Public and Help Seekers' Perceptions of Mental Health Services: Implications for Help Seeking

by

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A thesis submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

DOCTOR OF PHILOSOPHY

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Abstract

This study empirically identified and compared the perceptions of mental health services held by 127 mental health outpatients and a randomly selected sample of 187 Winnipeg residents. One-half of the clients were from a city hospital outpatient department and one-half from a university psychology clinic. The respondents completed a questionnaire asking them to agree or disagree with each of 64 statements reflecting expectations and fears about the process of seeking help. Multivariate analyses indicated that help seekers were discriminated from non-help seekers by their greater expectation that therapists would be trustworthy, understanding, and interested in the help seeker. Similarly, members of the public who expressed the strongest willingness to seek help were also more likely to perceive therapists as trustworthy, understanding, and interested in help seekers, than were respondents less willing to seek help. Those most willing to seek help, however, also reported fewer fears of an interpersonal or practical nature. They were less embarrassed or ashamed to discuss problems or seek help and they perceived therapy as more convenient and accessible. Perceptions also discriminated across age and gender but not across socioeconomic status or network characteristics. The implications of these findings for mental health services is discussed.

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Introduction

Traditionally, most research in the mental health field has focused on the problems and treatment of individuals who present themselves for professional help. Until recently, there has been little interest in how people make the decision to seek help and how they choose a helping resource. Horwitz (1977) noted that the "processes mediating between the development of symptoms and the actual entry into treatment have, for the most part, been neglected" (p. 169). Early research regarding pretreatment behavior consisted mostly of epidemiological studies documenting the rates of treated and untreated symptoms among various social groups (e.g., Srole, Langer, Michael, Olper & Rennie, 1962).

Since the mid seventies, however, there has been increasing interest in the help seeking process of individuals experiencing psychological distress. The community mental health movement has stressed the need for greater accessibility of services to a wider cross section of society which, combined with a growing demand for consumer relevant and accountable services, has increased the interest in help seeking behavior. Knowledge and understanding of why and how people choose to seek professional help has important implications for program planning and the effective distribution of mental health resources. Identification of barriers to help seeking can

help to orient education campaigns and outreach programs, bolster social supports, and increase the availability and accessibility of mental health services (Gourash, 1978). Today, the literature on help seeking covers a broad range of topics ranging from the type of help one receives from informal helping resources to the processes underlying the seeking of professional mental health services. This latter area, specifically research on how perceptions or expectations may influence help seeking, is the primary focus of this investigation.

The present study empirically identified and compared the perceptions of mental health services held by both help seekers and the general public. Particular emphasis was placed on identifying and comparing the perceptions individuals held of the procedures associated with professional help and the fears and concerns they had about seeking help from mental health professionals. Differences in the perceptions of help seekers (clients) and non-help seekers (general public) were examined in order to identify those expectations or beliefs which likely facilitated or hindered help seeking. The perceptions of subsamples of the public which differed in their likelihood of seeking help were also compared (e.g., groups differing in gender, age, socioeconomic status, type of social network, or expressed willingness to seek help). This facilitated the identification of perceptions which were likely to influence an individual's decision to seek professional help.

The identification of perceptions related to help seeking is only one step toward more fully understanding the many variables affecting the help seeking process. For many people (e.g., those in great distress or non-voluntary clients), perceptions of mental health services are unlikely to have an important influence on their help seeking behavior. For many others, however, perceptions may effect both where and when someone seeks professional assistance. This research documents which perceptions are associated with the help seeking process and examines how the mental health professions can correct public misperceptions or alter their services to be more responsive to public needs. Documentation of these perceptions also encourages the further research needed to fully understand why certain perceptions exist and how they are related to help seeking.

Rationale for the Present Study

The need to understand the determinants of help seeking is illustrated by the research documenting the differential use of services by various social groups. Several studies have found that help seekers differ from the general population on a number of sociocultural and demographic variables (Gurin, Veroff & Feld, 1960; Hollingshead & Redlich, 1958; Kadushin, 1969; Kulka, Veroff & Douvan, 1979; Ryan, 1969). Gourash (1979) reviewed the help seeking literature and concluded that there was substantial agreement that those who utilize mental health services

(including mental health agencies, social services, legal facilities, and self help groups) tended to be young, white, and middle class. More recent investigations, however, suggested that social class may no longer differentiate help seekers from non-help seekers (Tischler, Henesz, Meyers & Boswell, 1975).

Greenley & Mechanic (1976) found that clients seeing psychiatrists or utilizing psychiatric clinics were disproportionately representative of urban and Jewish individuals, as well as those with low religiosity and higher education and income. Gender has also been found to be a major determinant of help seeking (Horwitz, 1977; Kessler et al., 1981). A recent national survey (Veroff, 1981) confirmed the often reported ratio that compared to men, women are twice as likely to seek professional help (66 percent versus 34 percent).

Not only are help seekers a somewhat select group of the general population but it is clear that not everyone who needs help will actually seek it. Srole et al. (1962) interviewed 1600 residents of New York City and reported that only a minority could be considered "well". "Definite impairment" ranged from 18 percent in the highest socioeconomic class to 33 percent in the lowest. Such high rates of impairment suggest that many people fail to seek help when needed. This hypothesis is supported by Ryan (1969), who surveyed emotionally disturbed individuals in

Boston. He found that only 10 percent of the sample would apply for treatment at any of Boston's outpatient psychiatric clinics. Based on a national survey of 6,913 adults, Kessler, Brown and Broman (1981) reported that only 24 percent of the individuals who felt they had a problem which required professional help actually sought such help.

A number of surveys report that persons seeking professional help for mental health related problems are most likely to seek help from non-mental health practitioners such as clergy or police (Gurin et al., 1960; Rosenblatt & Mayer, 1972; Ryan, 1969). Although Kulka et al. (1979) reported that help seeking from mental health professionals tripled between 1957 and 1976, (from four percent to thirteen percent of the general population), the authors also found that fifty percent of those seeking help went to individuals outside of the mental health professions. Medical doctors and the clergy were among those most likely to be consulted.

The literature clearly demonstrates that there is differential use of mental health services by various sociocultural groups. Furthermore, many people who need help fail to seek such services and those who do seek help often prefer to consult with non-mental health professionals. Surprisingly, there is little empirical evidence exploring the underlying variables which account for the decision of one individual or group to seek

professional help while others fail to do so. The identification and understanding of these variables would seem to be an important step in developing services which are accessible to all social groups and which are utilized by those most in need.

Although the help seeking literature is largely speculative, a few studies have attempted to empirically identify some of the variables associated with help seeking from professionals. One approach (e.g., Horwitz, 1977) has been to use questionnaires or interviews to identify those variables which correlate with differential rates of help seeking due to gender, socioeconomic strata, or cultural background. Other researchers have followed a similar procedure, only comparing help seekers at university counselling clinics with a sample of the general student population in order to ascertain those characteristics believed to influence the help seeking process (e.g., Bosmajian & Mattson, 1980; Greenley & Mechanic, 1976). Several large scale surveys of the general public have also been conducted. These studies identified characteristics discriminating those likely to seek help from those unlikely to do so (Gurin et al., 1960; Kulka et al., 1979). These few investigations have been primarily correlational designs identifying demographic variables related to help seeking behavior (e.g., gender, socioeconomic status, culture).

A review of the above mentioned literature indicates that the variables associated with help seeking from professionals include: differential knowledge of and access to resources (Tomlinson, 1971), psychological mindedness (Redlich, Hollingshead & Bellick, 1955) knowledge of other help seekers (Greenley & Mechanic, 1976), and differences in the recognition of problems as psychological in nature (Kulka et al., 1979). The cost and availability of services are also major variables which determine who can and cannot seek professional help. Gourash (1979) and Kadushin (1969) also stressed the importance of one's social network and the social norms of one's reference group in determining the choice of formal versus informal sources of help. Fischer & Turner (1970) have found that fear of stigmatization, confidence in the efficacy of professional help, and interpersonal openness were also related to an expressed willingness to seek professional help. While a number of help seeking determinants have been identified, there are many possible variables which have yet to be investigated.

One area which has received scant attention in the literature is the role which perceptions play in an individual's decision to seek professional help. The attitudes people hold toward psychological help and mental health professionals, as well as their expectations or preconceptions about the nature of therapy, may be important determinants of help seeking behavior (Nuttbrook & Kosberg,

1980). Although there has been substantial interest in the expectations which clients have when they present themselves for treatment (Aronson & Overall, 1966; Balch, Spencer, McWilliams, Lewis & Ireland, 1979; Overall & Aronson, 1963; Rapoport, 1967), few researchers have examined the public's specific expectations and perceptions of the process of seeking help. The few studies which have explored this subject have often used small, non-representative samples, global measures, and the researchers often failed to examine the relationship between perceptions and actual help seeking behavior. Clearly, there is a need for research which documents the specific perceptions of the general public and which examines whether these perceptions are related to help seeking behavior. This was the rationale for the present investigation.

The following sections examine in greater detail the types of perceptions which may influence help seeking behavior and a model is presented which clarifies how perceptions are related to other help seeking variables. Lastly, there is a more thorough review of the literature pertaining to people's perceptions of mental health services.

Perceptions of Mental Health Services

Perceptions is a broad term which is utilized in the present study to refer to at least three major concepts, namely attitudes, expectations, and fears or concerns. Although the three concepts are not mutually exclusive, it is useful to differentiate them. In the context of this research, an attitude can be defined as an evaluative judgement about the worth or appropriateness of professional help and psychological theories. Attitudes also include an individual's disposition or feelings toward mental health professionals or agencies. An important aspect of attitudes is that they are usually defined as being a motivating or driving force which influences one's beliefs, ideas, and behavior (Oskamp, 1977).

For the purposes of the present study, expectations are defined as more specific beliefs that certain behaviors or activities are characteristic or representative of psychological help or mental health professionals. An expectation is the distinct anticipation of some event, practice, or outcome. There are numerous types of expectations which people might have regarding professional help. Individuals may have expectations about the form of treatment, the specific activities characteristic of therapy, and about the behavior and role of both therapists and clients.

Individuals may also have fears and concerns about the process of seeking professional help. Fears and concerns are the anticipation of some aversive or unpleasant outcome as a result of the help seeking process. Individuals may question the likelihood of successful outcome or the possibility that therapy will be an embarrassing, hurtful, or stigmatizing experience. Both expectations and fears reflect an individual's beliefs about the process of therapy and the possible consequences of seeking help.

Some authors have argued that expectations or fears are simply a cognitive component of attitudes, while others have argued that there is no necessary congruence between the two (Oskamp, 1977). For practical purposes, however, attitudes can be considered to influence fears and expectations, while the reverse is also true.

Perceptions are only one of the possible determinants of help seeking behavior and they have a specific role within the sequence of events culminating in someone actually obtaining help. A model of help seeking is presented in Figure 1, which outlines the role of perceptions in help seeking and the relationship of perceptions to other important variables. The model represents a combination of earlier models devised by Gurin et al. (1960), Kadushin (1969), and Yokopenic, Clark, & Aneshensel (1983). This model represents only one aspect of the help seeking process. It includes only the decisions made by a potential

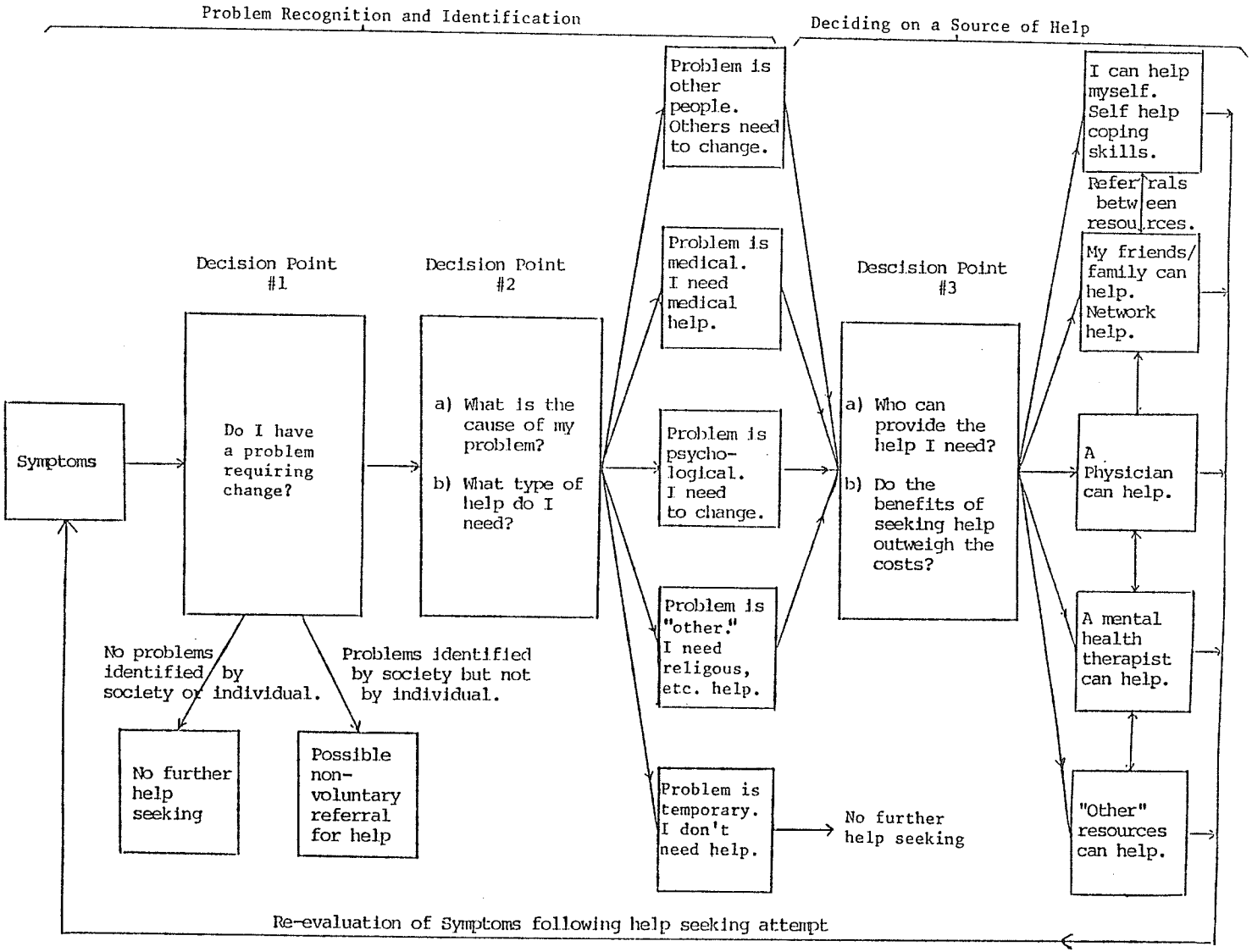

Figure 1. The role of perceptions in help seeking: A model.

help seeker between the onset of symptoms and their initial decision of where to seek help. As such, it excludes factors which might create the symptoms in the first place and excludes the processes which take place once actual help or treatment begins. Others such as Wills (1982), present broader models incorporating the entire help seeking process.

The model presented suggests that there are at least three stages in the process of deciding upon a helping resource. Each stage includes a major decision point for a potential help seeker. The first two decision points represent a phase of problem recognition and identification. The final phase reflects the actual decision of where to seek help. It should also be noted that although a uni-directional model is presented, the help seeking process itself may be bi-directional. Potential help seekers may move forward or backwards within the model as they continuously re-evaluate and reformulate their decisions.

The help seeking process begins when an individual experiences some form of unusual symptoms, which may be quite specific or more vague in nature. The individual must decide whether these symptoms represent a problem they would like to see change (i.e., the symptoms are distressing or ego-dystonic). This decision (like all help seeking decisions) is strongly influenced or perhaps even determined by the norms of the individual's social network and culture.

If neither the individual nor his or her network and culture perceive the symptoms as problematic, then no further help seeking would occur. If, however, society perceives the symptoms as a problem in need of change but the individual does not, then that individual may be involuntarily treated. The individual may also be treated involuntarily if they acknowledge a problem exists but refuse to get help. Such individuals may receive unwanted advice from friends or relatives, or spouses may leave them hoping they'll change. More severely disturbed individuals may be certified and treated in hospitals against their will. In such circumstances, the perceptions of mental health services held by the non-voluntary patient would have little importance in their decision of where to seek help.

If the potential help seeker decides that they have a problem requiring change, they face the second stage in the decision making process. The potential help seeker must answer two questions: (a) What is the cause of my problem, and (b) what type of help do I need? An individual may attribute his or her symptoms to a medical disorder, a psychological or relationship problem, a lack of resources (financial, employment, education, etc.), or any other number of causes (e.g., mystical or spiritual causes). What an individual causally attributes their problems to is clearly an important variable, as this determines the nature of help they are likely to seek. For example, if an

individual does not identify their problem as psychological in nature, they are unlikely to voluntarily consider mental health professionals as an appropriate resource. Many people define psychological problems in physical terms, which may at least partially explain why many individuals seek medical help for emotionally based problems.

Attributions about the cause of the problem will also effect decisions about whether further help seeking is even required. If the potential help seeker perceives their symptoms as temporary in nature or self limiting, they may decide that further help seeking is unnecessary. For example, someone who interprets their depressive feelings as natural in the wake of a loved one's death, may not actively attempt to change these feelings.

How an individual interprets their symptoms is influenced by such variables as "psychological mindedness", perceived locus of control, and education. Redlich et al. (1955) have reported that the lower classes were less psychologically minded. They were less introspective, more interested in comfort and advice, and believed their locus of control was external to themselves. Greenley and Mechanic (1976) found that both degree of introspectiveness and psychological mindedness were correlated with the likelihood of college students seeking psychiatric counselling. Other researchers have also suggested that differential recognition of symptoms as psychological in nature may account for at least

some of the differences in help seeking due to gender and SES. Some researchers have suggested that compared to men, women are quicker to translate non-specific feelings of psychiatric symptoms into conscious problem recognition (Kessler et al., 1981; Mechanic, 1975; Phillips & Segal, 1969). This has been postulated to at least partially account for women's greater propensity to seek professional help (Horwitz, 1977; Veroff, 1981). Kessler et al. (1981) presented the best data to clearly indicate that given the same psychiatric symptoms of depression or low well being, women were more likely than men to perceive themselves as having emotional problems. The authors also reported that given more severe disorders (ones less likely to be dismissed), the psychiatric utilization rates for men and women were very similar. Kessler et al. estimated that 10-30% of excess female morbidity could be accounted for by gender differences in problem recognition.

Differences in the identification of problems as psychological in nature have also been found to account for some of the differential rates of help seeking in different socioeconomic (SES) classes. Kulka et al. (1979) found that if one controlled for education, the association between help seeking and family income disappeared (which was not true in the Geroff et al. survey in 1960). Furthermore, among those who reported having problems which were amenable to professional help, there was no association between help

seeking and education or income. This suggests that lower SES classes were less likely to interpret symptoms of distress as psychological problems.

Another factor which may influence whether a person perceives themselves as having a mental health problem which requires psychological help is simply the severity of their psychological distress. Many authors have found that help seekers are more distressed than non-help seekers (Bosmajian & Mattson, 1980; Kellner & Scheffield, 1973). Kessler et al. (1981) found that distress increased the chances that an individual would report having an emotional problem (and consequently would be more likely to seek mental health services). Once an individual recognized that a mental health problem existed, however, there was no longer a relationship between distress level and help seeking. These results are similar to the findings of Kulka et al. (1979) who found that problem recognition was more important than severity of disorder in stimulating help seeking. While this may be true at low to moderate levels of distress, other authors have argued that at high levels of distress, almost every individual will seek whatever help is needed, regardless of any other variables (e.g., attitudes, fears, etc.) which might normally influence their decision to seek help (Scheff, 1966).

While help seekers are clearly more distressed than non-help seekers in general, it appears that distress level

itself does not account for differential help seeking by various socioeconomic groups (Greenley & Mechanic, 1976; Kulka et al, 1979). This is illustrated by the fact that the lower SES classes have been found to have the highest level of severe distress (Fried, 1969) but traditionally have been among those least likely to seek help. Other studies have reported that gender differences in rates of help seeking may not be related to gender differences in psychological disorders (Veroff, 1981). Clearly, a certain level of distress or need is a prerequisite for help seeking, but whether this need is recognized (i.e., the problem is perceived as psychological) and whether one actually seeks help, is likely related to a number of other factors.

To return to the help seeking model, the help seeker eventually identifies the perceived cause of their problem and develops some idea of the type of help they require. The next decision point (decision point 3 in Figure 1) typically involves addressing two questions: (a) Who can provide the help I need, and (b) do the benefits of seeking help outweigh the costs involved?

Simply because a problem is perceived as "psychological" does not mean that the help seeker chooses to seek professional mental health services. Other resources may be perceived as equally or more helpful for these problems and may be considered preferable for a number of reasons. The

first choice is most likely to be self help and the use of personal coping strategies (Cook, Park, Williams, Webb, Nicholson, Schneider and Bassman, 1984). Of course the choice of one helping resource does not rule out the simultaneous use of alternate resources. A person using self help skills may also be utilizing network help or even professional help from outside agencies.

While self help strategies are usually the initial help seeking route, the individual's social network is likely their second choice (Cook et al., 1984). Birkel and Reppucci (1983) reviewed several studies which all concluded that individuals perceived network help as preferable to and more effective than professional services.

Gottlieb (1985) noted that social networks provide troubled individuals with information regarding their problem and advice in resolving their situation. The social network helps to alleviate problems by removing or softening the effects of the stressor (i.e., by providing additional resources, extra help, companionship, or simply comfort and support). Social networks also provide a model of appropriate or adaptive solutions and serve as a source of social comparison (e.g., Is this problem "normal"?; Is it my fault?; Am I unique?).

A decision concerning whether to seek help outside of the network is faced by those individuals who (a) are not helped

by their network (they exhaust their network resources), (b) are referred to outside help by their network, (c) have limited or nonexistent networks, (d) interpret their problem as unsuitable for network help (especially if it involves network members or is very embarrassing), and (e) have problems that are created by, or exacerbated by, their social network.[1] Shumaker & Brown (1984) also noted that distressed individuals may consider seeking help outside their networks when they feel they are overly indebted to their families or friends and feel unable to adequately reciprocate.

As already stated, the decision to seek mental health services depends not only on self help or network help being ineffective or bypassed, but also on whether the help seeker perceives professional help as offering the help they need and whether the potential benefits of seeking professional help outweigh the costs involved. It is at this last stage where an individual's perceptions of mental health services are likely to be an important determinant in their decision to seek help (Murphy, Remenyi, & Hudson, 1978; Nuttbrook & Kosberg, 1980).

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[1] The help seeking literature rarely discusses how social networks or helping resources may contribute to dysfunction. Social networks, like any helping resource, can exacerbate problems or even create new problems for the help seeker. The help seeking model incorporates this factor in a feedback loop which indicates that help seeking might actually create new symptoms which leads to a repetition of the entire help seeking process. This cycle is most evident in those instances when the "solution" becomes part of the problem itself (e.g., side effects of medications, dependency on therapists, etc.).

