer et al., 1983).

A brief review of the contents of DePaulo, Nadler, & Fisher's (1983) second volume, part of a series on help-seeking and help-giving, illustrates the conceptually fragmented nature of the literature. This volume, the most comprehensive review of the literature to date, contains ten chapters; each chapter describes a different model of help-seeking. Additional theoretical perspectives are presented in volume three of this series (Nadler, Fisher & DePaulo, 1983). The large number of proposed models, based on different conceptual frameworks - to name a few: attribution theory, cognitive consistency models, need for achievment, role theory, decision-making theory, social labeling theory, social comparison theory, embarrassment theory - clearly reflects the conceptually fragmented nature of the literature. Further, this fragmentation is also evident in the difficulty in finding a series of studies that systematically build on some core of common concepts (see Gourash, 1978).

Indeed, social demographic variables are the most commonly studied factors across studies (Gourash, 1978; Fischer et al., 1983). Yet, little is known of, for example, the underlying determinants of the oft-replicated association between gender and help-seeking (Fischer et al., 1983). Another example of this fragmentaion is in the area of psychotherapeutic help-seeking where most studies, with some exceptions (e.g.,Veroff et al., 1981), have focused on an extremely limited number of variables (Fischer et al., 1983). Fischer et al., (1983) point out that the tendency to examine no more than a few determinants of help-seeking at a time leads to an inability to articulate the complexity of the forces that eventuate in help-seeking decisions.

Overall, the current state of the field suggests that there is little consensus on what constitutes the significant dimensions of help-seeking. Nor is there agreement on what conditions influence help-seeking over time or across different kinds of problem situations. These circumstances are not the result of some malign conspiracy of incompetants, but may, in part, be due to the purposes of past investigators. For instance, some investigators have been primarily interested in characteristics of those who employ their services, so providers can in turn better construct services for those who do utilize their programs or facilities (Brown, 1978). Whatever the reasons, the fragmented nature of the research is only one problem to contend with. If this research was founded on sound methodology, a firm basis for theory construction would exist. Unfortunately, the difficulties arising from the methods employed have been

problematic for model development.

Methodological Limitations

The methodological limitations of past help-seeking studies are too extensive to review comprehensively, but a selective review can highlight the major approaches and shortcomings (see Gourash, 1978; Mckinley, 1972; Fischer et al., 1983, for reviews). This review will discuss general methodological features of the help-seeking literature, and then focus on research concerning psychotherapeutic help-seeking.

Missing Comparison Groups. A majority of past studies focus on characterisitcs of individuals who have already obtained help (see Gourash, 1978; McKinlay, 1972). In many cases this work utilizes samples drawn from hospital clinics or social service agencies (e.g., Horwitz, 1977; see Mckinlay, 1972; Gourash, 1978, for reviews). By selecting samples from the clientele of formal agencies, researchers have ignored those who only consulted members of their informal support system and people who elected to negotiate troublesome changes without outside assistance. Thus prior studies based on, for example, clinic samples have lacked comparisons with individuals exhibiting similar problems, but who did not seek professional help. This shortcoming may reflect the fact that service agencies have a vested interest in tracing the common characteristics of their clients and less concern with people they will never see: those who fail to seek help or rely on informal supports exclusively (Brown, 1978).

Cross Sectional Designs. With few exceptions (e.g., Brown, 1978; Mechanic, 1978) most help-seeking studies are based on cross sectional designs. In these studies important "determinants" of help-seeking are assessed only after individuals have sought help. Thus, there may be a danger of "contamination" of independent by dependent variables: because information was gathered after the fact, variables used to predict or explain patterns of help-seeking may have been influenced by respondents efforts to obtain assistance. Cross sectional studies also oversimplify the nature of help-seeking by treating it as a single action instead of a sequence of decisions and responses. Friedson (1969,p. 137-138), for example, has noted that "...the whole process of seeking help involves a network of consultants, from the intimate and informal confines of the nuclear family through successively more salient, distant and authoritative laymen, until the professional is reached" (also see Gross & McMullen, 1983). In general, prospective research designs are needed to adequately address the complexities of the help-seeking processes.

Longitudinal Designs & Retrospective Reports. Although longitudinal studies may solve problems posed by cross sectional designs, past longitudinal studies have their own difficulties. Longitudinal studies have sought to predict, for instance, self-reported behavior assessed at time two with independent variables measured at time one. The behavior reported at time two, in some instances, is based on retrospective reports of help-seeking behaviors performed over the time interval between assessments (e.g., Brown, 1978). Thus, the dependent variable may be based on

a measure subject to considerable memory distortion, depending on the time interval between assessments (see Bradburn, Rips, & Shevell, 1987). This difficulty can be remedied by obtaining objective indicators of help-seeking following assessment of the independent variables (e.g., hospital attendance records; Mechanic, 1978). The present study employs this approach by obtaining objective measures of referral requests and therapy attendance following assessment of the independent variables (see Chapter II for detailed discussion).

Laboratory Studies. Laboratory studies (e.g., Tessler & Schwartz, 1972; Nadler, 1983, pp. 310-317; see Nadler, 1983, for review) have been able to assess predictor variables prior to and nearly contiguous with help-seeking behavior. However, these studies have low external validity. That is, the problems for which help is sought typically involve difficulties with only a remote resemblance to the mental and physical health problems for which people seek assistance. For instance, laboratory studies have examined help-seeking associated with the task of rating dialogues (Tessler & Schwartz, 1972; Wallston; 1976), constructing paper boxes under conditions of simulated disability (Morris & Rosen, 1973), solving logic problems (Broll, Gross, & Piliavin, 1974; Nadler, 1983, pp. 310-317), and reducing test anxiety (Snyder & Ingram, 1983). In general, laboratory studies of help-seeking provide limited information because they narrow research to those independent variables most amenable to brief and ethical manipulations. This situation is problematic for research on help-seeking. To invoke help-seeking responses in the

lab, one must be able to create and manipulate powerful need states, which may be costly and unethical. Needed are field studies based on quasi-experimental designs (Cook & Campbell, 1979). The present study employs such an approach in examining psychosocial determinants of requesting referrals to psychotherapy (see Chapter II).

Psychotherapeutic Help-Seeking

In general, prior studies of psychotherapeutic help-seeking possess the methodological problems discussed previously (see Fischer et al., 1983; Gourash, 1978, for reviews). For instance, investigators have virtually ignored the time dimension in designing their studies, which have typically involved only a single data collection and concurrent assessment of psychological and sociocultural variables in addition to help seeking attitudes or behavior (Fischer, Winer and Abramowitz, 1983). The result is a data base that does not permit the directional kind of inference that would constitute an adequate test of a process oriented model of psychiatric help-seeking (Fischer, et. al., 1983).

Also problematic for model building is that past studies have tended to focus on social demographic charateristics of people seeking psychotherapy (see Fischer et al., 1983; Gourash, 1978, for reviews). As Gourash (1978) points out, demograpic variables are not of direct explanatory significance in addressing why psychotherapy is selected.

A few prospective studies of psychotherapeutic help-seeking have been conducted, but these have examined respondents

following their initial contact with a professional. For instance, two studies have investigated clients who had made an appointment to attend therapy, and examined differences between attendees and no-shows for this first appointment (Raynes & Warren, 1971; Noonan, 1973). Other reports have examined differences between attendees and nonattendees who had been referred to mental health clinics by previously contacted professionals (Seagraves et al., 1978; France, Weddington, & Houpt, 1978; Rogawski & Edumdson, 1971; Wilder, Plutchnik & Conte, 1977). Although both sets of studies focus on interesting pieces of the psychotherapeutic help-seeking process, they do not provide an important comparison group. That is, they have not examined those people who have similar psychosocial problems, but rely solely on self-help or informal helpers.

The above studies also fail to assess an important first step in the psychotherapeutic help-seeking process. That is, they do not assess differences between people at the information seeking phase of psychotherapetic help-seeking; a phase that must occur before those needing help can contact a professional. Indeed, many people canvass informal contacts for recommendations (Gourash, 1978), and in other ways attempt to determine who to select for treatment. Even when people have obtained this necessary information, some may still fail to contact a therapist. Determining the differences between these latter individuals and those who make appointments will provide additional insights into the conditions that inhibit or sustain help-seeking over time. The present study examines these issues within a two step model of psychotherapeutic help-seeking that

focuses on information seeking and attendance at therapy (to be discussed; see section 1.12 and Chapter II).

The Proposed & Past Help-Seeking Models: An Overview

Current help-seeking models invariably concern help-seeking wherein the person initially perceives a problem, the problem is of the type that might possibly be alleviated if others help out, and the needy person seeks aid in a direct way (Gross & McMullen, 1983). Thus, past models have typically dealt with "necessary help" (Gross & McMullen, 1983). Necessary help involves (a) tasks needing expertise (e.g., law, medical), (b) those tasks requiring more than one person (lift a heavy object), or (c) those tasks wherein resources need to be acquired to reach a goal (e.g., borrowing money). Less research or model development has concerned convenient help (Gross & McMullen, 1983); convenient help involves tasks where more than one person eases what one person could do alone at extra costs in time and energy.

In the present investigation, obtaining successful solutions to sexual problems is viewed as a task typically requiring necessary help. This assumption rests on the fact that most Americans have not received adequate sex education (Kirby et al., 1979), let alone the level of education that would engender self-diagnostic and self-treatment abilities. As with legal problems, the issue is typically one of finding a professional with the requisite knowledge. Even when problems may be alterable by self-education, that this information is current and the only remedy needed may still require professional assurances.

Some General Problems With Current Models

Current help-seeking models fall into four somewhat overlapping categories: a) self-esteem based (see section 1.08), b) decision making (see section 1.10), and c) social network (see section 1.09). The decision making and social network models often provide broad outlines without attention to how various components differentially apply over the help-seeking process (see Sections 1.09 - 1.11). For instance, Gross & McMullen (1983) posit a general sequence to help-seeking behaviors, and suggest that a cost-benefit decision making process motivates movement over this sequence (see section 1.12 for additional discussion of this model). However, it is unclear at which points in the help-seeking process particular cost/benefit factors (e.g., self-esteem considerations) come into play. Is every cost/benefit consideration equally applicable to informal and formal help? For example, financial resources are obviously not of equal importance to both types of help-seeking. In short, Gross and McMullen's model does not *a priori* state what the actual cost/benefit elements are in any given help-seeking situation. Indeed, it may be premature to expect such an *a priori* determination given how little is known of the conditions that affect help-seeking. Nonetheless, though broad frameworks may be useful for defining general processes, they fall short in specifiying details of the conditions that sustain movement over the help-seeking process.

Self-esteem based models typically possess greater specificity (e.g., see Nadler, 1983), but these models represent little more than a small collection of hypotheses anchored to a

single hypothetical construct (e.g., Tessler & Schwartz, 1972; also see Nadler, 1983, and section 1.08). Needed is an effort to delineate central help-seeking concepts, their inter-relationships, and how they affect behavior over the help-seeking process (Fischer et al., 1983, express a similar view). In sections 1.03 to 1.12 further discussion is given over to accomplishing these tasks. Provided below is a brief over view of this work.

Problem Context. Most investigators agree that help-seeking begins with the perception of a problem (e.g., See Gross & McMullen, 1983; Fischer et al., 1983, for reviews). However, it is also generally recognized that as regards help-seeking it is insufficient to simply perceive a set of symptoms as a problem (Gross & McMullen, 1983). Indeed, the problem must further be identified as being amenable to aid for the help-seeking process to be initiated (Gross & McMullen, 1983; also see Gurin et al., 1960; Nelson, 1980; Fischer et al., 1983). Based on literature reviewed in section 1.06, three elements are identified that may effect labeling of a problem as one requiring others' help. These elements include problem cause, problem locus, and the relative importance of the problem. Together, these elements define what is termed here, the problem context. That is, the problem context is not the problem itself, but features of the problem situation that arise after the individual perceives something to be "wrong". For example, the problem's cause needs to be identified as one that may be resolved by professional help, before formal help may be sought (e.g., Farina et al., 1978; Fisher & Farina, 1979). Additionally, if the problem is seen as extremely

important relative to other problems in one's life, then efforts may be made to seek help (Gross & McMullen, 1983). Moreover, personal as opposed to shared problems may have different consequences for help-seeking (Fischer et al., 1983; see section 1.06). These problem context elements are discussed in greater detail in section 1.06.

Helper Characteristics. Another help-seeking component concerns characteristics of helpers (see section 1.05). This component stems from the idea that once a problem is perceived as needing outside help to be solved, attention will then turn to the kinds of helpers one might select (Gross & McMullen, 1983; Fischer et al., 1983). Literature is reviewed in section 1.05 that suggests helper characterisitcs fall along two general dimensions regarding a) the perceived abilities of potential helpers to aid in solving the problem, and b) the resources that may be needed in acquiring help. In general, this factor is hypothesized here to contribute to the process of selecting specific helpers (e.g., professionals, friends, or lovers).

Problem Distress. Emotions have been a neglected element of prior help-seeking models. Studies reviewed in section 1.08 provide empirical support for the importance of problem distress to help-seeking. However, though problem distress has been examined, it has not been integrated with other help-seeking factors in a manner that reflects it's demonstrated importance to help-seeking behavior (e.g., see Mechanic, 1978). In section 1.08, the hypothesis is developed that problem distress represents a major element in stimulating and sustaining help-

seeking behavior.

Experience and Pre-Existing Conditions. Problem context, helper characteristics, and problem distress provide an organizational framework for a number of help-seeking elements (see section 1.12). As suggested earlier, these factors represent cognitions and emotions that follow the initial perception of a problem. Thus, still to take into account are the effects of effects of one's ongoing help-seeking experiences (e.g., Brown, 1978; Gourash, 1978), and more general personality and social conditions that might influence help-seeking decisions (e.g., Gross & McMullen, 1983; Nadler, 1983; Wilcox & Birkel, 1983; Clark, 1983). That is, each person carries into a problem situation some accumulated direct and vicarious experience with related situations, and a set of psychosocial factors that predate the onset of the problem (e.g., having chronic low self-esteem; being married; having friends). Past work has demonstrated such general life circumstances to affect help-seeking decisions (e.g., self-esteem; Nadler, 1983). Self-esteem and social network models have dealt more explicitly with these general factors (e.g., Nadler, 1983; Wilcox & Birkel, 1983). These models and their conceptual contributions will be reviewd in sections 1.08 and 1.09.

Sequencing of Help-Seeking Behavior. Is there a sequence to the possible problem solving behaviors that might be expected to occur following perception a problem? These behvaviors include, self-help, informal help-seeking, and formal help-seeking (Brown, 1978. Prior models have taken a wide variety of stances regarding sequencing. For instance, some models do not hypothesize an

expected sequence (e.g., Self-Esteem models; Nadler, 1983). Other models focus on only a subset of behaviors. For example, Clark's (1983) model of communal help-seeking suggests that help-seeking from initamtes will precede seeking assistance from other informal or formal helpers. Several models have been more inclusive (Gross & McMullen, 1983; Fischer et al., 1983). Their view is that our culture specifies help-seeking norms that attach progressively more stigma to, respectively, self-reliant actions, informal help-seeking, and formal help-seeking (Weber, 1930; Merton, 1968; Graf et al., 1979; Lee et al., 1974; Pettigrew, 1983; Nadler, 1983). Thus, self-help may occur before informal help-seeking, and informal help-seeking may precede formal help-seeking. This proposed sequence provides additional structure to the help-seeking process. That is, whereas the prior components concern the initiation and shaping of specific behaviors, and the sustaining of movement across the various steps in the help-seeking process, social norms provide an order to those steps. In sections 1.10 and 1.12 the sequencing issue will be discussed in greater detail.

An Integrated Model. In section 1.12 the previously described help-seeking components are organized into a motivation model. Within the framework of this model, all problem context, helper-characteristics, past experiences, pre-exsisting conditions, and help-seeking norms are conceptualized as a class of elements referred to as directive variables. These elements are directive in the sense that, under appropriate conditions, they shape the selection and sequencing of behaviors involved in

pursuing the goal of solving a problem. Problem distress is conceptualized as a motive force that interacts with directive variables to influence onset and continuation of goal oriented behaviors (e.g., help-seeking). In general, this model has considerable generalizability, and organizes the various help-seeking components into a conceptual whole. Also, in terms of these components, it achieves a level of specificity sufficient to identify important determinants of behavior at different points in the help-seeking process.

SECTION 1.03

PROBLEM CONTEXT

Overview

The problem context is conceptualized here as a set of cognitive conditions that follow the initial perception of a problem (for discussion of problem perceptions see section 1.06), and precede consideration of helper characteristics (Fischer et al., 1983; see Problem Cause, below). These cognitions are hypothesized here to include attributions, expectations, and priorities that are linked by their common association with the perceived problem (Fischer et al., 1983). Three fundamental questions arise from this matrix of cognitive elements: a) what is the cause of the problem, b) who does the problem encompass (problem locus), and c) what is the relative importance of the problem?

Problem Cause

As discussed previoulsy, a cause must be perceived before a problem can be labeled as being one that is amenable to help (Fischer et al., 1983; Ames, 1983). Findings relating locus of control to help-seeking can be interpeted as supporting this point. For instance, individuals who attribute health problems to fate or chance, relative to those making internal causal attributions, are less likely to seek health related information (Wallston, Maides, & Wallston, 1976). Once a causal attribution has been made, the nature of that cause may contribute to refinement of the help choices a person might make. For instance, attributions of psychological problems to physiological causes, relative to psychosocial causes, have been associated with less usage of mental health services (Calhoun et al., 1972; Farina et al., 1978; Fisher & Farina, 1979). Thus, perceiving a cause and recognizing the nature of that cause facilitates specific kinds of help-seeking. In general, people are expected to make a logical connection between problem cause and problem solution; correspondingly, physiological and psychological causes will be perceived to respectively require physiological and psychological solutions (Fischer et al., 1983; Farina et al., 1978; Fisher & Farina, 1979).

The discussion above also suggests that problem context elements may influence processes categorized under helper characteristics (see Perceived Helper Abilities, section 1.05). That is, causal attributions may help crystalize particular helper preferences; preferences may also facilitate predilections

towards particular causal attributions, attributions which further reinforce the initial preferences. The present study will focus on respondent's preferences towards psychotherapy as opposed to directly examining causal attributions (see Helper Characteristics).

Problem Locus

In general, past studies have not taken into account problem locus. Wallston et al.'s (1976) locus of control research, discussed above, can be interpreted, however, to suggest that perceiving a problem to reside within one's self, as opposed to having an unknown origin (fate, change, luck), results in more help relevant information seeking. However, it is uncertain how people may respond when a problem is perceived to reside within two or more individuals or their joint relationship. Current help-seeking perspectives typicially view problems as residing within the individual (e.g., Nadler, 1983; Fischer et al., 1983; Gross & McMullen, 1983; Ames, 1983). This is a limited view, since some problems may, at times, be seen as joint difficulties (e.g., marital difficulties). Shared problems may require joint decisions about help-seeking that involve negotiation and achieving a consensus. Relative to individual difficulties, shared problems may pose additional barriers to seeking help, particulalry when several people must agree on the type of help to be sought. Help-seeking issues around joint versus individual problems are discussed later (see Section 1.09).

"When It Rains It Pours": Problem Importance

Individuals usually develop strategies for prioritizing problems (Gross & McMullen, 1983). The reason is that almsot everyone has experienced the burden of simultaneously facing multiple problems. In responding to this kind of situation, most people learn that trying to solve all their problems at once quickly becomes hopeless unless some are put aside. The importance of this point is that individual problems may often be experienced against a background of other ongoing difficulties that vary in subjective importance. This ranking of personal problems (problem hierarchies) is a central component of decision making perspectives on help-seeking (Gross & McMullen), and will be discussed in detail later (see Section 1.10). Currently there no studies, to my knowledge, that have investigated the relationship of problem hierarchies to help-seeking behavior.

SECTION 1.04

HELPER CHARACTERISTICS

Informal & Formal Help

Helper characteristics can be distinguished along **informal** and **formal** lines (e.g., friends & psychotherapists respectively; Brown, 1978). Distinctions between informal and formal help sources are hypothesized here to be based on two related dimensions of helpers: their ability to provide necessary help, and the resources needed in obtaining their help. Although these dimensions are for convenience labeled as helper characteristics, they more accurately are the basis of an interpersonal exchange

between helper and help-seeker.

Perceived Helper Abilities

Selecting a specific helper is an outcome of the process of matching the help-seeker's needs with someone having the requisite "solution" (Gross & McMullen, 1983). Perceived differences in the helping abilities of informal and formal helpers, and of individuals within these categories (e.g., medical doctors vs. psychotherapists) will be reflected in people's help-seeking preferences (for discussion see Preferences, below).

Resources

Selecting a helper is also an outcome of the process of matching the helper's perceived needs (e.g., making an income) with the resources of the help-seeker. In the context of choosing between formal and informal helpers, psychotherapy may typically be perceived to have larger financial costs, to be less geographically convenient, and involve larger time expenditures than aid obtainable from a spouse or friends. Not surprisingly, greater geographical availability (Breakey & Kaminsky, 1982), and larger financial and time resources have been shown to be associated with use of formal services (McKinlay, 1972; Andersen et al., 1975; Veroff et al., 1981; Marcus and Siegel, 1982; Nathonson, 1975; Suchman, 1965; Marcus & Seeman, 1981).

Preferences

From the help-seeker's perspective, helper characteristics can be consolidated in terms of attitudes toward (Fischer et al.,

1983) or, as conceptualized here, preferences for specific help sources. These evaluative beliefs capture the idiosyncratic and normative perceptions people have of helpers (see Fischer et al., 1983, for review).

Prior work has focused on correlates of attitudes towards professional help for psychological problems, but not the relevant question of how attitudes influence the decision to request help (see Fischer, Winer, & Abramowitz, 1983, 167-172, for review). Moreover, focusing on attitudes towards a single service type, as prior investigators have done, fails to reflect preferences; **preferences represent the relative evaluative hierarchies associated with one's available help options.** Thus, preferences encompass a broader evaluative context than do attitudes towards a particular help source. For instance, people may feel only moderately favorable towards psychotherapy, but if all other help options appear undesirable, then indeed they may still seek psychotherapy.

SECTION 1.05

PRIOR EXPERIENCE

Prior help-seeking experiences can provide information relevant to both the problem context and processes that underly selecting helpers (see Helper Characteristics). For instance, in any given problem situation there may be some recall of and extrapolation from past difficulties - their causes, locus, importance and remedies. As antecedents to other problem context variables, these recollections are of less immediate interest. However, experience with prior helpers may also have a

direct impact on help-seeking. For instance, informal help sources have been found to influence formal help-seeking (Brown, 1978). Informal helpers may provide information on locating professionals, and support for continuing to the help-seeking process. In brief, past informal help-seeking efforts may guide future formal help-seeking choices by supplying needed factual and emotional resources with which to accomplish this task (for further discussion see Sections 1.09 & 1.12).

SECTION 1.06

PROBLEM RELATED EMOTION

Overview

A diverse literature indicates the degree of distress to be the single most important predictor of coping activities directed at the goals of reducing distress and/or solving physical or mental health problems (Brown, 1978; Coulton & Frost, 1982; Gortmaker et al., 1982; Kessler et al., 1981; Mechanic, 1978; Snyder & Ingram, 1983). Despite this overwhelming evidence, current help-seeking models either do not consider emotion(s) or fail to integrate them with other model constructs (e.g., Wills, 1983). A minor exception is Gross & McMullen's (1983) decision making model (see Section 1.10). They view distress as one of many elements in a cost-benefit matrix that affects help-seeking decisions. However, a very different view of the causal positioning and importance of distress to help-seeking can be derived from consideration of how "problems" come to be perceived as problems.

Perceptions of Problems

Based on direct and vicarious experience, people acquire cognitive-affective structures concerning what physical, psychological and social states are normal and what deviations from these internalized evaluative standards are unusual (Mechanic, 1968). Such "health related" cognitive-affective structures provide a basis for understanding why, given similar symptoms, people evidence such great variability in what they define as a problem (Mechanic, 1968).

Distress: A Primary Problem Feature

In general, neither the type of disorder nor objective symptomatology have been found to differentiate those who perceive a problem and obtain help from those who do not (for reviews see Stoeckle, Zola & Davidson, 1963; Zola, 1966). As Nelson (1980, p.181) emphasizes, "we must distinguish conditions from problems; conditions themselves do not define the problems that individuals have." In this context, it is both intuitively appealing and empirically consistent to postulate that emotional distress, as an outcome of one's "health related" cognitive-emotional structures, represents a primary subjective metric by which problems are defined. From this perspective, emotional distress is also a fundamental cause of decision making processes surrounding help-seeking and ultimately of help-seeking behaviors.

Emotion & Cognition: Circumventing A Causal Bias

As discussed, emotions have not been conceptually integrated nor accorded a "strong" causal position by current help-seeking

theorists. In part, this situation may reflect the tradition in American psychology that views emotions as outcomes of cognitive conditions (Izard, 1982). However, there are data suggesting that emotions also give rise to cognitions (Izard, 1982). This does not imply that emotions are unaffected by cognitions nor does it deny that emotions may interact with other factors to facilitate behavior.

The position taken here, based on Izard's (1982) perspective, is that emotions, cognitions and behavior represent unique streams of experience that intersect (linear and reflexive causality) as well as interact (catalytically) to create "pools" in which new possibilites can arise. This latter interaction perspective forms the basis for a theoretical integration of emotional distress with other help-seeking elements (see Section 1.12).

Problem Distress: Limitations of Prior Perspectives

Current views on how distress relates to help-seeking have several difficulties. From the perspective of this dissertation, two critical differences are that (also see Section 1.12):

a) Past studies examining problem distress have not considered the situation wherein problem locus and help source overlap (e.g., seeking help for a sexual problem from a sexual partner). In this situation, it is hypothesized that when a high degree of problem related distress is associated with the potential helper then help-seeking may be inhibted rather than facilitated (see Sections 1.03 & 1.09).

b) Past investigators have typically reported only tests of the linear relationship between distress and help-seeking (e.g., Snyder & Ingram, 1983; Brown, 1978; Mechanic, 1978). At present there is insufficient evidence to assume that the relationship between distress and help-seeking is only linear. As with the effects of negative feelings on the performance of other types of behavior (e.g., Janis, 1967; Leventhal, 1973), distress may have a curvilinear relationship with help-seeking behaviors.

SUMMARY: SECTIONS 1.02 - 1.06

From the previous discussion in sections 1.02 to 1.07, several important variables were identified for study. These include help-seeking preferences, resources, prior help-seeking experiences, problem hierarchies, interpersonal considerations surrounding problem locus (also see section 1.09), and problem related distress. With some exceptions (e.g., financial resources), these elements will be examined with respect to both formal and informal help-seeking (see section 1.12).

Although helper and problem context variables have value for predicting help-seeking, they have not been systematically integrated with prior models that focus on more general personality, and interpersonal considerations relevant to help-seeking (see sections 1.07 - 1.11). An effort will be made to consolidate these conceptual domains under a single conceptual umbrella (see section 1.12).

SECTION 1.07

MODELS & THEORIES OF HELP-SEEKING

The following sections review major psychosocial models of help-seeking, and relevant findings on psychotherapeutic (also see section 1.02) and informal help-seeking. These models are then synthesized within a motivational framework, and corresponding hypotheses developed (section 1.12).