If a help seeker is to make an informed decision to seek help, that individual, or their referral source, must have a reasonably accurate perception of the types of problems treated by mental health professionals. The decision to actually seek help also depends on the help seeker's perceptions about the efficacy of therapy, the process of therapy, and his or her fears and concerns about the process of seeking professional help. The perceptions and norms of one's reference group with regard to the appropriateness of seeking professional help should also be an important factor in the decision to seek help. Other important factors include the perceived cost, availability, and accessibility of services. These perceptions are likely to strongly influence the help seeker's choice of a helping resource as well as the decision whether the benefits of seeking help from that resource outweigh the costs involved.

The final step in the help seeking model is a continuous feedback loop in which the effectiveness of each help seeking attempt is constantly monitored by the help seeker. The help seeker continuously re-evaluates his or her symptoms, the causes of his or her problems, and the availability of alternate treatment resources. New sources of help may be sought if the original helping resource fails to adequately resolve the problems.

The help seeking model suggests that perceptions of mental health services are one of many factors influencing

help seeking and that their major role comes into play toward the end of the help seeking process. Perceptions appear to have at least a partial influence on whether individuals believe their problems are relevant to professional help and a more major role in whether an individual actually decides to proceed with psychological treatment. This raises two questions relevant to the present investigation. First, what perceptions do the public (potential help seekers) have of the mental health care field? Second, are these perceptions likely to influence the help seeking process? Surprisingly, there has been little research to either identify the public's perceptions or to establish the relationship between such perceptions and help seeking. These two areas are the major focus of the present investigation.

The help seeking model suggests another hypothesis of interest. The model proposes that social network and cultural norms have significant impact on all three help seeking decision points, including the decision to seek professional help. It follows that a help seeker's perceptions of mental health services may depend upon the type of network or cultural/demographic group to which they belong. It also follows that actual help seeking behavior may vary across network or cultural/demographic groups. These hypotheses are examined in the present investigation. Latter sections will more fully expand on the specifics of these hypotheses and their underlying rationale.

The following sub-sections examine the research related to the role of perceptions in help seeking. The topic is broad and ill-defined given the number of factors incorporated in the term "perceptions". For clarity, the following categories are reviewed separately: (a) attitudes toward help seeking; (b) public expectations regarding the process of therapy; (c) public fears and concerns about seeking help; (d) client and student expectations regarding the process of therapy; (e) public's choice of helping resources; and (f) public's knowledge of the resources available.

Attitudes Toward Help Seeking. It seems logical that an important determinant of help seeking is the attitudes which individuals hold toward seeking help or counselling in general. Such attitudes are evaluative judgements regarding the worth or appropriateness of seeking help or of utilizing mental health services. Those with favourable or positive attitudes toward seeking help or therapy should be those most likely to seek help. Fischer and Turner (1970) developed the first standardized, summative rating scale (likert-type) to identify attitudes toward seeking help from mental health professionals. The Attitudes Toward Seeking Professional Help Scale (ATSPH) was standardized on 492 female and 468 male students ranging from high school through college and university. The students were asked to agree or disagree, on a four point scale, with 31 statements

reflecting a variety of attitudes toward seeking professional help. Higher summated scores reflected more positive attitudes toward help seeking and the scale was found to reliably discriminate previous help seekers from non-help seekers. Factor analysis identified four factors representing: (a) recognition of the need for help, (b) stigma tolerance, (c) interpersonal openness, and (d) confidence in the mental health practitioner. Those who had sought help tended to have higher scores on all four factors. Compared to non-help seekers, previous help seekers were more likely to recognize the need for help, to more willingly discuss personal problems, to believe in the efficacy of therapy, and to perceive therapy as a non-stigmatizing experience. Whether these beliefs preceded help seeking or whether they were a result of help seeking is as yet unknown.

Using the ATSPH, Fischer and Cohen (1972) reported that students in their sample all had mostly positive attitudes toward seeking professional help. The authors, however, reported that psychology and social science students had more positive attitudes than did students with other majors. Jewish students, compared to Catholics, also had more positive attitudes. Fischer and Cohen also found that SES, based on father's occupation, was not related to attitudes toward seeking help, although father's level of education was. The subjects in this study were all high school or

college students and not typical of lower class individuals. This fact might account for these authors' failure to find an association between SES and attitudes. The same finding, however, was reported in clinical samples by Calhoun, Dawes and Lewis (1972) and Lorion (1974) using the same attitude questionnaire. In both these studies, clients across all socioeconomic classes had equally positive attitude scores based on the ATSPH. The literature utilizing the ATSPH scale is reviewed in greater detail in Appendix A.

Cook et al. (1984) surveyed 734 college students regarding the types of problems they experienced, where they sought help, and their general attitudes about counselling. The student's preferred to rely on themselves to solve problems but would ask their friends and relatives for help if needed. The authors reported that students held generally favorable attitudes toward help seeking from professionals. Eighty-three percent believed counsellors could be helpful, 80% said that they would seek counselling if their problems were serious, 87% felt counselling was not restricted to serious problems, 74% were not afraid of others knowing that they got counselling, 70% thought they would be treated seriously, and 81% felt their families would not mind if they sought help. Fifty percent stated that they did not have money to spend on counselling. Sixty percent reported that friends could help them better than counsellors and 55% felt that counselling was appropriate

only after personal problem solving efforts had failed. The authors reported that women held generally more positive attitudes on about one third of the attitudes statements and were more likely to endorse counselling as a preventive measure than were men. Men preferred to rely on self help. One-half of the sample also reported being unclear about what was involved in counselling or where they could find help.

Cook et al.'s study confirms that college students hold positive attitudes toward counselling but it was unclear in their study whether the attitudes examined reflected perceptions of academic counselling, career counselling, or personal counselling (no specification was apparently made by the researchers). This study is noteworthy for addressing a number of potential fears and concerns that help seekers might have, as well as examining the types of problems individuals would seek help for. The study could not address whether these perceptions were related to help seeking behavior, although such information would have been valuable in identifying which beliefs or concerns facilitated or hampered help seeking.

Utz (1983) examined how attitudes toward counselling and counsellors differed between help seekers and non-help seekers. Nineteen university students seeking career counselling completed a 10 item scale designed to measure the favorableness of their attitudes toward academic

counselling and counsellors. These responses were compared to the responses of 52 students enrolled in a career counselling course and 32 students who had reported career indecision but had not sought help. Counselling students were found to have more positive attitudes toward counselling than did non-help seekers. It was unclear whether the positive attitudes preceded help seeking or were a result of the help seeking process and it remains unknown whether findings based on students seeking career counselling can be generalized to the general public seeking psychological help. Utz did demonstrate, however, the importance of assessing whether attitudes and actual help seeking behavior are related.

Flaskerud and Kviz (1983) surveyed 2564 rural residents of Illinois via a mailed out questionnaire. They examined attitudes toward mental disorders by asking respondents to agree or disagree with 12 statements reflecting a variety of opinions about the etiology and treatment of mental disorders. There was overwhelming agreement with positive statements but these positive attitudes reflected how extremely stated were the items (e.g., "most psychiatrists are more interested in locking people up with mental disorders than in helping them recover" or "most mental disorders are inherited"). No demographic differences were found, perhaps because of the low variability in the responses and the use of a dichotomous measure (agree or

disagree). The items did not reflect specific expectations or concerns regarding help seeking and as such add little to our understanding of why some people decide to seek help. The study is noteworthy, however, as it remains one of the few studies examining the general publics' attitudes toward help seeking from professionals.

There is clearly growing evidence that clients and students hold positive attitudes toward seeking help from professionals and that SES differences, at least within these two populations, may be rapidly decreasing or even non-existent. Whether social class differences in attitudes continue to exist in the general public has yet to be fully established.

The above conclusions are based on a limited number of studies which have utilized mostly students or clients. Both of these groups might be expected to hold generally positive attitudes. Clients have made the decision to seek help and hence are likely to have reasonably positive attitudes. University or college students tend to be upwardly mobile, from a higher socioeconomic class, verbally skilled, and more highly educated. All these factors may make psychotherapy more attractive or socially acceptable. Consequently, student attitudes may be more favorable than those of non-students. The ATSPH was designed, and has been used, as a global measure of the favorableness of attitudes toward seeking professional help. While attitude measures

may identify which groups are more likely to utilize help, they do not clearly distinguish why different groups hold more positive or negative attitudes. Fischer & Turners' scale did identify several of the factors contributing to positive attitudes (interpersonal openness, stigma tolerance) but research in this area has not adequately specified the underlying beliefs or expectations which influence one's attitude toward seeking professional help.

While the literature suggests that individuals hold generally positive attitudes toward seeking help from professionals, there is less information about the public's specific expectations about the process of therapy. professional services. The literature which does examine this area is reviewed in the following section.

Public Expectations Regarding the Process of Therapy. An individual's expectations about therapy include the types of activities they believe are characteristic of therapy or therapists, the role a client is expected to play, and their expectations regarding the outcome of therapy. Strupp (1975) has argued that even clients have vague expectations about the process of psychotherapy. There is seldom a specific contract or agreement in therapy about the roles and responsibilities of either the client or therapist. Strupp has also suggested that there is a "growing demand for a clearer definition of what psychotherapy is and what psychotherapists do" (p. 39).

This reviewer found only one study which specifically examined lay expectations of psychotherapy. Kupst & Shulman (1979) interviewed 52 adults (all but one of whom were female) who had accompanied children to an outpatient pediatrics clinic for non-psychiatric health care. Each respondent was asked to agree or disagree (on a five point scale) with 100 items representing various expectancies about mental health care. These items reflected beliefs about a variety of concepts, including: etiology, medical model, social model, treatment activity, therapist characteristics, duration of therapy, ideology, and help seeking attitudes. The lay sample's responses were compared to the responses of a sample of 25 mental health workers employed in child psychiatry at a separate Chicago hospital. The results indicated discrepancies between the samples on at least nine items and similar responses on five items. Unfortunately, the published paper neither reported the content nor the results of the remaining 86 items.

Kupst & Shulman (1979) reported that their lay sample believed more strongly than the professionals that most problems could be traced to a lack of money; that people could change their behavior; that most people work out their own problems; that therapy would not take years to be effective; and that it is better to express your feelings than to keep them inside. Some of these findings are quite surprising and, given the variety of items examined, the

overall implications of the results are difficult to interpret. Most of the reported items reflected theoretical beliefs and it is unclear whether discrepancies in these areas would be likely to influence either the decision to seek help or the process and outcome of therapy. The small sample sizes and restricted sample selection also questions how representative these findings are of mental health professionals and the general public. Despite these interpretive difficulties, this is the first study in recent years to examine lay perceptions of psychotherapy and it suggests that substantial differences may exist between the beliefs of professionals and the public.

One other study examined public expectations. Gurin et al. (1960) interviewed 2,460 adults regarding the psychological well-being of the American public. While not a study of perceptions, the authors included several questions related to this issue. Of particular interest were the responses of individuals who reported having had problems which could have used professional help but who did not seek such help. Twenty-four percent of this sample relied on self help for relief. Twenty percent reported that the major reason for not seeking help was a lack of knowledge about the means of getting help and fourteen percent reported concerns about being ashamed to need help. Seven percent thought professional services would not be able to help. This study is somewhat dated and examined

only a few of many possible perceptions but it is significant both as a survey of the general public and for its attempt to examine a group of potential help seekers, who for some reason, did not seek help.

In summary, only a few studies have specifically explored the public's expectations or beliefs about the process of psychotherapy or the process of seeking professional help. These studies are limited by small, non-representative samples which focus on a limited number of possible perceptions. To overcome some of these limitations, the present research utilizes a cross-sectional survey design which compares the perceptions of mental health services held by a sample of help seekers with those held by a random sample of the general public.

While there have been few studies examining the public's expectations about professional help, there is a growing body of literature documenting the fears and concerns which inhibit individuals from seeking help from any resource. The following section examines this literature.

Public's Fears and Concerns About Seeking Help. Fisher, Nadler, & Whitcher-Alagna (1982) reviewed the literature examining recipient reactions to aid. This literature consists mostly of questionnaire and laboratory analogue studies investigating how situational conditions and helper characteristics influence an individual's likelihood of

seeking help and an individual's reaction to any help offered. While not specific to help seeking from professionals, this research has identified several factors which might influence a help seeker's decision about seeking formal mental health services.

Fisher et al. (1982) reviewed numerous studies supporting their hypothesis that people avoid seeking help if such help is threatening to their self esteem. Individuals have been found to reject aid or avoid seeking help for fear of damaging their feelings of self worth by appearing incompetent or overly dependent. Those most concerned about societal norms regarding self reliance or independent problem solving may also be those most reluctant to seek help.

Included within Fisher et al.s' threat-to-self-esteem model are recipients' concerns that they will become overly indebted to the help giver and be unable to reciprocate the help. Fisher et al. cite many studies supporting this hypothesis. Recipients of aid may also avoid help which has "strong strings attached" or which in some way limit their freedom. Lastly, Fisher et al. reviewed studies supporting their contention that individuals are reluctant to seek help if they perceive the helper as having ulterior motives with unfavourable intent.

It remains unclear whether the above mentioned factors actually influence help seeking from professionals. Psychotherapy is usually voluntary and confidential, which may decrease a help seeker's concerns about embarrassment, shame, or loss of freedom. Seeking help from a highly skilled professional may also be less threatening to one's self esteem than seeking help from family or friends. Fisher, Harrison, & Nadler (1980) for example, found that subjects reported greater feelings of incompetence seeking help from a peer than from someone with expertise in the field of help required.

As a therapist is paid for his or her services, either directly by the help seeker or indirectly by an agency, research suggests that help seekers may have fewer concerns about indebtedness and whether they will have the opportunity to reciprocate (Fisher, Harrison, & Nadler, 1978). If the therapist is paid for his or her work, the help seeker may also have fewer reasons to question the therapist's ulterior motives.

The recipient reaction to aid literature has identified several factors which might influence a potential help seeker's decision to seek professional help. These factors include fears of violating norms of self reliance and of being perceived as incompetent. Anything which leads to one's self esteem being threatened is likely to decrease the likelihood of seeking help. Concerns about becoming overly

indebted and worries about the therapist's motives might also influence the help seeking process.

DePaulo (1982) speculated that individuals might also avoid asking for help for fear of what they might find out about themselves. Help seekers might also fear being refused help, of being a nuisance, or of being disliked by the helper.

The relationship between fear perceptions and help seeking remains unclear. While analogue studies have identified several fears and concerns which may influence help seeking behavior in general, it remains unknown whether these fears are likely to influence help seeking from professional resources. The present research examines many of these fears in order to identify those associated with the decision to seek professional mental health services.

The public's perceptions of therapy are not well documented, but there has been considerable interest in the expectations of clients prior to therapeutic contact. This literature is reviewed in the following section.

Client Expectations Regarding the Process of Therapy. Client expectation research has been encouraged by the widespread belief that disconfirmed expectations will lead to early drop-out or poor outcome of therapy (LaTorre, 1977). Research in this area has followed two tracks. Some

investigators have documented the expectations of various client groups, while others have tried to determine whether "disconfirmed expectations" are related to premature termination of therapy. The literature in this last area will not be specifically reviewed but it may be noted that the literature is evenly divided on whether disconfirmed expectations are related to poor outcome (Duckro, Beal, & George, 1979). The following section will, however, review those studies which document client expectations as they have some relevance to public perceptions.

The studies examining client expectations have identified a wide variety of expectations held by clients regarding their own role and the style and personality of their therapists. (Apfelbaum, 1958; Aronson & Overall, 1966; Balch, Spencer, McWilliams, Lewis & Ireland, 1979; Begley & Lieberman, 1970; Heine & Trosman, 1960; Overall & Aronson, 1963; Rapoport, 1967; Williams, Lipman, Uhlenhuth, Rickels, Covi & Mock, 1967). These studies are reviewed in detail in Appendix B. In general, findings indicate that most clients expected a directive, advice oriented exchange and yet recognized the "psychological" nature of therapy (i.e., they expected to do a lot of talking about their problems and emotions, to discuss sensitive issues, and to discover why they behave the way they do).

Differences in expectations of various social classes has also been a favoured research question. Early studies

(Aronson & Overall, 1966; Williams et al., 1967) supported the widely held observation that lower class clients expected therapists to be even more supportive, directive, and active, than did the middle or upper classes. Later studies, however, have failed to find significant differences between SES classes in their expectations about the therapist's style (Balch et al., 1978; Lorion, 1974; Rapoport, 1976). These apparent changes in the expectations of lower class clients coincides with the lower SES classes' increased utilization of mental health services and their increasingly positive attitudes toward help seeking. The present research endeavours to confirm whether SES differences in perceptions have disappeared within a public, non-client population.

Although there has been considerable interest in client expectations, Duckro et al. (1979) noted that much of the literature is based on imprecise or global measures. Furthermore, asking clients "what they expect" may have confounded the client's anticipation of some event (the intended meaning) with their preferences (an alternative meaning of the word expectation). The literature has focused on ratings of the therapist's expected orientation (i.e., directive, passive, psychological, medical or supportive) while specific expectations (e.g., the client's role, the outcome of therapy, or fears and concerns) have not been so closely examined. The generalizability of these

results to the public domain is also unknown. The client expectation literature is based on client samples whose perceptions may have little correlation with those of the public. As Balch et al. (1978) pointed out, "clients may be a non-representative, overselected group of people who know well what is provided [in therapy] and what to expect and seek out such services specifically for these reasons" (p. 112).

Tinsley & Harris (1976) overcame some of the above mentioned obstacles by expanding the arena of client expectations to include college students' perceptions of counselling centres. Tinsley & Harris developed a 73 item questionnaire and administered it to 287 psychology students. They found that students expected an experienced, expert, genuine, and accepting counsellor they could trust. Men were more likely than women to expect directiveness, whereas women expected greater acceptance from the therapist and expected a longer duration of therapy.

Tinsley, Workman, & Kass (1980) developed a more extensive questionnaire consisting of 135 items representing 17 dimensions. The questionnaire was administered to 446 psychology students. Women were found to have greater personal commitment to therapy, expected more facilitative conditions, and expected less expert counsellors than did men. There was a trend for women to expect more nurturance. The research by Tinsley and colleagues is examined in

greater detail in Appendix C. These studies have been a major step in broadening the range of perceptions examined within a non-help seeking population. It remains unclear, however, whether these findings based on student's perceptions of counselling centres can be generalized to perceptions of outpatient mental health services held by the general public. The present investigation explores this issue by examining a broad range of perceptions held by a sample of the general public. The relationship between perceptions and help seeking behavior is also investigated.

Public's Choice of Helping Resources. As noted previously, potential help seekers must at some point decide who can provide the help they need (decision point #3 in the help seeking model). This decision is partially influenced by the help seekers' perceptions about the types of problems treated by mental health professionals. A number of investigators have examined which helping resources the public are likely to choose for different types of problems (Anshuetz, 1979; Murphy, Remenyi & Hudson, 1978; Small & Gault, 1975; Wilkinson et al., 1978; Wilcove, 1971). The literature in this area suggests that the public is somewhat reluctant to utilize mental health services for psychological problems. Anshuetz (1979) asked 1,230 families where they would seek help if they had child rearing problems. The respondents were just as likely to consult with their physician or clergy as with a

psychologist. Similar findings were reported by Murphy, Hudson & Neville (1982). Wilkinson et al. (1978) also found that the public were more likely to consult a general practitioner than a clinical psychologist for a variety of problems (including child problems, mental problems, smoking, care of the elderly, depression, and drug abuse). One might argue that consultation with a general practitioner would lead to an appropriate referral but available evidence suggests that physicians are likely to treat psychological difficulties themselves rather than refer them to mental health professionals (Nunnally, 1961; Small & Gault, 1975).

The reasons for the public's reluctance to utilize mental health professionals remains unclear. Perhaps the public fail to recognize the types of problems treated by mental health professionals or perhaps they lack confidence in the efficacy or expertise of mental health care providers. The public may also have specific fears or concerns about seeking psychological help (such as embarrassment, loss of self reliance, etc.) or hold misperceptions (or simply negative perceptions) about the process of psychological treatment. These possibilities raise two questions relevant to the present investigation: (a) What problems do the public perceive as relevant for professional intervention; and (b) what perceptions or beliefs do the public hold which are likely to account for their avoidance or at least non-

consideration of mental health professionals? The present investigation examines these two questions. First, the types of problems the public believe professionals are qualified to treat are documented. Second, the perceptions held by clients are compared to those held by the general public. Lastly, the perceptions of individuals preferring to consult with non-mental health professionals (friends, family, clergy or general practitioners) are compared to those held by individuals with a stronger preference for help from mental health professionals (social workers, psychiatrists, psychologists). These comparisons tentatively identify why some individuals avoid seeking help, especially from mental health professionals.

Public's Knowledge of the Resources Available. Related to perceptions of mental health services is knowledge of what helping resources are available and how to contact them. Although not a "perception", this information is part of the public's understanding of the role of mental health professionals and may be an important determinant of whether one decides to seek help.

Heinemann, Perlmutter & Yudin (1974) surveyed 180 residents living within one-half mile of local satellites of a community mental health centre. They found that only 15% of the residents were aware of the existence of the main centre and only 32% of the population were aware of the

satellite centres. Furthermore, only 13% would utilize the community mental health centre for help with a "mental, nervous, or emotional" problem. The majority would seek help from either a medical doctor (10%), the police (14%) or a general hospital (46%). The findings confirmed the results of a study by Tomlinson (1971) which utilized similar methodology but with a sample of low income residents.

On a more positive note, Flaskerud and Kviz (1983) surveyed rural residents in Illinois and reported that 80% of the respondents knew that mental health services were available somewhere in their community. Younger people, males, those with less education, and those with lower incomes, however, had less knowledge of the availability of mental health centres. Older respondents had less knowledge of the availability of psychiatrists.

Related to the knowledge of the resources available is the question of how accessible the service is to respondents, even if they know of its existence. Breakey and Kaminsky (1982) reported finding a correlation of -.61 between mental health clinic utilization and distance to the centre. Utilization rates declined steadily up to a distance of three quarters of a mile (walking distance), after which utilization rates were much higher along bus routes. Many low income individuals may fail to seek help if access to bus or car transportation is limited.

The literature investigating the public's knowledge of how and where to find professional help suggests that a proportion of the public have limited knowledge and understanding of where to find help or even where to begin the search. Glastonbury et al. (1973) suggest the confusion is due to the "use of technical terms, the fragmentation of statutory and voluntary services, and the absence of information, education and communication" (p. 202). Mental health services are seldom housed in a unitary setting and the official name often varies between regions or with a change in government policy. Mayr (1975) described professional help as a "mental health maze" noting that services have low visibility and help seekers are often shunted by phone on what can be a difficult and embarrassing search for an appropriate resource. Even information or advertising campaigns are of limited use in reaching people in need. Leutz (1976) argued that information from agencies are "rationalized" and seldom consists of more than a brochure describing the services available. Poorer groups in society tend to rely on personalized and expressive communication, which makes it difficult to acquire knowledge on how a bureaucracy works or what it provides.

Lack of knowledge and access to services may be two factors accounting for the lower rate of help seeking by the lower socioeconomic classes. The present investigation includes items examining each respondent's perceptions

regarding the cost, availability, and accessibility of mental health services. The study helps determine if these variables are related to the differential rates of help seeking by individuals from different social or demographic groups. The public's confusion over how and where to find services also suggests there may be a great deal of confusion over what to expect from professional help, another area examined in this research.

To this point, the possible influence of public and client perceptions on help seeking has been examined. Emphasis has been placed on identifying people's attitudes toward help seeking in general and public, student, and client expectations and fears regarding the process of therapy. The literature related to how the public chooses a helping resource and their knowledge of and access to the services available has also been examined. Throughout, there has been a general assumption that an individual's perceptions at least partially influence their help seeking behavior. Group or network perceptions, however, may be equally important in influencing the help seeking behavior of individuals. The following section examines this assumption.

Network Norms and Perceptions: Influence on Help Seeking

Help seekers are likely influenced by their own perceptions of mental health services but they are also greatly influenced by the perceptions and beliefs of friends, relatives, or significant others. Gourash (1978) hypothesized that social networks affect help seeking by: (a) buffering the experience of stress, which obviates the need for help; (b) providing affective and instrumental support, which precludes professional assistance; (c) acting as a screening and referral agent; and (d) transmitting attitudes, values, and norms about help seeking. Gourash argued that this last factor had received scant empirical attention.

There is little understanding of how network norms influence help seeking. There is also little information on how network norms may vary across sociocultural groups. These norms may determine whether one's reference group is likely to endorse professionals as an appropriate coping strategy or whether they encourage self reliance and the help of immediate friends or family. Although the term "norms" includes many variables or factors, it would seem that a reference group's perceptions about professional help and professionals would significantly contribute to the network's establishment of a set of norms. In this sense, group perceptions may be just as important as individual perceptions in influencing help seeking. This has important

implications, as the present investigation basically identifies group as opposed to individual perceptions. Networks also serve as referral agents and, once again, the perceptions of one's reference group may well determine both whether one refers someone to professional help and to whom one refers them.

There is substantial evidence that a decision to seek help is strongly influenced by significant others within a help seeker's network. Booth and Babchuk (1972) interviewed 400 adults to better understand how they came to utilize new health resources. They reported that 78% of the help seekers in their study had been influenced by another individual (30% were influenced by more than one person). Those who sought advice before deciding on treatment were those most concerned with the cost of treatment, the need for time off work, and the possibility of painful or embarrassing aspects to the treatment. Forty-five percent of the respondents had consulted relatives before seeking treatment and 26% consulted their spouse. Approximately 50% of the referral agents had used the service before and 66% of the respondents felt their advisors were very influential in their decision making process. Those who were most influential had the most knowledge about the medical services and had previous contact with the service.

Liberman (1965) surveyed 52 psychiatric admissions and found that 70% reported that their decision to seek

treatment was influenced by relatives and neighbors. Those most influential had previous experience with mental illness. These results suggest that an individual's perceptions of health care services not only influence their own decision to seek help but also where they refer their friends or relatives. Of particular note is that those most influential in swaying a decision were also those with the most knowledge about the proposed treatment and those who could ease a person's fears and concerns. These findings lend support to the assertion by Gottlieb and Schroter (1978) that "if lay referrals are based on accurate and comprehensive information about the professional health care world, they promote early utilization of formal services" (p. 616).

The above discussion suggests the importance of group perceptions in establishing network norms and implies that group or network norms are likely to influence the help seeking behavior of network members. The network literature also suggests that there are many different types of networks and that these networks provide different types of assistance as a function of a help seeker's needs. The literature implies that networks with differing structure may each have their own set of norms regarding the appropriateness of seeking professional help. It follows that the structure of a network (e.g., its size, the proportion of kin in the network, its density) may well

influence the perceptions held by each of its members. The following section examines the relationship between social network characteristics and actual help seeking. The role of perceptions in this process is also explored.

A number of studies have reported a correlation between network size and help seeking. The greater the number of social supports, the less effect stress is hypothesized to have on an individual (Gourash, 1976). Some studies have demonstrated that psychiatric patients, for example, tend to have fewer confidants or social contacts (Horwitz, 1977). Perhaps the most definitive study in this area was undertaken by Berkman & Syme (1979). Based on a nine year prospective study, they reported that members of the public who were most "socially embedded" (i.e., had more social contact, belonged to more groups, organizations, etc.) had mortality rates which were 2 - 4.5 times lower than did those with fewer social ties. Clarifying these findings, Gottlieb (1985) reported more recent research indicating that it is not the sheer number of social contacts but rather the quality and content of social relationships that are the best predictor of health. Evidence suggests that even one "confidant" may be all that is necessary to avoid psychiatric impairment (Lowenthal and Haven, 1968). This suggests that the overall "helpfulness of a network" may be a good predictor of whether people have mental health problems and, if so, whether they need help outside of their social network.

McKinlay (1973) was one of the first to identify the relationship between help seeking and the proportion of kin in one's network. He found that low income women who utilized pre-natal services had social networks made up predominantly of friends and acquaintances. Non-utilizers, on the other hand, lived either with or close to their family and relatives and had significantly more contact with kin as opposed to friends. Furthermore, utilizer's networks had a strong boundary between friends and family, whereas in under-utilizers' networks, family and friends often knew one another and their relationships were interwoven.

McKinlay used the term "close-knit" to describe the kin dominated network of close dependent ties in which most members knew one another. Later researchers have redefined this concept as "density", to indicate that an individual's network members tend to know and interact with one another independent of that individual. Obviously, kin dominated networks tend to be more dense. Several studies which followed McKinlay's work have confirmed that help seekers are less likely to come from dense, kin dominated networks (Birkel and Reppucci, 1983). Horwitz (1977), for example, found that psychiatric help seekers had less dense networks and Salloway and Dillon (1973) found that health care utilization was negatively correlated with density. Birkel and Reppucci (1983) examined attendance of 47 women at a parenting class and discovered that low attenders had a

greater degree of contact with kin. Interestingly, the density of either the friendship network or the family network by itself was not always related to help seeking, although overall network density was. The authors explained this finding by suggesting that the lack of a "friendship-family boundary" (i.e., the lack of a group of friends who were independent of the family system) was the real factor predicting poor attendance. In other words, the most important influence on attendance was whether the help seeker had access to a group of friends or acquaintances who were independent of the family. Birkel and Reppucci (1983) replicated these findings on a second sample of help seekers consisting of 31 women seeking child rearing advice from professionals.

While there is growing evidence that dense, kin dominated networks are negatively associated with help seeking, the underlying reasons for this are mostly speculative. It has been suggested that dense social networks: (a) provide more assistance or treatment precluding the development of problems or the need for treatment when problems do occur; (b) may provide a consensus on appropriate solutions and provide less information regarding treatment alternatives; and (c) may accept more deviant behavior precluding the need for treatment. Each of these possibilities will be examined in greater detail.

Perhaps the simplest explanation for the relationship between density and help seeking is that dense, kin dominated networks provide stronger social support and more instrumental aid, thereby reducing the prevalence of distress or providing aid when necessary. There is mixed evidence, however, on whether members of dense networks have lesser or greater levels of distress than do members of less dense networks. Wellman (1978) reported that dense family networks have been associated with greater perceived support, which would be consistent with intuitive impressions that such networks can more easily provide material assistance (financial aid, babysitting etc.) and strong emotional support. This hypothesis is supported by Calman (1983), who found that family members were much more likely than friends to take responsibility for caring for other family members. He reported that, of patients seen in emergency, those who contacted relatives immediately following an accident took longer to seek medical attention (despite similar injuries). He suggested that non-kin took less responsibility for their friends lives and were much quicker to refer them to professional help, whereas family felt responsible for providing help themselves and delayed asking for outside assistance.

There is some evidence, however, that dense networks do not necessarily provide greater support and assistance. Hirsch (1978), for instance, found that for women undergoing

life-changes (widowhood, entering graduate studies), high density networks were associated with lower self-esteem and less perceived support. Hirsch (1980) reported that when friend and kin networks were densely connected (no family-friendship boundary), recently widowed women and women going back to university suffered greater symptomatology and lower self esteem than did women with low density networks, with greater separation between family and friends. Hirsch suggested that dense networks placed greater pressure on the women to conform to established domestic roles and avoid radical change. Although dense or kin-dominated networks may well provide assistance, such aid may at times be oriented toward the acceptance of network norms and standards and, consequently, at times be "counter-therapeutic". In summary, the helpfulness and supportiveness of dense networks may depend on a number of factors, including the existence of a family-friendship boundary, the type of change desired, and the type of assistance required.

McKinlay (1973) identified a second possible explanation for the association between density and help seeking. Networks may have strong normative prohibitions against seeking outside help. McKinlay suggested that "a major source of an individual's orientation and behavior are the values and norms of the groups or networks to which he relates himself" (p.288). McKinlay hypothesized that

members of dense networks are confronted by similar values, norms, and attitudes from all network members and may feel great social pressure to conform. Dense networks may "entrap an individual within a limited set of normative expectations, information and social contacts" (Walker, MacBride & Vachon, 1977; p. 336). Outside help may also be discouraged by network members concerned that such help will violate norms of self reliance or perhaps induce changes which are contrary to network or family expectations. Members of dense networks may also have access to less diverse information regarding alternative treatments and consequently have fewer treatment options.

Lastly, Birkel & Reppucci (1983) offered a third explanation for the correlation between density and help seeking. The authors suggested that dense, kin dominated networks may be more tolerant of deviant behavior. Consequently, potential help seekers may be under less pressure to seek outside help for their problems. There is little evidence at this time either confirming or disconfirming this hypothesis.

The preceding discussion leads to the hypothesis that network norms may be an important determinant of help seeking behavior and that these norms may vary depending on the type of network in question. The present investigation examines in greater detail two main questions; (a) Is network structure related to help seeking; and (b) do

networks in fact differ in their normative expectations and perceptions regarding professional help?

Perceptions of Various Demographic Groups

Gender. The present research also investigates whether men and women differ in their perceptions of mental health services. As noted earlier, women are nearly twice as likely as men to seek therapy (Veroff, 1981) . While differences in problem recognition partially account for this situation, it is possible that the differential rate of help seeking may be partially attributed to different social norms applying to men and women. Both Veroff (1981) and Horwitz (1977) reviewed evidence that women are socialized to attribute problems to personal failure, to admit to stress, and to be more expressive about unpleasant feelings and problems. Consequently, their problems are more visible and they may be exposed to more information regarding helping resources. Women may also perceive professional help as less threatening to their self esteem. Conversely, men are socialized to deny emotional feelings and are encouraged to externalize their feelings and problems. This may decrease their probability of seeking help. These gender differences suggest that men and women may have different perceptions of mental health services. There is evidence that women hold more positive attitudes toward seeking professional help (Fischer & Turner, 1970; Cook et

al., 1984), expect less directive, less "expert", and less advice oriented therapy (Tinsley, Workman & Kass, 1980), and have fewer concerns about relying on others for help (Cook et al., 1984). The present research documents these and other perceptions which may account for some of the gender differences in help seeking. It is possible that men and women may differ in their understanding of the process of therapy, hold different beliefs regarding the efficacy of therapy, or have different fears about the process of seeking help.

Socioeconomic Status. As noted earlier, there is substantial evidence that lower SES groups were under-represented in the help seeking population, at least in the past (Gourash, 1979). There is also evidence that lower SES individuals have traditionally held more negative attitudes toward seeking professional help (e.g., Hollingshead & Redlich, 1958). Recent research, however, has failed to find SES differences in attitudes and perceptions within client and student populations (Fischer & Cohen, 1972; Lorion, 1974). Others have suggested that the correlation between SES and help seeking itself may have significantly weakened if not disappeared (Tischler et al., 1975). The present study examines whether perceptions do vary across socioeconomic level and whether differences in perceptions are related to differential rates of seeking help.

Age. Age is a well documented determinant of help seeking with older individuals much less likely to seek help than are younger individuals, despite their having a higher general rate of mental health problems (Smead, Smithy-Willis, & Smead, 1982). Tischler et al. (1975) reported that age is the best predictor of utilization of mental health services (accounting for 12% of the variance). While part of the elderly's under-representation in seeking services may be due to factors such as poor accessibility to services, lack of knowledge of services, or non-recognition of symptoms as psychological in nature, there is substantial evidence that the elderly's perceptions and beliefs play an important role in their not seeking aid when needed. Gurin et al. (1960) reported that the elderly they surveyed had strong beliefs in self reliance and often refused to ask for help when needed. Waxman, Carner, and Klein (1984) also reported that, based on a questionnaire survey of 88 community elderly, the elderly were often unwilling to admit to problems and held a very low opinion of the effectiveness of mental health professionals. Although 88% would seek help for depression from their family physician, 60% would not seek help from mental health services, even if severely depressed. This suggests the presence of specific fears or biases regarding mental health above and beyond norms of self reliance and self help. The present investigation examines how perceptions of mental health services differ across age groups.

Summary

Perceptions of mental health services is one of the many variables which influence an individual's decision to seek professional help. Understanding the public's perceptions may help to design appropriate services and to correct misperceptions or attitudes which may be a barrier preventing some individuals or groups from seeking help. Perceptions itself is a broad term which encompasses both attitudes toward professionals and toward help seeking in general. Perceptions also include the expectations, fears, and concerns individuals hold about the process and outcome of therapy and the roles of both clients and therapists. The breadth of this concept is one reason why there is no single body of research which clearly addresses this area.

Some researchers have examined student attitudes toward seeking help but, until recently, research in this area has concentrated on developing a single attitude measure as opposed to examining the actual nature of the perceptions or how they might influence help seeking. Others have examined recipient reactions to aid in experimental and analogue situations, which has indirectly identified a number of factors which might influence help seeking from professionals. There is a substantial literature which documents the expectations of clients with regard to their own role in therapy and the style of their therapist. However, public expectations directly related to seeking

professional help have seldom been examined. The few studies examining public perceptions have utilized small, non-representative samples, and examined only a few of the perceptions which might influence help seeking from professionals.

The literature examining attitudes and expectations has not adequately explored those perceptions which might act as a barrier to seeking help. Of particular interest to the present investigation is not whether attitudes are positive or negative (although this certainly influences help seeking), but rather identifying the public's specific expectations and fears about the process of seeking professional help. This study examines how these perceptions differ between various groups, especially those who seek help and those who do not.

Several questions remain unanswered. What does the general public believe happens in therapy? What fears or concerns do individuals have regarding the process and outcome of therapy? Do client expectations differ from those of the general public? Why do some help seekers prefer non-mental health professionals? Does network structure influence group norms or perceptions? The present study investigates these questions, with emphasis on developing a questionnaire which documents public perceptions of professional help and the fears and concerns which people have about seeking professional help. Priority

is given to identifying perceptions which may deter or hinder the help seeking process.

Purpose of Research and Hypotheses

First, the present study identifies and compares the perceptions of professional help held by a randomly selected sample of the general public (previous help seekers excluded) with those held by first time help seekers (sampled from a university psychology clinic and an adult psychiatric outpatient department at a general hospital). Second, this study examines whether the public's perceptions of professional help are related to: (a) willingness to seek help, (b) preference for mental health professionals as opposed to lay help, (c) gender, (d) age, (e) socioeconomic status, and (f) social network characteristics.

The following hypotheses were advanced:

Hypothesis One.

a) Help seekers (i.e., the client sample) would have significantly fewer fears and concerns about therapy than would the non-help seekers (i.e., the general public with previous help seekers excluded).

b) Help seekers would also have different expectations about the process of therapy, than would non-help seekers. Help

seekers would expect a more non-directive, insight oriented treatment. Examples of items which might measure these domains include "the therapist will mostly listen while I do most of the talking", "the therapist will point out the difference between what I am and what I want to be", "the therapist will help me put my feelings into words so I can understand them", and "I will discover how my problems relate to my upbringing". In contrast, the non-help seekers would expect more directive interventions such as advice, medication, or specific skill training. Examples of items which might measure these domains include "The therapist will point out how I should behave", "I will get lots of advice on how to solve my problems", "I will likely receive a drug prescription", "The therapist will teach me new skills", and "The therapist will give me homework assignments".

c) Help seekers would also believe that mental health professionals are qualified to treat a broader range of problems than would the non-help seekers.

Hypothesis Two.

a) The non-help seekers will be divided into three equal size groups based on their expressed willingness to seek professional help. It is hypothesized that those most willing to seek help would have significantly fewer fears and concerns about the process of therapy than would those less willing to seek help.

b) Those most willing to seek help would also expect a more non-directive, insight oriented therapy, with more sympathy, support, and reassurance, than would those less willing to seek help. In contrast, those less willing to seek help would expect more directive interventions such as advice, medical interventions, or specific skill training. Items measuring these domains have been specified in hypothesis one above.

c) Lastly, compared to those least willing to seek help, those most willing to seek help would report that mental health professionals are qualified to treat a broader range of problems.

Hypothesis Three.

a) The non-help seekers will be divided into three equal size groups based on their preference to receive help from mental health professionals as opposed to non-mental health professionals or lay helpers. It is hypothesized that those preferring help from mental health professionals would have significantly fewer fears and concerns about the process of therapy than would those preferring lay help.

b) Those most preferring professional help would also expect a more non-directive, insight oriented therapy, with more sympathy, support, and reassurance, than would those

preferring lay help. In contrast, those preferring lay help would expect more directive interventions such as advice, medical interventions, or specific skill training. Items measuring these domains have been specified in hypothesis one above.

c) Lastly, compared to those preferring lay help, those preferring professional help would report that mental health professionals are qualified to treat a broader range of problems.

Hypothesis Four.

a) The perceptions of men and women in the non-help seeking sample would differ, with women holding significantly fewer fears or concerns about seeking help.

b) Women would also expect more non-directive, insight oriented treatment, whereas men would expect more directive interventions such as advice, medical interventions, or specific skill training. The items measuring these domains have been specified in hypothesis one.

c) Compared to men, women would also report that mental health professionals are qualified to treat a broader range of problems.

Hypothesis Five.

a) Compared to younger respondents, older respondents in the non-help seeking sample would have significantly more fears and concerns about seeking help, especially in terms of loss of self-reliance and independence (e.g., "I might feel worse if I talk about problems", "I would be admitting defeat") and concerns about betraying others (e.g., "I would be disloyal to my family", "Others would be disappointed I did not speak to them).

b) Older respondents would expect more medical interventions (e.g., "I would likely receive a drug prescription") and more explanation and advice (e.g., "The therapist would explain why I have these problems", "I would get lots of advice"), than would younger respondents.

c) Younger respondents would report that mental health professionals are qualified to treat a broader range of problems than would the older respondents.

Hypothesis Six.

a) Lower SES respondents, in the non-help seeking sample, would have perceptions significantly different from those of higher SES classes. Compared to higher SES respondents, lower SES individuals were expected to have more fears and concerns about seeking help, especially concerning the amount of interest or trust to be expected from the therapist.

b) Lower SES respondents were also hypothesized to expect more explanation and more directive interventions such as advice, medical interventions, or specific skill training. Higher SES respondents would expect more non-directive and insight oriented therapies.

c) Higher SES respondents would also report that professionals are qualified to treat a broader range of problems, than would lower SES respondents.

Hypothesis Seven.

The networks of help seekers would be significantly smaller, less dense, less kin dominated, and rated as less helpful than the networks of non-help seekers.

Hypothesis Eight.

a) The networks of the non-help seekers who were most willing to seek help would be significantly smaller, less dense, less kin dominated, and rated as less helpful than the networks of the non-help seekers who were least willing to seek help.

b) The networks of non-help seekers who preferred professional help would be significantly smaller, less dense, less kin dominated, and rated as less helpful than the networks of non-help seekers preferring lay help.

Hypothesis Nine.

a) Non-help seekers with denser or more kin-dominated networks would have significantly more fears and concerns about seeking help, especially fears of betrayal, hurting others, or of loss of self-reliance.

b) Individuals from denser or kin dominated networks would also expect more directive interventions, especially advice and medication.

c) Individuals from denser or more kin-dominated networks would report that mental health professionals are qualified to treat a narrower range of problems.

Method

Subjects

Help Seekers. The survey included two samples of help seekers, the first consisting of 70 adults seeking psychotherapy at the Psychological Services Centre (PSC), University of Manitoba, and 58 seeking psychotherapy from the adult and adolescent Psychiatric Outpatient Department of the Kitchener-Waterloo Hospital (K-W), Kitchener, Ontario. All help seekers were over 17 years of age and were seeking individual, marital, or family therapy. All help seekers meeting these requirements were chosen over a three to four month period from both clinics. Samples from the two outpatient clinics were utilized in order to ensure that a wider cross section of help seekers were sampled and thereby avoid possible selection biases which might exist if only a single setting was sampled.

Public. Three hundred and fifty members of the general public (over 17 years of age) living in the City of Winnipeg were also sampled. Subjects were systematically sampled from the name listings of the Winnipeg City Directory (Henderson, 1983). Systematic sampling was achieved by choosing every "nth" name starting at a randomly chosen spot in the directory. The number of names skipped (in practice the number of inches to skip) was calculated on the basis of

the estimated number of entries divided by the required sample size (350). Sampling proceeded until 350 names were selected. When the end of the directory was reached, the sampling procedure continued at the beginning of the directory, treating the listings as though they were continuous.

Married couples were listed as a single entry (i.e., Mr. and Mrs. Smith) and married women employed outside the home were listed both with their spouse and independently. In order to ensure that married individuals were sampled proportionate to their frequency in the population, an initial sample was drawn from married men, single men, single women, and married employed women who were listed independently but who were not also listed with their husband (i.e., they were likely separated, divorced, or widowed). This initial sample basically excluded married women (employed or unemployed) who were living with their spouse. Initial sampling continued until the sample size was short by the number of married men sampled. The remaining sample was chosen only from married women living with their spouse. These women were sampled using the same sampling procedure, however, each time a married couple was selected, only the woman's name was retained. This procedure resulted in a sample containing equal numbers of married men and women.

City directories are based on thorough block enumerations and they are estimated to be more than 90% complete (Sudman, 1976; Kish, 1965). Sudman and Kish suggest that for small samples they can be used without supplements. Especially created block listings are unlikely to be more complete. Both authors also argue that a systematic sample of directory listings is basically equivalent to a simple random sample. Directory sampling identifies a general cross-section of the city population, although transients and people residing in hospitals, institutions, motels, hotels, military establishments, or similar settings are excluded.

Survey Procedure

Help Seekers: PSC. Each adult help seeker requesting an intake assessment at the PSC was mailed a questionnaire complete with a personally addressed covering letter and a stamped, addressed, return envelope. The covering letter (see Appendix D) explained the rationale for the research and requested that the help seeker complete and return the questionnaire prior to their first appointment. They were assured that their responses were strictly confidential and anonymous and that their participation was voluntary and not a prerequisite for treatment. If the identified patient was under 18 years of age the covering letter was addressed to the legal guardian who requested the counselling. The

covering letter in this case (and for individuals requesting family therapy) asked respondents to complete the questionnaire as though they themselves were seeking individual counselling.

To avoid undue pressure on help seekers who were already under a great deal of stress, no reminder letters or follow-ups were utilized. Respondents were assured that they would receive a copy of the results if they enclosed a separate sheet of paper with their name and address. The name and telephone number of a contact person was included if respondents wanted additional information.

Information regarding the research was also provided to all therapists at the PSC and K-W clinics (see Appendix E).