As discussed previously (section 1.02), I have grouped current help-seeking models into four somewhat overlapping categories: a) self-esteem based, b) decision making, and c) social network. With some exceptions, these models focus on more general aspects of personality and interpersonal relations applicable to a broad range of behaviors including help-seeking. However, some models include consideration of elements defined previously in terms of problem context. The application of these elements by past models provides additional insights into the role played by the problem context in help-seeking. To some extent, previous models have also postulated particular patterns or sequences to help-seeking actions. These considerations have been briefly touched upon earlier in this chapter, and will be further explicated in discussing individual models.

SECTION 1.08

SELF-ESTEEM MODELS

Overview

Self-esteem is the pivotal construct in several help-seeking models (Fisher et al., 1982; Rosen, 1983; Shapiro, 1983), and

important, but less central, to several others (Wills, 1983; Gross & McMullen, 1983). Despite the popularity (Nadler, 1983) and intuitive appeal of self-esteem as a motivating factor in help-seeking, the literature is not entirely consistent in establishing a relationship between help-seeking and self-esteem. Empirical studies and the contrasting conceptualizations of the relationship between self-esteem and help-seeking are reviewed in the following sections.

Conceptual Underpinnings

Self-efficacy theory underlies the hypothesized relationship between self-esteem and help-seeking. The self-efficacy motive (Bandura, 1986; Stotland & Canon, 1972; White, 1959) is associated with the goal of maintaining or increasing one's self-esteem. Thus, activities implying a high sense of personal competance are valued because they enhance or maintain self-esteem. To the extent that help- seeking activities are perceived to reflect on one's competance, then self-esteem becomes a relevant consideration (Tessler & Schwartz, 1972; Fisher, Nadler & Whitcher-Alagna, 1982).

Studies examining self-esteem have focused on the potential self-threatening implications of seeking help. That is, seeking aid from others may violate American norms of self-sufficiency, and therefore, implies that one is somehow inadequate (Gross & McMullen, 1983; Graf et al., 1979; Lee et al., 1974; Pettigrew, 1983; Nadler, 1983). If one adopts this view, it is reasonable to assume that people with high and low levels of self-esteem will be differentially sensitive to such a threat. Although the

conceptual link between self-esteem and help-seeking seems consistent, the specific direction of the relationship is not at all clear. In fact, two opposing predictions have been formulated, the vulnerability and the consistency hypotheses (Tessler & Schwartz, 1972).

Vulnerability. The vulnerability hypothesis suggests that because low self-esteem individuals possess less positive self-evaluations, they are more vulnerable than high self-esteem people to self-threatening information (Tessler & Schwartz, 1972). If seeking help is perceived as a self-threatening admission of personal incompetance (i.e., I failed to prevent or solve this problem), then low self-esteem individuals are more likely than high self-esteem people to avoid seeking help (Tessler & Schwartz, 1972).

Consistency. The consistency view stipulates that people will find self-relevant information to be threatening only when it is inconsistent with existng self-evaluations (Bramel, 1968; Tessler & Schwartz, 1972). Accordingly, people with higher positive self-evaluations (high self-esteem) will be more threatened by information about failure and incompetance, and therefore, seek less help than low self-esteem individuals (Tessler & Schwartz, 1972).

Empirical Findings

Nadler (1983) has reviewed the self-esteem and help-seeking literature; a review which emphasizes supporting evidence for a consistency hypothesis from laboratory simulation and field studies of help-seeking. However, Nadler omitted reference to at

least one major longitudinal study which found no relationship between self-esteem and help-seeking (Brown, 1978). Nadler also dismisses studies supporting a vulnerability hypothesis by suggesting the problems examined were of low ego-relevance, even though ego-relevance was not assessed in those studies (e.g., Morris & Rosen, 1973). In brief, the self-esteem - help-seeking relationship requires further examination.

Sequencing of Help-Seeking

Self-esteem theorists (e.g., Nadler, 1983) have not specified any particular sequence to help-seeking actions (e.g., Nadler, 1983); this omission may be related to their unstated assumption that self-esteem considerations are equally applicable to all help-seeking behaviors. A problem with this is assumption arises if help-seeking actions occur in a sequence that not everyone sucessfully navigates (e.g., see Brown, 1978; Veroff et al., 1981). Consider the proposed sequence involving, respectively, self-help, informal help-seeking, and formal help-seeking (Gross & McMullen, 1983). Given that not everyone performs each step in the sequence, then on each succesive step there may be a continuous "falling out" of either high or low self-esteem people. This reasoning suggests that self-esteem may have it's largest effect at the first step in the social help-seeking process. If this first step typically involves movement from self-help to informal help-seeking, then the continuation of help-seeking from informal to formal help may be less influenced by self-esteem. This reasoning obviously depends on the accuracy of the proposed help-seeking sequence. If, for example, people by-pass informal helpers in moving from self-help to formal help

(e.g., Brown, 1978), then self-esteem may influence formal help-seeking.

Summary

Self-esteem models of help-seeking provide contrasting predictions in terms of vulnerability and consistency views of the relationship between help-seeking and self-esteem. Self-esteem models are reductionistic in that they rely on a single inclusionary rule: "what ever threatens or enhances self-esteem in the help-seeking situation is important". Moreover, these models fail to adequately consider the possibility of a normative sequence to help-seeking activities. From a self-esteem perspective, all forms of help-seeking, informal and formal, are treated as equivalent. Evidence to be reviewed suggests this is not the case (see section 1.10).

SECTION 1.09

SOCIAL MODELS

Overview

Since help-seeking is a social activity, several theorists have considered how social conditions affect its occurrence (e.g., Wilcox & Birkel, 1983; Clark, 1983). Social models of help-seeking (e.g., Wilcox & Birkel, 1983; Clark, 1983) have focused on (a) how decisons are influenced by the help-seeker's pre-existing social relationship to the potential helper, and (b) how one type of helper may influence decisions to seek help from another type of help source. Below these issues are considered in

the context of network theory and intimate relationships.

Social Network Theory: Diversity

Network theorists have primarily focused on how informal social networks affect formal help-seeking (Wilcox & Birkel, 1983; see Brown, 1978; Gourash, 1978, for reveiws). A key network dimension in this regard is diversity (Wilcox & Birkel, 1983). **High network diversity is indicative of having social contacts beyond those defined by birth and marriage** (Granovetter, 1973; 1982; Wilcox & Birkel, 1983).

Among other functions, more diverse networks are hypothesized to facilitate contact with and adoption of new ideas relevant to obtaining help (Wilcox & Birkel, 1983). These functions derive from the fact that diverse networks are composed of more nonintimates, who are usually less invested in the helping role intimate members occupy

The helping role which intimates perform can be highly reinforcing/beneficial to the helper (Clark, 1983). Indeed, the helping role intimates hold may often rest on a desire to enhance or maintain intimacy, test the relationship, or in some other way benefit the donor (Clark, 1983). For instance, a spouse may satisfy his/her need to nurture or boost a flagging self-esteem by helping to solve their partner's problems (Clark, 1983, pp. 211-215). In brief, intimate network members have a vested interest in exerting pressure on the help-seeker to remain within the bounds of the network, and are reluctant to relinquish their role to others.

Empirical Support

Informal help sources (e.g., friends) often provide information on locating professional help for a problem (Veroff et al., 1981). Several studies indicate that the greater the diversity of one's informal network, the more likely that professional help will be obtained (Granovetter, 1973; 1982; Lee, 1969; McKinlay, 1973; Wilcox & Birkel, 1983, pp. 241-251). In reviewing this literature, Wilcox and Birkel (1983) conclude that smaller networks expect network members to utilize the network for assistance, and, therefore, inhibit going outside the network for help (e.g., Baker, 1977; Vaillant, 1972; also see Gottlieb & Hall, 1980, for review). Alternatively, the more diverse one's informal network the more likely that "new ideas" will reach the help-seeker, such as suggestions to obtain professional help.

Intimates & Communal Help-Seeking

Network theory views help-seeking as an individual task. This view, as mentioned previously, neglects problem contexts that may involve joint help-seeking (as may occur with sexual problems). That is, **seeking help from one's sexual partner (communal help-seeking)** may lead the couple to jointly confront the problem; an effort that, at times, may generate the suggestion to seek outside help. When this suggestion is agreed to in the spirit of maintaing/enhancing intimacy and mutual nurturance, then benefits to be derived from the helping role may not be threatened. In brief, network theory does not consider communal problem solving responses that may elicit psychotherapeutic help-seeking.

Communication

Network theory emphasizes differences in the types of social relationships people possess (see Wilcox & Birkel, 1983). Although these differences may be important to help-seeking, it is also relevant to consider skills needed to access or build helping relationships. Based on pilot findings (see Appendix, B) and the results of prior studies (Brown, 1978; Horwitz, 1977), verbal communication is hypothesized be of fundamental importance in all social help-seeking situations. Communication skills may be of considerable importance when difficulties in accessing a network member arise because of that person's role in causing the problem (see Problem Locus, section 1.03). For instance, one's sexual problem may be associated with the person typically turned to for help in solving problems. That is, people often turn to their closest intimates before anyone else (Clark, 1983, p. 206). In this situation, the ability to communicate about sex may be an essential determinant of whether one's partner is approached for help on a sexual difficulty.

One hypothesized consequence of poor communication between sexual partners is that the partner may be side stepped in favor of other informal or formal help sources. That is, it may be far more distressing to discuss the problem with the partner than with others. Greater distress may then inhibit problem solving efforts involving the partner, and lead the troubled person to go outside the relationship for help. Thus, communication abilities may both inhibit, as mentioned above, and facilitate different types of social help-seeking.

Communications: Empirical Support

Pilot data (see Appendix B) suggested that people who utilize social sources of help are significantly better communicators than those who rely solely on self-help. This finding may not be generalizable to both informal and formal help-seeking. For instance, Brown (1978) found that people who use formal services are signifcantly less capable of discussing their problems than people who employ only informal help. Brown's findings suggest that poor problem communication at the informal level results in seeking help from professionals. However, Brown did not examine the effect of communication in the context of communal help seeking. As hypothesized previously, communal help-seeking may facilitate a decision to seek psychotherapy; a process that may be facilitated when partners can adequately communicate about the problem. Prior work has not addressed the question of how communication between spouses effects other types of informal help-seeking (e.g, from friends).

Sequencing of Help-Seeking

Social models assume that help-seeking most often begins with informal sources (intimate and nonintimate; Clark, 1983; Wilcox & Birkel, 1983). Clark (1983) has proposed that since people in intimate relationships feel a special responsibility for each other's needs, whereas nonintimates may not, then - everything else being equal - people should turn to their intimate relations first when they need help. It is only when problems are not solved at the level of intimates that other informal or formal sources of help will be sought out. This

"social theory" formulation does not take into consideration self-help. As noted elsewhere in this chapter (section 1.02; 1.10), self-help may be the first response to troublesome situations. In general, social models of help-seeking have focused more on informal help-seeking, to a lessor extent on formal help-seeking, and have paid little attention to what factors might discriminate these latter groups from those who rely solely on self-help. Nonetheless, the social models suggest a needed distinction between intimates and other informal contacts; a distinction that subdivides the informal help-seeking portion of the help-seeking sequence proposed by Gross and McMullen (1983).

Summary

Social models of help-seeking provide several interesting contrasts of how social relationships are expected to influence informal and formal help-seeking. Network theory predicts that diverse social networks will facilitate seeking psychotherapy, while intimates will inhibit both nonfamilial and formal help-seeking. An analysis based on communal help-seeking and communication perspectives suggests that either a) communal help-seeking and good communication facilitates seeking psychotherapy, or b) poor communication inhibits communal help-seeking and thereby facilitates extrafamilial and formal help-seeking. In addition, though network theory does not propose a sequence to help-seeking behavior, a communal model suggests that intimates are first approached, and only then are others sought out.

SECTION 1.10

DECISION MODEL

Overview

Gross and McMullen (1983) have developed a decision making model that extends and adapts models of help-utilization (Piliavin, 1972), coping with bereavement (Shulman, Rosen, & Gross, 1976), social service usage (Nelson, 1980), psychiatric help-seeking (Gurin et al., 1960; Veroff et al., 1981; Fischer et al., 1983), and help-seeking by children (Nelson-LeGall, et al., 1983). This model assumes people make help-seeking decisions based on the expected psychological, social and material costs and benefits associated with a particular help source. Emotional (see section 1.06), self-esteem, and social considerations enter into help-seeking decisions in terms of the costs and benefits to one's emotional well being, self-concept, and social relationships associated with a line of action.

"Normative Sequence"

Based on past theory and research (Weber, 1930; Merton, 1968; Graf et al., 1979; Lee et al., 1974; Pettigrew, 1983; Nadler, 1983), Gross and McMullen (1983) propose the following normative sequence to help-seeking:

a) First, selfhelp is considered.

b) If selfhelp fails than decisions regarding social help sources are made.

c) The most convenient and least costly social sources will be considered/used first - typically informal sources of help.

d) If informal help fails, then formal help may be considered and/or used.

This sequence rests on evidnece suggesting there is a

normative structure to help-seeking behaviors (Gross & McMullen, 1983). For instance, self-help may typically be considered as an initial problem solving response, because the norm of rugged individualism predominates in American culture (Merton, 1968; Weber, 1930; Graf et al., 1979). In turn, informal help-seeking may occur prior to formal help-seeking, because informal help-seeking is less stigmatized (Lee et al., 1974; Pettigrew, 1983)

Problem Hierarchization: A Fundamental Step

As suggested above, each help-seeking step initially involves an assessment phase. The depth of this assessment for a given problem situation is largely determined by it's importance relative to other problems in one's life (also see section 1.03). Thus, **a fundamental proposition of the decison model is that problems are hierarchically structured.** Indeed, problem hierarchization follows from the model's assumption that decisions surrounding problem solutions have a rational component. That is, even if hierarchies have not been constructed on a rational basis, the final structure provides a "rational" basis for deciding which problem one should first devote attention and resources to.

The problem hierarchy - help-seeking relationship has not been rigorously tested. Prior work shows a related construct, ego centrality, to be predictive of help-seeking under laboratory conditions (Tessler & Schwartz, 1972). However, this relationship only held under conditions of high self-esteem. In brief, one of the fundamental constructs of Gross and McMullen's decision model remains to be tested.

Summary

More so than other help-seeking models, the decision making approach provides a broader statement on the sequencing of problem solving behaviors. Given this sequence and the underlying problem hierarchy assumption, then one contributor to continuation of help-seeking behavior over time is prior failure to solve the problem. Unfortunately, Gross and McMullen's model does not specify other cost-benefit conditions that sustain movement over the sequence. Thus, as with other help-seeking models, Gross and McMullen's decision making approach provides a general framework with few guidelines on what else to investigate.

SECTION 1.11

LIMITATIONS OF CURRENT MODELS

General Limitations

In general, past models share in certain limitations. These include:

a) Neither cognitive (self-esteem, decision making) nor social models of help-seeking, integrate emotional considerations.

b) These models also fail to specify the conditions that stimulate help-seeking, and sustain a series of help-seeking or problem solving actions over time.

c) Current models fail to consider that some factors which influence help-seeking may vary in importance over the life span (see section 1.12). Indeed, developmental issues are noticeably lacking in the empirical literature, with a few exceptions (e.g., Veroff et al., 1981; Brown, 1979).

d) Present formulations typically view formal help-seeking as a one step process (attendance). This view is problematic, since it assumes people already have knowledge of where to obtain professional help. Thus, formal help-seeking represents, at a minimum, a two step process - information acquistion and eventual contact. Moreover, since not everyone moves from the first to the second stage, then clearly these steps are influenced by different conditions. In brief, a two step process, which this study explores, offers a useful distinction.

In addition, each model has specific problems. For example, self-esteem models do not specify if self-evaluation considerations are of equal importance across sequential acts of seeking help, and between different types of help sources. Social models fail to specify what motivates the decision to seek help as opposed to, for instance, employing self-help (e.g., network theory). Decision making models do not indicate what specific cost/benefit considerations are important across types of help-seeking or under what conditions some costs become more salient than others. In the following section these limitations are addressed through a reconceptualization of the help-seeking process in terms of a motivational framework.

SECTION 1.12

MOTIVATIONAL MODEL

Overview

Madsen (1968) has conducted a comparative meta-theoretical study of twenty major theories of motivation developed since 1930. Madsen derived a common framework from this meta-analysis that can be applied to help-seeking behavior. The concept of motivation, broadly defined, refers to all variables which arouse, sustain and direct behavior (Madsen, 1968, p. 46). Help-seeking can be understood then in terms of conditions that arouse, sustain and direct behavior towards the goal of solving a problem. This general framework, in Madsen's terms, reduces to three central concepts: **a) Motive Force(s), b) Goals, and c) Directive Variables.** These three concepts provide a means of integrating the emotional, problem context, helper characterisitcs, and general factors previously described in sections 1.02 to 1.10. The following disucssion applies the concepts of motive force, directive variables, and goal(s) to the situation of seeking help for sexual problems. Lastly, help-seeking predictions associated with prior models will be recast in motivational terms, and specific hypotheses will be derived.

Motive Force and Goals

According to Madsen (1968), two basic criteria are necessary for a motivational theory: (a) specification of a **motivational force(s)** and (b) identification of a **force related goal(s).** The term motivational force is used here as an adaptation of Madsen's concept of motive, which is defined in terms of basic human

neuro-physiological processes and their associated emotional states. Since assessing neuro-physiological process is beyond the scope of this study, their (self-reported) associated emotional states will be used to index motive force.

For sexual problems, two motive forces and three goals are evident:

a) a primary sex motive having the associated goal of attaining sexual gratification (e.g., orgasm), and

b) a problem associated distress motive that has two goals, reducing distress and/or solving the problem.

Sexual Distress: A Motive Force

For sexual disorders, the sex motive and its related goal represent givens. That is, sexual problems are operationalized in terms of inhibited sexual gratification. When sexual gratification is frustrated, distress is experienced. As discussed previously (Section 1.06), a diverse literature indicates that distress is the single most important predictor of coping activities directed at the goals of reducing distress and/or solving physical or mental health problems. Thus, distress stimulates and sustains **goal directed activities** (e.g., help-seeking) which affect achievement of distress related goals.

Directive Variables

Variables interacting with a motive force to affect goal directed activities are referred to as **directive variables** (Madsen, 1968). Directive variables function to determine the characteristics and organization of behavior. Problem context

factors, helper characteristics, help-seeking experience, social norms, and pre-existing psychosocial conditions (e.g., self-esteem, social networks, communication skills) all represent directive variables. In short, a motive force determines the onset of action, but directive variables determine the type of action that may take place. For example, problem distress may elicit problem solving behavior, but self-esteem levels, for instance, may help determine whether that behavior is social (help-seeking) or nonsocial (e.g., self-help).

Which directive variables are important to particular acts of help-seeking when faced with a sexual problem is a question that exceeds the level of specificity in Madsen's framework. To a large extent the answer to this question must be empirically derived. That is, observation of people in help-seeking situations and assessments of their problems will generate the necessary material to flesh out the broad framework provided by Madsen. This process can proceed here by considering the observations discussed previously in sections 1.02 to 1.10. These considerations are summarized below.

a) Sexual problems may have psychological/social or physiological causes; thus preferences for distinctly different types of formal services may be expected (e.g., psychotherapy vs. medical services; see Section 1.04).

b) Sexual problems may be perceived to occur at individual and dyadic levels (e.g., marital dyads); thus, communal help- seeking and communication considerations may be involved (see Sections 1.03 & 1.09).

c) Given that most people view their sexual functioning as an important part of their life (e.g., Mancini & Orthner, 1978), then sexual problems may occupy relatively high positions in people's problem hierarchies (see Section 1.03). A further consequence of the fundamental importance of adequate sexual functioning to the self, is that some people will view sexual problems as highly threatening; thus, sexual problems would have a greater likelihood than more mundame difficulties (e.g., a toothache) of involving self-esteem considerations in the decision to seek help (see Section 1.10).

d) Attempts to solve sexual problems can involve self-help (Rosen, 1987), and informal (Appendix B; Cowen, 1982) and formal social help-seeking. Thus, resource and preference considerations (also see (a) above) are implicated as people choose between various types of help (see Section 1.04).

e) Since informal help-seeking (Cowen, 1982; Appendix B) occurs around sexual problems, then network diversity considerations become salient with respect to seeking formal help (see Section 1.09).

Taken together, the considerations above define three sets of directive variables for examination. For ease of reference, these sets will be referred to as <u>person</u> (self-esteem, preferences, problem hierarchies), <u>social</u> (communal help seeking, communication, network diversity) and <u>resource variables</u> (finances, time flexibility, transportation availability).

The Interaction of Distress & Directive Variables

In general, directive variables are assumed, in the present adapation of Madsen's framework, to have little influence on obtaining solutions without a sufficient motivational force to stimulate and sustain behavioral action (or vice versa). That is, neither distress nor directive variables can individually provide sufficient conditions for performance of help-seeking behaviors. Rather, it is the interaction of distress intensity and directive variables which provide the requisite conditions for locating solutions (also see Section 1.06).

In other words, emotional distress is the yardstick by which people judge the severity of their problem, and the extent of their need to generate and sustain cognitive or behavioral activities that reduce distress to comfortable levels. The specific behavior(s) produced are, in turn, dependent on the levels of the directive variables involved.

Age & Help-Seeking

As mentioned, prior help-seeking models have not considered adult developmental issues. However, several studies have found help seeking behaviors to vary over the adult life span (Veroff et al., 1981; Waxman et al., 1984). To summarize these findings: a) Use of mental health services decline with age (Veroff et al., 1981; Waxman et al., 1984). Although a slight increase in usage is evident among middle aged males (Veroff et al., 1981), this latter result may reflect the greater monetary resources of that group (Veroff et al., 1981; Waxman et al., 1984).

b) For marital problems in particular, older, relative to younger, people use fewer formal services, but more self-help strategies (e.g., Pearlin & Schooler, 1978).

Although help-seeking may covary with age, age/time is not considered an explanatory variable (Baltes et al., 1980; Schaie & Hertzog, 1982). That is, time/age is a framework by which we organize experience and not a cause of those experiences. Age then is a proxy variable for a complex assortment of underlying causes and processes (Schaie & Hertzog, 1982). Thus, to explain variation in help-seeking with age, consideration should be given to causes which are expected to covary with both variables. A number of variables from both sexual and nonsexual domains are expected to meet these conditions.

Sexual Variables. There is a well documented decline in the importance of sexual activity with age (Mancini & Orthner, 1978; see Berezin, 1976, for review). This suggests that sexual problem associated distress and the position of those difficulties in problem hierarchies may decline with age. In addition, sexual communication declines significantly with age (see Appendix B; perhaps reflecting cohort differences in the ability to discuss sexual matters).

Nonsexual Variables. Income, transportation capabilities, time flexibility, and size of informal networks are known to covary with both age and help-seeking behavior. Lastly, the available behavioral data also suggests that preferences for psychotherapy may decline with age (e.g., Waxman et al., 1984).

Overall, two general age trends are expected. Psychotherapeutic and informal help-seeking are expected to be less

prevalent among older relative to younger respondents with sexual problems.

Sequencing

Although there may be a "normative" help-seeking pattern (self-help, communal, extrafamilial, formal), this sequence is not universal (Veroff et al., 1981; Brown, 1978). For instance, some people employ formal help without having sought informal aid (Brown, 1978). Nonetheless, neither a norm governed sequence nor deviations from this progression are inconsistent with the present motivational model. Social norms, in the present context, can be construed as directive variables that influence the organization of problem solving behaviors in our culture.

Summary & Overview of Analytic Model for This Research

Emotional distress provides a subjective gauge with which to judge the severity of a problem and the necessity for seeking help. Thus distress affects initiation and continuation of help-seeking over time. Performance of particular help-seeking behaviors and the order in which they are performed is, in turn, dependent on directive variables relevant to the psychological, social and resource conditions surrounding the person, problem situation and potential helper.

The proposed framework is broader in scope than prior models. It addresses conditions that lead to initiation, continuation, and sequencing of help-seeking activities. The present model also incorporates prior models without difficulty. For instance, self-esteem is not construed as a fundamental

motivational force as prior formulations propose. The importance of self-esteem is seen here in terms of a directive variable which interacts with distress to influence help-seeking activities. All other relevant social, resource and psychological conditions are similarly viewed as directive variables.

Table 1 provides a summary of the hypotheses derived from discussion presented in sections 1.02 - 1.12. These have been subdivided along lines of social, informal and formal help seeking. Social help-seeking is the most general form as it encompasses informal and formal help-seeking, and contrasts with self-help and other coping responses. These analyses focus on help-seeking as a social action irrespective of differences between helpers. Analyses involving informal help center on communal and extra-familial help-seeking. Formal help-seeking analyses are restricted to actions surrounding a two stage process of attaining psychotherapy (requesting referrals and attending a first appointment).

Table 1

Summary of Hypotheses by Type of Help-Seeking

SOCIAL HELP-SEEKING

A-1) Self-Esteem Consistency Hypothesis: Self-esteem and sexual distress interact such that low self-esteem leads to social help-seeking only under conditions of high distress; nonsocial coping is associated with low self-esteem and low distress, or high self-esteem under conditions of either high or low distress.

A-2) Self-Esteem Vulnerability Hypothesis: Self-esteem and sexual distress interact such that high self-esteem leads to social help-seeking only under conditions of high distress; nonsocial coping is associated with high self-esteem and low distress, or low self-esteem under conditions of either high or low distress.

Table 1 Continued

Summary of Hypotheses by Type of Help-Seeking

B) As age increases, sexual distress decreases. As age increases social help-seeking will decrease.

INFORMAL HELP-SEEKING

A) Hypotheses concerning social help-seeking also apply.

B) Subjects employing their sexual partner as a help source will have lower interpersonal distress than subjects not using their partner.

C) Subjects employing their sexual partner as a help source will evidence better sexual communication than subjects not using their partner.

D) Under conditions of high sexual distress, failing to seek communal help will be associated with seeking help from extra-relationship sources; failure to seek extra-relationship help is associated low distress and failing to seek communal help, or having sought communal help under conditions of either high or low distress.

PSYCHOTHERAPEUTIC HELP-SEEKING

A) Hypotheses concerning social help-seeking also apply.

B) Under conditions of high distress, high preferences for psychotherapy will lead to requesting referrals and attending therapy; failure to request or attend therapy will be associated with low distress and high preferences, or low preferences under conditions of either high or low distress.

C) Problem hierarchies and distress interact such that high distress and high problem rankings of sexual problems, relative to other personal difficulties, lead to requesting and attending psychotherapy; failure to request or attend therapy will be associated with high rankings and low distress, or low rankings under conditions of either high or low distress.

D) Diversity of informal help sources and sexual distress interact such that high sexual distress and greater diversity of informal contacts lead to requesting referrals and attending therapy; failure to request a referral is associated with high diversity and low distress, or low diversity under conditions of either high or low distress.

Table 1 Continued

Summary of Hypotheses by Type of Help-Seeking

E-1) Under conditions of high distress, seeking communal help and good (high scores) communication are associated with requesting and attending therapy; failure to request referrals and attend therapy are associated with any one of these conditions - a) low distress, seeking communal help, and good communication, b) not seeking communal help, poor communication and either high or low distress, c) seeking communal help, poor communication and either high or low distress, d) not seeking communal help, good communication, and either high or low distress.

E-2) Alternatively, under conditions of high distress, not seeking communal help and poor communication are associated with requesting and attending therapy; failure to request and attend therapy are associated with any one of these conditions - a) low distress, not seeking communal help, and poor communication, b) seeking communal help, good communication and either high or low distress, c) not seeking communal help, good communication and either high or low distress, d) seeking communal help, poor communication, and either high or low distress.

F) Under conditions of high distress, greater financial, time and transportation resources will lead to requesting referrals and attending therapy; failure to request or attend therapy will be associated with low distress, and greater financial, time and transportation resources, or low financial, time and transportation resources under conditions of either high or low distress.

CHAPTER II

METHOD

Overview

Chapter II provides details of the research sample, sampling sites, procedures, and measures (Sections 2.01 - 2.06). Strengths and weaknesses of these methodological components are examined (Section 2.07). Also discussed are problems with past design/measurement efforts and how the present work addressed these difficulties. In addition, questions of internal and external validity of the current study are considered (Section 2.07).

SECTION 2.01

Subjects

Sample Characteristics

Five hundred and three participants were recruited at "pleasure parties" in the California Bay Area (82%), and at church meetings and college classes in Colorado (18%). A majority of the sample were heterosexual, caucasian females (See Table 2). Approximately 67% of respondents were currently living with a sexual partner.

SECTION 2.02

Sample Limitations

White-Female Bias

Since the sample was one of convienence, generalization of the findings is limited. The present sample also under-represented men and noncaucasians, thereby restricting analyses of sex and racial/ethnic differences in help-seeking.

Table 2

Sample Characteristics

Females N = 455		Sexual Orientation:	97% heterosexual
Males N = 45			3% bi-/homosexual
Race/Ethnic:	86% Caucasian	Education:	M = 14.5 yrs.
	14% Other		SD = 2.7
		Junior High	.4%
Age: M = 31.8 yrs., SD = 9.6		High School	33.7
		Jr. College	32.5
Age groups:	18-29 yrs. N = 257	College	22.9
	30-39 yrs. N = 141	Post College	10.6
	40-49 yrs. N = 69		
	50-65 yrs. N = 35	Relationship Length (yrs):	M = 8.1, SD = 8
			Range = 1-39
Income: M = 29, SD = 16			
Range = 5-60+			

Note. Education assessed in terms of enrolled in/level completed; Income is in thousands of dollars; Ethnic/Race Other category = Black, Hispanic, Asian, Pacific Islander, Native American.

Age Bias

Late middle aged (50s) and elderly (60+) respondents were also under-represented (see Table 2). Analyses of age differences in help-seeking were, therefore, primarily based on comparisons of respondents in their 20s, 30s and 40s. Since the elderly are the lowest utilizers of psychological services (Waxman et al., 1982; 1984), then less age variation in psychotherapeutic help seeking may be evidenced than actually occurs.

Education Bias

Formal education is a powerful predictor of psychological service use (i.e., college educated more likely to use psych. services; Gourash,1978). Consequently, it was important to examine for education bias in the sample.

The data indicated that approximately 33.5% of respondents (see Table 3) were enrolled in or had completed a four year college. This compares favorably to the National figure for adult whites of 32% (U.S. Statistical Abstract, 1984). In terms of education then, the present study would not over-estimate psychological service use.

SECTION 2.03

Sampling Sites

California Pleasure Parties

As mentioned, data were collected at "Pleasure Parties", Church meetings, and University classes. Since some readers may be unfamiliar with pleasure parties and a majority of the data were collected at these occasions, a description of how they function is provided. However, it is not the purpose to present a lengthy explanation of the social phenomena of pleasure parties, though the topic is fascinating. The relationship between the social structure of these parties and resultant sample characteristics is discussed.

Pleasure Party Settings

Pleasure parties are similar to Tuperware parties except the items being sold are sexual in nature. Parties are presided over by a company representative who displays and discusses the products. Parties are hosted in private residences for groups composed of friends, acquaintances, coworkers, and friend's of friends of the host. Typically, guests sit around the presentor in a semi-circle while the products (e.g., massage oils, lingerie, vibrators, books etc.) are described and circulated. A secondary purpose of these parties is to provide a general education on the health benefits of and myths surrounding "sex toys".

Transition from Party to Data Collection

At each party, the company representative began the "pitch" by describing her educational background and expertise in human sexuality. The presentor (the same one was used throughout the study) described how she entered the field after reading Shere Hite's book, which reported survey results on human sexuality. This provided a convenient transition to describing the opportunity that the attendees could have, if desired, to participate in a survey on human sexuality (note. the idea of conducting the survey was cleared with the party hostess prior to guests' arrival). The study's general purpose, procedures and information on who was conducting the survey was then described (see also Procedures). In short, subject recruitment and collection of the data occurred prior to any product demonstrations/discussions.

Composition of Party Guests

A majority of parties (95%) were hosted by white heterosexual women in their 30s and restricted to women guests (a few couples parties occurred). As a consequence, pleasure party participants reflected the demographic characteristics of the social networks of this group of women. While black women, other racial groups, lesbians, and women in their 40s, and 50s hosted parties, the frequency was much lower than for the group previously described. In addition, pleasure parties were seemingly not part of the elderly person's leisure experience. No parties were hosted by elderly people over the course of this study.

Colorado Schools & Churches

In addition to California Pleasure Parties, two types of Colorado research sites were used: churches and University classes. The church meetings were Christian sponsored adult education classes for married couples, and dealt with topics of church and family. The University classes were typical Sophomore Psychology courses conducted by the University of Colorado, Colorado Springs Psychology Department.

Accessing Senior Citizens

It was the intent of this study to access organizations with elderly memberships. Accordingly, a number of such groups were approached (Calif.). However, an unfortunate form of protectionism (perhaps infantilization) arose. In short, requests to recruit at group meetings were turned down, apparently because organization leaders feared their members would be offended by this research. As a side note, I found it easier to collect data of this nature from elderly people in the bible belt of Texas than in the Bay Area.

SECTION 2.04

Procedure

Overview

The analytic design provided direction in determining the specific research procedures to be followed. The present design was prospective with regard to requesting referrals and attendance at therapy, but retrospective with respect to palliative coping, self-help, and informal help-seeking. Table 3 summarizes the overall research design and procedures.

Table 3

Summary of Design and Procedures

Step 1
- A. Self-Administered Questionnaire & Referral Requests
- B. Data Collected in Groups or Take Home & Return by Mail

Step 2
- A. If Referral Request Made, then Referrals Provided by Telephone 1-5 days later.
- B. Additional Data Collected at Telephone Contact
- C. Therapists Notified of Subject Being Referred

Step 3
- A. Monthly Contact With Therapists
- B. If Referred Subject Attends Therapy, Attendance Data Collected

Step 4
- A. If Referred Subject Did Not Attend Therapy Within 6 Months Then The Subject Was Telephoned
- B. Additional Data Collected at Telephone Contact

Data Collection: Questionnaires

Data were collected through self-administered questionnaires (see Appendix A) distributed at group meetings/"parties". Self-administered questionnaires, as compared to face-to-face

interviews, generate less skewed data with respect to measures of sexuality (Catania, McDermott, & Pollack, 1986). Subjects were informed that the study concerned issues surrounding how people cope with sexual problems, but they did not have to have a sexual problem to participate (see Data Collection Sites).

Data Collection: Referral Requests

The last page of the questionnaire described an opportunity for subjects to request referrals to private psychotherapists specializing in treatment of sexual problems (Note. Though it did not occur, subjects without problems could have requested referrals - perhaps to give to someone else).

Since subjects might not request referrals because of (a) misinformation regarding length of treatment, (b) uncertainties about therapist gender/location, and (c) ignorance of sliding fee scales or third party payments, the following instructions addressed these issues and informed subjects of the referral opportunity (instructions printed at top of referral page).

"Although psychotherapy or counseling for some sexual difficulties may take longer, many sexual problems can be treated in ten sessions and others in one or two sessions. As a service to you for having completed this questionnaire, the Sex Help Seeking And Referral Project (Project SHARP) is providing (free of charge) referrals to private psychotherapists specializing in the treatment of sexual problems. If you request referrals from Project SHARP you (a) are not obligated to use the referrals given (b) will receive names, and phone numbers of two therapists in or near your city and (c) you may choose either male or female therapists. You may discuss some type of fee reduction when visiting or calling a therapist if the usual costs of therapy would prove a hardship. Many therapists also accept insurance payments. If you would like these referrals, then complete only the information required in item number one below and stop (Note. item number one asked for first name, birthdate, phone number(s), times to be called). We will contact you by phone and provide the two referrals within five working days from now."

Requesters provided their first name, phone number, birth date, and times to be called. Thus, a degree of anonymity was maintained while allowing for subject indentification when providing referrals. Subjects not requesting referals completed a check list (same page) indicating why no request was made.

SECTION 2.05

Comparing Two Collection Methods

Group Collection

Since reporting sexual probems and requesting referrals may be considered sensitive activities, two methods of data collection were employed to address privacy issues. Method-one subjects completed questionnaires at meetings/"parties". Respondents were given legal size folders containing the questionnaires to enhance privacy while completing materials and alternate/spaced seating was used. In addition, the questionnaire was constructed so subjects could not tell if others were requesting referrals (i.e., since nonrequesters also had responses to make on that page). All questionnaires were administered and collected prior to any group activities. Approximately 72% of subjects (N = 360) were obtained by method-one. Less than 10% of subjects recruited through method one refused to participate.

Take-Home Method

Instead of completing materials at the time of distribution, method-two subjects took questionnaires home to complete and mailed them back (stamped return envelopes provided). Subjects were instructed not to discuss the questionnaire with anyone until it was mailed, and to complete the materials under private circumstances. Approximately 28% of subjects were obtained through method-two. Although some 96% of subjects recruited with method two took questinnaires home, only approximately 45% returned materials through the mail.

Comparing Methods: Privacy Concerns

Since method-two provides more privacy than method-one, it may have been associated with more sexual problem reporting and referral requests than method-one. Chi square analysis indicated no significant differences across methods for reporting sexual problems (For problem-self, $X^2(1,N=503) = .30$, $p > .10$; for problem self & partner, $X^2(1,N=308) = .13$, $p > .10$) or for requesting referrals ($X^2(1,N=216) = .52$, $p > .10$). These results suggest that method-one procedures provided sufficient privacy.

Providing Referrals

Participants were given referrals within five working days of making a request. Subjects were telephoned, identifed, and given two referrals (if still desired). Referrals conformed to subjects' desired options regarding sex of therapist and location. Requesters were told that they were not obligated to use the referrals (for protocol and data records, See Appendix A). Therapists were contacted by telephone immediately after referring a subject, and given the subject's identifiers.

Psychotherapists

Psychotherapists (5 at each site) were recruited on the basis of having advanced training in the field of sex therapy and private practices in the urban areas covered by the study. Therapists were provided a verbal description of the study, but were blind to specific hypotheses. Therapists were instructed on procedures for reporting subject contacts and record keeping (see Appendix A). Therapists kept records of all new client contacts during the course of the study (see Appendix A). If a contact resulted in an appointment, then at the first session therapists obtained the subject's consent, and informed them that no other information than their identifiers, date of contact, and date of first attendance at therapy would be reported. Subjects were also told that no additional participation in the study was involved, and that treatment, treatment costs and therapy outcomes were not dependent on their willingness to participate.

Follow-Up Contacts

Subjects who failed to contact or attend therapy within an average of 6 months post referral, were telephoned a second time. Subjects were told that they were being called to determine if they were satisfied with the referrals they received, and if they had any difficulties reaching or complaints concerning the therapists referred to. Follow-up calls determined what respondents did in the interim to obtain treatment, particular barriers they may have encountered in seeking help, and other reasons for not seeking treatment.

SECTION 2.06

Measures

Overview

Table 5 provides a summary of the various measures by collection method. Though some measures employed here have an extensive body of research behind them, several instruments were developed in pilot work preceding the dissertation research (see Appendix B). A number of measurement concerns arose during the analysis portion of this study. Though these concerns are mentioned here, additional discussion is given in Chapter III.

Table 4

Summary of Measures

Self-Report Questionnaire	Telephone Referral Contact	Telephone Follow-Up
1. Demographics	1. Referral desired	1. Use of professional to solve problem
2. Finances	2. Sex of Therapist desired & given	2. Reasons for not contacting professional
3. Marital Sat.		3. Reasons for not going to therapy
4. Therapy Hist.		
5. Sexual Problem		
6. Sexual Distress		
7. Self-Esteem		
8. Problem Hierarchy		
9. Communication		
10. Preferences	Therapist Record	
11. Informal/Self-help behaviors	1. Date of initial contact	
12. Referral requests 1 contact	2. Subject Identifiers	
12. Referral requests	2. Subject Identifiers	
	3. Was Appointment Made	
	4. Date of Attendance	

Note. All telephone data collected by means of structured questions except for one open ended item each under reasons for not wanting referrals/not contacting professional/not going to therapy.

Demographics & Relationship Descriptors

Demographics assessed were age, sex, marital status, sexual orientation, race or ethnic group, spouse/partner's age, and education (Appendix A, Items 1-7). Relationship descriptors measured were type of sexual relationship and relationship duration (Appendix A. Items 10 & 11).

Time Flexibility

Time flexibility was indexed by work hours outside the home per week. (Item 14, Appendix A). The time flexibility index is comparable to that used by Marcus and Siegel (1982).

This index is limited since it does not take into account

child rearing responsibilities that may constrict the time available for seeking professional help. Another problem is that time flexibility was conceptualized as an individual matter. In some cases couples' joint time flexibility may be the more appropriate measure if partners wish to seek help together. In addition, there would be the added consideration that partners' "free time" would need to overlap. Given a restricted time allotment for collecting data at pleasure parties, the "short" time flexibility index was opted for.

Pregnancy Status

Pregnancy status (item 12, Appendix A) was assessed in an attempt to rule out couples whose perceptions of a sexual problem (i.e., anything that may prevent attaining the degree of sexual satisfaction desired) might be based on the transitory conditions of pregnancy. This is a "crude" index in that, unless special circumstances arise, only the third trimester is typically considered a problematic time for sexual intercourse. As one might note, sexual activity may involve other pleasurable activities besides intercourse; in which case, the exclusionary rule employed may not be warranted. Further, not taken into account was the post-birth period of 2-3 months where sexual activity may again be restricted. As noted with respect to time flexibility, time restrictions on collecting data limited the assessments.

Financial Resources

Information on net family income for the latest tax year and mental health insurance coverage were obtained by means of structured response questions (items 8 and 9, Appendex A). A difficulty with the health insurance meaure is that some people did not know if their coverage included mental health services (19%). A limitation of the income index is that it did not assess disposable income; that is, cash left over after paying neccessary bills (heating, food, mortgage etc.).

Marital Satisfaction

Marital satisfaction was assessed by a single item "...degree of satisfaction, everything considered, of your present relationship with your spouse or partner." Ratings made on 7 point Likert-type scale (1 = extremely unsatisfied, 7 = extremely satisfied; item 13, Appendix A). It was selected from the Locke-Wallace marital satisfaction scale (Locke & Wallace, 1959) based on findings which indicated this item correlated .80 with the total Locke-Wallace scale score (L. Fisher, Personal Communication Aug. 1984).

Marital satisfaction was intended to index an additional source of distress to the distress relevant to the sexual relationship alone (see below). In this regard, the present index may not provide as broad a range of scores as more extensive measures of marital distress/satisfaction. Thus, meaningful differences may have been obscured, particularly between people in the middle portion of the distribution generated by the present measure.

Therapy History

A check list was used to determine whether subjects or their partners were currently using or had used (a) psychotherapy/counseling for a nonsexual problem, (b) marital therapy or counseling, (c) psychotherapy/counseling or sex therapy for a sexual problem, and (d) medical treatment for a sexual problem (item 40, Appendix A). For each service that had been employed, respondents also indicated if their feelings about that service were positive or negative (item 40, Appendix A).

Sexual Problems

Two items assessed sexual problems (see items 67 & 68, Appendix A): (a) To your knowledge is there a problem(s) or difficulty(ies) which currently prevents your spouse/sexual partner from having as satisfying a sexual relationship as he/she wants?, and (b) Is there some problem(s) or difficulty(ies) which currently prevents you from having as satisfying a sexual relationship as you want?

Validity & Reliability of Sexual Problem Measure

In a study of cohabiting couples excellant agreement (91%) was found between couples' independent reports of which partner had a sexual problem (using identical measures, See Appendix B). This finding suggests two things. First, based on spousal/partner confirmation the present measure is reliable. Secondly, reports by individual partners are a fairly good estimate of the nonreporting partner's sexual problem status. That is, the subject's view that his/her partner has a problem is a reasonably accurate reflection of the partner's self-perception.

For the present sample (see also Appendix B), subjects who reported problems, relative to those who did not, had significantly higher marital and sexual distress, poorer sexual communication, and lower self-esteem (see Table 5). These results were in the expected direction, and support the construct validity of the sexual difficulties measure.

Diagnostic validity of self-reported sexual difficulties was of less concern given a phenomonological approach. That is, of critical importance to help seeking is the perception of a problem rather than the objectively determined existence of a difficulty.

Table 5

Comparison of Sexual Problem & Nonproblem Subjects

	Means(SD)			
	Problem	No Problem	t	df
Marital Distress	4.8(1.3)	6.0(1.1)	-7.72*	283
Sexual Distress	70.7(15.5)	84.9(10.7)	-11.04*	420
Sexual Comm.	53.0(13.0)	63.7(10.2)	-9.32*	416
Self-Esteem	47.3(9.3)	51.2(6.7)	-5.12*	420
Education(yrs.)	14.2(2.5)	14.7(2.8)	-1.87	419
Income(thousands)	30.3(16.0)	29.0(15.2)	.68	419
Age	31.7(9.8)	32.0(9.7)	-.30	420

Note. Ns = problem 168, no problem 254. Marital distress comparison includes only subjects living with partner/spouse (Ns = 110 problem, 175 no problem). Lower Marital/Sexual Distress scores equal more distress. Lower Sexual Comm. scores mean poorer communication and higher self-esteem scores mean more self-esteem.
* p = .0001, t-tests are two tailed and p values adjusted (Bonferroni method) so that only values of p = .002 or less are considered significant.

A General Approach to Assessing Sexual Problems

Specific types of problems were not determined. It was assumed that the degree of sexual distress, and not specific diagnostic categories, would be the primary determinant of help seeking behavior. Wills (1983), for example, presents a cogent argument that the degree of distress determines the type of help sought. However, Wills was not concerned with sexual problems, which may have a wider range of types than other specific psychosocial problems. In retrospect, the current assumption may hold for help-seeking in general, but fails when it comes to specific types of help-seeking activities. For instance, a purely informational problem (e.g., how can I make my partner more sexually interested in me) may elicit more self-help behavior and informal help-seeking than professional service use.

Impact of Collection Method on Sexual Problem Assessments

Another important question is, how willing were people to report sexual problems under "public" circumstances (as with group data collection)? Data reported earlier on the comparison between group and mail return methods suggests that the group situation did not influence the frequency of reported problems (i.e., frequency of problems did not differ by method). However, the question remains of subjects' willingness to report problems on self-administered questionnaires.

Sexual Distress

Sexual distress was measured by the short form of Hudson et al.'s (1981) sexual discord measure (see items 15-39, Appendix A). This measure has good internal consistency (Alpha = .92 for the present sample), high test-retest reliability, and validity (discriminant, concurrent; Hudson et al., 1981; Catania et al., 1984; Catania et al., 1981). Lower scale scores are indicative of greater distress.

Problems With the Hudson Scale

There is a problem with the Hudson scale as an index of sexual relationship distress. Inspection of scale items suggests this measure does not directly assess the emotional component of sexual difficulties. In effect, items measure sexual complaints, but not the degree of upset associated with such complaints (eg., "When we have sex it is too rushed and hurriedly completed", "My partner has good personal hygiene"). At present, the assumption that increasing sexual complaints lead to a corresponding increase in distress remains untested.

Another difficulty was documented by the relationship found in the present study between the Hudson scale and self-esteem. Longitudinal research (e.g., Brown et al., 1975; Pearlin & Schooler, 1978; Pearlin et al., 1981) has shown self-esteem to covary significantly with distress. Thus, if the Hudson scale measures sexual distress it should covary with self-esteem. However, the Hudson scale and self-esteem were not significantly related for subjects with sexual problems ($r(103) = .12$, $p = .10$). In short, despite the fact that the Hudson scale

discriminates sexual problem and nonproblem subjects (see Table 4; Hudson et al.,1981), it may measure a dimension of the sexual situation other than distress.

The above issues arose as a matter of hindsight. That is, as will be discussed (see Chapter III), the Hudson scale "bombed" as a distress index. Fortunately, there are empirical and conceptual reasons to believe that the sexual communication measure represents a viable index of sexual distress (see Chapter III). The sexual communication measure, described below, was substituted for the Hudson scale as a measure of sexual distress (see Chapter III).

Sexual Communication

Communication of sexual matters with one's partner was measured by a 13 item scale (Items 54-66, Appendix A; also see Appendix B). This measure assesses respondents' perceptions of the communication process encompassing their sexual relationships. Responses were recorded on 6 point Likert-type scales (1 = Disagree Strongly, 6 = Agree Strongly). After reverse scoring approximately half the items, a total score is produced by summing across items. Table 6 shows the communication items.

Communication Scale: Reliability & Validity

Pilot data (See Appendix B) indicated this measure has high internal consistency and test-retest reliability, and construct validity (see also Table 5); Cronbach Alpha for the present sample was also high (Alpha = .87). Factor analysis of the communication items (current sample) indicated this measure was composed of a single dimension.

Table 6

Sexual Communication Scale Items

1.My partner rarely responds when I want to talk about our sex life.

2.Some sexual matters are too upsetting to discuss with my sexual partner.

3.There are sexual issues or problems in our sexual relationship that we have never discussed.

4.My partner and I never seem to resolve our disagreements about sexual matters.

5.Whenever my partner and I talk about sex, I feel like she or he is lecturing to me.

6.My partner often complains that I am not very clear about what I want sexually.

7.My partner and I have never had a heart-to-heart talk about our sex life together.

8.My partner has no difficulty in talking to me about his or her sexual feelings and desires.

9.Even when angry with me, my partner is able to appreciate my views on sexuality.

10.Talking about sex with my partner is usually a satisfying experience for the both of us.

11.My partner and I can usually talk calmly about our sex life

12.I have little difficulty in telling my partner what I do or don't like sexually.

13.I seldom feel embarrassed when talking with my partner about the details of our sex life.

Self-Esteem

Rosenberg's self-esteem scale (10 item, adult version) was employed (Rosenberg, 1965; see items 43-52, Appendix A). Item ratings were summed to produce a total score (Alpha = .88 for the present sample); higher scores indicate greater self-esteem.

Problems With Rosenberg Scale

One limitation of the Rosenberg scale is that scores may reflect both actual levels of self-esteem along with other

related constructs (eg., need for achievement, ego-defensiveness; Wells & Marwell, 1976). For example, high self-esteem scores may indicate either a genuine belief in one's self-worth, or a need to defend a weak ego resulting in high "self-esteem like" responses (e.g., Dion & Dion, 1975); presumably these two groups of "high self-esteem" respondents would behave differently in help-seeking situations.

There are several reasons, however, to retain the Rosenberg measure. Recent work, comparing eight different self-esteem measures, demonstrated the Rosenberg scale to be one of two measures supported by strong validity data (Demo, 1985). Secondly, the Rosenberg scale has been shown in laboratory research to be a signficant predictor of formal help seeking behavior (Tessler & Schwartz, 1972). However, in a longitudinal study (Brown, 1978) the Rosenberg scale did not predict formal help seeking. Since the laboratory study has low ecological validity, and the longitudinal study was based on unvalidiated self-reports of formal help-seeking, it was important to examine the Rosenberg measure in the context of the present study. That is, the current study has greater ecological validity than a laboratory simulation, and validated formal help seeking. (referral requests and attendance at therapy). Since the present work sought to reconcile conflicting results from prior studies, it was advisable to use the same measure of self-esteem (to achieve cross study comparisons).

Problem Hierarchy

Problem hierarchies (referred to as Problem Rank) were assessed in terms of how important the person considered the sexual problem relative to other personal problems being experienced ("All individuals have personal problems from time to time, for example, work and health problems. Compared to all other problems you are personally experiencing, how important to you are your sexual problems"). This item was rated on 6 point Likert-type scale (1 = extremely unimportant, 6 = extremely important; item 72, Appendix A)

Help-Seeking Preferences

Subjects were asked what they would prefer to do if they currently had a sexual problem which was keeping them from having as much sexual satisfaction as they would like to have (see item 41, Appendix A). Responses were made by rank ordering (1-4, with 1 = most preferred thing to do) four possible scenarios: (a) do nothing about the problem, other than to keep from getting upset, (b) try solving the problem on my own without seeking help from others, (c) seek help from psychological/marital/sex therapists or counselors, (d) seek help from a medical professional.

Past work has typically concerned attitudes toward specific services (e.g., Fischer & Cohen, 1972; see Chapter 1). However, it is not clear if assessing attitudes toward specific services accurately reflect help preferences. Rather, it may be that it is the perceived utility of, for example, psychotherapy relative to other available help options which influences seeking therapy. Even given ambivalent feelings towards psychotherapy, if people

have high interest in solving the problem and perceive other help options as undesirable, then they may still seek therapy. By having subjects rank order different coping options, the present study was able to assess subjects' preferences for a particular service relative to other types of help

Preference Measure: Limitations

Informal help-seeking preferences were not measured, instead subjects' current informal help-seeking activities were assessed; the reason being that current behaviors were expected to reflect preferences. In retrospect, there were costs in not assessing preferences towards informal help. In particular, respondents' rankings may have been distorted by not having informal help as an option to rank.

A general criticism of the rank order method is that it might force preference choices that may not always occur. That is, some coping responses may share identical preferences. In addition, rank orderings are not as an extensive of assessment as would be provided by multiple item scales for each coping response. Thus, there maybe more variance in people's preferences towards particular coping responses than was generated by the present measure.

Transportation Resources

Transportation availability was examined (see item 42, Appendix A), but found to be relatively constant across subjects (95% had a vehicle to drive, 60% had someone who could drive them to therapy, and 45% had public transportation readily available). Further, of those subjects with sexual problems 100% had vehicles

to drive. Thus, transportation resources represent a constant. Lastly, only 2 subjects who requested referrals were adamant on seeing therapists in their home communities, which happened to be communities over 300 miles from the Bay Area. This latter situation hardly represents a reasonable test of a transprotation resource hypothesis, unless we were to include small aircraft availability into the definition (small joke). For these reasons transportation resources were dropped from consideration.

Informal Help-Seeking and Self-Help Activities

A ten item check list assessed informal help seeking and self-help activities engaged in with respect to a current sexual problem (see item 73, Appendix A). Items were selected on the basis of a literature review, discussion with sex therapists, and interviews with people who had sexual problems. Additional items were generated from pilot work (see Appendix B). Pilot research indicated that the present categories (see below) provide a nearly exhaustive listing of help sources people utilize for sexual problems (in the present sample only 3% of subjects with a current sexual problem indicated using help sources other than those listed).

The following instructions preceded the list of help-seeking items:

"People often seek help for sexual problems or concerns. Please indicate below where you have sought help for a current sexual problem (The help sought may be any of these: Advice, Information, Treatment). In the second column below, please write in the approximate number of seperate occassions on which you used this type of help for a current sexual problem. For example, if you talked to a friend about a current sexual problem on ten different occassions you would write in the number 10."