Help Seekers: K-W Outpatient Department. The K-W hospital ethical review committee required that all help seekers give their consent prior to their receiving a questionnaire. Consequently, all new referrals attending an initial intake interview with one of two intake workers were asked if they would consent to being given a questionnaire which they could examine and respond to if they felt able to do so. If consent was provided, a questionnaire was given personally to the help seeker, complete with a covering letter (similar to the one used at the PSC but with appropriate name changes) and a stamped, addressed return envelope. In a number of cases, consent was obtained over

the phone and the questionnaire was mailed to the help seeker because the intake worker had forgotten to discuss the questionnaire at the initial interview or because the help seeker had been referred directly to a therapist without an intake assessment. Only one help seeker refused to at least accept the questionnaire packet. All K-W help seekers were given the same assurances as were PSC help seekers and the same inclusion requirements and general procedures were followed. A small number of help seekers were excluded from the sample due to the severity of their pathology. Unfortunately, the exact number of refusals was not recorded by the intake workers but these occurrences represented a very small percentage of the total sample.

General Public. Each respondent sampled from the Winnipeg City Directory was mailed a questionnaire complete with a personally addressed covering letter and a stamped, addressed return envelope (see Appendix F for a copy of the public's covering letter and reminder letters). The covering letter explained the rationale for the research and noted the importance of each respondent's viewpoint whether positive or negative, informed or not informed. Respondents were assured that their results were confidential and that a copy of the results would be mailed to them if requested. Respondents also had a contact name and number to call for further information.

One week following the first mailing, a reminder post-card was sent to all respondents reinforcing the importance of their reply and thanking them for their help if they had already responded. Two weeks following the reminder card, a reminder letter complete with another questionnaire and a stamped, addressed envelope was sent to all individuals who had yet to respond to the survey. The initial return envelopes had been coded to facilitate this follow-up. The second questionnaire and return envelope were not coded as no further follow-up was planned.

Questionnaire Design

Help Seekers. The questionnaire for K-W and PSC help seekers was printed in booklet form and each page is reproduced in Appendix G. The first page provided additional information regarding the research and the initial section consisted of 64 randomly ordered statements reflecting perceptions about the process of psychotherapy. Each statement began with the stem "When I receive psychotherapy or counselling..." and the respondent indicated on a seven point scale how strongly they agreed or disagreed with each statement.

The second section of the questionnaire consisted of a list of 8 problem areas with which people might need help. Respondents were asked to rate, on a 7-point scale, how well

qualified or trained they believed mental health professionals were to help people with each of the problems listed.

Section III of the questionnaire consisted of three short scenarios describing individuals who were either depressed, anxious, or having marital problems. For each scenario, respondents were asked to rate (on a 7-point scale) seven help givers on how helpful they would be to a friend of theirs suffering from the type of problem described. The help givers consisted of three mental health professionals (social worker, psychiatrist, psychologist) and four non-mental health professionals or lay helpers (general practitioners, clergymen, nonprofessional helpers, and family or friends). The helpfulness ratings for each of the mental health professionals were summed across all three scenarios and then the helpfulness ratings of the non-mental health professionals were subtracted. The resulting scores represented the preference for mental health professionals index (PMHP). Higher scores indicated that the respondent perceived mental health professionals as more qualified than non-mental health professionals or lay helpers to treat the problem areas described.

The fourth section of the questionnaire collected information regarding the respondent's social network. Each respondent listed the initials of all adult persons who were important to them and with whom they discussed personal

problems or worries. For each person listed, the respondent indicated whether they were kin (family or relative) or friend and rated the helpfulness of that person's support and advice. Lastly, they indicated how many other people on their list each listed person knew and visited even when the respondent was not with them.

The number of social supports listed was summed to represent network size and the proportion of kin was calculated by dividing the number of supports who were kin by total network size. The average degree of helpfulness of the network was calculated by summing the helpfulness ratings and dividing by network size. Density was calculated by summing the number of contacts each network member had with one another and then dividing this total by the total number of possible contacts:

density = sum of contacts / (network size x [network size - 1]).

Twenty percent of the sample listed either one social support or no social supports making it mathematically impossible to calculate density in every case. To simply assign a density of 100% to a network of one support person would make some theoretical sense (i.e., only one person presents an extremely unified viewpoint) but this would have contaminated the real meaning of density. As a compromise, individuals with zero or one network members were excluded from the calculation of density.

The final section of the questionnaire requested basic demographic information and determined whether the respondent had received therapy previously, whether they had friends or relatives who had sought help, how long they had considered seeking help, and how hesitant they were about seeking help. Information about their referral source and the referral source's own therapy experience was also gathered as was the respondent's expectations regarding the duration of therapy.

Public. The help seeker questionnaire was slightly modified for use with the public sample and it is reproduced in Appendix G. Each of the 64 statements was written in the future rather than present tense. The respondent was also asked to rate the statements as though they themselves were seeking help. Each statement began "If I received psychotherapy or counselling...".

The public also completed an additional section consisting of 16 statements from Fischer and Turner's (1970) Attitudes Toward Seeking Professional Help Scale. Fischer and Turner found that their scale reliably discriminated previous help seekers from non-help seekers and had a low to zero correlation with social desirability. Test-retest reliability was high (.73 - .89), as was internal reliability (.85). Factor analysis extracted four dimensions representing stigma tolerance, interpersonal

openness, recognition of need for psychotherapy, and confidence in mental health practitioners. The last two factors correlated .58 and had internal reliabilities of .67 and .74. The authors suggested that these two factors were the "essence of the attitude toward seeking professional help" and hypothesized they would be highly correlated with actual help seeking behavior. Sixteen items[2] making up these two scales were utilized in the present questionnaire as an index of each respondent's willingness to seek help (WTSH). These items reflected a recognition that some people need psychotherapy, a confidence in the efficacy of professional help, and a personal willingness to seek such help if needed.

Each of the items on the WTSH scale reflected a belief or attitude toward professional help which the respondent was asked to agree or disagree with on a seven point scale (e.g., "psychotherapy would have doubtful value for a person like myself"). The scoring of negatively stated items was reversed and the ratings for each statement were summed to produce a final index theoretically ranging from 16 to 112. Higher scores indicated a stronger willingness to seek help.

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[2] Note that one item from Fischer and Turner's original 17 items, namely "Considering the time and expense involved in psychotherapy it would have doubtful value for a person like me", was not included in the WTSH scale. This item is a very specific expectation or perception as opposed to a general measure of one's willingness to seek help.

The final section of the public questionnaire requested demographic information identical to the client questionnaire but questions specific to help seekers were not included. The public were also asked if they had ever received psychotherapy or counselling for a personal problem in the past and, if not, whether they had ever experienced a personal problem for which they might have used professional help.

Questionnaire Development

The final questionnaire as just described was developed in several stages. Six mental health professionals and ten lay members of the public were asked to identify people's potential concerns about seeking help, what people might anticipate would happen during psychotherapy, and any other factors which might make people reconsider seeking help. The lay individuals also completed a written questionnaire asking the same three questions. The research literature was also reviewed to identify possible expectations and fears which might influence help seeking behavior. Based on this literature review and the interviews with the professionals and members of the public, nine general categories of fears or concerns which might inhibit people from seeking help were identified. These categories included fears of: embarrassment, lack of interest from the therapist, receiving bad news, of hurting others, philosophical or value differences between clients and

therapists, inability to perform in therapy, lack of confidentiality or trust, loss of self reliance, and concerns about the cost or availability of services.

The literature review and interviews also identified eight categories of practices or procedures which might occur during the course of psychotherapy. These categories represented procedures which might be implemented by a therapist or aspects of therapy which might be considered helpful to clients. These categories were: medical interventions, support, advice, behavioral skill training, collaborative exploration of problems, development of insight, testing and diagnosis of problems, and mystical or spiritual interventions.

In addition to identifying general categories of fears and expectations about the process of therapy, the interviews and a review of previous questionnaires generated a large pool of more specific items which reflected the above named categories. Questionnaires which were reviewed included those by Aronson & Overall (1966), Balch et al., (1978), Fischer & Turner (1970), Snyder, Hill, & Derksen (1972), Tinsley, Workman, & Kass (1980) and Tinsley & Harris (1976). Three or more items were then selected from this pool to reflect each of the 17 possible fears and expectations.

Pilot Testing of Preliminary Questionnaire. In all, 89 initial items were selected and were incorporated into a preliminary questionnaire which also included the WTSH scale and the original versions of all of the other sections of the final questionnaire. This preliminary questionnaire, along with a social desirability questionnaire (Crowne and Marlow, 1960), was pilot tested using 100 households in five different neighborhoods in the cities of Kitchener and Waterloo, Ontario. Neighborhoods were chosen as representative of a wide cross-section of the city's population. Within each neighborhood, four blocks were selected by randomly dropping a pin on a street map. Five questionnaires were delivered to each block starting with a randomly chosen house and delivering to every second household. One apartment block was chosen as a substitute for one street block.

A covering letter accompanied the questionnaire, which explained the rationale for the research and informed the respondent that the surveyor would call back in person the following weekend to collect the survey (see Appendix H for a copy of the preliminary questionnaire, social desirability questionnaire, and the covering letter). Respondents had the option to leave the survey in their mailbox if they were not going to be home or wished not to be disturbed. All but two respondents were either contacted personally or their questionnaire returned over the following 4 weeks.

Completed questionnaires were received from 48 households out of the 100 surveyed. All respondents who were contacted personally (74) were asked for their opinion of the questionnaire and about any problems which they had completing it. Eight respondents also agreed to brief interviews about their perceptions of mental health services in order to elicit other possible perceptions not previously identified.

Frequency distributions for each of the 89 statements were calculated and each item was correlated with social desirability scores based on Crowne and Marlow's (1960) Social Desirability Questionnaire. In order to ensure that the final questionnaire items were not endorsed because of a social desirability bias, those items with social desirability correlations over .30 were dropped (five items). Only two items were retained and another two reworded which had social desirability scores over .25. All other items had desirability correlations less than .25, with 75% of them under .20. As a result, the final questionnaire items are unlikely to have a social desirability response bias.

Items were also rejected or reworded if their frequency distribution was strongly skewed (skew greater than 1.0), if their kurtosis exceeded 1.0, or if their variance was very small. Items selected were those which had response frequencies approximating a normal curve, or which had a bi-

modal distribution suggesting they tapped opinions which were strongly polarized in the population. Overall, items were selected for their ability to discriminate across the pre-test population, their low correlation with social desirability, and to ensure that at least three or more items were included that represented most of the pre-determined factors.

The data was also examined for outlyers which might indicate the presence of extreme responses due to unknown factors such as misunderstood directions or unique characteristics of certain respondents. Given the relatively narrow range of responses (1 - 7) and the good distribution of scores across the range, no specific outlyers or unusual response tendencies could be detected.

The interviews with respondents and the feedback from colleagues who reviewed the questionnaire led to a number of new items being added and to modifications of other sections of the questionnaire.

It is important that the final 64 items selected actually represent either fears about seeking professional help, or expectations about the process of therapy. If this basic assumption is false, a meaningful interpretation of any factors derived from these items would be difficult. To examine this issue, four lay individuals rated each item as to whether it represented a fear about psychotherapy, a

description of the process of therapy (an expectation), both, or neither. Lay judges were chosen because members of the public had initially selected or identified many of the categories and items. As a result, the lay public seemed best qualified to rate whether the items actually reflected possible fears or expectations which the public might hold about seeking professional help.

The raters were chosen by requesting the help of four individuals who were casual acquaintances of the researcher. These individuals were unaware of the research design and hypotheses being tested. Fear items were defined as statements describing fears, worries, or concerns that some people might have about getting professional help. Fear statements represented what some people might consider an unpleasant possibility that might occur while looking for help, during therapy, or as a result of therapy. Expectation items were defined as statements describing some practice or procedure which might be carried out by a therapist to help a client or a statement representing some aspect of therapy which might be helpful to people.

Results indicated that the researcher and the judges agreed 88% of the time on whether an item reflected a fear about the process of therapy (range: 84% to 90%). The judges agreed with the researcher's opinion 86% of the time on whether an item represented an expectation about the process of therapy (range: 83% to 88%). These relatively

high agreement ratings did not reflect a tendency by judges to rate all items as either fears or expectations (i.e., there was no evidence of a "yes set"). An average of 94% of the items considered non-fears by the researcher were also considered non-fears by the judges (i.e., they were rated as either an expectation or neither an expectation nor fear). In other words, the judges did not have a tendency to rate non-fear items as fears. Similarly, 94% of the items considered non-expectations by the researcher were also considered non-expectations by the judges.

The judges ratings of the items indicated that the items included in the questionnaire represented possible fears and expectations in the eyes of the public and that the two categories of items could be reliably distinguished. These findings support the face validity of the questionnaire items.

Results

The results section begins with an examination of the sample return rates for each group surveyed and then identifies and compares the demographic characteristics of each sample. The demographic correlates of help seeking are of particular interest, as this identifies groups which may hold differing perceptions of mental health services. Following the demographic analyses, the results of a factor analysis of the perception items is documented, leading to an examination of each of the main hypotheses. Prior to discussing the results for each hypothesis, however, there will be a brief description of the statistical analyses utilized and an overall descriptive analysis of the perceptions held by each sample group. The results section concludes with a comparison of the perceptions held by current help seekers and previous help seekers.

Sample Return Rates

General Public. Of the 350 questionnaires mailed to the public, 187 were returned completed and 26 were returned as undeliverable. This represents an overall return rate from the public of 58%. Another 11 (3%) were returned with an explanation that the respondents were non-english speaking, illiterate, or too elderly to respond. A return rate of close to 60% can be considered reasonably good given the

length of the questionnaire and the breadth of the population surveyed. Given that only 72% of Winnipeg's population has english as their mother tongue (census tract, 1981) the final sample may be considered fairly representative of the literate, english-speaking population of Winnipeg.

Help Seekers. Thirty PSC help seekers of the 70 surveyed returned a completed questionnaire. One was returned as undeliverable resulting in a return rate of 44% for individuals seeking help at the PSC. Twenty-four of the 58 individuals surveyed at the K-W hospital returned completed questionnaires representing a 41% return rate. The overall return for all help seekers equalled 43% (54 out of 127). Given that less than one-half of the help seekers returned questionnaires, generalizations from their responses to help seekers in general must be made cautiously.

General Comments from the Public

Fifty individuals from the public sample added additional comments to their questionnaires. Ten respondents (5% of the sample) made comments revealing negative perceptions of mental health services, with 7 of these citing examples of individuals who were not helped or whose problems worsened because of their seeking professional help. Mental health therapists were described as "too theoretical", "lacking common sense", "unrealistic", "one-sided", "power hungry",

"uninterested" (2), and "too expensive" (2). Another four respondents stressed the importance of self help or network help and several commented on the stigma associated with help seeking. Eight individuals (4%) reported positive feelings about professional help and another eight recounted their own problems and needs. Lastly, one individual "disliked the questionnaire" although 8 (4%) "liked the questionnaire" and commented that completing it had been an enjoyable or good educational experience.

Demographic Description and Comparison of Samples

The following sections describe the demographic composition of each sample and identifies those demographic variables associated with help seeking.

PSC versus K-W Help Seekers. Table 1 presents a breakdown of the PSC and K-W samples by various demographic variables. Chi square tests of significance indicated that there were no significant differences between these groups on any of the measured demographic variables including gender ((1, N = 54) = 2.05, p = .15), marital status ((3, N = 54) = 4.43, p = .22), ethnicity ((7, N = 54) = 5.15, p = .64), SES[3] ((2, N = 54) = 1.92, p = .38), religion ((7, N = 54) = 7.7, p = .36) and age ((2, N = 54) = 5.4, p = .07). There was a trend, however, for K-W

[3] SES was assigned based on Blishen's Socioeconomic Index (range 25-77) which consists of a rank ordering of 320 occupations by SES.

Table 1

Demographic Comparison of PSC and K-W Help Seekers

Variable	K-W Clients n	K-W Clients (%)	PSC Clients n	PSC Clients (%)
Gender				
Male	10	(42)	6	(20)
Female	14	(58)	24	(80)
Marital Status				
Single	7	(29)	15	(50)
Married/Common-Law	12	(50)	7	(23)
Separated/Divorced	4	(17)	7	(23)
Widowed	1	(4)	1	(4)
Ethnicity				
Canadian	8	(38)	8	(33)
British	5	(24)	3	(13)
French	0	(0)	3	(13)
German	2	(9)	2	(8)
Irish	1	(5)	2	(8)
Scottish	1	(5)	1	(4)
Italian	1	(5)	0	(0)
Other	3	(14)	5	(21)
Religion				
No Affiliation	10	(45)	9	(35)
Catholic	3	(13)	5	(20)
Protestant	4	(18)	8	(30)
Jewish	0	(0)	2	(8)
Other	5	(23)	2	(8)

	K-W Clients	PSC Clients
Mean age	34.6	30.1
Mean SES	41.0	45.0

clients to be slightly older than PSC clients, especially in the over 50 category. The lack of significant demographic differences between the two help seeking samples, one taken from a university based clinic in Winnipeg, and the other from a general hospital outpatient department in Kitchener, suggests that there were no selection biases operating which might have been unique to only one setting. The lack of differences also enables further analyses to utilize a pooled sample of PSC and K-W help seekers, which has greater generalizability than using a sample of help seekers from only one setting.

Public Sample versus Census Data. Table 2 compares the demographic breakdown of the public sample with a demographic breakdown of the Winnipeg population based on the 1981 census. Visual examination reveals a very close correspondence between the two sources of data. There are no observable differences between the two groups on ethnicity, religion, age, marital status or average number of children. SES differences could not be compared as the census did not utilize the socioeconomic index used in this research. However, the sample, like all mail surveys, is likely to be over-representative of higher socioeconomic classes. The public's mean socioeconomic index score of 45 is one half a standard deviation above the mean index score for Manitoba (39) as reported by Blishen in 1961. The average socioeconomic level, may have increased since that

Table 2

Demographic Comparison of Public Sample with Census

Variable	Public Sample (%)	1981 Census (%)
Gender		
Male	40	51
Female	60	49
Ethnicity		
Canadian or British	34	36
French	9	8
Other	57	56
Religion		
Protestant	43	49
Catholic	34	34
Jewish	2	2
Other	4	3
No affiliation	16	9
Age		
18 - 36	34	37
37 - 50	32	35
51 and up	34	33
Marital Status		
Never Married	16	27
Married/Common-Law	73	62
Separated/Divorced	7	4
Widowed	4	7
Number of Children	2.4	2.2

Note. The discrepancy between the sample and census data for marital status is likely because the census data considers individuals living common-law as single rather than married. The sample data does not distinguish between married and common-law. If the two categories (married or common-law and never married) are summed, both the sample and census data produce identical results (89%).

time. A rough estimate of the public sample's socioeconomic level can be made by examining the occupations associated with the mean score. Occupations of the "average" respondent included trade foreman, telephone linesman, locomotive engineer, and window dresser-interior decorator.

The research sample appears slightly over-representative of women (60% in the research sample versus 49% in the census data) suggesting the presence of a gender response bias. Men may have been less willing to participate or they may have been more likely to ask their spouse to complete the questionnaire for them (as did several men in the pre-test sample). Overall, the research sample can be considered highly representative of the demographic characteristics of the general population of Winnipeg with the exception of being slightly over representative of women and individuals from higher socioeconomic classes.

Help Seekers versus Non-Help Seekers. Of the 187 public respondents, 151 had never sought psychotherapy or counselling for personal problems in the past. Table 3 compares this group of non-help seekers (NHSs) to the help seekers (HSs) on all measured demographic variables. ANOVA and chi square analyses indicated that HSs, compared to NHSs, were younger (M = 32 vs. M = 44), $F(2, 195) = 17.3$, p = .0000, more likely to be never married, separated, or divorced, $(3, N = 197) = 28.3$, p = .0000, less likely to

Table 3

Demographic Comparison Non-Help Seekers, Current Help Seekers and Previous Help Seekers

Variable	Non-help Seekers n	(%)		Current Help Seekers n	(%)		Previous Help Seekers n	(%)	
Age			*			**			
18 - 37	44	(31)		42	(77)		17	(47)	
37 - 50	44	(31)		8	(15)		11	(31)	
51 and older	53	(38)		4	(8)		8	(22)	
Marital Status			*			**			***
Never Married	27	(19)		22	(41)		1	(3)	
Married/Common-law	104	(73)		19	(35)		28	(78)	
Separated/Divorced	6	(4)		11	(20)		7	(19)	
Widowed	6	(4)		2	(4)		0	(0)	
Religion			*			**			***
Protestant	55	(41)		12	(25)		19	(54)	
Catholic	51	(38)		8	(17)		6	(17)	
Jewish	1	(1)		2	(4)		3	(9)	
Other	8	(6)		7	(15)		0	(0)	
No Affiliation	21	(15)		19	(40)		7	(20)	
Ethnicity			*						
Canadian	18	(14)		16	(36)		5	(15)	
British	24	(19)		8	(18)		8	(24)	
German	15	(12)		4	(9)		6	(18)	
Ukrainian	21	(16)		0	(0)		4	(12)	
Scottish	13	(10)		2	(4)		5	(15)	
French	14	(11)		3	(7)		0	(0)	
Other	25	(19)		12	(27)		5	(15)	
Gender									***
Male	66	(46)		16	(30)		5	(14)	
Female	79	(54)		38	(70)		31	(86)	
SES						**			***
High	37	(29)		7	(16)		17	(47)	
Medium	43	(34)		16	(37)		9	(25)	
Low	47	(37)		20	(46)		10	(28)	

* Significant difference ($p < .05$) between Non-help seekers and Current help seekers.
** Significant difference ($p < .05$) between Current help seekers and Previous help seekers.
*** Significant difference ($p < .05$) between Non-help seekers and Previous help seekers.

be Catholic or Protestant and instead much more likely to have no religious affiliation, (7, N = 184) = 25.8, p = .0005. The HSs were under representative of Ukrainians and tended to have no distinct ethnic background other than "Canadian", (8, N = 175) = 20.4, p = .009. The HSs tended to be predominantly female (70%). However, the gender differences between the two groups only approached significance, (1, N = 199) = 4.1, p = .06, perhaps because the sample of non-help seekers was slightly over representative of women (54%). In contrast to previous literature reports, SES did not differ between NHSs and HSs (M = 45 and M = 43 respectively). Actual SES differences between HSs and NHSs, however, may have been masked, as the public sample itself may slightly over-represent the higher socioeconomic classes.

It is possible to argue that the identified differences between HSs and NHSs was due to sampling bias in the help seeking sample, rather than actual differences between these two groups. In other words, help seekers at the PSC and K-W Hospital might not be representative of help seekers in general. To examine this possibility, a group of previous help seekers (i.e., the sample of the general public which had previously sought help from any professional group or agency) was compared to the NHSs in the same fashion as were the current help seekers.

The results of the chi square analyses are presented in Table 3 . The same general findings emerged although there were some differences which could be accounted for by the age differences between previous and current help seekers. For brevity, the differences between past help seekers and non-help seekers or current help seekers will not be elaborated on. However, examination of Table 3 indicates that the sampling characteristics of current help seekers are similar to that of previous help seekers. One difference that is noteworthy is that previous help seekers, unlike the current help seekers, did differ from non-help seekers in socioeconomic status, $F(2, 203) = 4.0$, $p = .02$. Previous help seekers were more likely to be of high SES (mean score of 51 on the SES index compared to 45 for NHSs), whereas in the current help seeking sample the trend is actually reversed (current help seekers had a mean score of of 43). This suggests that while high socioeconomic status might have been correlated with help seeking in the past, this association may no longer exist.

In summary, a comparison of the demographic characteristics of NHSs with those of both current and previous help seekers indicated that help seekers tended to be younger, more likely to be divorced or single, more likely to have no religious affiliation, and to be non-Catholic. Previous HSs were more likely to be women, although this relationship was not statistically significant

when current HSs were compared to NHSs. Higher SES status was also correlated with help seeking in the past but this association no longer pertained to the current help seekers. Overall, the results suggest that the sample of current help seekers is representative of help seekers in general.

It might be helpful at this time to review the subsamples which will be utilized in the following analyses. Table 4 lists each sample's abbreviated name, its size, and definition.

The following section outlines the results of several factor analyses which were used to reduce the data in preparation for further multivariate analyses.

Factor Analyses of Expectation and Fear Items

The questionnaire contained 33 statements reflecting possible fears or concerns which help seekers might hold regarding the process of seeking help. It also contained 35 statements reflecting expectations about the process of therapy. Both sets of variables were factor analyzed separately in order to reduce the number of variables being compared between groups and to identify meaningful factors or dimensions measured by these two sets of variables. Principle factor analysis was utilized to identify factors made up of variables sharing a common variance. The squared multiple correlations between a variable and the rest of the variables were used as the initial estimates of communality.

Table 4

Name, Size, and Definition of Each Sample or Subsample

Sample Name	Abbreviation	N	Definition
General public	-	187	All members of the public who returned a questionnaire.
Non-help seekers	NHSs	151	Members of the general public who reported never having sought counselling in the past.
Previous help seekers	previous HSs	36	Members of the general public who reported having received counselling in the past.
Help seekers	HSs	54	All PSC and K-W clients who returned a questionnaire.

The factor analyses were calculated based on a pooling of the HSs, previous HSs, and NHSs. This created a sample of 241 individuals (i.e., all of the general public and all of the clients were included in the analysis). Prior to pooling the HSs and the general public, the homogeneity of the dispersion matrices of these two samples was tested using Box's M. No significant differences were found between the two groups for either the fear items (Box's M = 850.3, p = .02) or for the expectation items (Box's M = 1017.5, p = .02).

Fear Items. Factor analysis of the fear items identified nine factors each with an eigenvalue greater than one (Kaiser-Guttman criterion). Examination of Cattell's Scree Test (Figure 2) and the eigenvalues associated with each factor suggested retaining either the first four factors (accounting for 37.4% of the variance) or retaining seven factors (accounting for 50.7% of the variance). To aid in the decision of which factors to retain, each of the factor solutions extracting three through seven factors were examined. The extraction of five factors resulted in a factor structure which was stable and interpretable. Extracting more than five factors resulted in single item factors or factors of questionable reliability. Extracting less than five factors resulted in the loss of some potentially useful data. Chronbach coefficients of alpha were calculated for each factor and they are reported in

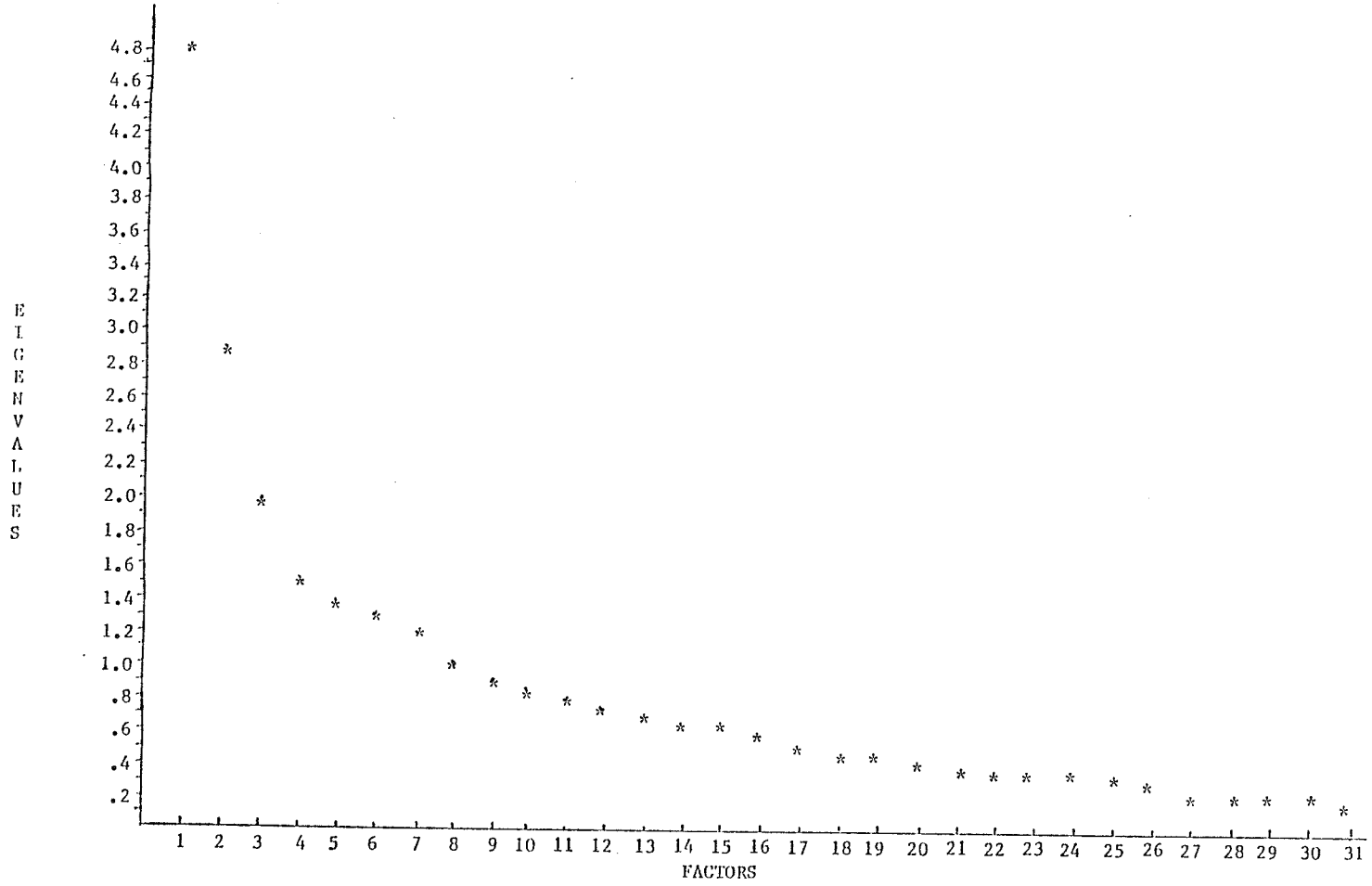

Figure 2. Eigenvalues for each fear factor.

Table 5. All five factors had adequate internal reliability, with alpha coefficients ranging from .51 to .72. These five factors were retained for further analyses. Table 5 also lists the variance accounted for by each factor after rotation.

It is desirable to demonstrate that the factor structure identified from the pooled sample, is equally applicable to the help seekers. This is important because the help seekers were sampled from a different population than were the general public and, as already reported, the Box's M test of the homogeniety of the dispersion matrices between the two groups had a trend towards significance. Unfortunately, the help seeker's sample was too small to be factor analyzed independently. However, it was possible to pool the HSs with the previous HSs from the general public sample to create a sample of 93 individuals who were either currently seeking help or had done so in the past.

The pooled sample was factor analyzed with a varimax rotation and five factors were extracted. The relationship between these five new factors and the five originally extracted from the pooled sample were compared using coefficients of congruence (Harman, 1976). These measures are interpreted in a manner similar to product moment coefficients. A coefficient of congruence does not, however, represent a true correlation. Rather it represents the degree of relationship between the factor loadings of

Table 5.

Eigenvalues, Variance Accounted For, and Reliabilities for each Fear and Expectation Factor

Factor	Number of Items	Eigenvalue	Percentage of Variance Accounted For	Cumulative Percentage of Variance Accounted For	Reliability
			FEAR FACTORS		
1	7	4.8	14.0	14.0	.73
2	3	2.9	7.4	21.4	.62
3	5	2.0	4.5	25.9	.59
4	5	1.5	2.8	28.8	.62
5	4	1.4	2.5	31.2	.51
			EXPECTATION FACTORS		
1	9	8.0	21.2	21.2	.85
2	9	2.4	5.0	26.2	.77
3	8	2.0	3.7	29.9	.70

Note. Eigenvalues prior to rotation are reported. Variance accounted for was calculated after rotation.

two different factors taken from two different populations. The five coefficients for Factors 1 through 5 were .94, .94, .84, .73, and .84 . This indicated that similar factor structures existed in both the pooled sample (the general public and the current HSs) and in the sample of current HSs and previous HSs. This lends some support to the decision to pool the general public and the HSs for purposes of factor analyses.

For the purposes of future between group comparisons of factor scores it is preferable to identify orthogonal factors, as was done in this case. It is possible, however, that fear perceptions may be highly correlated and that the varimax solution distorted the true factor structure. To test this possibility, an oblique rotation (oblim) extracting five factors was also performed. The resulting factor structure was compared to the orthogonal solution. The root mean square deviations between the factor loadings on each pair of comparable factors was calculated (Harman, 1976). These scores represented the average deviations between the factor loadings on two separate factors. Deviations less than .10 can be considered indicative of very similar factors. The five deviations for Factors 1 through 5 were .06, .05, .07, .06, and .04 . This indicates that the oblique solution identified the same five factors as did the orthogonal rotation. Furthermore, of the 15 intercorrelations between oblique factors, only two exceeded

.20, one being .25 and the other .30 . This indicates that the fear factors were not strongly correlated with one another, and supports the decision to utilize orthogonal factor scores for further between group comparisons. While the orthogonal solution does not eliminate interfactor correlations, it does minimize these correlations. This makes the interpretability of between group differences simpler and easier to understand.

Table 6 displays the factor loadings for each of the five fear factors. Examination of the factor loadings for Factor 1 indicates that this factor loaded heavily on "I might get too embarrassed to talk about extremely personal problems", "I doubt I would be able to talk about my true feelings or even admit them to myself", "I would be embarrassed to tell my family and friends", "I would worry I was being disloyal to my family", and "I would feel like I was admitting defeat". There were slightly lower loadings on "What I say might get back to my boss", "The therapist would expose things I would rather forget or not know", Others might be disappointed that I didn't talk to them instead of a therapist", and "I would worry how my relatives and family would feel or react if I made real changes in my life". This factor was named "Too Embarrassed or Ashamed to Discuss Problems or Seek Outside Help", as it loaded highly on items related to being too embarrassed to talk about personal problems or to even admit to others (family, friends, boss)

Table 6

Factor Loadings based on Factor Analysis of Fear Items

Item	Factor 1	2	3	4	5
Too embarrassed to talk	62	13	- 12	08	16
Couldn't admit feelings	58	04	10	17	09
Embarrassed to tell family	57	08	- 22	09	13
Worry disloyal to family	54	- 03	- 01	04	- 13
Feel I was admitting defeat	51	- 02	- 05	16	00
Might get back to boss	44	- 14	06	12	- 11
Expose things rather forget	40	- 13	03	- 07	24
Others disappointed in me	36	- 12	- 04	- 07	05
Worry how relatives react	36	- 21	02	- 06	25
Feel worse if talk	30	- 02	01	00	10
Therapist think I was weak	29	- 15	20	01	11
Could trust my therapist	- 10	78	24	- 25	- 07
Therapist understand beliefs	- 11	65	28	- 18	- 05
Problems taken seriously	- 13	59	05	- 39	- 02
Therapist well adjusted	19	29	14	09	- 14

Table continued....

Table 6 (continued)

Item	Factor 1	2	3	4	5
Easy to talk to therapist	- 26	13	52	- 07	- 13
Religious faith encouraged	11	01	50	- 05	- 42
Reassured mind is okay	03	11	47	- 04	02
Therapist's values similar	03	24	44	- 01	- 19
Therapist of any age okay	- 18	14	41	- 01	13
Asked to give up beliefs	16	- 03	29	23	- 05
Therapist interested in me	00	13	23	- 55	- 15
Therapist too well off	18	- 22	13	47	06
Family's role recognized	13	08	14	- 43	18
Get therapy only if serious	14	01	09	41	16
Friends-relatives admire me	- 09	11	25	- 32	- 29
Always wait for therapist	23	- 12	20	24	07
Take great effort to change	12	00	- 02	09	46
Therapy a lot of hassle	20	- 33	04	29	44
Easy to find therapist	- 10	24	16	- 01	- 32

Note. $\underline{N} = 241$. Sample included all help seekers and members of the general public combined. Decimal points in factor loadings have been omitted for clarity.

that one was seeking help. Included is a sense of shame in that one might not even be able to admit to problems and feelings that one is admitting defeat. This factor includes four items reflecting fears of what one's family will think or react if outside help is sought. Perhaps the help seeker perceives family pressure to keep family problems within the family, not to be disloyal to other family members by seeking outside help, and not to make changes that are contrary to family wishes (worry about family's reaction to changes).

Examination of the factor loadings on the second factor indicates that the items most heavily weighted were "I would always be able to trust my therapist", "The therapist would fully understand and value my cultural or traditional beliefs", and "The therapist would take all of my problems seriously". This factor was named "Therapist Trustworthy and Understanding" as it represents a belief that a therapist will not intentionally harm someone and that he or she will make every effort to understand and value the help seeker's opinions.

Factor 3 loaded heavily on "It would be easy to talk to the therapist and explain why I am upset", "My religious faith and beliefs would be strengthened and encouraged", and "I would be reassured there was nothing wrong with my mind". There were slightly lower loadings on "The therapist would have values similar to my own", and "A therapist of any age

would be just as helpful to me". This factor appears to reflect a belief that the therapist will be easy to talk to, reassuring, and will have values similar to the help seeker. Therapy will involve either some form of religiously oriented counselling or at least lead to the help seeker's religious faith and beliefs being strengthened. The item "I would be asked to give up some of my moral beliefs and values had a loading of only .29 on this factor but it supports the interpretation that the help seeker is expecting a focus on examining and changing one's belief system. This factor was named "Therapist Shares Beliefs and Values".

"The therapist would be very interested in me as a person" loaded highly in a negative direction on Factor 4. "The therapist would be sure to recognize the important role my family and friends play in my problems and worries" and "The therapist would take all of my problems seriously", also had moderate to low negative loadings. There were moderate positive loadings on "The therapist might be too well off financially to understand or "tune in" to my problem" and "I would only seek psychotherapy if my problems were extremely serious". This factor was named "Therapist Indifferent and Uncaring". The therapist is perceived as being uninterested in the help seeker and as too well off to understand the help seeker's problems. Similarly, the therapist may fail to take the help seeker's problems

seriously and perhaps be somewhat blaming as the therapist may fail to recognize the role of the help seeker's family in his or her problems. Talking to a therapist is apparently an aversive process and the help seeker would seek help only for problems which a therapist would have to consider serious.

Factor 5 loaded strongly on "It would take a great deal of time and effort to make any real changes in my life or situation", and "Finding a therapist, making an appointment, and getting to each appointment would create a lot of hassles and difficulties". There was a much lower (- .32) but negative loading on "It would be easy to find a therapist I could afford to see". This factor was named "Therapy Inconvenient and Inaccessible".

In summary, the five factors extracted by factor analysis of the fear items were as follows:

1. Too Embarrassed or Ashamed to Discuss Problems or Seek Outside Help
2. Therapist Trustworthy and Understanding
3. Therapist Shares Beliefs and Values
4. Therapist Indifferent and Uncaring
5. Therapy Inconvenient and Inaccessible

Expectation Items. Factor analysis of the expectation items identified 10 factors each with an eigenvalue greater than one. Together they accounted for 61.4% of the variance within the items. Examination of Cattell's Scree Test (Figure 3) and the eigenvalues associated with each factor suggested retaining either two factors accounting for 40.3% of the variance within the items or seven factors accounting for 52% . To aid in the decision of which factors to retain, the factor solutions extracting two through seven factors each were examined. The extraction of three factors proved most stable and interpretable. Table 5 displays the variance accounted for and the Chronbach coefficients of alpha for each factor. The coefficients of alpha ranged from .70 to .85.

As was done with the fear items, the expectation items were also factor analyzed on the sample of HSs and previous HSs. The coefficients of congruence between the factors extracted from the entire pooled sample and from the help seekers and previous help seekers sample were .98, .96, and .97. The same factor structure existed in both samples.

Oblique rotations were also carried out and once again, the oblique and varimax solutions yielded very similar findings (root mean square deviations between paired factors of .09, .01, and .08). The correlations between the oblique factors were also low, with only one correlation (.37) exceeding .30 . Based on these findings, the three

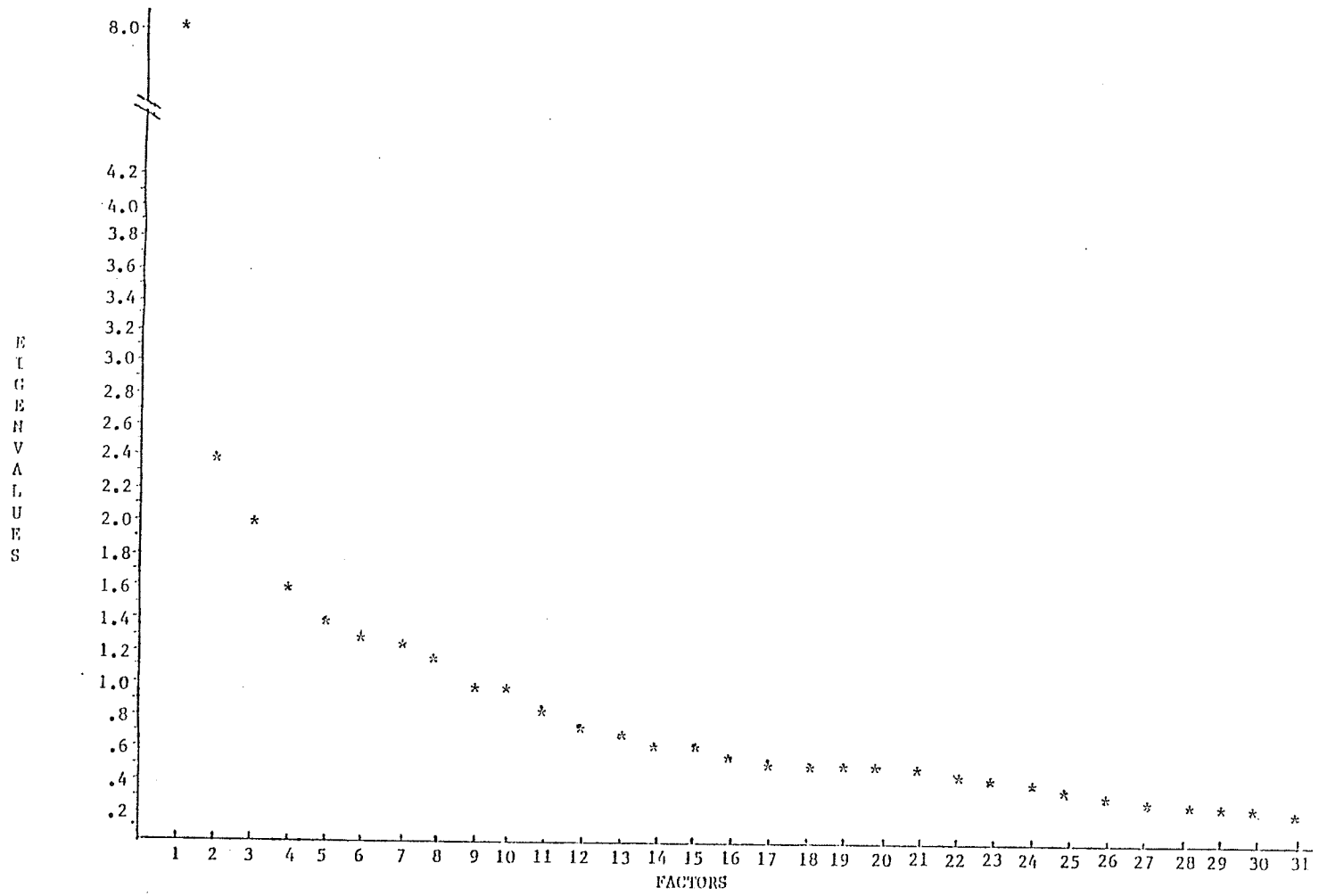

Figure 3. Eigenvalues for each expectation factor.

orthogonal factors were retained for comparisons between groups.

Table 7 displays the factor loadings for each of the three expectation factors. Examination of the factor loadings for Factor 1 indicates that the items most heavily weighted were "The therapist would analyse my personality and point out areas I need to change", "The therapist would explain why I have certain problems", "The therapist would tell me what is wrong with me", and "The therapist would tell me what to do or show me a new way to solve my problem". There were moderate weightings on "I would get a lot of advice on how to solve my problems", "The therapist would focus on how to change my behavior", "The therapist would identify my character traits which contribute to my problems", and "I would learn to increase my will power so I could better control my behavior". There was a lower loading on "The therapist would try to cheer me up by pointing out things I do well". This factor was named "Explanation and Advice" as it clearly represents an "advice columnist" approach of explaining why the help seeker has a problem followed by advice and recommendations for change.

The second factor loaded heavily on "The therapist would point out how I should behave", "The therapist would measure my brain waves to identify any mental problems", "I might be asked to give up some of my moral beliefs and principles", "The therapist would tell me to do things I would rather not

Table 7

Factor Loadings Based on Factor Analysis of Expectation Items

Item	Factor 1	Factor 2	Factor 3
Analyse personality, areas to change	76	15	02
Explain why I have problems	67	08	11
Therapist tell me what's wrong	66	24	11
Therapist tell me what to do	65	25	08
Get a lot of advice	59	30	10
Focus on how to change behavior	53	13	13
Identify traits causing problems	51	17	11
Learn to increase will power	51	04	29
Cheer me up-point out what I do well	40	21	34
Learn a new life philosophy	39	00	36
Learn to be less emotional	39	34	23
Help me put my feelings into words	39	- 17	27
Point out how I should behave	35	58	12
Measure brain waves-identify problems	27	56	25
Asked to give up moral beliefs	07	51	18
Asked to do things I'd rather not	- 14	48	01
Likely receive a drug prescription	00	47	00
Try to change my mind about things	27	45	05

Table continues...

Table 7 (continued)

Item	Factor 1	Factor 2	Factor 3
Therapist analyse my dreams	18	43	30
Recommend hobbies or books	41	42	25
Give me tests to identify disorder	20	41	03
Give details of medical problems	23	34	18
Changed without knowing how	09	27	25
Therapist listen while I talk	- 10	- 16	09
Learn to meditate	25	11	58
Practice what I need to learn	38	02	52
Encouraged to take chances	06	10	46
Teach me new skills	39	- 17	42
Reassured mind is okay	12	10	39
What I am versus want to be	30	03	36
Give me assignments to do	- 01	10	35
Religious faith encouraged	21	25	32
Therapist discuss own life	00	27	30
Sympathy, support and encouragement	10	12	29
Discover role of upbringing	00	00	26

Note. $N = 241$. Sample included all help seekers and members of the general public combined. Decimal points in factor loadings have been omitted for clarity.

do", "I would very likely receive a drug prescription", "The therapist would try to convince me to change my mind about some things", "The therapist would analyse my dreams to discover the cause of my problems", "The therapist would recommend hobbies or books to take my mind off my worries", and "The therapist would give me tests to identify my disorder". This factor was named "Diagnosis and Confrontation". It reflects an expectation that therapy will include some type of testing designed to identify some mental disorder, followed by prescriptions or directives to remedy the problem. Rather than simply expecting advice, however, the help seeker apparently expects the therapist to be quite confrontive and perhaps authoritarian. The help seeker expects to be told to give up some of his or her moral beliefs and to change his or her mind about some things. The help seeker also expects to be told to do things he or she would rather avoid. This factor incorporates a perception that therapists are very directive and controlling, perhaps like a traditional physician who diagnoses the patient's problem and then directs the patient to correct the problem. For the help seeker, it is a passive process as the therapist takes responsibility for diagnosing deficiencies, identifying the solutions, and then directing or convincing the help seeker to change.