The following categories were listed:

- Have not sought help from anyone,
- Tried to solve the problem on my own,
- Friends of mine,
- My spouse or sexual partner,
- Relatives excluding spouse,
- An extramarital sexual partner,
- Books - magazines newspapers-television-radio (listening to),
- Clergy or Spiritual leader,
- Call-In radio programs (where you called in),
- Prostitute(s),
- Bartenders.

Additional sources of help could be written by the respondent and the list included a "have not tried to solve the problem" item.

Frequency of Informal Help

In addition to reporting which help sources were used, subjects also recorded the frequency of contacts/use of each help source (see item 73, Appendix A).

Frequency of informal support contacts was dropped as a measure because of difficulties respondents had in providing these data. Some respondents did not understand the instructions and instead of providing numbers, gave responses like, "many times", "alot", and "more than a thousand". Some 30% of subjects having used informal help failed to provide any response. In addition, extreme values were sometimes given (e.g., 500+) which were difficult to take seriously. In retrospect, these data would best be obtained in face to face situations where an interviewer might have a better chance of eliciting more complete answers.

Referral Contact Measures

During the referral telephone contact (for data collection record see Appendix A), subjects indicating they no longer desired the referrals were asked their reasons for not wanting them (and had they discussed the referral request with their partner/spouse). If subjects still wanted referrals, they were asked if their partner was willing to come to therapy (yes, no, uncertain, not discussed yet).

Follow-up Measures

Subjects given referrals, but not contacting therapists were asked at follow-up if they had contacted/seen a therapist other than one of those they had been referred to. If therapists or other professionals had not been contacted, subjects reasons for not doing so were obtained. If subjects had called a therapist and either did not make or attend an appointment, then their reasons for doing so were sought. A list of reasons were first read to subjects (eg., financial costs, time problems) and then respondents were asked to supplement this list (see Appendix A for data collection record).

SECTION 2.07

Discussion

Sampling Frame Limitations

Ideally, the subject pool for this study should have been one that over-represented people with sexual problems. This was desireable so as to generate sufficient subsamples for statistical purposes with regard to requesting referrals and attending therapy. To accomplish this goal a majority of subjects were recruited at pleasure parties. Conceivably, larger numbers of people with sexual concerns would attend pleasure parties to obtain "remedies".

Nonetheless, only a small number of referral requests were obtained; which was particularly problematic for accruing subjects who attended therapy. Indeed, based on this study some 4,000 subjects would be needed to attain approximately 50 attenders. One way of increasing the yield would be to sample from populations with higher frequencies of sexual problems. Unfortunately, epidemiological studies of sexual problems have not been conducted, so identification of groups at high risk for sexual difficulties was not readily feasible.

Procedural Limitations

In the sections below, a number of methodological concerns of the present investigation are covered. Of general interest were the problems posed by prior studies and attempts to remedy these in the current work. In addition, a number of specific issues surrounding the topics of internal and external validity are considered.

Help-Seeking: Measurement Validity

Chief among the methodological issues of past help seeking studies is the problem of validity (Gourash, 1978; Mechanic, 1978; McKinlay, 1972). Informal help-seeking is particularly difficult to validate, and to date no one has succeeded in moving beyond self-report measures. Practically speaking, direct observation of "daily" events would be very time consuming even if participants were willing to allow such extensive intrusion. To paraphrase Heisenberg, it may also be that direct observation might change the object of examination. Needless to say, the present study did not remedy the validity problems surrounding self-reported informal help-seeking.

For formal help-seeking behavior the problem of validity was less difficult to solve, since verification was attainable through records of cooperating professionals.

Achieving Comparison Groups

More so than for informal help seeking, the major difficulty with studying formal help-seeking is in generating appropriate comparison groups. Aside from laboratory studies, rarely have investigators of help seeking for psychosocial problems employed appropriate comparison groups (one exception is Brown, 1978; though Brown's service use measure was self-report). Most studies have been based on clinic samples (e.g., Horowitz, 1977), and others on inter-clinic referrals (e.g, Segraves et

al., 1978; France et al, 1978). Both approaches are problematic, since the subjects represent only people who have sought help; a comparison group sharing similar problems, but not seeking treatment, are needed to draw meaningful inferences.

Retrospective Reports

In addition, there is the issue of utilizing retropsective reports of help seeking activities. Studies based on retrospective reports confound outcomes and predictors of help seeking (Gourash, 1978). That is, it is impossible to tell if the hypothesized predictors have changed as a function of seeking help, or if they represented conditions that existed prior to help-seeking.

Current Remedies

The present study was designed to remedy the problems associated with measurement validity, appropriate comparison groups, and retrospective reports in the specific context of psychotherapeutic help seeking. This was accomplished by (a) assessing predictor variables for respondents with and without problems, (b) gathering those data prior to providing subjects with opportunities to request referrals, (c) recording the requests, and (d) tracking respondents to determine if they attended therapy (therapist verified).

At the level of self-help and informal support, self-report validity problems were still evident. When employed as dependent variables, self-help and informal help-seeking also fell victim to the criticism of being based on retrospective reports. Appropriate comparison groups (e.g., people not seeking informal

help) were generated for self-help and informal help-seeking, but the cross sectional assessment of these variables remains problematic. That is, it was uncertain if, for example, comparisons of self-help and nonself-help groups represented contrasts of a typological nature, or of people at different time points in the same process.

Further Problems of a Cross Sectional Design

Another problem for both past (e.g., Veroff et al., 1981) and present studies is the reliance on cross sectional designs to address the question of age differences in help-seeking. It is well known that cross sectional studies confound age and cohort effects. Thus, evidenced age differences in help-seeking activity can not be taken to imply change with age alone.

The value of a cross sectional approach at this juncture was that it offered a low cost method of determining if "age-related" relationships existed (age-related meaning composed of cohort and/or developmental effects). Given reliable (replicated) confirmation of "age-related" relationships, then more sophisticated (and expensive) studies which address age and cohort effects should be conducted. The draw-back to this approach is in the instance that the age and cohort effects are of equal size, but opposite sign. In this case, one would find no "age-related" relationships in a study of cross sectional design (i.e., the age and cohort effects cancel to produce a net effect of zero). It would be erroneous then to conclude that nonsignificant correlation between age and help-seeking implies no age or cohort effects existed

In brief, the present study solved some, but not all of the methodological problems troubling prior research on help-seeking. In the next section other issues threatening the external and internal validity of the current work are considered.

Other Validity Issues

There were several threats to external/ecological and internal validity posed by the procedures and design of this study. Threats to internal validity included the time gap between questionnaire administration and attendance at therapy, possible group affects on the decision to request referrals, and the limited decision time during group data collection procedures. Threats to external/ecological validity were generated by the unsolicited opportunity to request referrals, and the absence of normative data on self-initiated referral requests.

Time Gap

The time gap between obtaining the questionnaire data and attending therapy was problematic, since subjects may have changed during that interval on some of the independent variables examined. Since questionnaire data and referral requests were obtained during the same sitting, the corresponding relationships represented the firmest evidence upon which to draw inferences.

Group Data Collection

Since referral requests for the majority of subjects occured under group circumstances, it was relevant to ask if group pressures affected the frequency of requests. This issue was addressed by comparing two data collection methods (group, mail

return; described previously). Subjects who took materials home and returned them by mail did not make requests under group circumstnaces, yet they did not differ in frequency of requests from respondents making the decison in a group situation (results reported earlier). In short, evidence of group pressure on frequency of referral requests was not found. Thus, the frequency of requests was not an artifice of "group" data collection procedures.

Decision Making Time

Subjects completing materials during group sessions were not given much time (five minutes at best) to consider the issue of making a request. It is possible that some subjects failed to request because they wanted more time to ponder the decison. This issue was addressed by comparing the two data collection methods mentioned previously. Results of this comparison indicated the time criticism may not be viable (data presented earlier). That is, subjects returning requests by mail had ample opportunity to think the issue over, but were not different from "group" subjects in frequency of requests.

Validity of Referral Request Procedures

An ecological validity question raised by the present design was the issue of the representativeness of the manner in which subjects requested referrals. Subjects did not spontaneously ask for referrals, instead they were presented with an unsolicited opportunity. Without a doubt, it is not typical for people to be approached in an unsolicited manner and asked if they would like referrals. However, a favorable point is that all subjects were

faced with the same decision. Thus, under the conditions created by the study valid comparisons of subjects making and not making requests were possible. However, studies which follow subjects over time and assess self-initiated referral requests would be one step closer to determining people's actual experience.

Summary

In brief, there are a number of threats to the validity of the results generated by the present research design and procedures. Although subjects decisions to attend therapy may have occurred under "normal" circumstances, the decision to request referrals may not have taken place under typical conditions. On the other hand, there was less interpretative ambiguity in the predictor-outcome relationships in the referral request situation than with respect to attendance at therapy. Though some of these problems seem large, as is usually the case, replication by studies employing different designs and procedures are a better judge than argument alone.

Chapter III

RESULTS

Overview

Chapter III is organized into seven major sections (3.1-3.7). Logistic regression and the subsample selected for hypothesis testing are discussed in Section 3.1. Section 3.2 describes the distribution of sexual problems in the overall sample. The analytic framework and problems encountered in measuring distress are discussed in Section 3.3.

Data on social help-seeking are presented in sections 3.40 - 3.43. In sections 3.50 - 3.53 the emphasis shifts to informal help-seeking. Psychotherapeutic help-seeking, a major focus here, is examined in Sections 3.60 - 3.67; the analyses concern personaltiy, social and resource effects on a two step model of psycotherapeutic help-seeking (requesting referrals and attending therapy). An exploratory analysis of sex differences in psychotherapeutic help-seeking is presented in Section 3.68. Lastly, Section 3.7 summarizes Chapter III.

Results are discussed throughout this Chapter, with a broader perspective provided in Chapter IV. The major independent and dependent variables of interest are listed in Table 7.

Table 7

Major Independent and Dependent Variables of Interest

Dependent Variables	Independent Variables
1. Social vs. Nonsocial Help-Seeking	Self-Esteem, Sexual Distress, Age, Problem Hierarchies
2. Informal Help Seeking	Sexual Distress, Self-Esteem, Problem Hierarchies
a. Communal vs. Noncommunal b. Friends vs. No Friends c. Relatives vs. No Relatives	
3. Requesting Referrals & Therapy Attendance	Self-Esteem, Distress, Problem Hierarchies, Preferences, Financial Resources, Time Flexibility, Network Diversity, Communal Help
a. Requesting vs. Not Requesting b. Attending vs. Not Attending	

SECTION 3.1

DATA ANALYSIS & SAMPLE

Logistic Regression

A few comments are needed on the mainstay of the analyses, logistic regression. Logistic regression overcomes difficulties posed by analyses involving dichotomous dependent variables, as occurs in the present study. A logistic Maximum Likelihood model was employed (BMDP algorithms), with all independent variables entered hierarchically. Goodness of Fit Chi Squares were based on the C. C. Brown method, appropriate for continuous independent variables. Though the Improvement Chi Square follows the usual logic of significance and nonsignificance, it should be noted

that the Goodness of Fit Test must be nonsignificant in order to accept the model. Improvement Chi Squares were not always reported due to a program cost-saving feature that leaves uncalculated results for variables failing to meet a minimum Improvement Chi Square (p = .30 was set as the tolerance level).

A limitation of logistic regression is that the reliability of the technique and associated tests of significance (e.g., Wald's Test; Hauck & Donner, 1977) have not been thoroughly examined for small samples. Moreover, there are serious difficulties in calculating effect size estimates from regression parameters, particularly when psychological measures are utilized (Walter Hauck, personal communication, Jan. 1987; see Greenland, Schlesselman & Criqui, 1986).

Subsample for Hypothesis Testing

Hypothesis testing was based on a subsample (N = 168) selected to control for possible confounding factors (see Table 8). The rationale for the criteria presented in Table 8 was provided in Chapter II.

Table 8

Hypothesis Testing: Subsample Selection Criteria

1. 18 yrs. and older
2. have a current sexual partner
3. subject/partner not pregnant
4. report a sexual problem
5. not currently receiving treatment for a sexual problem
6. not presently receiving, for any reason, psychotherapy, marital therapy, pastoral counseling

SECTION 3.2

SEXUAL PROBLEMS

Prevalence

Of 500 respondents, approximately 43% (N = 216) reported sexual problems (similar to pilot findings, 37%, N = 384; see App. B). For the 432 subjects with sexual partners, 23% indicated they and their partner had a problem, 18% reported only they had a problem, and 4% said only their partner had a difficulty. Unclear, was whether these problems were primary dysfunctions or secondary to other disorders (e.g, depression).

Age Distribution

Although the number of individuals reporting sexual problems did not vary with age, perceived dyadic problems did (see Table 9; dyadic problem = both partners reported as having a problem). For dyadic difficulties, the point of increase occured between the 20s and 30s ($Z = 2.146$, $p = .02$), and then stabalized. The relationship between age and dyadic problems was unaffected by relationship length, or experiences that might facilitate perceptions of dyadic difficulties (e.g., psychotherapy; see Tables 9 and 10).

The increase in perceived dyadic sexual difficulties may be a function of increases in chronic life strains over early adulthood (e.g., establishing careers, child rearing; Chiriboga & Cutler, 1980; Pearlin, 1980; Pearlin & Lieberman, 1979; LoPiccolo, 1975; Lobitz & Lobitz, 1978). Interpretation of the sexual problem data is limited by the cross sectional design, which confounds age and cohort effects. For instance, the

observed age effects may be due to cohort differences in health practices (e.g., alcohol consumption, exercise), or in onset of life course transitions.

Table 9

Relationship of Age & Relationship Length to Problem Status

	Log Likelihood	Chi Squares Improvment	Fit	Gamma
Step 0	-163.19			
Step 1	-160.17	6.03*	.34**	
Age				.34
Length	nonsignificant			
Age x Length	nonsignificant			

Note. Length = relationship duration and Age = age of respondent
*p < .007, df = 1; **p = .84, df = 2

Table 10

Relationship of Age and Prior Psychotherapy Use to Dyadic Vs. Single Person Sexual Problems

	Log Likelihood	Chi Squares Improvment	Fit	Gamma
Step 0	-120.91			
Step 1	-120.39	1.04	.16	
Therapy				
Step 2	-116.39	9.03*	.11**	
Therapy				.13
Age				.51
Age x Therapy	nonsignificant			

Note. Therapy = prior use of psycotherapy.
*p < .003, df = 1; **p = .94, df = 2

SECTION 3.3

"THE GUIDING THEORY"

Motivation Model

This study employed a motivation model. The model's primary tenet posits that only high levels of distress, in conjunction with appropriate levels of relevant directive variables, will generate help-seeking. Thus, the present model is "interactive". Table 11 lists the directive variables of interest.

Table 11

Directive Variables to be Examined

Self-Esteem	Friends/Relatives
Preferences	Financial Resources
Problem Hierarchies	Time Flexibility
Network Diversity	
Communal Relationships	

As The Measure Turns: A Distressing Problem

The initial distress index (Hudson scale) failed to predict any type of help-seeking (neither interaction nor additive models). This was unexpected, since level of distress has consistently been found to predict help-seeking behavior (e.g., Mechanic, 1978; see Chapt. I). Criticism of the Hudson scale centers on the fact it assesses sexual complaints, and not the degree of emotional upset associated with those complaints (see Chapter II).

Problems with the Hudson Scale do not mean, however, that

the distress model is untestable. Needed is a measure which more clearly assesses the emotional component of sexual problems. The sexual communication scale (SCS) meets this requirement.

The assumption underlying use of the SCS is that the emotional valence of a verbal exchange reflects the degree of upset related to the object of that communication (e.g., the sexual relationship). The strong correlation between the SCS and marital distress ($r = -.42$) supports this assumption. However, it is recognized that interpersonal communication processes may contribute to, as well as be affected by distress.

Employing the SCS as a distress measure has several unavoidable consequences. First, hypotheses involving communication will no longer be considered. Secondly, interpretation of distress effects will always be two edged - either as distress or as communication effects. The importance to the present work of obtaining a resonable index of distress, however, outweighs these limitations.

SECTION 3.4

SOCIAL HELP-SEEKING

Overview

Analyses of social help-seeking concern comparisons of people who have initiated at least one help contact with those who have not accomplished this. Thus, the focus of these analyses is not on specific helper characteristics (e.g, friend, professional), but concerns chiefly the social nature of seeking help. Social help-seeking was defined in terms of (a) having employed informal help sources and/or (b) attending

psychotherapy. Nonsocial help-seeking consisted of using only self-help or "doing nothing" about the problem. For subjects reporting sexual problems (N = 225), social help-seeking was considerably more prevalent (80%) than nonsocial coping. The following sections examine a) problem context and general personality variables relevant to social help-seeking (3.41 - .42), and b) variation in social help-seeking with age (3.43).

SECTION 3.41

Effects of Distress & Self-Esteem

Within the present theoretical framework, self-esteem is viewed as an important cognitive determinant of social help-seeking. The importance of self-esteem is in its expected relevance across situations regardless of the specific characteristics of the potential helper. There are two views on self-esteem's relationship to help-seeking, the vulnerability and consistency hypotheses (see below).

Hypothesis

Consistency. Self-esteem and sexual distress interact such that low self-esteem leads to social help-seeking only under conditions of high sexual distress; while nonsocial coping is associated with low self-esteem and low distress, or high self-esteem under conditions of either high or low distress.

Vulnerability. Alternatively, Self-esteem and sexual distress interact such that high self-esteem leads to social help-seeking only under conditions of high sexual distress; while nonsocial coping is associated with high self-esteem and low distress, or low self-esteem under conditions of either high or low distress.

Distress. Distress and the distress x self-esteem interaction model were nonsignificant predictors of social help-seeking (see Table 12; Note, quadratic and cubic equations for distress were nonsignificant). Discussion of the distress motivation model will be provided after examining all relevant data, but it is clear that these findings were not supportive.

Self-Esteem. There was a significant self-esteem main effect (see Table 12); higher self-esteem scores were associated with obtaining social help (Self-Esteem: Social M = 47.9 , SD = 8.8 ; Nonsoc. M = 45.1, SD = 9.0). Quadratic/cubic equations for self-esteem were nonsignificant, militating against curvilinear relationships.

Table 12

Effect of Distress, Self-Esteem and Their Interaction on Social Help-Seeking

	Log Likelihood	Chi Squares Improvment	Fit	Gamma
Step 0	-87.56			
Step 1 Esteem	-86.08	2.95*	2.3**	.35
Step 2 Esteem	-85.25	1.66	4.8	.41
Distress				.29
Step 3 Dist. x Esteem nonsignficant				

Note. Dist. X Esteem = Distress, Self-Esteem, Distress x Self-Esteem.
*p < .04, df = 1; **p = .32, df = 2

A Vulnerability View

The self-esteem data provide partial support for the vulnerability hypothesis; that is, high self-esteem subjects were more likely to seek social help. Since threat associated with social help-seeking was not measured, it can only be assumed that high self-esteem people felt less threatened than low self-esteem respondents.

The self-esteem data also raise another consideration. People with high self-esteem often enjoy a relatively active social life, composed of meaningful and intimate relations (Hansson et al., 1984; Jourard, 1971; Rosenberg, 1965). Intimate social supports may take an active role in soliciting problem disclosures and offering help. Thus, the high self-esteem person may more often be a recipient of aid than an active help-seeker. Future studies should examine this "passive-active" view in relating self-esteem to social help-seeking.

SECTION 3.42

Self-Esteem & Problem Hierarchies

The hypothesis was examined that self-esteem is predictive of help-seeking only when problems are ranked highly in a person's problem hierarchy (Gross & McMullen, 1983; See Nadler, 1983). With respect to sexual problems, problem hierarchies were operationalized in terms of how important the person considered the sexual problem relative to all other personal problems (Problem Rankings).

Regression analysis (see Table 13) indicated significant main effects for self-esteem [Social M(SD) = 47.9 (8.8); Nonsocial M(SD) = 45.1 (9.0)], and problem rankings (self-esteem & problem rankings r(168) = .03, p >.10). Higher problem rankings were associated with obtaining social help [Social M(SD) = 4.2(1.3); Nonsocial M(SD) = 3.5(1.3)]. The self-esteem by problem rankings interaction equation was nonsignificant. Results of a distress x Problem Rankings analysis indicated only a significant effect for Problem Rankings (distress & Problem Rankings r(168) = .01, p >.10).

Table 13

Regression Results for Self-Esteem and Problem Rankings

	Log Likelihood	Chi Squares Improvment	Fit	Gamma
Step 0	-87.56			
Step 1 Rank	-85.56	4.00**	.30***	.28
Step 2	-84.04	2.95*	1.6***	
Rank				.28
Esteem				.35
Step 3 Rank x Esteem	nonsignficant			

Note. Rank X Esteem = Problem Rankings, Self-Esteem, Problem Rankings x Self-Esteem.
*p < .04, df = 1; **p .02; ***Fit Chi Squares both at p >.33

A Problem Hierarchy Perspective

The problem hierarchy results underscore the importance of the "problem context". Obviously, people may perceive a number of

problems in their intimate relationships, only one of which may be sexual. How the individual or couple structure difficulties may be more important to subsequent help-seeking choices than merely having a particular problem. That is, as present results suggest, when sexual difficulties were of low priority a less threatening coping strategy was selected (e.g., self-help). How problems are ordered and how these hierarchies change over time are significant developmental issues for help-seeking research (see Chapter IV).

SECTION 3.43

Social Help-Seeking: Distress & Age

Help-seeking for psycohosocial problems was expected to vary over the life span (see Chapt. I). For instance, older (relative to younger) adults may use fewer formal services, but more self-help strategies. As stated elsewhere, age is not an explanatory variable, but a proxy for an assortment of cohort and developmental causes. The relationships between distress, help-seeking and age were examined with this perspective in mind. Since age may be a proxy for unspecified directive variables, its interaction with distress was also examined (as follows from the motivation model).

Hypothesis

As age increases sexual distress decreases. Consequently, older subjects will utilize social sources of help less than other age groups as a function of having lower distress.

Age correlated significantly, albeit a small relationship,

with distress ($r(168) = -.14$, $p = .03$). Contrary to predictions, sexual distress increased with age. This result is consistent with findings indicating that sexual satisfaction decreases with age (for review, see Berezin, 1976). Put another way, declining sexual satisfaction with age may, in part, be attributable to a problem related increase in sexual distress with age.

The age-distress result may be viewed as an effect of "first-time" late onset sexual problems. That is, some of the older subjects (50s & 60s) may have been experiencing their first sexual difficulties. The onset of sexual problems, after years of relatively good function, may accentuate or be heightened by fears of other age related declines. Thus, sexual problems may elicit greater distress for older individuals, because the negative implications of the problem may be larger than for younger people.

Age, and the interaction between age and distress were nonsignificant predictors of social help-seeking. This finding contradicts reports indicating that, for marital problems, younger individuals are more disposed than the middle aged/elderly towards seeking help (i.e., Older subjects prefered self-help; Pearlin & Schooler, 1978). This raises the question of whether help-seeking related to sexual concerns is atypical of that associated with other relationship problems. Perhaps sexual problems are not linked with other relationship difficulties, or are perceived to differ in terms of the type of solution needed. Additional work is needed to address these questions.

Social Help-Seeking: Summary

A substantial percentage of subjects had sought social help. Sexual distress and age did not differentiate social from nonsocial copers. Self-esteem was related to social help-seeking; higher levels of self-esteem being associated with obtaining social help (vulnerability hypothesis). Problem rank (hierarchies) was also a significant predictor, independent of self-esteem; the more important the sexual problem, relative to other problems in a person's life, the greater the likelihood of obtaining social help. In general, the distress based motivation model was not supported.

Limiting the findings is the difficulty associated with retrospective reports in seperating outcomes from determinants. Retrospective reports of informal help-seeking and self-help defined the bulk of subjects grouped, respectively, as social and nonsocial help-seekers. Thus, the inability to substantiate a) distress as a determinant of social help-seeking, and (b) the distressed based motivation model, may be due to design-measurement problems. For instance, distress may have decreased for social help-seekers to levels of nonhelp seekers as a function of having obtained emotional support.

SECTION 3.5

INFORMAL HELP-SEEKING

Overview

Since there is a paucity of research on informal help-seeking related to sexual problems, there were a number of basic questions to be addressed. Is informal help-seeking a typical

coping response or do people prefer other responses (e.g., self-help)? If people seek informal aid, who do they seek it from? Since the sexual partner may be a valuable participant in solving sexual difficulties, are partners/spouses uniformlly sought out for help? In addition, what conditions prevail when people seek extrarelationship aid? These are some of the fundamental issues to be addressed.

In the following section the various types of informal support and their distribution across age groups are described (3.51). Sections 3.52 and 3.53 focus, respectively, on communal and extra-relationship (e.g., friends) help- seeking. Helper characteristics specific to informal helpers were not assessed in this study. Consequently, the emphasis in these analyses is on relevant problem context and general personality variables.

SECTION 3.51

TYPES OF INFORMAL HELP

Age Distributions

A majority of respondents (approximately 90%) had sought solutions through self-help and/or informal help-seeking (see Table 14). No age differences in informal help-seeking or self-help were found.

Inspection of Table 14 indicates that self-help was the most frequent response across age groups. The doctorine of "rugged indiviudalism" appears to be alive and well in the bedroom. However, approximately 80% of subjects also had sought help from informal sources. Clearly, there is a social component to coping

with sexual problems.

Table 14

Percent Respondents by Age Group Employing Palliative, Self-Help & Informal Help Sources For A Current Sexual Problem

	Age Group			
Activity/Help Source	20s	30s	40s	50+
Palliative Copers	11%	8%	18%	6%
Self-Help	75	70	57	75
Self-Help:Media Resources	61	60	60	50
Call-In Radio Programs	4	3	0	0
Friends	57	45	49	31
Sexual Partner/Spouse	60	60	54	63
Relatives(not spouse)	23	13	8	31
Extramarital Partner	11	23	11	6
Clergy/Spiritual Leader	3	6	9	13
Prostitute	4	3	0	0
Bartender	3	2	0	0
Other Informal Sources	0	2	5	18
Total N =	110	67	35	16

Note. Subjects could respond to more than one self-help or informal help category so totals exceed 100%. Palliative copers are those not attempting to solve their sexual problem. Self-help: Media Resources include use of books, magazines, newspapers, television and radio (listening to). Call in radio programs refer to the subject calling in for help.

Primary Informal Help Sources

Major informal sources were one's partner (56%), friends (48%) and to a lesser extent relatives (19%). Although sexual partners were more frequently sought out, it was still surprising that the figure was not higher. One might expect the primary sex partner to be one of, if not the first person to be approached for help. Obviously, this was not the case. Indeed, friends occupied nearly an equal position with partners as a source of help. Possible explanations for these data will be discussed

later.

In the following analyses, attention is turned to conditions that affected seeking help from specific informal sources. Also considered was the issue of the adaptive value of having sought help from one's sexual partner. Variables of primary interest in the following sections were sexual distress, problem rank, and self-esteem.

SECTION 3.52

COMMUNAL HELP-SEEKING

Self-Esteem, Problem Rankings & Distress

As discussed in Chapter One, relationship discord should disrupt efforts to seek help from one's partner (communal help-seeking). That is, it is difficult to seek help from an individual who is contributing to your distress. This situation represents an exception to the rule that high distress leads to help-seeking. In addition to distress, the effects of self-esteem and problem rankings on communal help-seeking were examined.