The third factor loaded highly on "I would learn to meditate to increase my peace of mind", "The therapist would

help me practice what I need to learn", and "The therapist would encourage me to take chances and be less fearful". There were lower loadings on "The therapist would teach me new skills such as assertiveness and relaxation", "I would be reassured there was nothing wrong with my mind", "The therapist would point out the difference between what I am and what I want to be", "The therapist would give me assignments to do outside of the therapy sessions" and "I would learn a new life philosophy to help me look at the brighter side of life". This factor was named "Teaching New Coping Skills". The help seeker expects to develop their coping skills and learn new ways to deal with problems. The therapist acts in teaching role, helping the client to identify goals (difference between what they are and what they want to be) and actively teaching the help seeker new ways to obtain these goals. This contrasts with the previous factor in which the therapist focused on identifying problems instead of goals and on directing the help seeker to change rather than teaching them specific skills.

In summary, factor analysis of the expectation items identified the following three factors:

1. Explanation and Advice
2. Diagnosis and Confrontation
3. Teaching New Coping Skills

Data Analysis for Testing Hypotheses

The following section provides a brief overview of the type of data analysis utilized to test the hypotheses and the rational underlying the interpretation of the results. Multivariate analyses of variance were used to compare the perceptions held by the various groups referred to in each hypothesis. For clarity, and to reduce the number of variables per multivariate analysis, the perceptions related to fears were examined separately from those related to expectations.

Multivariate analyses, unlike repeated univariate tests, take into account the correlations between dependent variables within each group and can identify common trends within the data. In other words, knowing the value of a single variable for any subject may not significantly predict group membership, but knowing the value of an individual's scores on a number of variables, all with common trends, may improve the accuracy of predictions about group membership. The multivariate analyses can identify those dependent variables which significantly contribute to group differences but which might not have been significant given repeated univariate analyses. The multivariate test also helps to avoid the inflation of alpha associated with repeated F tests and consequently protects the familywise Type I error rate.

The factor scores utilized in the between group comparisons are based on orthogonal factors which are theoretically uncorrelated. If the factors were totally uncorrelated, then the multivariate analyses would not be required. The multivariate tests would have no specific advantages over doing repeated univariate tests with uncorrelated variables. Even orthogonally derived factors, however, have some intercorrelations present and for this reason, multivariate analyses were utilized.

An alpha level of .05 was used throughout this investigation to identify demographic and network differences between subsamples. Multivariate tests examining each of the main hypotheses regarding perceptions were tested at the .01 confidence level. A relatively stringent alpha level was chosen to test the main hypotheses in order to protect the experiment-wise error rate. There remains, however, a possibility that some analyses may have achieved significance by chance, given that 27 MANOVAs were required to examine the study's nine main hypotheses.

A significant multivariate result meant that at least one dependent variable, or some combination of dependent variables, differed significantly between the comparison groups. If the overall multivariate test was significant, then post-hoc analyses were utilized to identify which specific variables differed across groups. Univariate F tests, discriminant function coefficients, and structure

coefficients were examined for each variable. The univariates were tested at an alpha level of .05.

The reader is reminded that univariate results indicate which variables significantly differed across groups on an individual basis. The discriminant analysis derives weights for each dependent variable. These weighted variables, when summed, produced a composite score which maximally discriminated between the comparison groups. The standardized discriminant weights applied to each dependent variable were examined post-hoc to identify variables contributing the most to the discrimination between the groups.

Standardized discriminant weights, like Beta weights in multiple regression, may be small when there is redundancy between the dependent variables (i.e., if two variables are highly correlated, only one will be needed to discriminate between groups and only one will have a large discriminant weight). In the majority of multivariate analyses, however, the dependent variables are orthogonal factor scores. Consequently, redundancy and suppressor effects are minimized. Nonetheless, structure coefficients (the correlation of each dependent variable with its composite score) are also reported.

The reader is reminded that the variables with significant univariate results but low discriminant weights

may simply represent a chance finding. In the opposite direction, variables with nonsignificant univariate results may still contribute to discrimination between groups (as part of a trend or in a suppressor relationship) when considered in relationship to other dependent variables. These variables may be identified because of their large standardized discriminant weights. Suppressor effects should be considered when standardized discriminant weights are large but the univariate is nonsignificant and the structure coefficient is low.

The factor scores utilized in the majority of the analyses which follow are standardized scores and were calculated by summing the cross-products of the standardized score given each variable multiplied by its factor coefficient. The mean standardized factor scores and standard deviations are presented in the results section but such scores provide no indication of whether a group actually "agreed" or "disagreed" with a perception. It is of general interest, however, to know which perceptions each group actually endorsed. This information is descriptively presented in Table 8 . These factor scores have been computed by summing the mean scores given each item which was heavily loaded on each factor and then dividing this sum by the number of items included in the factor. This produced a mean factor score ranging from one to seven. Perceptions with mean ratings falling into the categories

Table 8

Agreement Ratings with Fear and Expectation Factors for Current and Previous Help Seekers and Non-Help Seekers

Group		
Current HSs	Previous HSs	Non-help Seekers
Agree (mean factor scores of 4.6 - 5.5)		
E1, E3, F2	F2	E1, E3, F2
Neither Agree nor Disagree (mean factor scores of 3.5 - 4.5)		
F3, F5	E1, ,E3, F3, F5	E2, F3, F5
Disagree (mean factor scores of 2.5 - 3.4)		
E2, F1, F4	E2, F1, F4	F1, F4,

Note: HSs = help seekers

F1 = Too Ashamed or Embarrassed to Discuss Problems or Seek Outside Help

F2 = Therapist Trustworthy and Understanding

F3 = Therapist Shares Beliefs and Values

F4 = Therapist Indifferent and Uncaring

F5 = Therapy Inconvenient and Inaccessible

E1 = Explanation and Advice

E2 = Diagnosis and Confrontation

E3 = Teaching New Coping Skills

described in the table have been grouped together to indicate how strongly each group agreed with each perception. Note that differences between categories are not necessarily statistically significant and that groups may statistically differ on a perception even though that perception falls within the same general category for both groups.

Hypothesis One: Help Seekers versus Non-help Seekers

Comparison of HSs and NHSs: Fears. A one-way multivariate analysis of covariance (MANCOVA) was utilized to compare the fear perceptions of HSs and NHSs with the effects of gender and age partialled out. Gender and age were utilized as covariates as HSs were younger than NHSs and tended to be over-representative of women. Differences in fear perceptions between HSs and NHSs might be attributed to these demographic differences between the groups. No gender by group or age by group interactions were significant, Λ (5, 159) = .96, p = .42 and Λ(10, 318) = .96, p = .76 respectively, supporting the appropriateness of a MANCOVA analysis.[4] The MANCOVA indicated that there were significant differences between HSs and NHSs, independent of gender and age differences between these two groups, Λ(5,

[4] For brevity, covariate by group interaction analyses will not be reported in future MANCOVA analyses. The reader may be assured that whenever MANCOVA analyses have been utilized, there have been no significant covariate by group interactions present.

166) = .87, p = .001. The cannonical correlation between the cannonical variable and group membership was .35, indicating that 12% of the variance in group membership could be accounted for by differences in fear perceptions, after the contribution of age and gender were removed. Sixteen percent of the variance in group membership was accounted for by fear perceptions when the contributions of age and gender were not partialled out. Table 9 presents the means, standard deviations, univariate ANOVAs, standardized discriminant weights (SDWs), and structure coefficients (SCs) for each fear factor. Based on the univariate tests, HSs were more likely to endorse Factor 2 (Therapist Trustworthy and Understanding) than were the NHSs. NHSs were more likely to support Factor 4 (Therapist Indifferent and Uncaring). Examination of the SDWs support these findings. HSs were discriminated from NHSs by a large positive loading on Factor 2 and a strong negative loading on Factor 4. These results indicate that HSs, compared to NHSs, had fewer fears about what would happen in the actual encounter with a therapist. The HSs perceived therapists as more trustworthy and understanding and as more likely to be interested in them and to be caring and nonjudgemental.

Comparison of HSs and NHSs: Expectations. A MANCOVA analysis was utilized to compare HSs and NHSs on their expectations of therapy with the effects of gender and age partialled out. The MANCOVA was not significant, Λ(3, 165)

Table 9

Significance Tests Comparing Fear Perceptions of Help Seekers and Non-help Seekers With Age and Gender Partialled Out

Factor	Mean Standardized Scores		Standard Deviation	F	p	SDW	SC
	NHSs	HSs					
1) Too Embarassed to Seek Help	.08	-.15	.87	1.1	.30	-.25	-.22
2) Therapist Trustworthy	-.05	.36	.85	8.2	.005	.52	.59
3) Therapist Shares Beliefs/Values	.10	-.26	.81	0.9	.33	-.29	-.20
4) Therapist Indifferent	.18	-.24	.80	11.4	.001	-.64	-.68
5) Therapy Inconvenient	-.07	.21	.75	2.3	.13	.43	.31

Note. SDW = standardized discriminant weight; SC = structure coefficient; NHSs = non-help seekers; HSs = help seekers. Degrees of freedom for univariate tests: 1, 170.

= .98, p = .49 indicating that these groups did not differ in expectations with the effects of age and gender controlled.

Comparison of HSs and NHSs: Range of Problems Treated. The questionnaire included a list of eight problem areas and asked each respondent to rate how qualified they believed mental health professionals were to treat each problem. A MANOVA was used to compare the ratings given by HSs to those given by NHSs. The MANOVA was significant $\Lambda(8, 187) = .89$, $p = .005$, and the results are reported in Table 10 . Based on univariate results, the HSs perceived professionals as more qualified to treat bad habits and child problems than did the NHSs. This finding is confirmed by the multivariate analysis which indicates that bad habits had a strong negative loading and child problems a moderate negative loading. Brain disorders, criminal behavior, and financial concerns had moderate to low positive weightings, although the last two had structure coefficients close to zero suggesting they served only in a suppressor relationship. Overall, these results indicate that HSs perceived therapists as more qualified to provide help for bad habits (e.g., smoking, overeating) and, to a lesser degree, for child misbehavior. There was a weak trend for NHSs to perceive therapists as more qualified to treat brain disorders or injury.

Table 10

Help Seekers versus Non-Help Seekers on How Qualified Professionals are to Treat Eight Problem Areas

Problem Area	F	p	Standardized Discriminant Weight	Structure Coefficient
Fears and anxieties	1.3	.25	-.12	-.23
Habits (e.g., smoking)	11.9	.001	-.80	-.70
Headaches-backaches	0.8	.38	.04	-.17
Financial worries	0.0	.84	.38	.04
Criminal behavior	0.1	.73	.41	.06
Child misbehavior	4.0	.05	-.48	-.40
Legal concerns	0.0	.86	-.25	-.03
Brain disorders-injury	2.6	.11	.47	.32

	Mean Ratings	
	NHSs	HSs
Fears and anxieties	5.9	6.1
Habits (e.g., smoking)	4.5	5.3
Headaches-backaches	3.4	3.6
Financial worries	3.9	3.9
Criminal behavior	4.8	4.7
Child misbehavior	5.2	5.6
Legal concerns	3.2	3.2
Brain disorders-injury	4.6	4.0

Note: Degrees of Freedom for ANOVAs = 1, 194.

Summary: Hypothesis One. In summary, the results partially support hypothesis one. The evidence indicates that the HSs and NHSs held perceptions significantly different from one another. Compared to NHSs, HSs had fewer fears and concerns about therapists and and about what would happen in an encounter with a therapist. The HSs perceived therapists as more trustworthy and understanding and expected the therapist to be interested in them as a person and nonjudgemental about their problems.

Contrary to hypothesis one, HSs and NHSs did not hold significantly different expectations about the process of therapy when gender and age differences between these groups were controlled. Also contrary to expectations, HSs did not believe that therapists treated a greater range of problems, than did NHSs. They did, however, believe that mental health professionals were more qualified to treat "bad habits" (such as smoking or over-eating) and child misbehavior. There was a weak trend for NHSs to believe that mental health professionals were more qualified to treat brain disorders or injury.

Hypothesis Two: Differences Across Willingness to Seek Help

Hypothesis two predicts that there should be significant differences between the perceptions of NHSs who were the most willing to seek help and the perceptions of NHSs who were the least willing to seek help. To test this

hypothesis, the NHSs were trichotimized into three equal size groups based on their scores on the Willingness To Seek Help Scale (WTSH). As described in the method section, high scores on the WTSH Scale represented a recognition that some people need psychotherapy, confidence that psychotherapy would be helpful, and a willingness to use professional help if needed. Prior to examining group differences, the validity of the WTSH Scale will be examined and its correlation with other demographic variables explored.

Willingness To Seek Help Scale. The WTSH Scale had good internal reliability based on a Chronbach's alpha of .85. Good predictive ability was also evident in that previous HSs had significantly higher WTSH scores (M = 85) than did the sample of NHSs (M = 75), $F(1, 77) = 18.7$, $p = .0000$. No comparisons between current HSs and NHSs were possible, as current HSs were not asked to complete the WTSH Scale.

Examining the sample of NHSs, it was evident that women had significantly higher scores (M = 79) than men (M = 73), $F(1,77) = 7.5$, $p = .007$. Older individuals also had more positive attitudes than did younger ones (high scorers had a mean age of 51 versus 39 for low scorers), $F(2, 130) = 7.7$, $p = .0007$. High WTSH scores were also associated with higher scores on the preference for mental health professionals index, indicating that those who preferred professional help to lay help were also more willing to seek

professional help, $F(2, 135) = 5.3$, $p = .006$. SES did not differ across WTSH, $F(2, 116) = .14$, $p = .87$.

Comparison of Fears Across Willingness to Seek Help. A MANCOVA, utilizing age and gender as covariates, indicated that there were significant differences in fear perceptions across the three WTSH groups, $\Lambda(10, 238) = .71$, $p = .000$. Age and gender were used as covariates as both were correlated with WTSH. The cannonical correlation was .52, indicating that 27% of the variance in reported willingness to seek help could be accounted for by differences in fear perceptions, even with the contributions of age and gender removed. Table 11 presents the results of this analysis. Inspection of the univariate ANOVAs, reveals that the high and moderate WTSH groups were more likely than the low WTSH group to endorse Factor 2 (Therapist Trustworthy and Understanding). Those least likely to seek help were more likely to endorse Factor 1 (Too Embarrassed or Ashamed to Discuss Problems or Seek Help) and Factor 4 (Therapist Indifferent and Uncaring). As willingness to seek help decreased, there was also a corresponding increase in the endorsement of Factor 5 (Therapy Inconvenient and Inaccessible). Examination of the SDWs confirms these findings. Factor 2 has a moderate positive loading, whereas Factors 1 and 4 have low negative loadings. Factor 5 has a strong negative loading. Individuals who were very willing or moderately willing to seek help perceived most strongly

Table 11

Significance Tests Comparing Fear Perceptions Across Willingness to Seek Help with Age and Gender Partialled Out

Factor	Mean Standardized Scores			Standard Deviation	F	p	SDW	SC
	High	Med	Low					
1) Too Embarassed to Seek Help	-.09	.03	.32	.84	3.3	.04	-.33	-.38
2) Therapist Trustworthy	.11	.16	-.53	.90	6.6	.002	.47	.51
3) Therapist Shares Beliefs/Values	.32	.13	-.24	.83	2.7	.07	.18	.34
4) Therapist Indifferent	-.03	.07	.59	.80	6.0	.003	-.31	-.51
5) Therapy Inconvenient	-.35	-.08	.35	.73	10.2	.000	-.61	-.66

Note. SDW = standardized discriminant weight; SC = structure coefficient.

Degrees of freedom for the univariate tests: 2, 123.

that therapists were trustworthy and understanding and that the therapist would be interested in them, caring, and nonjudgemental. They also reported less embarrassment or shame about discussing problems or seeking outside assistance than did those reporting the greatest reluctance to seek help. As willingness to seek help increased, there was also an increasingly strong perception that therapy would be convenient, accessible, and could be accomplished with a minimum of effort.

There were two fears (perceiving little shame or embarrassment about discussing problems or seeking help and perceiving little inconvenience or difficulty in finding a therapist) which discriminated across willingness to seek help but not between HSs and NHSs. This suggests that those who theoretically agree that seeking help is a good idea may have perceptions somewhat different from those individuals who actually seek help (i.e., fears may change as one actually considers the reality of seeking help or some of the perceptions held by those willing to seek help may not be related to actual help seeking behavior). It is also possible, however, that those most willing to seek help and actual HSs have similar perceptions, only the reference groups each was compared to (i.e., those less willing to seek help and NHSs) may be very different. Two identical groups compared to different reference groups would identify separate sets of discriminating fears. To clarify this

issue, the fear perceptions held by the group of NHSs who were most willing to seek help (the upper one third of the WTSH distribution) were compared to the fear perceptions held by the HSs. Age was used as a covariate as the two groups differed on this variable, $\underline{F}(1, 105) = 66.0$, $\underline{p} = .0000$. A MANCOVA indicated significant differences in fear perceptions between HSs and those most willing to seek help, $\Lambda(5, 89) = .79$, $\underline{p} = .001$. Table 12 displays the multivariate and univariate results. Examination of the univariate ANOVAs indicates that the HSs were more likely to endorse Factor 5 (Therapy Inconvenient and Inaccessible). Examination of the SDWs and SCs confirm this finding. Both have strong positive loadings on Factor 5. Factors 3 and 4 have strong negative loadings on their SDWs but they have nonsignificant univariate results. The SCs for Factors 3 and 4 are also weaker than their SDWs suggesting that the two factors have a partial suppressor relationship with Factor 5. In other words, they may contribute to the discriminant function's ability to discriminate between groups but there are not significant differences in the mean values assigned these factor by the two groups.

These results indicate that HSs, compared to those most willing to seek help, had greater concerns that finding help might be difficult and time consuming.

Table 12

Significance Tests Comparing Fear Perceptions between Help Seekers (HSs) and Non-help Seekers Who Were Most Willing to Seek Help (WTSH)

Factor	Mean Standardized Scores		Standard Deviation	F	p	SDW	SC
	WTSH	HSs					
1) Too Embarassed to Seek Help	-.09	-.15	.85	0.3	.60	-.06	.10
2) Therapist Trustworthy	.11	.36	.70	1.7	.18	.47	.26
3) Therapist Shares Beliefs/Values	.32	-.26	.79	3.9	.06	-.60	-.39
4) Therapist Indifferent	-.03	-.24	.72	3.3	.07	-.50	-.36
5) Therapy Inconvenient	-.35	.21	.79	10.3	.001	.72	.63

Note. SDW = standardized discriminant weight; SC = structure coefficient

Degrees of freedom for the univariate tests: 1, 93

Comparison of Expectations Across WTSH. A MANCOVA indicated that the three expectation factors did not discriminate across the three levels of WTSH, with age and gender partialled out, $\Lambda(6, 230) = .95$, $p = .29$.

Comparison of Types of Problems Treated Across WTSH. A multivariate analysis indicated that the NHSs most willing to seek professional help did not significantly differ from those least willing to seek help on their ratings of how qualified mental health professionals were to treat various types of problems, $\Lambda(16, 256) = .84$, $p = .13$.

Summary: Hypothesis Two. These results confirm that individuals expressing the greatest willingness to seek help would have the fewest fears about the process of psychotherapy. Compared to those less willing to seek help, those most willing to seek help had fewer fears about the behavior of a therapist. They perceived therapists as more trustworthy, understanding, nonjudgemental, and as more interested in the help seeker as a person. Those most willing to seek help also perceived fewer interpersonal or practical costs in seeking help. They reported less embarrassment and shame about discussing problems or seeking help and perceived therapy as more accessible and convenient than did those less willing to seek help.

Contrary to hypothesis two, expectations about the process of therapy did not differ across willingness to seek help. Perceptions of how qualified mental health professionals were to treat various disorders also failed to discriminate across willingness to seek help.

Another unexpected finding was that fear perceptions which discriminated HSs from NHSs were somewhat different from the fears discriminating across WTSH. Both HSs and those most willing to seek help had fewer concerns about the therapist's expected behavior. Both groups were discriminated from their comparison groups by their perceptions that therapists were trustworthy, understanding, caring, and interested in their clients. Those most willing to seek help also perceived fewer personal or social costs in seeking help than did those less willing to seek help. These perceptions did not discriminate HSs from NHSs, however. In fact, HSs compared to those most willing to seek help perceived therapy as more inconvenient and less accessible.

Hypothesis Three: Preference for Mental Health Professionals

The preference for mental health professionals index (PMHP) was used to divide the NHSs into three approximately equal size groups representing high, medium, and low preference to receive help from mental health professionals as opposed to non-mental health professionals or lay

resources. The predictive validity of this scale is supported by its ability to significantly discriminate NHSs (M = - .3) from both current HSs (M = 7.5) and previous HSs (M = 5.4), $F(2, 230) = 12.2$, $p = .0000$. Women had a significantly stronger preference for help from professionals as opposed to lay resources than did men (mean scores of 3.7 and .5 respectively), $F(1, 226) = 4.7$, $p = .03$. There were no age, $F(2, 134) = .58$, $p = .56$, or SES, $F(2, 120) = 1.07$, $p = .34$, differences across PMHP. The perceptions of groups differing on PMHP will be examined next.

Differences in Fears Across PMHP. A MANCOVA using gender as a covariate indicated that fear perceptions did not differ across PMHP, $\Lambda(10, 244) = .89$, $p = .07$.

Differences in Expectations Across PMHP. A MANCOVA using gender as a covariate indicated that there were no significant differences in expectations across PMHP, $\Lambda(6, 232) = .82$, $p = .83$.

Comparison of Types of Problems Treated Across PMHP. A multivariate analysis indicated that NHSs preferring professional help did not differ significantly from those preferring lay help on their ratings of how qualified professionals were to treat various problem areas, $\Lambda(16, 268) = .81$, $p = .03$.

Summary: Hypothesis Three. Hypothesis three was not supported as neither fears nor expectations differed across PMHP. Furthermore, those preferring professional help to lay help did not report that professionals were more qualified to treat a broader range of problems.

Hypothesis Four: Differences in Perceptions across Gender

Comparison of Men and Women: Fears. A MANOVA indicated that fear perceptions did not discriminate across gender within the non-help seeking sample, $\Lambda(5, 128) = .97$, $p = .61$.

Comparison of Men and Women: Expectations. A MANOVA indicated that men and women in the non-help seeking sample had different expectations about the process of psychotherapy, $\Lambda(3, 124) = .80$, $p = .000$. Examination of the univariate results in Table 13 indicates that men more strongly endorsed Factor 2 (Diagnosis and Confrontation), whereas women more strongly endorsed Factor 3 (Teaching Coping Skills). Examination of the SDWs and SCs confirms these findings. Factor 2 has strong negative loadings and Factor 3 has strong positive loadings.