Communal help-seekers (versus nonseekers) had significantly lower distress [Used Communal Help M(SD) = 57 (11.2); Not Using M(SD) = 48 (13.7); see Table 15] and higher problem rankings [Used Communal Help M(SD) = 4.2 (1.2); Not Using M(SD) = 3.7 (1.3); see Table 15). The effect of problem rank was independent of distress (see Table 15). Self-esteem was not associated with communal help-seeking, and none of the interaction models were significant (see Table 15).

Table 15

Regression Results: Communal Help-Seeking

	Log Likelihood	Chi Squares: Improvement	Fit	Gamma
Step 0	-115.25			
Step 1	-105.89	18.7***	2.92	
Distress				.18
Esteem	Nonsignificant			
Distress x Esteem	Nonsignificant			
Step 1	-105.89	18.7****	2.92	
Distress				.12
Step 2	-103.08	5.6**	9.13	
Distress				.12
Rank				.30
Distress x Rank	Nonsignificant			
Step 0	-74.56			
Step 1	-68.82	11.4***	3.2	
Distress				.11
Length	Nonsignficant			
Length x Distress	Nonsignficant			

Note. For Distress high scores = lower distress; Fit Chi Squares: Distress p's >.20, Rank p's >.30;
*p <.05; **p >.01; ***p <.001; ****p <.0001

Experience With Communal Help-Seeking

Presumably, past experiences with communal help-seeking would affect current communal help-seeking behavior. In this context, people in longer standing relationships may have more extensive experience with communal help-seeking. However, relationship length was not related to communal help-seeking (see

Table 15). This suggests that overall-communal help-seeking experience may not be relevant to the current situation. That is, it may be erroneous to assume equivalence across all problem situations in which communal help-seeking has occured. Communal help-seeking may frequently be employed for mundane problems, but these experiences may not prepare one for seeking communal help on highly charged issues. In short, assessments of communal help-seeking experience should examine the types of problem situations in which it has occured.

Communal Help-Seeking: Summary

The communal help-seeking data did not support the distress based motivation model. However, there were a number of interesting relationships. Communal help-seeking was associated with distress and problem rank, but not self-esteem. Thus, self-esteem may be relevant at a general social level, but is not a determinant of specific types of social help-seeking. Communal help-seeking was unrelated to relationship length. This tenatively suggests that overall experience with communal help-seeking may not be relevant to sexual problem situations.

SECTION 3.53

EXTRA-RELATIONSHIP HELP-SEEKING

Self-Esteem, Distress & Problem Rankings

Self-esteem, distress, and problem rank were examined as predictors of help-seeking from friends and relatives (seperate models). Only problem rank had a significant effect and only with respect to help-seeking from friends [see Table 16; Used Friends

M(SD) = 4.3(1.2); Did Not Use Friends M (SD) = 3.7(1.4)].

Table 16

Regression Results: Influence of Distress and Problem Rankings on Seeking Help from Friends

	Log Likelihood	Chi Squares Improvement	Fit	Gamma
Step 0	-116.34			
Step 1	-114.88	2.92*	1.6**	
Rank				.20
Distress	nonsignificant			
Dist.x Rank	nonsignificant			

*p < .04; **p = .45

Effects of Communal Help-Seeking

Next, the hypothesis was examined that in the absence of communal help-seeking people turn outside the relationship for help.

Hypothesis

Extra-relationship informal help sources will be more likely employed under conditions of high sexual distress and failing to employ communal help.

Inspection of Table 17 shows that communal help-seekers were more likely to seek help- outside the relationship than noncommunal help-seekers. This impression was confirmed by regression analysis (see Table 18). For both friend and relative help-seekers, communal help-seeking was found to be a significant predictor independent of distress; in neither case was the communal help-seeking x distress interaction model significant.

Thus, contrary to expectations, failure to achieve communal help-seeking was associated with less use of other (major) informal supports.

Table 17

The Percentage of Extra-relationship Help-Seeking by Communal Help-Seeking

	Communal Help	
Help Source	Sought(%)	Not Sought(%)
Friends	34	14
Relatives	14	5
N =	94	74

Note. Percentages based on total subsample N of 168.

A Process of Informal Help-Seeking

In addition to exhibiting lower distress, higher problem rankings, and more help-seeking from friends, communal help-seekers were less likely than nonseekers to prefer palliative coping (Used Part M = 3.5, SD = .9, Not Used M = 2.1, SD = 1.1; $t(164) = 3.50$, $p = .001$; i.e., noncommunal help-seekers prefered a nonproblem solving coping response). It can be infered from these findings that (a) communal help-seekers were highly motivated to find a solution, (b) had failed to solve the problem at the partner level (i.e., since these subjects reported current sexual problems, than communal help-seeking obviously had not been successful in solving the problem), (c) were managing their distress at levels that facilitated decision making, and (d) were actively seeking information and support (e.g., from friends) for

Table 18

Regression Results: Influence of Distress and Communal Help Seeking (CHS) on Seeking Help from Friends and Relatives

	Log Likelihood	Chi Squares: Improvement	Chi Squares: Fit	Gamma
Friends				
Step 0	-116.34			
Step 1	-109.63	13.4**	55.3****	
CHS				-.58
Distress	nonsignificant			
Dist.x CHS	nonsignificant			
Relatives				
Step 0	-80.33			
Step 1	-77.65	5.36*	53.6***	
CHS				-.60
Distress	nonsignificant			
Dist.x CHS	nonsignificant			

Note. CHS = Communal Help-Seeking
*p = .02; **p = .0001; ***p = .15, df = 44; ****p = .12, df = 44

locating a solution. Thus, managable distress, high problem rankings, and failure to solve the problem at the communal level generate a continuing sequence of informal help-seeking activities.

Informal Help-Seeking: Summary

Self-Esteem. The informal support seeking data failed to confirm the motivation model. In addition, self-esteem was not associated with informal help-seeking. Thus, self-esteem may primarily operate at the most general level of help-seeking (i.e., social vs. nonsocial), and is irrelevant when distinctions

are made between social help sources. This also suggests that self-esteem may be of import to initation, but not necessarily to maintenance of help-seeking behaviors.

Distress. Low distress increased the likelihood of seeking communal help. The distress findings were consistent with the view that low levels of distress facilitate help-seeking, particularly when the problem locus may encompass both helper and help-seeker (see Chapter I, Section 1.11).

Distress: An Outcome. The distress findings also serve to remind us of the limits of retrospective data. That is, high distress may have influenced communal help-seeking which, in turn, reduced distress to lower levels. This interpetation furthers the view that communal help-seeking is important to managing emotional distress - the consequence may be a person or couple more capable of making decisions and developing problem solving strategies.

Lovers & Others. Communal help-seeking was related to obtaining help from friends and relatives, but not in the expected direction. Indeed, communal help-seekers were more likely than nonseekers to have sought friends and relatives for help.

Problem Hierarchies. Maintaining a sexual problem near the top of one's problem hierarchy increased the likelihood of seeking help from lovers and friends. Thus, problem context considerations prevade nearly every facet of help-seeking from the most general (social) to the specific (informal). Why problem rankings were unrelated to seeking help from relatives is

unclear; it may be a consequence of the small numbers of people who actually sought help from relatives (19%).

Overall, the findings suggest that informal help-seeking represents a sequence wherein progression overtime is influenced by a continued interest in solving the problem (high problem ranks), having or acquiring interpersonal skills (i.e., the distress measure also indicates that communal help-seekers were better communicators than noncommunal help-seekers), managing distress, and failure to achieve solutions at earlier steps. Examination of coping sequences, their respective outcomes, and identifying the most efficacious sequences with respect to obtaining solutions are areas for further investigation.

SECTION 3.6

PSYCHOTHERAPEUTIC HELP-SEEKING

Overview

Prior sections have concerned social vs. nonsocial, and informal support seeking. Sections 3.6 - 3.68 focus on formal help, specifically psychotherapy. The analyses center on a two step model of pscyotherapeutic help-seeking composed of requesting referrals and subsequent therapy attendance. Recall that the strongest tests of the hypotheses were based on the referral request data. This strength rests on the fact that requests were made immediately following assessment of the independent variables.

Section 3.61 provides descriptive data on respondents who requested referrals and attended therapy. This is followed by a

consideration of sample attrition over the time interval between requesting referrals and follow-up (Section 3.62). Section 3.63 provides data on subjects' prior use of psychological help, and addresses the question of, does prior use influence future selections? Next, age differences in psychotherapy experience, requesting referrals, and therapy attendance are examined (Section 3.64). Subsequent Sections (3.65 - 3.68) consider the full range of problem context, helper characterisitcs, and general personality and social variables assessed in the present study. These analyses are grouped under general headings of person, social, and resource factors.

SECTION 3.61

BACKGROUND CHARACTERISTICS

Requesters and Attenders

Two hundred thirty-one subjects reported that they, their partner, or both had a sexual problem [19% (N = 45) requested referrals]. Mirroring the demographics of the total sample, requesters and attenders were predominately female, heterosexual, and caucasian (see Tables 19 & 20). The typical requester was in his/her thirties, with two years of college, and of middle economic class.

Table 19

Background Characteristics of Subjects Who Did and Did Not Request Referrals

	Requested Referrals	
	Yes	No
Female	94%	93
Male	6%	7
Caucasian	85%	87
Married	56%	49
Education:M(SD)	14.3(2.7)	14.2(2.5)
Respondent's Age	31.2(10.4)	31.8(9.6)
Income	28.0(13.0)	30.5(17.0)
Partner's Age	33.4(9.8)	34.3(10.1)
Relationship Length	6.6(6.9)	8.8(8.3)
N =	34	134

Note. Income in thousands of dollars (net) and education in years completed. Percentages based on subjects meeting selection criteria (N = 168).

Table 20

Background Characteristics of Requesters Who Did and Did Not Attend Therapy

	Attended Psychotherapy	
	Yes	No
Female	83%	100
Male	17	0
Caucasian	100	80
Married	68	53
	M(SD)	M(SD)
Education:M(SD)	13.3(1.0)	15.4(3.6)
Respondent's Age	36.8(12.8)	31.1(7.6)
Income	28.0(15.0)	32.0(15.1)
Partner's Age	37.4(11.6)	33.4(7.6)
Relationship Length	12.0(14.3)	5.1(4.0)
N =	6	15

Note. Income in thousands of dollars (net) and education in years completed. Above N is less than the number of subjects requesting referrals since some requesters could not be recontacted.

SECTION 3.62

SAMPLE ATTRITION

Table 21 provides a breakdown of requesters' dispositions at referral contact and post referral. No significant differences on the variables assessed were found between follow-up and non follow-up subjects (see Table 22; 2 tailed t-tests).

Table 21

Disposition of Requesters at Referral and Follow-up

	Referral Contact %(N)
Accept Referral	82.2(37)
Refused Referral	4.4(2)
Geographic Problem	4.4(2)
Unable to Contact	8.8(4)
Total N = 45	

	Follow-Up %(N)
Attended Therapy	16.2(6)
Non Users:	
Still Interested	16.2(6)
Problem Improved	8.1(3)
Stay with Current Therapist	8.1(3)
No Reason Given	16.2(6)
Unable to Contact	35.1(13)

Note. One refuser at referral contact decided to stay with a current therapist (note this respondent was eliminated from the analytic sample since she was currently in therapy), and the other gave no reason for refusing. Geographic problem = geographic preferences could not be met. Unsuccessful follow-ups were primarily due to subjects relocating. Based on successful follow-ups the percentage of subjects going to therapy was 25%.

Table 22

Comparison of Follow-up and Non Follow-up Subjects

Variable	Follow-up M(SD)	Non Follow-up M(SD)	t Value
Education	14.9(3.3)	13.3(1.4)	1.36
Age	31.5(7.6)	28.3(8.7)	.99
Time Flexibility	27.6(19.3)	23.4(21.1)	.53
Income(Thousands)	30.5(15.5)	20.5(6.0)	1.83
Relationship Length	5.0(3.8)	3.2(2.7)	.98
Marital Distress	4.5(1.6)	5.2(.83)	-1.21
Palliative Rank	3.4(.94)	3.8(.33)	-1.50
Self Rank	2.3(.97)	2.8(.60)	-1.66
Psych Rank	1.4(.60)	1.1(.33)	1.57
Med Rank	2.8(.95)	2.1(.60)	1.99
Problem Ranking	4.8(.74)	5.1(.78)	- .86
Self-Esteem	47.6(8.6)	47.4(12.5)	.04
Distress	49.0(14.1)	54.3(12.8)	- .97
Network Diversity	2.6(1.2)	2.3(.78)	.67
Health Insurance	χ^2 (1,25) = .50, p>.10		

Note. df = 36; Self Rank = Ranking of Self-help relative to psychological (psych rank), and medical services (med rank), and doing nothing (palliative rank)

SECTION 3.63

CURRENT AND PRIOR USE OF FORMAL SERVICES

The findings indicate that few people had used formal help to solve their sexual difficulties (Psychotherapy, 3%; Medical, 0.5%; see Table 23), despite a high prevalence of sexual problems (43%). The most frequent coping activities were self-help and informal help-seeking (see Section 3.51, Table 15). Yet, the usefulness of these latter efforts in deriving solutions is unknown; though self-help books have been found to be either ineffective or detrimental (Rosen, 1987).

Generalizations of the above data are limited. Since this is the first study on sexual problem related help-seeking, comparisons to studies with more representative samples is hindered. However, the overall psychotherapy figure (Psychotherapy for Nonsexal + Sexual problems = 27%) is remarkably similar to that reported for a national probability sample (26%; Veroff et. al., 1981). This similarity supports the validity of the sexual problem associated psychotherapeutic help-seeking data; that is, if one assumes equivalence between samples in proportions employing psychotherapy services for specific problems.

Table 23

Past and Current Use of Psychological/Medical Services: Total Sample & Subjects With A Current Sexual Problem

	Total Sample[a]		Sexual Problem Subjects[b]	
	Using	Used	Using	Used
Psychotherapy Nonsexual	8%	24%	14%	28%
Marital Therapy	3	14	4	16
Psychotherapy Sexual	2	3	3	5
Medical Sexual	1	3	0.5	5

Note. Psychotherapy Nonsexual (Sexual) = psychotherapy for a nonsexual problem (for a sexual problem); Medical Sexual = medical treatment for a sexual problem.

[a] N = 502; [b] N = 216.

Prior Service Use: Effects on Requesting & Attending

Table 24 shows the percentages of requesters and nonrequesters who are or have used various services. The effect of prior experience with psychotherapy on requesting referrals/attending therapy was examined. Two experience indices were constructed: a) use of psychotherapy for sexual difficulties, and b) overall use of psychological services (psychotherapy for sexual and nonsexual problems + marital therapy); these were entered (seperately) into regression equations along with distress.

Table 24

Past & Present Service Use by Requesters and Nonrequesters

	Requesters		Nonregusters	
	Using %(N)	Used %(N)	Using %(N)	Used %(N)
Psychotherapy Nonsexual	18(8)	31(14)	13(24)	27(51)
Marital Therapy	2(1)	13(6)	5(10)	16(30)
Psychotherapy Sexual	2(1)	9(4)	3(6)	5(9)
Medical Sexual	2(1)	2(1)	0	4(8)

Note. Ns for Requesters = 45 and Nonrequesters = 186. Psychotherapy Nonsexual (Sexual) = psychotherapy for a nonsexual problem (for a sexual problem); Medical = medical treatment for a sexual problem.

Neither experience index nor distress were predictive of attending therapy. Distress was significantly related to requesting referrals [M(SD): Requesters = 48.8(13.3); Nonrequesters = 54.1(12.8)], but again experience was not predictive (see Table 25). Higher distress was associated with requesting referrals (for discussion of distress findings see sections 3.6 - 3.7). In brief, prior experience with attending psychotherapy had no effect on requesting or attending psychotherapy.

Table 25

Relationship of Prior Therapy Experience & Distress to Requesting Referrals

	Log Likelihood	Chi Squares Improvement	Fit	Gamma
Step 0	-84.61			
Step 1	-82.72	3.79*	2.26***	
Distress				-.61
Step 2	-81.57	2.30	2.83	
Distress				-.65
Therapy				.82
Step 3				
Dist. x Therapy	nonsignificant			

Note. Therapy = Prior use of psychotherapy for sexual problems; Lower distress scores = higher distress; Since both prior use indices were nonsignificant only the results for psychotherapy for sexual problems are presented; Sample size for this analysis = 168.
*p < .03, df = 1; ***Fit Chi Squares all at p >.28

Prior Qualitative Experiences with Therapy

It is important to consider respondents' subjective reactions to prior therapy experiences. Previous experience alone is not grounds for future use, particularly if it was negative. The influence of subjective experience (positive/negative) on requesting and attendance was neglibible (dependent variables regressed on distress, positive:negative ratings); distress was a significant predictor of requesting (see Sections 3.6 - 3.7). All interaction models were nonsignificant.

Summary: Prior Use of Psychotherapy

The evidence indicates that prior therapy experiences did not effect requesting or attending therapy. These results run contrary to the "salted peanut effect" view of therapy. This perspective suggests that the best predictor of future use is past use. So why was this intuitively appealing hypothesis not supported? For one, the present findings may reflect the novelty of seeking psychological help for sexual problems. That is, even among those who had used psychological services, there were few who had employed it in solving sexual difficulties (5%). Consequently, past experience would provide little basis from which to judge future behavior.

SECTION 3.64

AGE AND PSYCHOTHERAPEUTIC HELP-SEEKING

Age & Prior Service Use

The percentage of subjects who had used psychotherapy or medical services for a sexual problem were relatively similar

across age groups (see Table 26). In contrast, there was a significant increase from the 20s to 30s in proportion of subjects who had used psychotherapy for a nonsexual problem ($Z = 3.55$, $p = .01$). No age differences were found for past or present use of formal services for sexual difficulties (all Z tests nonsignificant at $p = .05$).

Table 26

Percentage of Subjects by Age Groups Previously or Currently Using Services

Age Group	Psychotherapy Nonsexual		Marital Therapy		Psychotherapy Sexual		Medical Sexual	
	Using	Used	Using	Used	Using	Used	Using	Used
18-29 yrs.	6%	15%	2%	4%	1%	2%	1%	4%
30-39	13	30	4	16	2	2	0	3
40-49	7	41	3	33	3	7	0	3
50-65	9	34	3	32	0	9	0	6

Note. Ns for age groups (youngest to oldest) are 254, 141, 69, 35; Psychotherapy Nonsexual (Sexual) = psychotherapy for a nonsexual problem (sexual problem); Medical = medical treatment for a sexual problem.

Age & Distress: Effects on Requesting/Attending

It was previously shown that neither social nor informal support seeking varied systematically with age. Here the issue of age differences in psychotherapeutic help-seeking was examined. The hypothesis below summarizes the expectations in this regard.

Hypothesis

As age increases sexual distress decreases (previously disconfirmed). Consequently, older subjects will utlize social sources of help (requesting and attending) less than other age groups as a function of having lower distress.

Higher distress was associated with making requests [M(SD): Requesters = 48.8(13.3); Nonrequesters = 54.1(12.8)], but age and the interaction between age and distress were nonsignificant (see Table 27; also see sections 3.6 - 3.7); neither variable was related to attending psychotherapy. These findings are consistent with those results indicating similarities across age groups in past and present use of psychotherapy for sexual problems.

Table 27

Relationship of Age & Distress to Requesting Referrals and Attending Therapy

		Chi Squares		
	Log Likelihood	Improvement	Fit	Gamma
Step 0	-84.61			
Step 1	-82.72	3.79*	3.30**	
Distress				-.61
Age	nonsignificant			
Age x Distress	nonsignificant			

Note. Lower Distress Scores = Higher Distress.
*p < .02, df = 1; **p = .19, df = 2

Summary: Age and Psychological Help-Seeking

Psychotherapeutic help-seeking was age invariant, whether viewed retrospectively or prospectively. This conclusion held despite the fact that dyadic sexual problems increased with age. Why should this be? One possibility is that we are observing the cancellation of cohort and age effects. That is, older subjects, though evidencing more problems (age effect) than younger respondents, were less likely to seek psychological help for sexual problems (cohort effect) than their younger counter parts. Younger subjects may more often seek help, but evidence fewer

problems than older subjects. Consequently, younger and older subjects would have similar rates of help-seeking. Future investigations should examine for cohort differences in seeking professional help.

SECTION 3.65

PERSON VARIABLES & SEEKING PSYCHOTHERAPY

Overview

Self-esteem, preferences towards psychotherapy, and problem rankings were examined with respect to psychotherapeutic help-seeking (i.e., within the context of the distress model).

Self-Esteem & Distress

It was suggested earlier (Section 2, Chapt. III) that the relationship between self-esteem and help-seeking may be stronger at more general (social vs. nonsocial) than at specific levels of help-seeking (e.g., informal vs. psychotherapy). Thus, self-esteem may be related to requesting referrals and attending psychotherapy (see below), but the relationships were expected to be small.

Hypothesis

Consistency. Self-esteem and sexual distress interact such that low self-esteem and leads to requesting (attending) only under condtions of high sexual distress; while not requesting (attending) is associated with low self-esteem and low distress, or high self-esteem under conditions of either high or low distress.

Vulnerability. Self-esteem and sexual distress interact such that high self-esteem and leads to requesting (attending) only under condtions of high sexual distress; while not requesting (attending) is associated with high self-esteem and low distress,

or low self-esteem under conditions of either high or low distress.

Distress was significantly related to requesting referrals, but self-esteem and the interaction between self-esteem and distress were not predictive (see Table 28). That is, increasing distress enhanced the likelihood of requesting a referral. Lastly, distress, self-esteem, and their interaction were unrelated to attendance.

Table 28

Effects of Distress & Self-Esteem on Requesting Referrals to Psychotherapy

	Log Likelihood	Chi Squares: Improvement	Chi Squares: Fit	Gamma
Step 0	-84.61			
Step 1	-82.72	3.79*	2.25**	
Distress				-.61
Esteem	nonsignificant			
Distress x Esteem	nonsignificant			

Note. Esteem = Self-Esteem; Low Distress Scores = High Distress.
*p < .03, df = 1; **p = .32, df = 2

Distress & Self-Esteem: Summary

The results support the view that self-esteem, though predictive of social help-seeking in general, does not discriminate particular types of social help-seeking (i.e., informal or formal). If replicable, these results are an important refinement of the self-esteem help-seeking hypothesis.

Distress was related to requesting referrals, but not attending therapy. As discussed earlier, the referral request situation represents the purest test of the distress hypothesis.

The relationship was not confounded by having already obtained help (as with informal help-seeking), and the measures were contiguous (unlike for attending therapy).

The absence of a distress-attendance relationship may be related to differential changes in distress as a function of requesting referrals. That is, some subjects may have experienced relief at the idea that help was in reach and, subsequently, felt less need to attend therapy. Distress was not measured post request, so a "relief" effect is speculative (a ceiling effect for distress is also possible).

Self-Esteem, Problem Rankings and Distress

As mentioned previously (Section 3.4), self-esteem may be of importance only under conditions of high problem rank. This possibility was examined, but the results failed to support a self-esteem or self-esteem x problem rank relationship with requesting or attendance. However, problem rank and distress were both significantly related to requesting (but not attendance; see Tables 29 & 30). These results indicate that high distress and higher problem rank [M(SD): Requester = 4.9(.83); Nonrequesters = 3.7(1.3)] significantly increased the likelihood of requesting referrals. Problem rank and distress were considered in the next section, along with preferences towards psychotherapy, as predictors of requesting referrals.

Table 29

Effects of Distress & Problem Rank on Requesting Referrals for Psychotherapy

	Log Likelihood	Chi Squares Improv.	Fit	Gamma
Step 0	-84.61			
Step 1	-72.86	23.50**	1.08***	
Rank				.89
Step 2	-70.01	5.71*	1.7***	
Rank				.98
Distress				-.84
Dist. x Rank	-69.45	1.10	1.9	

Note. Rank = Problem Hierarchy Rankings
*p < .009, df = 1; **p < .0005; ***Fit Chi Squares all at p >.35

Preferences Towards Psychololgical Services

Preferences towards psychololgical help have been argued, but not demonstrated, to predict psychotherapeutic help-seeking. The question here was, were preferences related to behavior independent of distress and problem rank?

Distress, Problem Rank & Preferences. Distress was unrelated to either preferences or problem rank (respectively, r's = -.02, .01), but problem rank and preferences had a significant relationship (r = -.19, p = .006, df = 166); more positive preferences were associated with perceiving the sexual problem as more important (relative to other problems). These data raise an additional issue; are preferences and problem rank reflective of a common underlying dimension (e.g., psychological sophistication) and, thereby, redundant with respect to help-seeking

behavior?

Effects on Requesting & Attending. The findings indicated that (see Table 30) problem rank, preferences and distress were all independent predictors of requesting referrals; all two way and three way interactions were nonsignificant. These results suggest that preferences and problem rank are not redundant with respect to requesting referrals. In brief, high distress, greater preferences towards psychotherapy and high problem rank increased the likelihood of requesting referrals.

Suprisingly, none of the psychological variables were related to attending therapy. Either there were ceiling effects or the measures were unstable over the time interval between requesting and attending therapy. The present design was insufficient for discriminating these possibilities. A post referral assessment would be needed to determine if distress, problem rank and preferences had changed (if scores remained stable then one would suspect a ceiling effect).

Summary: Person Variables

Distress, problem rank, and preferences towards psychotherapy were related to requesting referrals, but not associated with attendance. Self-esteem was unrelated to either outcome variable (see section summary for additional discussion).

Table 30

Relationship of Problem Rank, Preferences Toward Psychotherapy & Distress to Requesting Referrals

	Log Likelihood	Chi Squares Improvement	Fit	Gamma
Step 0	-84.61			
Step 1	-71.45	25.4**	.93***	
Pref.				-1.18
Step 2	-62.68	17.5**	.23***	
Pref.				-1.09
Rank				-2.84
Step 3	-60.35	4.6*	.28***	
Pref.				-1.06
Rank				.89
Distress				-.81
Interactions				
Two Way	nonsignificant			
Three Way	nonsignificant			

Note. Pref. = Preferences for Psychotherapy, low scores = greater preference for; Rank = Problem Rank
*p < .02, **p < .0001, df = 1; p's all > .62, df = 2

SECTION 3.66

SOCIAL VARIABLES AND SEEKING PSYCHOTHERAPY

Overview

Two major social influences on help-seeking were considered, partner/spouse and social network. In addition, the effects of relationship commitment and seeking help from friends were examined.

Network Diversity

Informal networks may both inhibit and facilitate formal

help-seeking. A key network dimension in this regard is diversity. High network diversity is indicative of having social contacts beyond those defined by birth and marriage.

Among other functions, more diverse networks facilitate contact with and adoption of new ideas relevant to obtaining help. These functions derive from the fact that diverse networks are composed of more nonintimates, who are usually less invested in the helping role intimate members occupy. In brief, intimate network members have a vested interest in exserting pressure on the help-seeker to remain within the bounds of the network. The relevant hypotheses linking distress and network diversity to requesting and attending therapy are presented below.

Hypothesis

Diversity of informal help sources and distress interact such that high distress and greater diversity of informal contacts lead to requesting referrals and attending therapy; failure to request referrals is associated with high diversity and low distress, or low diversity under conditions of either high or low distress.