Table 13

Significance Tests Comparing Expectations Across Gender

Factor	Mean Standardized Scores		Standard Deviation	F	p	SDW	SC
	Men	Women					
1) Explanation and Advice	.09	.08	.78	0.0	.92	-.08	-.01
2) Diagnosis and Confrontation	.44	-.12	.81	17.3	.000	-.84	-.76
3) Teaching New Coping Skills	-.22	.19	.80	8.8	.004	.67	.54

Note. SDW = standardized discriminant weight; SC = structure coefficient.

Degrees of freedom for the univariate tests: 1, 126.

Types of Problems Treated: Differences Across Gender. A multivariate analysis indicated that men and women did not differ in their ratings of how qualified mental health professionals were to treat various types of mental health problems, $\Lambda(8, 131) = .93$, $p = .35$.

Summary: Hypothesis Four. Hypothesis four was partially supported. As predicted, men and women differed in their expectations about the process of therapy. Men expected the therapist to be more directive in terms of prescribing solutions and intervening medically, however, men tended to expect more confrontation and perhaps conflict with an authority figure than was expected.

Contrary to predictions, both sexes equally expected explanation and advice and opposite to hypothesis four, women expected more coping skills training than did men.

No specific factor measuring insight oriented therapy emerged from the factor analysis. To test the hypothesis that women expected therapy to be more insight oriented than did men, men and women in the non-help seeking sample were compared on each of the four single items hypothesized to represent a non-directive, insight oriented treatment. These items were "the therapist will mostly listen while I do most of the 'talking", "the therapist will point out the difference between what I am and what I want to be", "the therapist will help me put my feelings into words so I can

understand them", and "I will discover how my problems relate to my upbringing". Repeated univariate tests comparing men and women across all of these variables were all nonsignificant, $F(1, 137) = .83$, $p = .36$, $F(1, 138) = .10$, $p = .74$, $F(1, 137) = .06$, $p = .80$, and $F(1, 136) = .22$, $p = .63$ respectively. Contrary to hypothesis four, women did not expect more insight oriented therapy than did men.

The prediction that men would have more fears than women about the process of seeking professional help was not supported. The results also failed to support the hypothesis that women would believe that mental health professionals were qualified to treat a broader range of problems.

Hypothesis Five: Differences in Perceptions Across Age

Comparison of Fears Across Age. The NHSs were trichotimized into three approximately equal size groups representing younger respondents (18 - 37 years of age), middle age respondents (38 - 50 years of age), and older respondents (50 years and older). A MANOVA was calculated to examine how fear perceptions differed across these three age groups. The overall multivariate test was not significant, $\Lambda(10, 248) = .86$, $p = .05$, indicating there were no significant differences in fear perceptions across age.

Comparison of Expectations Across Age. A MANOVA examining how expectations differed across age groups was significant, $\Lambda(6, 240) = .87$, $p = .01$. Examination of Table 14 indicates that older respondents expected more Advice and Explanation (Factor 1), and that the oldest group (those over 50 years of age) expected a greater focus on Diagnosis and Confrontation (Factor 2). Both these factors also had strong positive SDWs and SCs.

Comparison of Types of Problems Treated Across Age. A multivariate analysis indicated that the NHSs' ratings of how qualified mental health professionals were to treat various types of problems did not vary across age, $\Lambda(16, 254) = .90$, $p = .63$.

Summary: Hypothesis Five. Hypothesis five was partially supported. Contrary to predictions, fear perceptions did not discriminate across age. Concerns about loss of self reliance and betrayal of family were included in Factor 1 (Too Embarrassed or Ashamed to Discuss Problems or Seek Help) but this factor did not discriminate across age. Also contrary to expectations, the ratings of how qualified mental health professionals were to treat various problems did not vary across age.

The hypothesis that expectations would differ across age was supported. Older respondents expected more advice and

Table 14

Significance Tests Comparing Expectations Across Age

Factor	Mean Standardized Scores			Standard Deviation	F	p	SDW	SC
	Young	Med	Older					
1) Explanation and Advice	-.22	.16	.26	.78	4.4	.01	.71	.74
2) Diagnosis and Confrontation	-.02	.03	.40	.80	3.6	.03	.66	.69
3) Teaching New Coping Skills	-.02	-.14	.12	.80	1.0	.38	.11	.24

Note. SDW = standardized discriminant weight; SC = structure coefficient; Young = 18 - 37 years of age; Med = 38 - 50 years of age; Older = 51 years of age and older. Degrees of freedoms for univariate: 2, 122.

explanation and more medical interventions. In addition, the older respondents were found to expect the therapist to be more authoritarian and confrontive than did the younger age groups.

Hypothesis Six: Differences in Perceptions across SES

HSs and NHSs did not differ in socioeconomic status, $F(1, 168) = 1.2$, $p = .26$. Similarly, socioeconomic status was not found to discriminate across WTSH, $F(2, 116) = .1$, $p = .87$. Previous HSs, however, were from a higher SES background than were either the current HSs, $F(1, 77) = 7.6$, $p = .007$, or the NHSs, $F(2, 203) = 3.1$, $p = .02$. The previous HSs, current HSs and the NHSs had mean SES scores of 51.8, 43.1, and 45.9 respectively.

Although help seeking did not correlate with SES in this study, the perceptions held by different SES classes are of general interest to therapists who might want to anticipate and alleviate possible misperceptions of their clients. The following section examines whether perceptions varied across SES.

Comparison of Fears Across SES. The NHSs were trichotimized into three approximately equal size groups representing low, medium, and high socioeconomic status. Fear perceptions did not discriminate across these three groups, $\Lambda(10, 222) = 92$, $p = .51$.

Comparison of Expectations Across SES. A MANOVA analysis indicated no differences in expectations across SES within the non-help seeking sample, $\Lambda(6, 214) = .94$, $p = .37$.

Comparison of Types of Problems Treated Across SES. A MANOVA indicated that ratings of how qualified professionals were to treat various disorders did not vary across SES within the non-help seeking sample, $\Lambda(16, 226) = .78$, $p = .03$.

Summary: Hypothesis Six. Hypothesis six was not supported as perceptions and qualification ratings were not related to the respondents' socioeconomic status.

Hypothesis Seven: Network Type and Help Seeking Behavior

The questionnaire elicited information regarding each person's social networks and indexes were constructed which classified each respondent's network depending on it's network size, density, proportion of kin (PROPKIN), and it's average degree of helpfulness (DEGHELP). The following section examines hypothesis seven, which predicted that network type would discriminate HSs from NHSs. Prior to analysing group differences, the network characteristics associated with gender, age, and SES will be documented. These analyses were conducted on the entire sample of the general public.

A MANOVA indicated that there were significant differences in network characteristics across age, $\Lambda(8, 280) = .84$, $p = .002$, gender, $\Lambda(4, 142) = .92$, $p = .02$, and SES, $\Lambda(8, 254) = .87$, $p = .03$. As can be seen in Table 15, older respondents had denser, more kin-dominated networks. The lowest socioeconomic group had denser, more kin dominated networks than did the medium or upper classes (Table 16). The highest socioeconomic group rated their networks as more helpful than did the medium or lower class groups. Lastly, inspection of Table 17 indicates that men's networks were denser than those of women.

The four network measures were generally uncorrelated with two exceptions. There was a moderate correlation between PROPKIN and density ($r = .54$, $p = .000$), and PROPKIN had a very small but significant correlation with DEGHELP ($r = .15$, $p = .05$). As one might expect, kin dominated networks tended to be denser (network members knew one another) and had a very slight tendency to provide more help to their members.

To examine the association between network type and actual help seeking behavior, the network characteristics of HSs were compared to those of the NHSs. A MANCOVA utilizing age and gender as covariates revealed significant differences between these two groups, $\Lambda(4, 109) = .84$, $p = .001$ (Table 18). Both the univariate and multivariate results clearly demonstrate that HSs had significantly less

Table 15

Network Characteristics Across Age

Network Variable	Age Group			Standard Deviation	F	p	SDW	SC
	Young	Med	Older					
Network Size	4.7	4.8	4.2	1.9	1.1	.31	.04	.26
Density	49.8	57.3	75.5	34.6	6.9	.001	-.38	-.75
Proportion of Kin	52.0	66.2	77.1	29.6	10.0	.000	-.73	-.93
Degree of Helpfulness	4.8	5.1	4.9	1.2	0.0	.46	-.10	-.15

Note. SDW = standardized discriminant weight; SC = structure coefficient; Density and Proportion of Kin are expressed as percentages; Young = 18 - 37 years of age; Med = 38 - 50 years of age; Older = 51 years of age and older. Degrees of freedom for univariate tests: 2, 143.

Table 16

Network Characteristics Across Socioeconomic Status

Network Variable	Socioeconomic Status			Standard Deviation	F	p	SDW	SC
	High	Med	Low					
Network Size	5.0	4.6	4.5	1.9	.7	.47	.29	.29
Density	52.3	52.3	68.8	32.1	3.3	.04	-.39	-.57
Proportion of Kin	57.7	59.7	71.8	29.2	2.8	.06	-.38	-.57
Degree of Helpfulness	5.2	4.7	4.6	1.2	3.4	.03	.74	.62

Note. SDW = standardized discriminant weight; SC = structure coefficient.

Density and Proportion of Kin are expressed as percentages.

Table 17

Network Characteristics Across Gender

Network Variable	Gender		Standard Deviation	F	p	SDW	SC
	Men	Women					
Network Size	4.4	4.7	1.9	0.6	.45	-.26	-.21
Density	67.9	53.1	34.3	6.0	.01	1.08	.69
Proportion of Kin	60.7	62.0	29.3	0.0	.80	-.70	-.06
Degree of Helpfulness	4.7	5.0	1.2	1.3	.26	-.45	-.31

Note. SDW = standardized discriminant weight; SC = structure coefficient

Density and Proportion of Kin are expressed as percentages.

dense (sparser) networks than did the NHSs. HSs' networks were also rated as less helpful.

Summary: Hypothesis Seven. Hypothesis seven was partially supported in that HSs had less dense and less helpful networks than did NHSs. Contrary to predictions, however, the HSs' networks were not any smaller than those of NHSs, nor less kin dominated.

Hypothesis Eight: Network Characteristics and WTSH and PMHP

A MANOVA was utilized to compare the four network variables across the three levels of willingness to seek help. The multivariate test was not significant, $\Lambda(8, 216) = .92$, $p = .33$. The network variables also failed to discriminate between groups differing in their preference for help from mental health professionals as opposed to lay help, $\Lambda(8, 218) = .92$, $p = .36$. These results fail to support hypothesis eight. Those most willing to seek help, and those most preferring help from professionals, did not have networks any different from those individuals less willing to seek help or those preferring lay help to professional help.

Table 18

Comparison of the Network Characteristics of Help Seekers (HSs) and Non-help Seekers (NHSs) with Age and Gender Partialled Out

Network Variable	Mean Value		Standard Deviation	F	p	SDW	SC
	HSs	NHSs					
Network Size	4.9	4.5	1.9	0.4	.53	-.11	.14
Density	39.5	66.9	33.8	10.9	.001	-.72	-.72
Proportion of Kin	50.2	66.2	29.6	3.0	.08	-.01	-.38
Degree of Helpfulness	4.2	5.2	1.6	10.3	.002	-.70	-.70

Note. SDW = standardized discriminant weight; SC = structure coefficient

Density and Proportion of Kin are expressed as percentages.

Hypothesis Nine: Differences in Perceptions Across Networks

Differences in Fears Across Network Variables.

Multivariate analyses were utilized to compare fear perceptions across each network variable within the non-help seeking sample. Fear perceptions did not significantly discriminate across groups differing on density, $\Lambda(10, 194) = .82$, $p = .04$, PROPKIN, $\Lambda(10, 248) = .88$, $p = .12$, DEGHELP, $\Lambda(10, 250) = .97$, $p = .98$, or network size, $\Lambda(10, 253) = .90$, $p = .28$.

Differences in Expectations Across Network Variables.

Expectations failed to discriminate across density, $\Lambda(6, 188) = .96$, $p = .66$, PROPKIN, $\Lambda(6, 238) = .97$, $p = .78$, DEGHELP, $\Lambda(6, 238) = .96$, $p = .64$, or network size, $\Lambda(6, 242) = .96$, $p = .56$.

Summary: Hypothesis Nine.

Hypothesis nine was not supported as perceptions did not discriminate between network characteristics.

Comparison of Current HSs and Previous HSs

While not one of the original hypotheses of this investigation, the availability of a pool of previous help seekers provided the opportunity to contrast the perceptions of current HSs with those who had experienced therapy. Such a comparison tentatively identified how perceptions may be

altered by therapy. It also identified how clients recall the therapeutic process after termination. These comparisons may identify perceptions held by current HSs which are inaccurate or unrealistic. The small sample sizes involved, however, suggest that the data be considered speculative at this time.

Comparison of HSs and Previous HSs: Fears. A MANCOVA was utilized to examine whether fears discriminated between current HSs and previous HSs. As the two groups differed in age, $F(1, 88) = 19.2$, $p = .000$, a MANCOVA partialling out age differences was utilized. The multivariate test was significant, $\Lambda(5, 69) = .82$, $p = .01$, and the results are reported in Table 19 .

Both the univariate and multivariate results indicate that current HSs perceived therapists as more trustworthy and understanding than did previous HSs (Factor 2). The univariate results suggest that current HSs were more embarrassed about discussing problems or seeking help than were the previous help seekers (Factor 1). Factor 1, however, has a relatively low SDW (-.27) which questions the certainty of this finding.

Table 19

Significance Tests Comparing Fear Perceptions Between Current Help Seekers (CHSs) and Previous Help Seekers (PHSs) with Age Partialled Out

Factor	Mean Standardized Scores		Standard Deviation	F	p	SDW	SC
	CHSs	PHSs					
1) Too Embarassed to Seek Help	-.15	-.33	.82	1.3	.01	-.27	-.28
2) Therapist Trustworthy	.36	-.32	.87	13.9	.000	-.97	-.92
3) Therapist Shares Beliefs/Values	-.26	-.14	.77	0.0	.99	-.11	.00
4) Therapist Indifferent	-.24	-.26	.74	0.0	.96	-.09	-.01
5) Therapy Inconvenient	.21	.11	.83	0.1	.74	-.18	-.08

Note. SDW = standardized discriminant weight; SC = structure coefficient; Degrees of freedom for the univariate tests: 1, 73.

Comparison of HSs and Previous HSs: Expectations. A MANCOVA comparison of the expectations held by current help seekers and previous help seekers, with age controlled, revealed no significant differences between the two groups, Λ (3, 71) = .90, p = .07.

Discussion

The following discussion examines how perceptions of mental health services may influence an individual's decision to seek professional help. It should be noted that the discussion which follows applies specifically to perceptions of outpatient mental health services. Help seekers from inpatient services or other settings were not sampled and the general public's perceptions of such settings were not examined. The generalizability of these results to settings other than outpatient mental health services remains unknown.

The discussion begins with an examination of the relationship between perceptions and help seeking behavior, followed by a discussion of the implications for improving mental health services. Differences in perceptions across gender, age, and socioeconomic status are then discussed and the relationship between network norms and help seeking is reviewed. Lastly, the limitations of the research are reviewed and possible directions for future research explored.

Perceptions and Help Seeking

Fear Perceptions: Influence on Help Seeking. Help seekers in this investigation perceived therapists as more trustworthy, understanding, interested, caring, and nonjudgemental, than did non-help seekers. Help seekers clearly perceived therapists in a more positive light than did non-help seekers. Although fear perceptions are only one of many factors related to help seeking behavior, approximately 16% of the variance in group membership could be accounted for by the respondents' fear perceptions. When the variance accounted for by age and gender were partialled out, perceptions still accounted for approximately 12% of the variance in help seeking behavior.

This investigation also examined the differences in perceptions between non-help seekers who expressed a strong willingness to seek help versus those less willing to do so. Non-help seekers who reported a high willingness to seek help had apparently resolved all of the decision points in favour of seeking help. They recognized that some problems are psychological in nature, believed therapy to be an effective resource for psychological symptoms, and expressed a personal willingness to seek such help should they experience a problem in the future. As one might expect, the fears which discriminated help seekers from non-help seekers also discriminated across willingness to seek

professional help. Those reporting the greatest willingness to seek help were discriminated from those less willing to seek help by their stronger belief that therapists would be trustworthy, understanding, interested, caring, and nonjudgemental. Differences in fear perceptions accounted for 27% of the non-help seekers' expressed willingness to seek help, even with the contributions of age and gender removed.

The above findings suggest that positive perceptions of therapy may encourage individuals to seek help, whereas fears and concerns may dissuade people from seeking therapy. It would be improper to conclude, however, that fear perceptions were causally related to help seeking. There may have been a third variable which was causally related to both help seeking and fear perceptions. However, group differences in fears were not accounted for by gender, age, or socioeconomic status. It is conceivable that the positive perceptions held by help seekers were a result of their decision to seek help, as opposed to being a contributing factor to that decision. In other words, once the decision to seek help was made, help seekers may have convinced themselves that the therapist would be unusually trustworthy and understanding, or especially caring, interested, and nonjudgemental. This would be supported by cognitive dissonance theory, which predicts that perceptions change to reduce the anxiety produced when cognitive beliefs

contradict one's actual behavior. Additionally, the help seekers may have sought information about therapy after they made the decision to seek help but prior to the first interview. However, all the perceptions which discriminated help seekers from non-help seekers also discriminated across willingness to seek help. This suggests that the help seekers' positive perceptions may have existed prior to their decision to seek help. A conclusive answer to these questions must await longitudinal research.

Perceptions of therapists as trustworthy, understanding, caring, and nonjudgemental appear to be the major factors associated with help seeking behavior. This supports Tinsley and Harris' (1976) finding that college students seeking college counselling expected to see a genuine, accepting counsellor they could trust. They also support Fisher et al.'s (1982) assertion that individuals may react more favourably to aid if they perceive a help giver as having positive motives and favourable intent.

Fisher and colleagues reviewed numerous studies indicating that when aid recipients made positive attributions about a helper's motives, they were more likely to find the aid supportive, to reciprocate more, to accept more aid, and to engage in less self help. One could assume that a perception of therapists as trustworthy and understanding is very similar to perceiving therapists as having favourable intentions. If so, the present results

appear to support and extend the findings from the recipient reaction to aid literature. Positive attributions about help givers (in this case therapists) not only correlated with increased willingness to seek help, but also discriminated help seekers from non-help seekers.

The outcome of this study also supports DePaulo's (1982) hypothesis that individuals might avoid seeking help for fear the therapist will dislike them. Help seekers and those most willing to seek help were those most likely to perceive a therapist as interested in them, caring, and non-judgemental.

As noted, positive perceptions of therapists discriminated both help seekers from non-help seekers and across willingness to seek help. Those most willing to seek help, however, were also discriminated from those less willing to seek help by their greater beliefs that therapy would be convenient and accessible and that the process of getting help would not be an embarrassing or shameful experience. In other words, non-help seekers most willing to seek help not only perceived therapists in a more positive light, than did those less willing to seek help, but also perceived fewer practical or social costs in seeking help.

The above findings suggest that those who reported a strong willingness to seek help may have held perceptions of

therapy which were even more positive than those held by actual help seekers. This hypothesis was partially supported by a comparison of the perceptions held by help seekers to those held by the non-help seekers who were most willing to seek help. Those most willing to seek help perceived therapy as more convenient and accessible than did actual help seekers. There were not, however, any significant differences between help seekers and those most willing to seek help on the fear of being too embarrassed or too ashamed to discuss problems or seek help.

The above findings suggest two possibilities. First, help seekers may embark on the help seeking process with perceptions similar to those held by the non-help seekers who were most willing to seek help. As the help seeking process proceeds, however, they may begin to perceive therapy as less accessible and less convenient. Once the help seeker experiences difficulties in finding affordable services or confronts the reality of waiting lists, the help seeker may perceive therapy as less accessible than they had initially expected.

There is a second explanation for the above findings. As noted, non-help seekers who reported a low willingness to seek help tended to perceive therapy as less convenient and less accessible. Once these individuals experience significant distress and are in need for help, however, practical concerns about inconvenience and inaccessibility

may have little influence on actual help seeking behavior. Distressed individuals may seek help despite their perceptions of the process as expensive or time consuming.

The role which embarrassment and shame play in help seeking behavior remains unclear. Non-help seekers had no greater fears of embarrassment or shame in disclosing problems or seeking help than did actual help seekers. Clearly, the average member of the public was not deterred from seeking help because of these fears. However, non-help seekers who reported the greatest reluctance to seek help (those in the low willingness to seek help group) reported greater fears of embarrassment and shame, than did those in the medium to high willingness to seek help groups. Whether these fears of embarrassment and shame actually deterred these respondents from seeking help cannot be ascertained from the data. The data does suggest that the relationship (if any) between fears of embarrassment and actual help seeking is relatively weak. Therefore, the following discussion of the role of embarrassment in help seeking should be considered speculative.

The fear of embarrassment and shame in disclosing problems or seeking help appears to reflect several related constructs. First, there was a fear of disclosure as reflected in two factor items, namely "I would be too embarrassed to discuss problems" and "I would be unable to admit my true feelings, even to myself". Fischer & Turner

(1970) factor analyzed 31 statements reflecting attitudes toward mental health services. They identified a factor they named "Interpersonal Openness", which was similar to the fear of disclosure items identified above. Fischer & Turner's factor represented a willingness to disclose personal information and to openly discuss personal problems. Fischer & Turner's findings, in conjunction with the present results, support the possibility that fears of disclosure may be related to help seeking intentions.

One could hypothesize that individuals are embarrassed to ask for help or to disclose problems because societal norms encourage self reliance and family privacy. Violating these norms might result in feelings of shame, guilt, lowered self esteem, and feelings of incompetence. Such feelings were, in fact, included in the embarrassment factor (e.g., "I would feel as though I were admitting defeat", "I would worry I was being disloyal to my family"). Perhaps those least willing to seek help feared that the admission of problems and the need for help would lead to feelings of defeat and lowered self esteem. Perhaps they were also concerned that significant others would think less of them for seeking help (e.g., "I would worry about how my relatives would react).

The correlation between willingness to seek help and embarrassment or shame in seeking help supports the findings of Williams & Williams (1983). The authors reported that

subjects rejecting welfare aid (in analogue situations) reported greater fear of embarrassment and greater worry about loss of self esteem, than did those willing to accept such assistance. Gurin et al. (1960) reported a similar finding. Respondents to a national survey reported that feelings of shame were one of the major reasons they had avoided seeking help. Booth & Babchuk (1972) also reported that individuals seeking medical help frequently discussed with friends and advisors the potential pain and embarrassment associated with a proposed treatment.

One could speculate that although embarrassment and shame may relate to one's willingness to seek help, this fear may not be a critical determinant of help seeking behavior (recall that this fear did not discriminate help seekers from non-help seekers). Perhaps the most critical variable is the help seeker's perception of how trustworthy and understanding a therapist will be. Even though an individual may be embarrassed or ashamed to seek help, an individual might proceed with therapy if he or she expected the therapist to be trustworthy, understanding, caring, and interested in their welfare. Such a therapist would not use disclosures against the help seeker and would be unlikely to perceive the help seeker as incompetent. Consequently, help seeking would be less threatening to one's self esteem. Furthermore, if one is assured regarding the therapist's confidentiality, the possibility of others reacting

negatively to the help seeking attempt would be lessened. Fears of embarrassment might influence one's willingness to consider help but the most critical help seeking determinant may be perceptions of the therapist's trustworthiness. This hypothesis is speculative, but it is supported by the present findings.