Network Diversity was a significant predictor of attending [M(SD): Attenders = 2.8(.8); Nonattenders = 2.1(1.3)], but not requesting (see Table 31); more diverse networks increased the likelihood of attending therapy. If networks are utilized as "advisors" in terms of a decision making process, then it is apparent why networks were unrelated to requesting referrals. That is, when making requests there were not opportunities to consult the network, but there was plenty of time to do so prior to attending therapy (an average of 6 months). The present results support observations from employment, divorce, and

abortion research that show low density networks (indicative of diverse social contacts) to facilitate help-seeking outside social networks (Wilcox & Birkel, 1983; Granovetter, 1973; 1982; Lee, 1969).

Table 31

Relationship of Diversity of Informal Network & Distress to Attending Therapy

	Log Likelihood	Chi Squares Improvement	Fit	Gamma
Step 0	-12.56			
Step 1	-.002	25.12*	.01**	
Diversity				17.71
Distress	nonsignificant			
Dist. x Diversity	nonsignificant			

Note. (Diversity and Distress r = .12, p > .10)
*p < .0001, df = 1; ** p = .99, df = 2

Interpersonal Distress & Primary Partner

Network theory contends that intimate others inhibit psychotherapeutic help-seeking. However, network theory does not consider situations that might invoke a communal problem solving response; a response which could involve suggestions to seek professional help (see Chapter I, Sections 1.6 & 1.11).

Further, when partners jointly confront a problem there may be an increased sense of well being (i.e., misery enjoys company), and hopefullness that a solution can be found. Conversely, the absence of a communal response may lead to frustration and despair with respect to finding a solution. The

present study did not address all these relationships, but the data did suggest that lack of a communal response was associated with greater emotional upset than when a communal effort was made (see Section 3.52).

Based on the above arguments, communal help-seeking and distress were examined with respect to requesting and attending. Both variables were significantly related to requesting referrals, the results indicating that high distress and the presence of communal help-seeking were related to requesting (see Table 32). Distress was unrelated to attending therapy, but communal help-seeking had a significant association (% Using Partner: Attenders = 100, Nonattenders = 66; see Table 32). Thus, seeking help from an intimate facilitates professional help-seeking, contrary to social network theory.

Table 32

Relationship of Communal Help-Seeking & Distress to Requesting Referrals and Attending Therapy

	Chi Squares			
	Log Likelihood	Improvement	Fit	Gamma
Requesting				
Step 0	-84.61			
Step 1	-82.70	3.82**	.50****	
Distress				-.47
Step 2	-79.04	7.32**	4.80****	
Distress				-.72
Part.				-.58
Dist. x Part.	nonsignificant			
Attending				
Step 0	-12.56			
Step 1	-9.54	3.39*	1.31***	
Part.				-4.93
Distress	nonsignificant			
Part. x Dist.	nonsignificant			

Note. Part. = Communal help-seeking.
*p < .03, **p < .02, ***p < .0004, df = 1; ****p's > .10,df = 2

Communal Help-Seeking and Network Diversity

Since communal help-seeking and network diversity represent contrasting view-points, it was of interest to examine their relative contributions to requesting and attending therapy (see Table 33). Communal help-seeking had a significant effect on attendance and requesting, but network diversity was not significant when communal help-seeking was taken into account. Contrary to network theory, intimates were more influential than nonintimates with respect to psychotherapeutic help-seeking. This

does not mean, however, that all social network members were uninfluential on seeking external help.

Table 33

Relationship of Communal Help-Seeking & Network Diversity to Requesting Referrals and Attending Therapy

	Chi Squares			
	Log Likelihood	Improvement	Fit	Gamma
Requesting				
Step 0	-84.61			
Step 1	-82.70	3.82**	.50***	
Part.				-.39
Step 2				
Network	nonsignificant			
Part. x Network	nonsignificant			
Attending				
Step 0	-11.24			
Step 1	-9.54	3.39*	1.50***	
Part.				-4.93
Network	nonsignificant			
Part. x Network	nonsignificant			

Note. Part. = Communal help-seeking.
*p < .03, **p < .02, df = 1; ***p's > .20, df = 2;

Communal Help-Seeking & Friends

The data on informal help-seeking (section 2) suggests that people who utilized communal help-seeking, relative to those who did not, were more likely to employ friends for help. Consequently, though network diversity was not as important as communal help-seeking in facilitating professional help-seeking, it may still be that some network members were of influence.

Within the context of communal help-seeking, it is reasonable that a couple might agree to obtain advice from close friends. However, help-seeking from friends may also occur because a communal response can not be achieved. The latter perspective suggests that seeking help from friends may have an independent effect on obtaining professional help, while the former view suggests an interaction effect.

Results indicated that communal and friend help-seeking were predictors of requesting, but only communal help-seeking was related to attending therapy (see Table 34). In no instance was the interaction beween communal and friend help-seeking significant.

These data contradict the view that social networks were unrelated to requesting referrals, since the network could not be utilized. Speculatively, a supportive partner or prior encouragement from friends could, when given opportunity, facilitate a decision to obtain information (requesting referrals). Apparently this is not the case, however, with the decision to attend therapy; there, only communal help-seeking was relevant. Thus, friends impacted on information seeking, but friends alone were not enough to facilitate therapy attendance. Evidently, only when communal help-seeking has been achieved does movement occur from information seeking to attendance.

Table 34

Relationship of Communal Help-Seeking and Friend Help-Seeking to Requesting Referrals and Attending Therapy

	Chi Squares			
	Log Likelihood	Improvement	Fit	Gamma
Requesting				
Step 0	-84.61			
Step 1	-82.70	3.82**	.50***	
Part.				-.39
Step 2	-78.99	7.89**	1.20***	
Part.				-.58
Friend				-.67
Part. x Friend	nonsignificant			
Attending				
Step 0	-12.56			
Step 1	-9.54	3.39*	1.31***	
Part.				-4.93
Step 2	-9.41	.27		
Part.				-5.46
Friend				.40
Part. x Friend	nonsignificant			

Note. Part. = Communal help-seeking.
*p < .03, **p < .02, df = 1; ***p's > .50, df = 2

Relationship Commitment

Since communal help-seeking influenced both requesting and attending, a closer look at primary relationships seemed warranted. One line of reasoning suggests that people in committed relationships would be highly invested in solving the sexual problem in order to maintain the relationship; people in less commited relationships may ignore the problem or "dump" the

relationship, as opposed to seeking help.

In addition, relationship commitment may interact with communal help-seeking to influence external help-seeking. This perspective derives from the view that communal help-seeking (willingness to solve the problem), failure to solve the problem at the communal level, and a highly commited relationship are the more fertile conditions for seeking therapy. That is, communal help-seeking alone does not uniformly influence seeking psychotherapy. Communal help-seekers with low relationship commitment may terminate the help-seeking process when solutions are not found at the communal level. Thus, communal help-seeking was expected to interact with relationship commitment to influence requesting and attending therapy.

Relationship length was selected as an index of relationship commitment (i.e., increasing duration = greater commitment). Logistic regression indicated that only communal help-seeking was related to requesting referrals (see Table 35). However, both communal help-seeking and commitment were significant predictors of attending therapy (see Table 35). In no instance was there a significant interaction between communal help-seeking and relationship commitment. Thus, higher commitment to one's primary relationship facilitates, independent of communal help-seeking, therapy attendance. It is again apparent that conditions influencing information seeking differ from those that affect therapy attendance.

Table 35

Relationship of Communal Help-Seeking & Relationship Commitment to Requesting Referrals and Attending Therapy

	Log Likelihood	Chi Squares: Improvement	Chi Squares: Fit	Gamma
Requesting				
Step 0	-55.92			
Step 1	-54.40	3.04**	2.00***	
Part.				-.42
Step 2	-53.8	1.07		
Part.				-.39
Commit.				-.25
Step 3				
Part.x Comm.	-53.8	.009		
Attending				
Step 0	-8.02			
Step 1	-6.18	3.68*		
Part.				-5.09
Step 2	-4.57	3.21**	1.02***	
Part.				-3.87
Commit.				.37
Step 3				
Part.x Commit.	nonsignificant			

Note. Part. = Communal help-seeking.
*p < .03, **p < .04, df = 1; ***p's > .25, df = 2

Summary: Social Influences

Since help-seeking is a social activity, it is resonable that it would be influenced by other social factors. This mundane observation lends itself to the more complicated question of, are the steps in obtaining psychotherapy equally affected by the same social circumstances? The present data suggest that requesting referrals (information seeking) was influenced by prior

experiences with communal and friend help-seeking, but attending therapy was only effected by communal help-seeking. Thus, one's closest intimate affected each step in obtaining psychotherapy, but social network members influenced only the initial - information gathering - step. In many respects these findings were not entirely unexpected. One's sexual partner is typically in a more powerful position, relative to one's friends, to facilitate or inhibit decisions on obtaining therapy. Not obvious, from a network perspective, was why intimate relationships had a positive affect on seeking professional help.

The results did show an effect for network diversity on attending therapy, as expected. However, when both communal help-seeking and network diversity were examined with respect to attending therapy, only communal help-seeking was significant. These findings advance the proposition that seeking help from intimates is not antithetical to obtaining formal help, and may be a more powerful facilitator than diverse social networks. The problem with network theory is that it views help-seeking as an individual matter; that is, only one person within a primary relationship seeks help, and threatens the benefits others derive from the helping role. However, when partner's pursue the problem jointly (communal help-seeking) then, in a sense, they share the same helping role. Thus, extra-relationship help-seeking may be seen as mutually rewarding, and not as depriving one partner of the benefits of being a helper. Social network theory needs revision to account for problem solving contexts wherein the unit of analysis is dyadic.

An alternative view suggests that informal help-seeking does not influence psychotherapeutic help-seeking, rather they are parallel actions; that is, some people seek help from everybody - spouse, friends and professionals. However, this perspective would not address why relationship commitment is related to attending therapy, but not requesting. That is, there are elements of primary relationships that affect help-seeking independent whether help is sought within that relationship.

The present findings indicate that intimates were a major influence on the process of seeking help from psychotherapists. The data draw attention to needed revisions in network theory, and open the gate for further investigation of the effects of relationship variables on formal help-seeking.

SECTION 3.67

RESOURCES & SEEKING PSYCHOTHERAPY

Overview

Time and financial resources have been found to influence formal help-seeking. Examined here were two sources of financial capability (income & insurance) in addition to time flexibility. Time flexibility refers to the amount of time subjects had during a given week with which to seek therapy (indexed by hours employed outside the home).

Time and Money

The relevant hypotheses concerning financial resources and time are presented below.

Hypotheses

A) Financial resources and sexual distress interact such that high distress and greater resources lead to formal help-seeking (requesting and attending). Failure to request (attend) is associated with high distress and low resources, and low distress under conditions of either high or low resources.

B) Time flexibility and distress interact such that high distress and high flexibility lead to requesting and attending. Failure to request (attend) is associated with high distress and low flexibility, and low distress under conditions of either high or low flexibility.

Although distress (as reported previously) was related to requesting referrals, neither income (income and distress r = -.09, p > .10) mental health insurance were significant predictors of requesting (interaction models all nonsignificant).

Health insurance, but not income was related to attendance (Health Ins. Attenders = 80%, Nonattenders = 100%; see Table 36). Unexpectedly, fewer people with health insurance attended therapy.

Table 36

Relationship of Distress and Health Insurance to Attending Therapy

		Chi Squares		
	Log Likelihood	Improvement	Fit	Gamma
Step 0	-12.56			
Step 1	- 7.72	3.10*	4.20**	
Insurance				- 5.80
Distress	nonsignificant			
Distress x Ins.	nonsignificant			

*p < .04, df = 1, **p = .64, df = 6, (2*O*LN(O/E)

Time flexibility was significantly related to requesting [M(SD): Requesters = 24.7(21.0); Nonrequesters = 31.7(17.9)], but not attending therapy (see Table 37). The direction of the relationship suggests that as the number of hours working outside the home decreased the likelihood of requesting referrals increased.

Table 37

Relationship of Distress & Time Flexibility to Requesting Referrals

		Chi Squares		
	Log Likelihood	Improvement	Fit	Gamma
Step 0	-84.61			
Step 1	-82.72	3.79**	2.28***	
Distress				-.61
Step 2	-81.37	2.69*	2.95***	
Distress				-.53
Time				-.17
Distress x Time	nonsignificant			

Note. Time flexibility and stress r(168) = .16, p = .02 .
*p < .05, **p < .03, df = 1; **p > .22, df = 2

Resources: Summary

Financial and time resources were inconsistently related to requesting and attending (independent of distress). Greater time flexibility increased the likelihood of requesting, and insurance coverage decreased the chances of attending therapy. Income was not related to either dependent variable.

At first pass, the above results are confusing. On the one hand it seems resonable that time flexibility might enter into the initial decision to request referrals; later, it could be

less influential as therapists offer eavening and weekend sessions to accomodate those who work. However, the health insurance data are nonsensical. Possibly, more nonattenders than attenders held insurance plans which only reimburse participating therapists (e.g., HMOs; Note. study therapists were all in private practice). This does not explain why financial resources were unrelated to requesting referrals. Another possibility is the instructions respondents recieved. Subjects were informed prior to making requests that therapists would adjust fees or accept insurance coverage. Thus, financial concerns may have been delayed until the actual costs were ascertained by contacting a therapist.

It would be erroneous to conclude, however, that financial issues were not of import to attending/requesting. In particular, it is of interest to note that approximately 70% of both requesters and nonrequesters had mental health coverage; a finding which is indicative of the "middle classness" of the subsample. Thus, financial issues may have been of less concern to these participants.

Past studies have not examined the influence of resources on the help-seeking information gathering process; the primary focus has been on the act of obtaining professional help. The above evidence suggests that resources were not uniformly salient across the decision-making process. Further investigation of factors affecting resource salience over this process seems warranted. For instance, does awareness of payment options (e.g., sliding fee scales) facilitate seeking professional help?

SECTION 3.68

SEX DIFFERENCES: AN EXPLORATORY EXAMINATION

Overview

Sex differences in help-seeking would have been very interesting to examine if only more males had been represented in the present sample (10% males). Nonetheless, it may be instructive to examine if typically evidenced sex differences in utilization of psychotherapy are mirrod in the present study. Although few studies have examined sex differences in requesting referrals, prior work has demonstrated that women more often than men seek psychological help (see for review, Fischer et al., 1983). Thus, it would not be unexpected to find sex differences with regard to requesting and attending therapy.

Sex Differences

Requesting referrals and attending therapy were regressed on distress, gender, and their cross product (see Table 38). Distress was significantly related to requesting, and sex was the sole predictor of attending (women more likely to attend than men). The sex effect on attendance was not moderated by distress (i.e., their interaction was nonsignificant). The present findings indicated that though men and women did not differ on requesting referrals, they did diverge on using referrals. These results suggest, contrary to popular views, that men are not simply disinclined towards psychotherapy. Rather, men did not move beyond the information seeking stage. This conclusion underscores the importance of identifying where in the help-seeking process sex differences occur, and why they occur at

those points. This would provide considereable refinement in understanding sex differences in help-seeking.

Table 38

Effects of Distress & Sex on Requesting and Attending Psychotherapy

	Log Likelihood	Chi Squares Improvement	Fit	Gamma
Requesting				
Step 0	-84.61			
Step 1	-82.72	3.79*	2.25***	-.61
Distress				
Sex	nonsignificant			
Sex x Distress	nonsignificant			
Attending				
Step 0	-12.56			
Step 1	-11.24	2.64**	13.12^	5.39
Sex				
Distress	nonsignificant			
Sex x Distress	nonsignificant			

*p < .03, df = 1; **p < .05; ***p = .32; ^p = .44

SUMMARY SECTION 3.6

Overall, no support was found for a distress x directive variable interaction model. Further, roles were not confirmed for age, self-esteem, and prior therapy use in the decision to request or attend psychotherapy.

Emotional, problem context, and helper variables (distress,

problem rank, preferences) were found to influence requesting therapy, but not attendance. Methodological limitations of the study may account for the latter results (i.e., distress, problem rank and preferences need to be assessed just prior to the decision to attend therapy). In brief, people who were more distressed, considered their sexual problem to be highly important, and had greater preferences for psychotherapy more often requested referrals.

Among more general personality and social factors, only social conditions affected requesting and attending: (a) communal help-seeking was related to both outcomes, (b) seeking help from friends was related to requesting referrals, and (c) network diversity and commitment were predictive of attending therapy. However, the relationship of network diversity to attendance was not significant when controlling for communal help-seeking. Nevertheless, the relationship of prior help-seeking from friends to requesting referrals suggests that some social network members do affect seeking therapy.

The resource data were interesting, though puzzling. In particular, health insurance was found to be inversely related to therapy attendance. One explanation is that more nonattenders than attenders had restrictive insurance plans. Time flexibility was related to requesting referrals. This suggests that time requirements envisioned with respect to initiating therapy affects information seeking. Consequently, time flexibility was a barrier at an early stage of the formal help-seeking process.

Sex was related to attending therapy. The absence of sex differences in requesting referrals implies a more complicated

picture than portrayed by studies focusing only on the final outcome of the process - attending therapy.

The results suggest that requests were more strongly affected than attendance by psychological conditions. Design limitations or ceiling effects may account for this particular pattern of results. Design issues aside, the findings do indicate a need for future studies to discriminate at least two steps in the psychotherapeutic help-seeking process. In brief, it can not be assumed that each step will be affected by similar conditions.

SECTION 3.7

SUMMARY CHAPTER III

Table 39 provides an overview of the findings. Distress was controlled for in all analyses except where comparions involved competing perspectives (e.g., network diversity v.s. communal help-seeking).

Although in some instances distress was a predictor of help-seeking, it did not interact with other predictor variables. In part, this latter outcome may derive from those measurement problems discussed previously. In Chapter IV several additional issues surrounding emotions and help-seeking are addressed: a) duration of distress, b) multiple sources of distress, c) multiple emotional states.

Findings concerning age and prior help-seeking experience are not presented in Table 39. Help-seeking for sexual problems was age invariant; a finding unlikely to be related disclosure

prohibitions, since a majority of respondents had sought social help. Age differences in help-seeking, as discussed previously, may be obscured by the study's cross sectional design. Prior help-seeking experiences (communal or formal) were unrelated to current behavior, suggesting that sexual problems may represent a novel problem solving situation. Indeed, relative to the percentage of participants who had employed psychological services for other reasons, very few had employed these services for sexual problems - despite a high prevalence of sexual difficulties in the sample (43%). As expected, formal help-seeking was a minority coping response.

Table 39

Summary of Findings: Social, Informal and Formal Help-Seeking (X's = significant association)

Help-Seeking	Predictors								
	Psychological				Social			Resources	
	Dist.	Rank	Pref.	SE	CHS	Comm	Frnd	Time	Insur
Social		x		x					
Informal:									
Partner	x	x							
Friends		x			x				
Relative					x				
Request Referral	x	x	x		x		x	x	
Attend Therapy					x	x			x

Note. Dist = Distress, Rank = Problem Rank, Pref = Preferences Towards Psychotherapy, SE = Self-Esteem, CHS = Communal Help-Seeking, Comm = Relationshp Comittment (indexed by length of relationship), Frnd = Seeking Help From Friends, Time = Time Flexibility (Hours worked), Insur = Mental Health Insurance.

In brief, the findings indicate that social, psychological and resource factors do not uniformly affect each step in the social help-seeking process. General personality conditions, for instance self-esteem, may primarily be important to initiating the process, but problem context factors (e.g., problem hierarchies) influence each step in movement from self-help to requesting professional help. These findings document the need to examine help-seeking as a process, and provide a first glimpse of the differential impact of psychosocial conditions on a two step model of psychotherapeutic help-seeking.

CHAPTER IV

DISCUSSION

Overview

This study examined psychosocial determinants of help seeking behaviors exhibited by people with sexual problems. This investigation was the first to a) prospectively assess psychotherapeutic help-seeking, and b) examine the range of help-seeking behaviors associated with sexual problems.

Overall, the findings a) depicted a different picture of the psychotherapeutic help-seeker than previously described, b) revealed limitations in the proposed motivation model, c) provided support for a normative help-seeking model, d) established the importance of problem hierarchies and communal help-seeking as determinants of informal and formal help-seeking, and e) generated data on the import of help-seeking to adult sexual development. These findings are discussed in sections 4.01 to 4.10.

Additonal highlights of this study include the following:

- New data were provided on the prevalence of sexual problems; a previously unreported increase in perceived dyadic sexual difficulties over early adulthood was documented.
- The "salted peanut" effect was called into question; prior psychotherapy experiences were found to be unrelated to psychotherapeutic help-seeking.
- The results demonstrated needed revisions in social network theory; contrary to network predictions, psychotherapeutic and extrarelationship help-seeking occurred more often when

respondents had sought help from an intimate.

- The findings indicated that high distress levels may not invariably facilitate help-seeking; communal help-seeking was associated with lower, rather than higher levels of distress.
- The role of self-esteem was further delineated; the data suggest that self-esteem influences initial help-seeking contacts, but is of less consequence to subsequent contacts.
- A basic component of Gross and McMullen's decision-making model was substantiated; indeed, problem hierarchies were consistently important to social, informal and formal help-seeking behaviors.

In brief, the findings supplement a meager data base on the prevalence and distribution of sexual difficulties, and provide new insights on the fundamental components of previous help-seeking models. With respect to prior frameworks, the present investigation was unable to provide support for an integrative model. However, as the findings summarized above indicate, clarification was obtained for a number of midrange models.

SECTION 4.01

THE HELP-SEEKER

Past Perspectives

Prior investigators, based on inadequately designed studies, have concluded that people turn to professional helpers only when informal help is inadequate or unsuccessful, and they feel demoralized, overwhelmed, and out of control (e.g., Wills, 1983). The present study suggests a substantially different picture.

A New Look

Review of Findings. In the present study, psychotherapeutic help-seekers did not differ in self-esteem from those employing only informal aid (see footnote 2), and were no more distressed than those requesting, but not attending therapy. Moreover, it was not simply failure at the informal level which facilitated seeking psychotherapy. Indeed, a committed relationship, and a sexual partner willing to jointly confront problems were important to reaching psychotherapy. Lastly, people requesting referrals viewed their sexual problem as highly important, and psychotherapy as a viable solution to that problem.

Self-Efficacy. In brief, contrary to being at their "wits' end and psychologically scraping bottom", people who sought psychotherapy a) were distressed, but not overwhelmed by their problem, b) had moderate levels of self-confidence, c) had the abiltiy to organize and prioritize their problems, and d) believed solutions were possible, and sought those solutions. In Bandura's terms (1986), these characteristics depict a person with a relatively high degree of self-efficacy. In support of this characterization are data indicating that women with high, relative to low, levels of sexual self-efficacy (Catania et al., 1984) were significantly more likely to seek information on and to regularly practice Kegel exercises (a technique to strengthen the pubococcygeal muscle in order to increase, for example, orgasm frequency and ease, and enhance the pleasure of one's sexual partner; Cole; 1983).

Cole's results are particularly interesting because the self-efficacy measure employed assessed self-efficacy with

respect to one's sexual relationship. With regard to sexual relationships, increasing levels of sexual self-efficacy have been found to be significantly associated with higher levels of sexual satisfaction, more frequent sexual encounters, and higher frequencies of orgasm (Catania et al., 1984). Speculatively, people with high, relative to low, levels of sexual self-efficacy may perceive sexual difficulties to be associated with a greater loss of sexual rewards, and perhaps evidence more distress as a result. Consequently, people with higher levels of sexual self-efficacy may be more motivated to seek help when confronted with a sexual problem. In addition, individuals who have learned to requlate their sexual interactions so as to maximize their satisfaction may have had experience with solving sexual problems in their relationships. These prior experiences may lead to a pragmatic "problem solving approach" to one's sexual relationship; an approach that facilitates help-seeking efforts when confronted with a difficulty unresolvable through self-help, efforts that include seeking help from informal and formal sources. Furthermore, if sexual problems are more stigmatized than other psychosocial difficulties, then a high degree of self-efficacy may be advantageous in providing the psychic capability to surmount feelings of embarrassment or shame that might accompany help-seeking.

Other Characteristics of Psychotherapy Users

Although the psychotherapeutic help-seekers in the present study may differ in some respects from those who seek therapy for other types of disorders, there are also similarities. In

general, those seeking psychotherapy are young, white, educated, middle-class, and female (e.g., see Gourash, 1978, for review). The group of psychotherapy help-seekers in this dissertation fit this broad description of the psychotherapeutic help-seeker (see Chapter III, Table 19). Further, data from the Human Sexuality Clinic at the University of California - San Francisco, based on approximately 1,600 patients, also confirm this description of the psychotherapeutic help-seeker (Evalyn Gendel, personal communication). Reflecting on the major source of respondents for this study, a young, white, female, educated, middle-class person also describes those who attend pleasure parties; pleasure parties being, perhaps, another form of help-seeking for some people.

The psychotherapeutic help-seeker with a sexual difficulty may also be characterized by the type of sexual problems they exhibit. From my past experience in conducting brief sexual interventions (White & Catania, 1982), and the experience of the U.C.S.F. Human Sexuality Clinic (Gendel, personal communication), males who seek psychotherapy usually seek treament for an erectile difficulty, but only after they have first sought medical help (also see Seagraves et al., 1982). Women, however, seek psychotherapy for a much larger variety of complaints than those evidenced by men, and as often self-refer as they are referred by other professionals. Thus, more women than men with sexual problems may attend psychotherapy because women recognize or are willing to disclose a larger number of complaints. Similar factors, problem recognition and self-disclosure, have been shown to account for sex differences in psycotherapeutic help-seeking

for psychosocial problems in general (Kessler et al., 1981; Horwitz, 1977). However, there may be an additional element to consider. Men may spend considerable time, energy, and money pursuing medical treatment. In the long run these men may lose the motivation to continue help-seeking if the medical route fails to produce a cause. That is, men may be more threatened than women by the implication that their sexual difficulty is "psychological", but feel comfortable with the belief that the problem is physiologically caused (e.g., Veroff et al., 1981). In seeking this less threatening course of action, men reduce their chances of obtaining psychotherapy. The present study cannot address these issues, but they are mentioned as interesting avenues for future work.

SECTION 4.02

THE DISTRESS MODEL

Overview

Within the proposed framework, emotional distress provides a subjective gauge with which to judge problem severity, and the need to seek help. The interaction between distress and directive variables was expected to determine the performance of help-seeking behaviors. Directive variables were defined as problem context factors, helper characteristics, and general psychosocial conditions surrounding the help-seeker.

Although distress correlated significantly with several help-seeking activities, the expected distress x directive

variable interaction model was not substantiated. Design and measurement problems aside (see Chapters II & III), three central issues require further study before this approach is called into question. These issues include: a) distress duration, b) multiple sources of distress, and c) "mixed" emotions.

Duration

People with similar distress levels may make opposite help-seeking decisions depending on the duration of their distress. Distress of brief duration may be associated with expectations of spontaneous recovery and, consequently, little help-seeking. For instance, Seagraves et al., (1982) found greater problem duration to be related to increased attendance by urology patients referred to a sexuality clinic. Sexual distress was not assessed, but their findings are consistent with the proposed view. In short, both distress level and duration may be needed to fully operationalize the distress motive.

More enduring distress may also impact on help-seeking by focusing attention on problem context features. That is, longer duration will be associated with increasingly more thought devoted to the perceived problem's cause, locus, and relative importance. Consequently, enduring emotional states may stimulate directive variables that, in turn, interact with those same emotional conditions to influence help-seeking behavior.

Multiple Sources of Distress

The present study assessed distress associated with sexual problems and primary relationships. However, these sources may be insufficient to precipitate help-seeking without additional life

stresses present to exacerbate circumstances (e.g., work and parenting distress). Future studies should examine the effects of overall distress on help-seeking decisions (see Mechanic, 1978).

Mixed Emotions

Although distress is an important emotional contributor to help-seeking, there are other emotional considerations involved. People may feel embarrassment over revealing a problem or by being stigmatized for seeking psychological treatment. Some individuals may be motivated by the excitement of a challenge, joy of attaining mastery over a problem, love for another person, or fears of losing love to overcome their embarrassment and obtain help. From this perspective, distress is only one of several emotional forces that may motivate help-seeking. Future studies might focus on the ratio of "pro-" to "antihelp-seeking emotions" as one means of conceptualizing these multiple forces.

In sum, numerous emotional elements remain to be examined throughout the help seeking process, and deserve more serious study than they have received. Indeed, past studies often assume an underlying emotional state, but seldom assess these emotions.

SECTION 4.03

HELP-SEEKING: A SEQUENTIAL PROCESS

Overview

A major study objective was to examine the psychotherapeutic help-seeking process. In accomplishing this task, it was also possible to gain a broader picture of a proposed normative help-

seeking sequence (see Chapter I, Sections 1.12 & 1.14). In this sequence, self-help is purportedly the first problem solving response. If self-help fails, informal help-seeking may follow; of those failing to obtain a solution at the informal level, a small percentage will seek formal help. How did the present findings tally with this proposed sequence?

Findings

In accord with the norm of "rugged individualism", a majority (75%) of people with sexual problems had employed self-help. Supporting the view that self-help is typically obtained first, were findings indicating that most informal and all formal help-seekers had employed self-help. This interpretation receives added support from De Amici et al., (1984), who found a majority of clients intiating sex therapy had previously attempted self-help.

With regard to an informal-formal sequence, clearly informal help-seeking preceded obtaining psychotherapy. In particular, communal help-seeking was evidenced by all who attended therapy.

The current results provide the strongest evidence to date that help-seeking follows a normative sequence. These findings also suggest that investigators should consider the overall pattern of help-seeking in delineating at which points their model components apply. Self-esteem models, in particular, fail to consider this issue. The following section focuses on the determinants of the observed sequence.

SECTION 4.03

HELP-SEEKING DETERMINANTS

Overview

Self-esteem and problem hierarchies were found to influence movement from self-help or palliative coping to obtaining social help. Problem hierarchies also affected informal help-seeking, and along with distress, preferences, time flexibility and informal helpers, were important to obtaining formal help. These findings are disucssed in the following sections, and suggestions for further study offered.

Social vs Nonsocial Coping

Self-Esteem. People with high self-esteem[1] were those most likely to initiate social help-seeking. Self-esteem, however, was unrelated to specific levels of help-seeking (e.g., informal). Thus, self-esteem is primarily influential at the point of initial contact, regardless of who that person is. This interpretation makes intuitive sense, particularly if help-seeking is sequentially patterned. That is, as people with low self-esteem drop out of the process, eventually, only individuals with high self-esteem are left to continue. An alternative view stems from social support's ability to enhance self-esteem (House, 1981). That is, the therapeutic nature of social support

[1] People who seek help are typically considered to have low self-esteem (Nadler, 1983). The present study suggests a different picture. People without sexual problems reported the highest levels of self-esteem (M = 51.2, SD = 6.7), those who sought help reported intermediate levels (M = 47.9, SD = 8.8), and nonhelp-seekers reported the lowest levels (M = 45.1, SD = 9.0); all differences are significant (see Chapters II & III).

may, over the course of seeking help, produce a ceiling effect by enhancing the self-esteem of people at lower levels more than those at higher levels. Consequently, continued help-seeking would be associated with fewer and fewer low self-esteem respondents. Longitudinal studies and measures capable of detecting fine grained differences in self-esteem are needed to address these issues.

Problem Hierachies. People ranking sexual problems at or near the top of their problem hierarchies were more likely to obtain social help. Unlike self-esteem, problem rankings were also predictive of informal and formal help-seeking. Thus, the way people structure their problems contributes to the initiation and continuation of social help-seeking. Since problem hierarchies evidenced this strong showing, a more indepth discussion of this construct will be provided later (Section 4.05).

Informal Help-Seeking

Overview. Seeking help from one's spouse/sexual partner (communal help-seeking) is considered to precede other types of help-seeking. Consequently, analyses were conducted to examine the determinants of communal help-seeking, and the effects of communal help-seeking on obtaining help from other informal sources.

Communal Help-Seeking: Determinants. Low-moderate levels of distress were associated with communal help-seeking, suggesting that either a) communal help-seeking ameliorates distress, or b) when problem cause is attributed to the potential helper, then

high levels of distress may undermine conditions necessary for initiation of problem solving activities (e.g., verbal communication processes; for further discussion see Section 4.06). As mentioned before, people who perceived their problem to be relatively important were also more likely to use communal help-seeking (also see Sections 4.05 and 4.06).

Communal & Extra-relationship Help-Seeking. Communal help-seekers, independent of level of distress, were more likely to seek help from friends and relatives. Stated differently, the inability to obtain communal help does not motivate extra-relationship help-seeking, as others have speculated (e.g., Clark, 1983). Indeed, communal help-seeking plays an integral part in continuing the help-seeking process (for further discussion see Section 4.06).

Communal Help-Seeking vs Friends. The above view assumes communal help-seeking occurs first. Though there is support for this assumption (Clark, 1983), past studies have not examined problems arising within primary relationships (excluding divorce). In this situation, there are good reasons why extra-relationship help might be obtained first. Friends, for example, may provide a needed testing ground to discuss a problem, and emotional support for locating a solution. The net result is a person more capable of approaching the partner for help. This perspective suggests that the level of communication skill, confidence in one's skills, and comittment to obtaining a solution influence who will initially be approached for help. When skill, confidence and comittment are low, friends will be intially selected, while the opposite conditions facilitate

communal help-seeking at the onset.

In general, it is unnecessary to assume unidirectionality in the informal help-seeking process (e.g., friends to partner or vice versa). Informal help-seeking may be a multidirectional sequence, wherein friends and spouse are repeatedly sought out over time. Such a process also serves as a point of integration for research on help-seeking and social supports.

Psychotherapeutic Help-Seeking

For the proposed two step model of psychotherapeutic help-seeking, information-seeking and attendance, the following results were obtained:

a) high levels of distress, stronger preferences for psychotherapy, greater time flexibility, high problem rankings, and having sought help from friends or lovers all increased the likelihood of requesting referrals, and

b) having sought communal help and possessing a committed relationship facilitated movement from information gathering to attendance at therapy.

Findings concerning time flexibility, preferences and informal helpers on seeking psychotherapy are discussed below. Further discussion of problem hierarchies and communal help-seeking is provided in sections 4.05 and 4.06.

Resources. Resources are important elements in the decision to move from informal to professional helpers. Though there is ample literature to support this contention (see Chapter I, Section 1.04), prior work has not determined the point at which resources affect this decision making process.

Time Flexibility. In the present study, time flexibility influenced information seeking, but failed to affect attendance at therapy. The significance of this finding is apparent when one considers that, when requesting referrals, respondents were unaware of the actual time requirements involved in attending therapy (e.g., travel time, appointment availability). Consequently, resources may not influence help-seeking decisions on a rational level, but on an emotional-cognitive basis (i.e., the idea of attending therapy "feels" like it would take too much time). In general, there may be strong phenomenological components to resource considerations that are not tapped by objective measures (e.g., income, work time). These phenomenological characteristics need to be assessed if we are to understand how people employ resource issues in their decision making.

Also needing clarification is the impact resources have on couple's joint decisions to seek therapy, and on negotiations between potential helpers and the help-seeker. Social exchange (e.g., Walster, Walster, & Berscheid, 1978) and communal relationship models (Clark, 1983) offer useful frameworks for investigating these matters.

Preferences. Help-seeking preferences reflect, in part, the help-seeker's perceptions of a potential helper's ability to aid in solving the problem (See Chapter I, Section 1.04). The present investigation focused on people's general preferences for psychotherapy. The data indicate that preferences were important to information gathering, but unrelated to attending therapy. Thus, as with resources, preferences impact early in the formal

help-seeking process. However, the possibility remains that preferences assessed prior to requesting referrals may have changed subsequent to that event. Informal networks, for instance, may modify initial preferences (e.g., spouse refuses to go to therapy; friends mention negative therapy experiences; also see Section 4.06). Consequently, it would be useful to obtain preference measures more proximal to the decision to attend therapy.

Informal Helpers. Seeking help from friends or lovers increased the likelihood of requesting referrals. However, only communal help-seekers and people in committed relationships went on to attend therapy. Thus, it is not only failure to find an informal solution that facilitates formal help-seeking, but it is failure plus other important aspects of informal relationships that support seeking psychotherapy (see 4.06).

Summary. Overall, support for a two step process of psychotherapeutic help-seeking was provided. The methodologically strongest findings were obtained with respect to requesting referrals. The classic relationship between distress and help-seeking was observed, and the importance of intimate relationships to obtaining formal help was clarified. In section 4.01 these results were discussed in contrasting current and past views of the help-seeker.

SECTION 4.05

PROBLEM HIERARCHIES

Overview

Problem hierarchies provide a context for the decision to seek help. Moreover, these cognitive structures may help people cope with multiple difficulties without feeling overwhelmed. Despite the importance of problem hierarchies to help-seeking, few relevant conceptual or empirical studies have been conducted. The following material is an effort to provide directon in pursuing these goals.

Development

From a Piagetian or Wernerian point of view (Werner, 1957), the development of problem hierarchies would parallel cognitive processes underlying movement from concrete to abstract thinking. For instance, the ability to categorize problems and determine their singular or mutual priority would involve some degree of abstract thinking.

With the ability to generate problem hierarchies established, much internal development would still continue with respect to the problems comprising their structure. Obviously, problem hierarchies change as new difficulties and information on old problems are acquired. Friends, for example, may reduce a problem's importance by convincing us that, in their experience, the problem resolved when they stopped worrying about it. Thus, informal supports may help define the hierarchical position of a problem. Social comparison theory offers a useful approach to studying this issue (e.g., Wills, 1983) by focusing on the social

processes involved with people's judgements of how well they are doing.

Interconnections

The number of and relationships between difficulties may influence problem hierarchy formation, and consequently, help-seeking. When many unrelated problems are perceived, people may feel overwhelmed and unable to solve their difficulties. However, if problems are perceived to be interconnected, then the hierarchies appear smaller and more managable; the act of seeking help may then be easier. That is, help is more likely to be sought if one solution, as opposed to multiple solutions, can be applied to several problems. One implication of this perspective, is that it can not unequivocally be concluded that respondents were seeking aid solely because of a sexual problem.

For future studies, it may be useful to conceptualize problem interconnectedness in terms of role strains (e.g, Pearlin et al., 1981). Role strain represents a set of problems occuring within a particular social role (e.g, marital and work roles). Questions of how people order strains within and across roles, and how these priorites affect help-seeking warrant investigation.

Summary

In brief, the present findings suggest that the way people structure their problems contributes to initiation and continuation of social help-seeking behaviors. How the help-seeking process, in turn, produces change in these structures

provides another point of confluence for help-seeking and social support research (also see Section 4.03).

SECTION 4.06

COMMUNAL HELP-SEEKING

Overview

Communal help-seeking has been considered a "primordial" form of informal help-seeking (e.g., Clark, 1983). In the present study, communal help-seekers, relative to nonseekers, a) exhibited lower distress, b) attributed higher priority to their sexual problems, c) had lower preferences for palliative relative to problem solving coping, and d) more often sought help from friends, relatives, and psychotherapists. It can be infered from these findings that communal help-seekers, relative to nonseekers, a) were managing their distress at levels that facilitated decision making, and b) were highly motivated to find a solution.

Why are some people better at obtaining communal help. In part, the ability to employ communal help may well reflect the overall condition of a couple's relationship (Burke & Weir, 1982). Several relationship issues relevant to commuanl help-seeking are discussed below. This discussion is not exhaustive, but provides a stimulus for a broader perspective on how intimate relationships influence help-seeking.

Communal Help-Seeking & Shared Values

Pearlin's work (1975) on value systems points out the importance of relationship conditions to communal help-seeking. He found couples with common, as opposed to divergent, values on status striving evidenced a greater willingness to share problems. Thus, communal help-seeking may be affected by the values partners hold in common. From this perspective, partners who share a high regard for sexual activity are more likely, when a sexual problem arises, to perceive it as an important problem. As the present data show, this condition facilitates communal help-seeking.

Couples that value mutuality and nurturance may also be more likely to employ communal help-seeking. Further, when finding a solution is viewed as a mutally supportive and nurturing activity, then communal help-seeking may facilitate obtaining psychotherapy (see Chapter I). Thus, shared value systems may assist in preserving benefits partners derive from the helping role (See Chapter I, Section 1.11).

Conversely, discordant values on sex, mutuality, and nurturance may produce, over time, deleterious affects on goal attainment for one or both partners (e.g., in achieving sexual satisfaction). These conditions may facilitate resentment, retaliation, high distress, and less communal help-seeking.

Communal Help-Seeking & Relationship Systems

Divergent value systems are only one means of inhibiting communal help-seeking. The type of interaction system that encompasses a relationship may also effect the frequency of and

satisfaction with communal help-seeking. In this regard, two systems[2] have been distinguished, exchange and communal relationships (Clark, 1983). Exchange relationships are based on the principle that one expects to give only in the exact measure that one has received. Conversely, communal relationships are predicated on the basis of giving in response to anothers needs (emotional, physical or material).

Communal, relationships may enhance help-seeking, since partner's in communal, relative to exchange, relationships more often keep track of each other's needs (Clark, Mills, & Powell, 1986), and evidence greater confidence in their ability to help (Burke & Weir, 1982). Thus, help-seekers in communal relationships encounter an interested and receptive helper in their partner. Burke and Weir (1982) provided additional support for these considerations showing that greater satisfaction with communal help was associated with greater disclosing, trust, mutuality, and awareness of the partner's needs. In this respect, the greater degree of alturism and mutuality in communal relationships has been hypothesized to reduce perceptions of indeptedness that may be deterents to help-seeking (Greenberg & Westcott, 1983). In brief, communal relationships facilitate seeking help from one's partner and positive outcomes of those efforts. Outcomes which, in turn, may pave the way for future help-seeking ventures.

[2] Not to be equated with the present use of "communal" help-seeking which describes seeking help from one's partner or spouse.

Developmental Issues

As the last comment implies, "marital" relationships may affect the development of communal help-seeking patterns by influencing the perceived quality of the help given. In this regard, recent data indicate that the quality of communal help-seeking is dependent on the number of children living at home - the fewer children present, the greater the satisfaction (Burke & Weir, 1982). These data suggest that the development of communal help-seeking is dependent on the developmental course of the family.

So far, the discussion has not addressed communal help-seeking's "premarital" developmental antecedents. In this respect, it would seem reasonable to examine help-seeking processes in earlier child-parent, student-teacher, and friend-friend relationships as precursors to communal help-seeking in adulthood. The nature and extent of these influences on adult communal help-seeking remains to be examined.

Lovers: Additional Implications for Research

Past and present findings have clearly demonstrated that informal helpers are primary sources of help. Unfortunately, little is known of the help-seeking functions provided by these helpers. Primary partners do function to facilitate requesting referrals and attendance at therapy, but exactly how they accomplish this is unclear. Lovers may contribute to these outcomes by...

a) providing information on and reinforcing problem context parameters; for example, reinforcing attributions to psychological

causes which predispose to psychotherapeutic help-seeking (Farina et al., 1978),

b) giving opportunities to practice communicating problems which facilitate communication of the problem to friends and professionals,

c) sharing prior experiences with professional helpers which influence help-seeking preferences,

d) giving practical advice on obtaining professional help,

e) conveying norms about the appropriateness of seeking help from professionals, and

f) providing a central motivation, love, for solving relationship problems.

Determining which functions are most prevalent or useful to people at particular positions in the life-span deserve further research.

SECTION 4.07

DEVELOPMENTAL IMPLICATIONS

Overview

Two developmental considerations surround the issue of help-seeking: a) what is the developmental course for help-seeking behavior, and b) how does help-seeking impact on the development of other emotional, cognitive and behavioral elements?

Development of Help-Seeking

Age Norms. Formal operations, communal relationships, and life course tasks (e.g., parenting) were previously mentioned as possible developmental antecedents to help-seeking (Section 4.03

- 4.06). In addition, help-seeking development may be governed by age specific social norms. In our culture, these norms apply increasingly greater pressure towards self-reliance over childhood, adolescence, and into adulthood. These norms may facilitate ambivalence towards seeking help as people age.

Ambivalence. Over the formal education years, self-reliance norms may be at odds with the help seeking requirements of educational institutions. For instance, formal educators exhort students to seek help from teachers while also admonishing them to work and think on their own. Thus, students may receive contradictory messages from educational institutions. These mixed messages may contribute in adulthood to ambivalent feelings towards professionals. This ambivalence may be particularly relevant to adult psychotherapeutic help-seeking practices. Teachers impact on development starting at an early age, and they possess characterisitics of considerable generalizability to psychotherapists; indeed, educators are the first professional helpers we encounter on our own[3], and the form of aid teachers render is "mentalistic". These conditions may facilitate, among adults, lower preferences for and less use of mental health services relative to informal[4] and self-help.

[3] Childhood encounters with medical professionals differ from those with educators in that parents mediate medical help-seeking, but for the most part children deal with teachers on their own.

[4] Informal help during childhood represents an underground of educational experiences; children work together on their homework, cheat on tests together, and in general learn to depend on each other more than professional teachers.

Dysfunctional Norms. The elderly, in coping with infirmities, might benefit from obtaining help from others. However, society provides no mechanism for resocializing the elderly to a less self-reliant mode. For instance, despite increases in mental health problems with age, the elderly have little inclination towards obtaining psychotherapy (Waxman et al., 1984). Thus, self-reliant prescriptions may, in old age, undercut the adaptive benefits of help-seeking activities.

Historical Shifts. Help-seeking behaviors may also be dependent on historical conditions. Eighty years ago, for instance, sexual problems were not an appropriate topic for discussion. As sexual mores have changed, it is now common for people to discuss sexual problems with friends and relatives, as the present findings show. Thus, the type and extent of help-seeking for particular problems may shift historically as norms governing social exchanges change.

In general, developmental changes in problem context elements, perceptions of helpers, and skills needed to obtain help are all pertinent to the development of help-seeking behaviors. How those changes are influenced by historical shifts in social norms, asks a broader question than proffered by prior help-seeking models. A life-span developmental approach, with its' added emphasis on sociohistorical antecedents, provides a useful basis for understanding these larger concerns.

Help-Seeking: Impact on Development

Present findings suggest that help-seeking is associated with two routes to change. First, help-seeking acts as a filtering

mechanism with respect to changes facilitated by helpers. (see Chapter I). Secondly, the help-seeking process may generate change incidental to changes associated directly with solving one's problem.

Who Obtains Solutions? Help-seeking processes present barriers that reduce people's abilities to contact "change agents", and may selectively filter others towards certain types of change. For instance, the present study found people with high self-esteem were more likely to seek help than those with low self-esteem. If sexual problems are primarily solved through help-seeking, then individuals with high, relative to low, self-esteem will more often experience benefical changes in their sexual relationships. In general, when help is necessary to solving a problem, then help-seeking processes will influence who experiences beneficial change in the areas of life associated with the problem.

Secondary Effects. Changes incidental to the primary goal of seeking help may also occur. For instance, help-seeking may lead to skill acquistion (e.g., improved communication abilities) that does not directly solve the problem. In short, the help-seeking process may impact developmentally on behaviors other than those linked solely to the problem at hand.

Sexual Development. It is uncertain how much developmental impact help-seeking has on adult sexual development. Formal help-seeking (past & current use) is a minority coping response to sexual problems, regardless of the age group examined. Thus, a powerful mechanism for change is underutilized. Informal help-seeking is the normative response to sexual problems, but the

outcomes of this process are uncertain at best. Given the large numbers of respondents reporting sexual difficulties, it is important to a) find ways to facilitate seeking professional help, and b) examine the consequences of informal help-seeking. Indeed, as we confront the AIDS Era, the answers to these questions become increasingly important.

SECTION 4.08

IMPLICATIONS FOR CLINICIANS & SEX EDUCATORS

Results of the present study provide several suggestions for sex therapists and educators. For instance, pathways to therapy might be constructed so as to be more supportive of those with low self-efficacy. In addition, on a preventative basis, sex education programs may need to address ways of increasing people's sexual self-efficacy. Specific recommendations regarding these latter two issues stem from consideration of the belief systems underlying the construct of self-efficacy (Bandura, 1986). In the present context, low self-efficacy is associated with (Bandura, 1986) a) the inability to believe one can perform actions that will lead to obtaining therapy, b) inability to believe that the environment will be responsive to one's efforts or, in this case, that therapy will be effective, and c) the inability to perceive cause and effect relations with regard to sexual problems.

In the instance where the belief that one is unable to perform help-seeking behaviors that lead to psychotherapy is a belief attributable to experience deficits, then specific

information on how to obtain therapy may be needed. Weak response efficacy beliefs may also be a consequence of actual barriers to seeking therapy. For instance, a person's available time for attending therapy may not match the therapist's schedule. Solutions may involve therapists instituting home visits (to reduce time and transportation problems; A. Simon, personal communication, 1984), or use of "phone therapy" in some cases (L. Cole, personal communication, 1987; D. Bullard, personal communication, 1987). In general, some people may primarily need education programs emphasizing the steps and options available in seeking psychotherapy. Education may also be useful in strengthening the belief that psychotherapy can benefit sexual problems, and in instructing people to the possible causes of sexual difficulties. Indeed, one component of pre-adult sex education should include information on the types of sexual problems people face, their causes, treatments, and how to access those treatments. This type of information may go a long way in destigmatizing sexual problems and psychotherapy. Sex education progams do not currently focus on these issues (Kirby et al., 1979), although a brief adult sex education program has been shown to be effective in increasing sexual self-efficacy (White & Catania, 1982).

SECTION 4.09

SUGGESTIONS FOR FURTHER STUDY AND ANALYSIS

In previous sections a number of different topics have been identified for further research. To summarize, these include examination of:

a) the effects of sexual self-efficacy (Catania et al., 1984; Cole, 1983) on help-seeking,

b) the role of causal attributions and problem perceptions in accounting for sex differences in psychotherapeutic help-seeking,

c) the role of emotions in help-seeking that includes consideration of distress duration, multiple sources of distress, and the relationship between different ongoing emotional states with respect to help-seeking behavior,

d) the validity of the proposed problem solving behavioral sequences, and obtaining measurements of the degree of stigma attached to different help-seeking actions and types of problems,

e) the role of self-esteem in initiating social help-seeking,

f) the developmental processes involved in the construction of problem hierarchies,

g) the effects of the family life-course on the development of relationship systems and, in turn, examination of the consequences of these system changes for communal and psychotherapeutic help-seeking,

h) the specific contributions of communal help-seeking in accounting for it's observed association with help-seeking from extrarelationship helpers,

i) factors that effect the development of help-seeking behavior over the life-span, as well as the role help-seeking plays in facilitating sexual development, and

j) models that synthesize the processes involved in help-seeking, help-giving, and social support.

In addition to the above suggestions, it may also be important to examine the role that relationship problems, other

than sexual difficulties, play in facilitating help-seeking for a sexual problem. Problem hierarchy considerations, as discussed previously, would be important to examine in this regard. Fischer et al., (1983) have also touched upon this issue in hypothesizing a catalyst or precipitating event as a necessary component for mobilizing help-seeking actions. That is, an ongoing sexual difficulty may not elicit help-seeking until additional elements of the relationship breakdown and catalyze seeking assistance for the sexual problem. This perspective has some common threads with the role multiple stressors might be expected to play in help-seeking (see section 4.02).

An interesting data analytic avenue to pursue would be the use of factor or cluster analysis to examine if a common relationship and psychological profile exists for couples seeking help for their sexual problems. This approach might be applied to the present data set with respect to communal help-seeking.

Future studies utilizing the present research design might consider increasing the time interval over which people requesting referrals are followed. Gendel (personal communication, 1987) has observed some clients to take more than a year to follow-up on a referral and make an appointment for therapy. Assessment of respondent's changing life conditions over this interval would seem important, but need to be balanced against the problems of contaminating outcomes with the effects of making multiple observations.

SECTION 4.10

SUMMARY CHAPTER IV

The preceding material discussed and extended findings bearing on who seeks help for sexual problems, the patterns in which help is sought, determinants of those patterns, and the importance of help-seeking to adult development. In sum:

a) Contrary to prior views, those who sought psychotherapy in the present study evidenced a relatively high degree of self-efficacy.

b) The results document the need for examining help-seeking as a process, and provide a first glimpse of the differential impact of psychosocial conditions on this process.

c) The findings underscore the importance of decision making components and close interpersonal relationships to facilitating the process of obtaining psychotherapy.

d) Lastly, help-seeking processes are considered to impact on development by funneling people away from or towards helping relationships.

Facets of a number of middle range theories (Merton, 1968) of help-seeking were expanded upon. In sum:

a) Self-esteem models may have limited applicability, but at a very important point in the help-seeking process - the beginning.

b) A fundamental component of decision making theory, the problem hierarchy, was found to impact across the help-seeking process. Also of relevance to decision making models were findings indicating that preferences - a summary statement of the costs and benefits of seeking help - and time flexibility were

predictive of formal help-seeking, but primarily at the information-seeking stage.

c) Social Models - network diversity was found to be of limited utility in predicting formal help-seeking; specific informal network members, particularly sexual partners, were of major import to formal help-seeking.

A Final Note

When I began this study, recognition of the AIDS epidemic was just beginning. As routes of HIV (Human Immunodeficiency Virus) transmission became apparent, the present work has taken on a new significance. Indeed, many people now face a life and death situation as they confront difficulties in changing sexual behaviors that put them at risk for transmitting or contracting HIV. The primary problem is often one of trying to eliminate behaviors perceived as highly pleasurable and increase actions typically viewed as less satisfying (e.g., condom use). In this context, help-seeking becomes a primary means of initating needed changes in sexual behavior; for instance, people may need to elicit cooperation from their sexual partner's in reducing risky sexual behaviors, and may require professional assistance in accomplishing this task. In short, it has been uniquely satisfying, prior to completing this dissertation, to apply the results in ongoing studies of HIV transmission.

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APPENDIX A

Consent Form One: Prereferral Consent

A) Joseph A. Catania, a Ph.D. candidate in the Human Development and Aging program at the University of California San Francisco is conducting a study on how people cope with sexual problems and concerns. A person does not have to have a sexual problem in order to participate in this study.

B) I have been asked to participate in this study and if I agree the following will occur:

1. I will complete a questionnaire which asks about my background, interpersonal relationships and my sexual attitudes and behavior.

2. I will also complete the last page of the questionnaire which describes a free referral service. I understand that I am not obligated to use this service, but If I do I will need to give my first name, birth date, and a phone number so the referral service can contact me (within 5 working days from today). If I receive a referral(s) I understand that I am not obligated to use it.

3. If I contact a therapist that I have been referred to I understnad that my initial contact with the therapist will be reported to Project Sharp by my therapist, but my last name and any details concerning my reasons for seeking therapy will not be included in this report.

4. If I do not request a referral I will complete a short check list as to my reasons for not doing so.

5. It will take 20-25 minutes to complete this questionnaire.

C) I understand that the investigator will keep any information I provide in a locked file, that I will not be identified in any presentation of this research, and that the investigator will remove and destroy in 6 months any personally identify information that I have provided.

[Two more sections were included which provided standard statements on a) benefits subject may derive, b) risks to subject regarding privacy, and c) who they could contact with further questions.]

Subject signed and dated consent form.

Questionnaire

NOTE: THIS IS INSTRUMENT IS NOT REPRODUCED IN THE FORM USED FOR ADMINISTRATION TO RESPONDENTS, SINCE PRINTING REQUIREMENTS FOR THIS DISSERTATION DIFFER FROM THOSE USED FOR THE ORIGINAL MEASURE; ALSO, RESPONSE SCALES ARE NOT ALWAYS INCLUDED, THOUGH AN EXAMPLE IS TYPICALLY PROVIDED.

This questionnaire asks about your feelings and attitudes about yourself and your personal relationships, and asks about how you would or have coped with sexual concerns.

This questionnaire takes 20-25 minutes to complete. Please answer each question. If a question or statement does not apply to you then check ( ) NA.

The following questions ask for general background information on yourself and your personal relationships. Please begin.

1. How old are you? ____

2. Your gender: ____ (1) Male ____ (2) Female

3. Marital status:

____ (1) married ____ (2) live-in sexual partner

____ (3) never married ____ (4) divorced

____ (5) widow/widower

4. Your race or ethnic background:

____ (1) Caucasian (White) ____ (2) Asian

____ (3) Black ____ (4) Pacific Islander

____ (5) Hispanic (Mexican American) ____ (6) Native American (American Indian)

5. Your education (check highest level completed):

____ (1) Grade School (grades 1-6)

____ (2) Junior High School (grades 7-8)

____ (3) High School (grades 9-12)

____ (4) Junior College/Vocational School

____ (5) 4 Year College Degree

____ (6) Graduate/Professional Degree

6. Your sexual orientation: ___Heterosexual ___Lesbian/Gay

___Bisexual

7. Your current sexual relationship (check as many as apply to you):

____ (1) Living with sex partner
____ (2) Steady sex partner, not living with that person
____ (3) Sex partner(s) who I do not live with and do not see regularly
____ (4) No sex partner at present

8. Are you or your spouse/partner pregnant at this time? __Yes __No

9. In an average week how many hours do you work for pay:

____Outside the Home?

____At home?

10. What is (was) your approximate annual (net) income for the the most recent tax year? If you combine income with someone for tax purposes then answer in terms of your combined incomes. (check one)

___ less than $5,000
___ $5,000 to 10,000
___ $10,001 to 15,000
___ $15,001 to 20,000
___ $20,001 to 25,000
___ $25,001 to 30,000
___ $30,001 to 35,000
___ $35,001 to 40,000
___ $40,001 to 45,000
___ $45,001 to 50,000
___ $50,001 to 55,000
___ $55,001 to 60,000
___ Over $60,000

11. Do you have health insurance that covers mental health services?

____Yes
____No

12. Your spouse or partner's age:____Years. ____NA

13. How long have you currently lived with your current spouse or partner? _____Years. _____NA

14. If currently living with a spouse or partner: Circle the number on the scale below which best describes the degree of satisfaction, everything considered, of your present relationship with your spouse or partner. _____NA

1	2	3	4	5	6	7
Extremely Unsatisfied			Moderately Satisfied			Extremely Satisfied

The following statements concern your feeling about your current sexual relationship. If you do not have a sexualpartner at present, answer in terms of your most recent sexual relationship.

Please place beside each statement the number (using the key below) which best shows how often what is described in each statement occurs.

Key: 1 = rarely or none of the time
2 = a little of the time
3 = some of the time
4 = good part of the time
5 = most or all of the time

15. I feel that my partner enjoys our sex life._____
16. My sex life is very exciting._____
17. Sex is fun for my partner and me._____
18. When we have sex it is too rushed and hurriedly completed._____
19. I feel that my sex life is lacking in quality._____
20. I feel that my partner wants too much sex from me._____
21. I think that sex is wonderful._____
22. I feel that sex is something that has to be put up with in our relationship._____
23. My partner has good personal hygiene._____
24. I feel that some part of my relationship with my partner should involve sex._____
25. I feel that our sex life really adds a lot to our relationship._____
26. It is easy for me to get sexually excited by my partner._____
27. My partner is very sensitive to my sexual needs and desires._____
28. I feel that I should have sex more often._____
29. I feel that my sex life is boring._____
30. I feel that my partner sees little in me except for the sex I can give._____
31. I feel that sex is dirty and disgusting._____
32. My partner is sexually very exciting._____
33. I enjoy the sexual techniques that my partner likes to use._____
34. My partner thinks about sex too much._____
35. My partner is too rough or insensitive when we have sex._____
36. My partner does not want sex when I do._____
37. I would rather have sexual contact with someone else instead of my partner._____
38. I feel that my partner is sexually pleased with me._____
39. My sex life is monotonous._____

40. The following concerns services that people commonly use. First, place a check in the appropriate box if you have used or are using the service listed; If you are living with a spouse or sexual partner now, then also answer as best you can as to what services your spouse or partner has used or is using. If you are not living with someone at present then leave the last two columns (below) blank.

SERVICES	I AM USING NOW	I HAVE USED	OVERALL MY FEELINGS ABOUT THIS SERVICE ARE (CHECK BELOW)		MY PARTNER OR SPOUSE IS USING NOW	MY PARTNER OR SPOUSE HAS USED IN THE PAST
			NEGATIVE	POSITIVE		
Psychotherapy Counseling for a nonsexual problem						
Marital therapy or counseling for nonsexual problems						
Psychotherapy, counseling or sex therapy for a sexual problem						
Medical treatment for a sexual problem						

41. The following asks what you would do if you currently had some sexual problem which was keeping you from having as much sexual satisfaction as you would like to have.

Answer by rank ordering each statement below. That is, place a 1 beside what you would most prefer to do if you had a sexual problem now; Place a 2 by your second choice; Place a 3 by your third choice; and place a 4 by what you would least prefer to do if you had a sexual problem now. Please use each number only once.

____A. Do nothing about the problem other than to try to keep from getting upset about it.

____B. Try solving the problem on my own without seeking help from other people.

____C. Seek out help from psychological, marital or sex therapists and counselors.

____D. Seek out help from some tiype of medical professional (for example, Family Doctor, Urologist, gynecologist).

42. If I needed to travel i order to receive medical or psychological or counseling services for a sexual problem; I have access to (answer below)...

A. An automobile (or other vehicle) that I can drive. ___Yes ___No

B. Someone who could drive me. ____Yes ____No

C. Public transprotation I could use. ____Yes ____No

The following concern your feelings about yourself as a person. Please indicate how much you agree or disagree with eachof the following statements by placing the appropriate number on theline next to each statement (use the key below).

Key: 1 = disagree strongly 4 = agree a little
2 = disagree moderately 5 = agree moderately
3 = disagree a little 6 = agree strongly

___43. On the whole, Iam satisfied with myself.
___44. At times I think I am no good at all.
___45. I feel that I have a number of good qualities.
___46. I am able to do things as well as most other people.
___47. I feel that I do not have much to be proud of.
___48. I certailnly feel useless at times.
___49. I feel that I am a person of worht, at least on an equal plane with others.
___50. I wish that I could have more respect for myself.
___51. All in all, I am inclined to feel that I am a failure.
___52. I take a positive attitude toward myself.

The following statements concern the importance of sex to you and how you talk about sex with your sexual partner(s). For each statement circle a number to the right to indicate how much you agree or disagree with that statement as it applies to you and your primary sexual partner, someone you live with or see alot and feel a special commitment to.

If you do not have a primary sex partner, then answer each statement as it applies in general to you and your sex partner(s).

Use the scale below in choosing a number that best shows how you feel.

SCALE:

(1)	(2)	(3)
Disagree Strongly	**Disagree Moderately**	**Disagree A Little**

(4)	(5)	(6)
Agree A Little	**Agree Moderately**	**Agree Strongly**

	Disagree Strongly					**Agree Strongly**
a) My partner rarely responds when I want to talk about our sex life.	1	2	3	4	5	6

b) Some sexual matters are too upsetting to discuss with my sexual partner.

[note: scale repeats for each item b to n]

c) There are sexual issues or problems in our sexual relationship that we have never discussed.

d) My partner and I never seem to resolve our disagreements about sexual matters.

e) Whenever my partner and I talk about sex, I feel like she or he is lecturing to me

f) My partner often complains that I am not very clear about what I want sexually.

g) My partner and I have never had a heart-to-heart talk about our sex life together.

h) My partner has no difficulty in talking to me about his or her sexual feelings and desire.

i) Even when angry with me, my partner is able to appreciate my views on sexuality.

j) Talking about sex with my partner is usually a satisfying experience for the both of us.

k) My partner and I can usually talk calmly about our sex life

l) I have little difficulty in telling my partner what I do or don't like sexually.

m) I seldom feel embarrassed when talking with my partner about the details of our sex life.

n) Compared to all other things I do in my life, sex is the most important.

The folowing questions concern sexual difficulties that people sometimes face and how such problems are coped with.

67. To your knowledge is there a problem(s) or difficulty(ies) which currently prevents your spouse/sexual partner from having as satisfying a sexual relationship as he/she wants?

____Yes ____No

68. To your knowledge is there a problem(s) or difficulty(ies) which currently prevents you from having as satisfying a sexual relationship as you want?

____Yes ____No

69. All indivduals have personal problems from time to time (for example, work and health problems). Compared to all other problems you are personally experiencing, how important to you are sexual problems. Please circle the number on the scale below which best describes your answer.

1	2	3	4	5	6	7
Extremely Unimportant						Extremely Important

70. People often seek help for sexual problems or concerns. Please indicate below where youhave sought help fro a current sexual problem (the help sought may any of these: advice, information, treatment).

In the second column below please write in the approximate number of seperate occassions on which you used this type of help for a current sexual problem. For example, if you talked about a current sexual problem on ten different occassions you would write in the number 10.

	Check if Used	Number of Times Used
A. Have not sought help from anyone.	_____	_____
B. Tried to solve the problem on my own.	_____	_____
C. Friends of mine.	_____	_____
D. My spouse or sexual partner.	_____	_____
E. Relatives, excluding spouse.	_____	_____
F. Books, magazines, newspapers, television Radio (listen to)	_____	_____
G. An extramarital sexual partner.	_____	_____
H. Clergy or Spiritual leader.	_____	_____
I. Call-In Radio Programs (You Call In)	_____	_____
J. Bartenders.	_____	_____
K. Prostitutes.	_____	_____
L. Other, specify_____	_____	_____

Although psychotherapy or counseling for some sexual difficulties may take longer, many sexual problems can be treated in ten therapy sessions and others in one or two sessions.

As a service to you for having completed this questionnaire, the sex help-seeking and referral project (project SHARP) is providing (free fo charge) referrals to private psychotherapists specializing in the treatment of sexual problems.

If you request a referral from poject SHARP, you...

a. will not be obligated to use the referrals,

b. will receive names and phone numbers of two therapists in or near the city you live in.

c. You may choose either male or female therapists.

You may discuss some type of fee reduction when visiting or calling a therapist if the usual costs of therapy would prove a hardship. Many therapists also accept insurance payments.

<u>If you would like these referrals,</u> then complete only the information required in item number one (1) below and stop. we will contact you by phone and provide the two referrals within five working days from now.

<u>If you do not desire referrals,</u> then skip item number one (1) below and answer only item number two (2).

1. If you desire referrals complete the following:

First name only (print):_____

Phone Number:(area code:_____)_____

Your Birthdate: Month_____Day_____Year_____

Times you can be reached: AM_____ PM_____

2. Check below as many reasons as apply to why you do not desire referrals at this time.

____I do not have a sexual problem
____I am currently receiving treatment for a sexual problem
____Therapy is an expense that I can not afford financially at this time.
____I don't have the time to see a therapist.
____I would not request a referral without talking with my spouse or partner first.
____I would find it too difficult to discuss my sexual problem with anyone.
____I would prefer tomake referral requests under more private conditions.
____My sexual mproblem is not server enough to require therapy.
____At present my relationship with my spouse or sexual partner is so troublesome that I don't care if our sexual relationship is unsatisfying.
____I dont' think anyone can help me with my sexual problem.
____I would prefer toseek medical treatment for my sexual problem.
____It is my spouse's or sexual partner's problem so she/he should look for help.

[PLEASE NOTE THE PAGENATION AND LAYOUTS FOR THE QUESTIONNAIRE PRESENTED HERE ARE ONLY APPROXIMATE; THE ORIGINAL QUESTIONNAIRE WAS PRINTED ON LEGAL SIZE PAPER TO PROVIDE BETTER SPACING AND CONTINUITY OF ITEMS]

Providing Referrals: Protocol For Project Callers

1. Before phoning, record the following:
   Date of Contact Subjects No.
   Subject's First Name Subject's Birthdate
   Subject's Phone No.

2. Call Subject

3. Identify yourself by name and ask for subject by name. If asked to identify your purpose state that you are calling for poject SHARP and that the information is personal.

4. Verify subject identifiers to insure that this is the subject: birth date.

5. When verification obtained: indicate that you are calling to provide the referrals requested on (date referrals given).

6. Ask subject if he/she still desires the referrals. Yes__ No__

7. If answer to 6 is No, then....

   a. was their partner willing or interested in attending therapy?
   Yes__ No__

   b. what are their reasons for not wanting the referrals at this time (List below).

   c. conclude conversation

8. If question 7 is Yes, then...

   a. is there a preference for Male__ or Female__ Psychotherapists?
   b. Give locations of therapists corresponding to above preference.
   c. give names, phone numbers and addresses of two therapists corresponding to subject's preferences. Record below..
   Therapist 1_____
   Therapist 2_____
   d. if not all preferences can be met, then give best options from referrals list.
   e. inform subject that they are not obligated to use the referrals.
   f. ask if subject's spouse or lover is willing to attend therapy.
   Yes____ No_____
   g. conclude conversation

Call Backs To Subjects Receiving Referrals

[subject identifiers, phone number etc. recorded at top of form]

Interviewer: After identifying yourself and the approximate length of time since you called, then in your own words, state that you are calling to find out if individual was satisfied with the referrals they received from project SHARP. We're conducting this follow-up survey so we can decide fi we should add or drop therapists from our referral list. This will take about three minutes to answer a few questions; are you interested in participating?

1. Did you contact (call, write) any of the therapists we referred you to.

2. **f NO,**

   a. have you sought therapy with someone else?

   b. Stop and Conclude

   f YES,

   a. did you make an appointment?

I) No...then	:	II) Yes...then
	:	
Did you have trouble with	:	Were you satisfied with the
	:	treatment you received (are
1. getting in touch with the therapist?	:	receiving)?
2. getting an appointment?	:	
3. getting a convienent appointment time?	:	
4. Were the therapist(s) fees too high?	:	

[All questions above answered Yes, No]

Instructions to Psychotherapists

A) Referral Procedures

1. Joe Catania will call and provide the first name, birth date and phone number of referred subject.
2. Record subject's identifiers on record forms.
3. Phone calls will be followed up with letters containing information in No. 1 .

B) Subject Contact Procedures

1. Ss will be given your phone number and name; so Ss will be phoning
2. During the course of a study when a referred S calls or you call him/her back....

    a) record needed information on Attendance Contact record,

    b) obtain and record person's birth date, phone No., and first name.

3. Please complete Attendance and Contact records on all new subjects over the course of this year; these can be cross checked with our records so as to identify subjects.

C) Subject Attendance Procedures

1. given you have identified a SHARP subject, at a convenient time during the first appointment give the S two copies of the consent form to read.
2. The subject signs the consent form (if willing to participate) and keeps one copy to take home. Signed consent form is sealed by the S in envelopes provided.
3. Retain the signed consent form and mail to SHARP
4. Please provide any expalanations required regarding what information will be reported to SHARP.
5. Given subject's signed consent form then complete remainder of attendance record.

Therapist's Contact & Attendance Record

1. Date referral information received from project SHARP

2. Subject's.... First Name
   Birth Date
   Phone No.

3. Date Subject first called office
4. Date you (therapist) called back (NA)
5. Time at start of conversation with subject
6. Time phone conversation ended
7. Did Subject make an appointment
8. Date of appointment
9. Did subject attend appointment (resched. & Attend?)

Consent Form Two: Therapist Contact

A) Joseph A. Catania, a Ph.D.....Sometime during the past year you completed a questionnaire...requested a referral for psychotherapy and were provided two referrals.

B) This is to inform you and ask your participation in the final phase of this study.

C) I have been asked to participate as a subject and if I agree the following will occur...

1. I will agree to allow my psychotherapist, Dr._____, to release to Joe Catania my first name, birth date, dates I first contacted therapist for an appointment and attended my first appointment, and length of time our first phone conversation lasted. I understand that not other infomration will be released by my therapist and this ends my participation in this research project.

D) I understand that by allowing my therapist to release the above information there may be some loss of privacy....information will be coded...destroyed in 6 months...kept in locked file...

E) I have talked to may therapist about this study, and may call Joe Catania if I have more questions at...

F) I have been offered...consent form, bill of rights.

G) Participation is voluntary...I may refuse...without jeapordy.

Date & Signature

APPENDIX B

Three pilot studies were conducted to examine hit rates for subjects reporting a current sexual problem, to develop a sexual communication measure, and to assess couples' perceptions of sexual problems.

Pilot 1.

Self-report questionnaires were administered to 100 women and 50 men at pleasure parties in California (See App. A); Mage = 35.6 yrs., SD = 6.3, Meducation = 12.9 yrs., SD = 3.2, Mrelationship length = 6.7 yrs., SD = 5.3, all subjects married and heterosexual. Demographics, sexual problems (See Methods), and a series of open ended and check list items concerning help seeking for sexual problems were assessed.

Results. Approximately 35% (N = 53) of subjects reported a sexual problem. A wide variety of help seeking activities were employed by subjects; this information was incorporated into pilot studies 2 and 3 (See Table 6, Pilot 2 for a listing of help seeking categories derived from Pilot 1).

Pilot 2.

The main objective of this study was to develop a measure of sexual communication. A self-report questionnaire was administered to 200 University students (See Table 1 for sample descriptors). A random subsample received a second questionnaire administration one month later. Only subjects cohabiting for one or more years were included for analysis (N = 144).

able 1.

Pilot 2 Sample Description

	Cohabiting	Non Cohabiting
N: Total	79	65
Males	37	24
Females	42	41
Age: M(SD)	30.5 (9.6)	23.1 (6.1)
Range	19-62	18-44
Education: M(SD)	14.6 (1.4)	14.3 (1.2)
Relationship Length: M(SD)	5.2 (4.7)	
Range	1-44	
Partner's Age: M(SD)	31.2 (9.9)	23.4 (5.8)
Range	17-47	18-47

Note. All non cohabiting subjects listed above had a steady sexual partner.

Measures. Sexual communication items were derived from open ended interviews with couples and individuals concerning talking about sexual matters with their spouse/partner. Items were also selected from general marital communication measures and modified to reflect a sexual context. Items were counter balanced and responses were recorded on likert-type scales (1=agree strongly, 6=disagree strongly). Two items were dropped because of invariance. In addition, demographics, sexual problems, and help seeking activities were assessed.

Results. Approximately 42% ofthe total sample (N = 144) and 47% of cohabiting respondents (N = 79) reported a current sexual problem.

Principal components analysis with Varimax rotation was performed on the sexual communication items. Four and three

factor solutions both indicated that eigenvalues exceeded one only on the first two factors (eg., for three factors: Factor 1 eigen. = 4.2, Factor 2 eigen. = 2.15, Factor 3 eigen. = .66; the first two factors accounted for 91% of the variance). Results of a two factor solution are presented in Table 2. Table 3 shows two factor solutions by gender for the total sample and cohabiting subjects. In all cases the two factors correlated >.65, suggesting that the two factors may be redundant.

Table 2.

Sexual Communication Scale: Factor Analysis

Item	Total Sample		Cohab.	
Factor:	1	2	1	2
1.My partner rarely responds when I want to talk about our sex life.	.81	-.01	.77	-.01
2.Some sexual matters are too upsetting to discuss with my sexual partner.	.72	.10	.73	.20
3.There are sexual issues or problems in our sexual relationship that we have never discussed.	.42	.23	.54	.23
4.My partner and I never seem to resolve our disagreements about sexual matters.	.85	.09	.83	.09
5.Whenever my partner and I talk about sex, I feel like she or he is lecturing to me.	.91	-.05	.84	-.01
6.My partner often complains that I am not very clear about what I want sexually.	.61	-.03	.63	-.05
7.My partner and I have never had a heart-to-heart talk about our sex life together.	.87	.01	.85	.04
8.My partner has no difficulty in talking to me about his or her sexual feelings and desires.	.03	.48	.06	.46
9.Even when angry with me, my partner is able to appreciate my views on sexuality.	-.01	.56	-.10	.56
10.Talking about sex with my partner is usually a satisfying experience for the both of us.	.01	.73	.03	.77

11. My partner and I can usually talk calmly about our sex life.	.10	.77	.10	.80
12. I have little difficulty in telling my partner whant I do or don't like sexually.	-.01	.49	.06	.57
13. I seldom feel embarrassed when talking about the details of our sex life with my partner.	.06	.40	.13	.61
Eigen Values	4.10	2.09	4.16	2.39
% Variance	66.2	33.8	63.5	36.5

Note. Items arranged for ease of reading loading patterns.

Table 3

Sexual Communication Scale: Factors for Males & Females

Item	Total Sample				Cohabiting Subjects			
	Males		Females		Males		Females	
	1	2	1	2	1	2		
1.	.79	.05	.86	-.03	.80	.02	.77	-.04
2.	.72	-.10	.70	.23	.69	.05	.73	.31
3.	.44	.19	.39	.29	.48	.18	.55	.28
4.	.84	.11	.84	.05	.83	.14	.86	.01
5.	.93	-.14	.88	.01	.88	-.13	.82	.03
6.	.78	-.17	.49	.07	.75	-.12	.54	.01
7.	.91	-.05	.85	.04	.87	-.08	.84	.09
8.	-.08	.51	.15	.48	-.02	.31	.15	.55
9.	.04	.38	-.05	.64	-.07	.50	-.15	.64
10.	.08	.81	-.04	.68	.08	.83	-.01	.74
11.	-.04	.53	-.01	.48	.10	.61	.01	.56
12.	.01	.78	.17	.75	-.01	.82	.20	.78
13.	-.04	.49	.13	.36	.01	.59	.19	.63

Note. Item numbers correspond to items in Table 2.

A Total scale score was created by summing across items. Higher scores indicate greater communication content and more positive or easily communicated affect. Descriptive statistics and Cronbach Alphas for the total scale are given in Table 4. Scale score(s) distributions are not appreciably skewed and the Cronbach Alphas are satisfactory.

Table 4

Sexual Communication Scale: Descriptive Statistics & Alphas

	Total Sample	Cohab. Subjects
Total Scale: M(SD)	65.3 (14.2)	63.5 (14.8)
Range(Skew)	29-91 (-.07)	29-91 (.08)
Alpha	.81	.83

Table 5 contains the test-retest coefficients for the total sexual communication scale. Since subjects with sexual problems may be highly "reactive" to having completed a sexual

communication scale, seperate test-retest coefficients were computed for problem and nonproblem subjects. The results indicate excellant stability for the communication measure over a one month interval.

Table 5

Sexual Communication Scale: Test-Retest

	Total Sample	Cohab.	Problem	Nonproblem
Total	.93	.94	.91	.92

No sex differences were found ($t(77) = 1.06$, $p>.10$). Subjects reporting sexual problems relative to nonproblem respondents had significantly lower total sexual communication scores ($M_{problem} = 60.3$, $SD = 14.4$; $M_{nonproblem} = 66.5$, $SD = 14.9$; $t(77) = -1.86$, $p<.05$).

The total scale correlations with subject's age and partner's age were all significant, although small (r's -.19 and -.36, p's <.05 to .002). These latter findings suggest that older aged cohorts are somewhat less effective sexual communicators than younger cohort members.

Table 6 provides a breakdown of the various help sources subjects reported using in obtaining solutions, advice, and information concerning sexual difficulties. Approximately 74% of subjects used some type of help (self-help, informal or formal social sources). More women had used medical services for help than males utilized.

Table 6

Help Seeking Activities

Activity	Males % Using	Females % Using
Never sought help	35	19
Self-help only	35	50
Friends	5	31
Partner/Spouse	43	60
Relatives(not spouse)	0	7
Books, Other Readings	27	48
Extramarital Partner	5	7
Medical Doctor	0	24
Psychologist/Sex Therapist	11	14
Marital Therapist	11	10
Clergy/Spiritual Leader	3	2
Prostitute	0	0

Note. Ns = 37 males, 42 females; Since more than one category could be checked, totals exceed 100%.

Help seeking activities were grouped into self-help (used only self-help, reading materials), informal help seekers (used only non professionals for help), and formal help seekers (used only professional help sources). Social help seekers were defined as being either informal or formal help seekers. Since few subjects fell into these discrete categories, only self-help and social help seeking groups were compared. Self-help subjects had significantly lower total sexual communication scores relative to social help seekers (Mself = 54.4, SD = 14.3; Msocial = 64.8, SD = 15.7; $t(27) = -1.78$, $p<.05$). These latter results suggest that poor sexual communication skills confine people to self-help strategies, but it also possible that social help seekers become better communicators as a function of their social help seeking experiences.

Pilot 3

Subjects were recruited from University classes and were selected on the basis of having cohabited with a sexual partner for more than one year. Data were collected from both subjects and their partners (independent assessments; self-report questionnaires). The sample consisted of 45 heterosexual dyads (Mage males = 29.8 yrs., SD = 8.8; Meducation males = 14.6 yrs., SD = 1.4; Mage females = 27.8 yrs., SD = 4.09; Meducation females = 14.3 yrs., SD = 1.4; Mrelationship length = 4.96 yrs., SD = 3.1). Demographics, sexual communication (Alphas >.80 for all scales for the total sample and females and males seperately), help seeking activities, sexual problems, and problem attributions of causality.

Results. Approximately 24% of males and 40% of females reported a current individual sexual problem. Approximately 89% of couples agreed on whether or not the female had a sexual problem, and 91% agreed on if the male had a problem or not. Only three subjects indicated their partner had problems when the partner claimed not to have a problem. Six subjects reported a problem that was not confirmed by the partner. In general, couples show a high degree of agreement as to who has a sexual problem.

Fifty-three percent of the dyads reported one or both partners had a sexual problem. Of these dyads 79% saw the sexual problem as a single individual's problem. This latter result suggests that a majority of subjects did not perceive the sexual problem as a shared difficulty.

Attribution of sexual problems to health causes was found to

correlate signficantly with age (Males: r = .33, p = .05; Females: r = .37, p = .04). These results indicate that both males and females have stronger beliefs that their problems are caused by health difficulties as they get older.

Sexual communication scores for males and females were found to correlate signficantly with age (r's for total scale range between -.31 and -.55, p's = .02 and .0001). Communication scores created by summing partner's scores also correlated significantly with age (r's = -.38 and -.47, p's = .005 and .001). Scores created by subtracting partner's scores did not correlate with age.

Comparing informal help seekers and self-help subjects (See Pilot 2 for definitions) significant differences were found for individual communication scores and summated scores, but not for difference scores (t's > 5.42, p = .005) These results indicated that, for individual and summated scores, informal help seekers were more effective communicators relative to self-help subjects.