When the perceptions of previous help seekers were compared to those of current help seekers, the relationship of fears to help seeking was further clarified. Compared to current help seekers, previous help seekers perceived therapists as less trustworthy and understanding but reported less embarrassment about seeking help or disclosing problems. They did not differ from help seekers in their perceptions of how caring or interested in the help seeker a therapist might be. This suggests that the help seekers' perceptions of therapists as caring and interested were relatively "accurate". Furthermore, once one has experienced the process of getting help, concerns about being too embarrassed to disclose problems or admit to needing help appeared to have lessened. Perhaps help seekers do not find themselves as stigmatized or as ashamed of seeking help as they initially expected. Alternatively, therapy may have altered their beliefs such that help seeking was no longer considered an admission of failure or incompetence. The comparison of current and previous help seekers also suggests that current help seekers may have

held somewhat unrealistic expectations about just how trustworthy and understanding a therapist would be. This suggests that current help seekers may have "over-idealized" the therapist to some degree. These conclusions are based on cross-sectional data comparing relatively small samples of current and previous help seekers. These conclusions should be considered speculative at this time.

Contrary to hypothesis three, fear perceptions did not differ significantly across the preference for mental health professionals index. This index did not ask respondents whether they would or would not seek help, rather it questioned whether a respondent would refer friends to mental health professionals or to non-mental health care providers. The lack of differences in fear perceptions across this index suggests the public held no particular fears about seeking help from mental health professionals, as opposed to other helping resources, such as general practitioners, clergy, or friends. In other words, the fears associated with seeking help from professionals likely applied to help seeking from all sources. This is contrary to the initial hypothesis that differential perceptions of helping resources would determine a respondent's preference for one source of help over another.

The above section has examined the relationship of fear perceptions to help seeking behavior. It has been clearly documented that help seekers had significantly more positive

perceptions of therapists than did non-help seekers. These findings, however, should not be construed as evidence that non-help seekers held "negative" perceptions of mental health professionals. In fact, the opposite is true. If only the absolute rankings given each fear are considered (i.e., considering only a crude measure of whether a group "agreed" or "disagreed" with each fear factor), then non-help seekers, current help seekers, and previous help seekers all had basically positive attitudes toward therapists and seeking help. As was outlined in Table 8 in the results section, neither current help seekers, previous help seekers, or non-help seekers, actually "agreed" (i.e., a mean factor score above 4.5 on the 7-point scale) with any of the negatively worded fear factors (e.g., Therapist Indifferent and Uncaring). Furthermore, none of the groups "disagreed" (mean score less than 3.5) with any of the positively stated fear factors (e.g., Therapist Trustworthy and Understanding).

Examining the absolute agreement ratings, it was evident that non-help seekers perceived therapists as trustworthy and understanding. They expected therapists to be caring, interested in their clients, and nonjudgemental. They were unsure if therapists would share their beliefs or values and were unsure if therapy would be convenient and easily accessible. Non-help seekers did not expect to be too embarrassed or ashamed to discuss problems or to seek help.

The general perceptions of current and previous help seekers could be considered similar to those of the non-help seekers just described (at least in terms of the rank ordering of the fears within each group). It should be noted, however, that the help seekers more strongly agreed with some of the positive items and more strongly disagreed with some of the negative items. These findings confirm research which has found that help seekers and the general public perceive mental health services in a generally positive light (e.g., Cook et al., 1984; Dawes and Lewis, 1972; Lorion, 1974).

Expectations: Influence on Help Seeking. Contrary to the initial hypothesis of this investigation, expectations regarding the process of therapy did not vary between those willing to seek help versus those less willing, or between those preferring professional versus those preferring non-professional help. Although help seekers and non-help seekers had different expectations, these differences were accounted for by gender and age and will be discussed in a latter section. The lack of an association between expectations and help seeking supports an earlier study by Lorion (1974), which concluded that client attitudes toward help seeking (as measured by the ATSPH scale, from which the WTSH scale was derived) were uncorrelated with treatment expectations (as measured by another instrument, the Treatment Expectation Survey).

Although expectations did not discriminate across willingness to seek help or between help seekers and non-help seekers with age and gender controlled, it is of interest to document the actual expectations held by the respondents. There follows a brief summary of the non-help seekers' expectations regarding the process of therapy. This descriptive overview is based on the non-help seekers' agreement ratings with each of the three expectation factors.

The non-help seekers expected therapists to explain the cause of their problems and to give advice on the resolution of their difficulties. They expected the therapist to teach them new coping skills, such as meditation, and to encourage them to practice these new skills. The non-help seekers were unsure whether therapists would use tests to diagnose disorders. They were also unsure if therapists would be directive and perhaps even confrontive in their attempts to change the help seekers' beliefs and behavior. The help seekers held similar perceptions, although they disagreed with the perception that therapists would diagnose some disorder and be directive or confrontive.

Summary: The Influence of Perceptions on Help Seeking. The help seeking model presented in the introduction postulated that the choice of a helping resource depends on a help seeker weighing the potential benefits of seeking

help against the costs involved. This study confirms Fischer & Turner's (1970) finding that previous help seekers perceived greater benefits in seeking help than did individuals who had never sought therapy. Compared to non-help seekers, previous help seekers in this investigation scored higher on the willingness to seek help scale. Previous help seekers were more likely to perceive professional services as an appropriate resource for emotional problems and to believe in the efficacy of psychotherapy (differences in willingness to seek help could not be compared between help seekers and non-help seekers because the help seekers did not complete the willingness to seek help scale).

This investigation also suggests that individuals who seek help or who express a willingness to seek help have fewer fears or concerns about the process of seeking therapy (i.e., perceive fewer costs involved). Both help seekers and those most willing to seek help were more likely to perceive therapists as trustworthy, understanding, interested, caring, and nonjudgemental. In fact, help seekers may have had unrealistic perceptions of just how trustworthy and understanding a therapist might be. Those who expressed a willingness to seek help also perceived fewer practical or social costs in seeking help. Although concerns about the convenience and accessibility of therapy were related to willingness to seek help, these concerns

were not directly related to actual help seeking behavior. The relationship between help seeking and concerns about being too embarrassed or ashamed to discuss problems or seek help remains unclear.

Although fear perceptions discriminated help seekers from non-help seekers and across willingness to seek help, expectations about the process of therapy failed to discriminate help seekers from non-help seekers, when the contributions due to age and gender were removed. It would appear that most people hold similar perceptions of the process of therapy, with the exception of the gender and age differences yet to be discussed.

The original help seeking model postulates that the choice of a helping resource depends not only on a cost-benefit analysis but also on perceptions of which helping resources provide the help required. The following section examines this issue.

Range of Problems Treated by Mental Health Professionals. A comparison of help seekers and non-help seekers indicated that help seekers perceived mental health professionals as more qualified to treat bad habits (such as smoking, over-eating, or drinking) and to a lesser degree child misbehavior. There was a trend for non-help seekers to perceive mental health professionals as better qualified to treat brain disorders or brain injury. This suggests that

those who seek help may be more likely to perceive therapists as treating specific behavioral disorders as opposed to organic illnesses or disease. Those who believe therapists are trained to deal with organic disorders may hesitate to seek help from mental health professionals if they believe their problems are not organic in nature. These differences in expectations may reflect a weak belief that people who seek help must have something "wrong with their brain" or that they are "mentally ill". Such a conclusion is supported by an Australian study (Murphy et al., 1978) which found that 75% of the general public considered psychologists and psychiatrists as more involved in medical than psychological or social problems.

The differences between help seekers and non-help seekers on their beliefs about the range of problems treated by mental health professionals were generally small and restricted to only three of eight problem areas. Moreover, these findings were not replicated when comparing qualification ratings across willingness to seek help, preference for professional help, gender, age, or socioeconomic status. This indicates that differential perceptions regarding the range of problems treated by mental health professionals were restricted to only one comparison group. Other demographic or comparison groups all held similar perceptions regarding the range of problems treated by mental health professionals. Consequently, these

perceptions seem unlikely to account for the public's choice of one helping resource over another, especially their preference for non-mental health care professionals such as clergy, general practitioners, or lay helpers. As noted previously, the non-help seekers held no specific fears about seeking professional help any more than seeking lay help. Therefore, the public's preference for help from non-mental health professionals is likely determined by factors other than negative perceptions about professional help or major misperceptions regarding the range of problems treated by mental health professionals (other possible factors include: social customs and norms, recommendations of friends, availability of services, etc.).

Perceptions and Help Seeking: Implications. The outcome of this investigation emphasizes the importance of the public image of mental health professionals. If the public are going to utilize mental health services they must have faith that therapists are trustworthy, understanding, interested in the welfare of help seekers, caring, and nonjudgemental. The overall public image of the professions is quite positive at the present time, suggesting that the mental health professions have succeeded in alleviating many of the public's concerns. Nonetheless, professional associations must continue to ensure that their professions are well regulated, have high standards, and vigorously control ethical violations. Professional associations must

ensure that their positive reputation continues to be deserved and that their positive attributes are well publicized in the community.

The first contact with mental health services is likely a crucial point for help seekers. Help seekers are evaluating the validity of their perceptions of therapists and their fears and expectations will either be alleviated or confirmed. Initial telephone contacts with clients and the initial intake procedures provide an excellent opportunity to address a help seeker's fears and concerns. In many agencies, however, these services may be the ones performed by staff with the least clinical training. Given that many clients fail to keep intake appointments and many drop out of therapy prematurely, one must question whether professionals are adequately addressing their clients' initial concerns. Therapists may need to take greater account of a help seeker's fears and worries during the early stage of help seeking. Mental health programs should ensure that initial contacts with clients convey the impression that staff are trustworthy, understanding, concerned, and caring. Despite the reality of waiting lists, intake workers or clerical staff should not convey the impression of being too busy to take personal interest in each client. It might also be useful to immediately alleviate concerns about confidentiality or blame. Early therapeutic contact needs to focus on "joining" with the

help seeker, establishing trust, and demonstrating interest, empathy, and a strong nonjudgemental neutrality.

The results of this research also suggest that public education campaigns might stimulate a greater willingness in people to consider utilizing mental health services. Educational programs might focus on: (a) portraying help seeking and the discussion of problems as a healthy and effective option for coping with emotional or behavioral problems; (b) reducing the stigma and embarrassment associated with the disclosure of problems or seeking of help; (c) advertising services which are available, accessible, and convenient; and (d) ensuring that the public recognize the range of problems which are suitable for mental health interventions. While an education campaign based on the above principles might stimulate a greater interest in help seeking (from both professional services as well as other resources), it remains uncertain whether such a program would stimulate actual help seeking behavior.

The present results suggest there would be few if any benefits in developing programs designed to educate the general public about the actual process or techniques of therapy. Contrary to expectations, non-help seekers did not, in general, expect more directive interventions or more specific skill training than did help seekers. As will be seen in later discussion, however, expectations differed across age and gender. Educational programs targeted

specifically to these two groups might encourage men and older individuals to make greater use of mental health resources.

Perception of Mental Health Services: Gender Differences

The present research confirms the oft reported ratio that female help seekers outnumber males two to one (70% of the help seekers in this study were women). This research also confirms that women, compared to men, report a greater willingness to seek help (Fischer and Turner, 1970). They also had a greater preference than men to seek help from mental health professionals, as opposed to non-mental health care providers.

Comparison of Fears Across Gender. The original hypothesis that men would have more fears about seeking help, than would women, was not confirmed. This suggests that men do not avoid help seeking due to specific fears or concerns about the process of getting professional help. Alternatively, men may have been more likely than women to minimize or downplay their fears. This possibility is supported by Maccoby & Jacklin (1974) who found that men, compared to women, were less likely to report fears or anxieties on self report inventories (despite similar levels of actual anxiety).

Comparison of Expectations Across Gender. While fears did not discriminate across gender, there were significant differences in each gender's expectations about therapy (although the differences were not as originally hypothesized). Contrary to the initial hypothesis, both men and women expected therapists to explain the cause of their problems and to offer advice. As hypothesized, however, men were more likely to expect therapists to give tests and to diagnose some disorder. Additionally, they were more likely to expect therapists to be very directive and even confrontive in their attempts to change the help seekers' beliefs and behavior (e.g., "the therapist would point out how the help seeker should behave", "the therapist would ask the help seeker to give up moral beliefs and values", "the therapist would ask the help seeker to do things they would rather not do"). Men apparently perceived therapy as a somewhat passive process in which their deficiencies were diagnosed and their beliefs and behavior challenged. Such an expectation may conflict with male norms of self reliance and independence (Cooke et al., 1974). If true, this perception might partially account for men's under-representation in the help seeking population and their lower scores on the willingness to seek help scale.

McLatchie and Draguns (1984) reported findings which support the conclusion that men might avoid seeking professional help if they expect their basic beliefs or

values to be questioned. The authors examined attitudes held by 152 Protestant church members and discovered that those with the most conservative religious beliefs reported the strongest perception that mental health professionals would try to alter their beliefs in therapy. Such individuals preferred to seek help from clergy, who would be less likely to challenge their fundamental beliefs.

Men perceived therapy as somewhat more medically oriented than did women (in the sense that they expected testing, diagnosis, and specific directives regarding a "cure"). This suggests that men may have perceived therapists as more "expert" than did women. Such a finding would be consistent with the results of Tinsley & Harris (1976), Balch et al. (1978) and Tinsley et al. (1980), who all reported that men expected more expert and directive therapists.

In contrast to men's expectations for a directive, confrontive therapist, women perceived therapists as reassuring teachers who would encourage them to develop and practice new coping skills and to try new experiences. Women perceived therapy as a medium for personal growth and expected to take greater responsibility for developing new skills, rather than expecting directives or answers from the therapist.

Men's perceptions were somewhat similar to the perceptions held by clients who terminated therapy

prematurely, as identified by research 20 to 25 years ago. Heine & Trosman (1960) for example, reported that drop-outs from therapy anticipated a passive-cooperative role for themselves in therapy and expected diagnosis and prescriptions of medicine. Continuers, more like women in the present research, expected active collaboration, advice, and help changing behavior. Overall & Aronson (1963) also reported that all clients tended to expect a medical-psychiatric interview with the therapist taking a very active but permissive role. Over the past two decades, many therapies have incorporated a greater skill building or behavioral change component. In some ways, women's perceptions appear to have "kept pace" with these changes, whereas men have maintained a more traditional view. The women's movement has encouraged women to alter their roles and develop new skills. Perhaps these forces have helped to shape women's expectations about the process of therapy.

Perceptions of Mental Health Services: Age Differences

As noted in the introduction, age has been found to be one of the best predictors of the utilization of mental health services (Tischler et al., 1975). Older individuals are extremely under-represented in the mental health seeking population and elderly individuals seldom seek such help. This finding was confirmed by the present study, as only 8% of help seekers were over 50 years of age, compared to 38% of the non-help seeking sample.

Despite older individuals not seeking help, it is contradictory that older respondents, compared to younger respondents, reported a much greater willingness to seek professional help. Contrary to expectations, older individuals had no greater preference for lay help, as opposed to help from mental health professionals. Older respondents also reported no greater fears or concerns about seeking professional help than did younger respondents. These findings contradict previous literature reports that older individuals may prefer non-mental health care professionals or lack faith in mental health services (e.g., Waxman et al., 1984; Gurin et al., 1960). The sample of "older" individuals in this survey, however, included all individuals aged 51 and up. This group may not be representative of the "elderly', a term usually reserved in the literature for those at least 65 years of age or older. Older people with negative perceptions of professional help might also have been less likely to return the questionnaire. Ruling against these explanations, however, is the fact that the rate of help seeking for individuals in the age 51 plus category was significantly depressed, despite that age group also reporting the greatest willingness to seek help. In many ways, older individuals believed that psychotherapy was effective, useful, and they were even willing to seek such help if needed. At the same time, they felt they had little need for such help. There is no evidence, however, that older people have a lesser prevalence of emotional or mental disorders.

The apparent contradiction between older people's greater willingness to seek help versus their actual help seeking behavior may be partially accounted for by their perceptions regarding the process of therapy. Older respondents had somewhat outdated perceptions of therapy when compared to younger respondents. Older respondents expected more explanation and advice. They also expected a greater medical focus, with the therapist diagnosing disorders and directing or even confronting the help seeker to make the changes required. The fact that both men and older respondents expected a directive or even confrontive therapist, supports the possibility that this perception partially accounts for these two groups being under-represented in the help seeking population.

Perceptions of Mental Health Services: SES Differences

Socioeconomic status did not discriminate help seekers from non-help seekers suggesting that socioeconomic differences may no longer be strongly associated with seeking outpatient mental health services, at least in the two settings surveyed. This supports similar conclusions drawn by others such as Tischler et al. (1975). It is possible, however, that some socioeconomic differences may have been masked. The non-help seeking sample is likely less representative of lower socioeconomic classes, as is the usual case in survey research. Not only are lower socioeconomic groups less likely to respond, but those who

are illiterate, living in rooming houses or institutions, or who were simply transient are unlikely to have been included in the survey. Obviously, the present results are not applicable to these groups. The lack of socioeconomic differences between help seekers and non-help seekers within the present sample is, however, supported by the lack of an association between socioeconomic status and scores on the willingness to seek help scale. This supports earlier findings, based on student and client samples, that positive help seeking attitudes and socioeconomic status tend to be uncorrelated (e.g., Lorion, 1974).

Network Characteristics: Relationship to Help Seeking

The reliability and validity of the network measures used in this study remains unknown. Previous research in this area has relied upon face-to-face, structured interviews to gather the data defining network variables, such as density, proportion of kin, size, and helpfulness of network. The present research utilized a paper and pencil format to measure these constructs. Respondents may have misunderstood the directions or misinterpreted the intent of the questions. As this was the final section of the questionnaire, others may have rushed through the section due to fatigue. As a result, the validity of the network measures remain unclear. Given this uncertainty, the results and the following discussion should be considered tentative.

As hypothesized, help seekers rated their networks as less helpful than did non-help seekers. This supports the hypothesis that individuals seek professional help if their social network fails to provide the help required.

Contrary to the initial hypothesis, help seekers' networks were no smaller than those of non-help seekers. This contradicts the findings of previous studies which consistently report a negative correlation between network size and help seeking. Network size in the present study, however, was defined quite differently than in previous research. This likely accounts for the discrepancy in findings. The present study defined network size as the number of confidants with whom a respondent discussed emotional problems. This is not a measure of one's overall social support network as defined in most previous research (networks are more usually considered to include all individuals who provide a person with support or help, not just those in which an individual can confide in). Consequently, network size, as defined in the present study, cannot be directly compared to network size as defined in previous research.

There may be a second explanation for the lack of an association between network size and help seeking behavior. It is plausible that help seekers sought out more confidants because they had problems for which they needed help. In this case, the variable network size may have very little

relationship to the overall size of an individual's support network. Non-help seekers might have reported more confidants if they too had problems for which they needed help. Clearly, both definitional differences and methodological problems preclude firm conclusions regarding the relationship of network size to help seeking behavior.

There was a trend for the proportion of kin within a network to be associated with help seeking behavior. The contribution of this variable to the discrimination between help seekers and non-help seekers, however, was redundant to the contribution of density (recall that density and proportion of kin were moderately correlated). The weak relationship between proportion of kin and help seeking behavior raises two possibilities. Perhaps the increased mobility of people within society has lead to friends providing much of the help traditionally supplied by family. Family and relatives may not be such a vital resource to individuals as they were in the past. It is also plausible that, although kin may provide more help in certain circumstances (especially when physical or material aid is required), in other circumstances family members may increase stress and contribute to emotional or adjustment problems. Hirsch (1978, 1980), for example, found that women with dense, family-oriented networks felt greater pressure to conform to family norms and to avoid radical changes in their role, than did women with sparser networks.

Perhaps this accounts for the weak relationship between kin and help seeking in the present study. The helpfulness of a network may depend not on the presence of family, but rather on the type of help required and the types of change needed. This hypothesis is consistent with the very low correlation found between proportion of kin and ratings of network helpfulness.

As initially hypothesized, network density was found to significantly discriminate help seekers from non-help seekers. Individuals with dense networks were less likely to seek professional help, than were those with sparser networks. This finding is consistent with the general research literature. There are at least three possible explanations for the association between density and help seeking: (a) Denser networks may have stronger norms prohibiting outside help seeking and may present a consensus on appropriate solutions. They may also provide less information regarding treatment alternatives; (b) denser networks may provide more assistance precluding the need for help; and (c) denser networks may be more likely to accept and normalize deviant behavior, thereby reducing the need to change.

The first option, that dense networks have stronger norms prohibiting outside help seeking or provide less information about treatment alternatives, was not supported. There was no association between density and either expectations or

fears. Contrary to this study's hypothesis and the speculation of authors such as Gourash (1978), McKinlay (1973), or Walker et al. (1977), there was no evidence that any one network type held specific expectations, beliefs, or norms which were different from other network groups. If dense networks had greater prohibitions against help seeking, this should have been reflected in greater fears or concerns about hurting others or of being stigmatized. Such fears, however, were not significant. Evidence that dense networks provide less information about outside treatment resources was also lacking. Expectations about the process of therapy or perceptions of the availability of therapy did not vary across network density.[5] Furthermore, individuals with dense networks reported no lesser likelihood of seeking professional help on the willingness to seek help scale, than did individuals with sparser networks. Similarly, members of dense networks failed to report any greater preference for help from non-mental health professionals. Dense networks did not appear to present any strong normative prohibitions against seeking professional help.

It should be noted that there was a trend for members of dense networks to report greater fears of embarrassment and shame about seeking help or disclosing problems, than did

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[5] It is possible that awareness of treatment resources depends upon the existence of a friend-kin boundary (i.e., the presence of a group of friends independent of the family), rather than simply the overall density of the network. This hypothesis could not be examined as separate measures of kin and family densities were not obtained.

members of sparser networks (the univariate p value was .01 but the overall multivariate test was not significant with a p value of .04). This finding was not considered statistically significant and should not be further interpreted. The possible relationship between density and perceptions of therapy as an embarrassing and shameful experience, however, highlights the need for further research utilizing network measures with proven reliability and validity.

It has been suggested that dense networks provide more assistance than do sparse networks, thereby reducing the need for treatment. Dense networks may provide some form of treatment in lieu of professional help. The presence of a high proportion of kin was not strongly related to help seeking. Therefore, it appears there may be some factor specific to density which provides treatment, other than simply the presence of greater family support. This factor may be a sense of belonging to some form of group or strong support network. Density reflects a grouping of individuals who know one another. If simply being "family" is not the key factor, then the "curative" aspect may be the belonging to a close-knit group of friends and associates, either informally or through more formal channels such as clubs and organizations. If true, density reflects a measure of "social embeddedness", a term used by Berkman & Syme (1979) to describe individuals with many social contacts and who

belonged to many groups or organizations. Based on a prospective study, Berkman & Syme discovered that socially embedded individuals had significantly lower mortality rates than did those who were less embedded. The "curative" factor may include not only the greater aid available in a dense network but more importantly for mental health, dense networks may provide a sense of belonging and identity as well.

Apparently contradicting the above hypothesis is the fact that the rated helpfulness of a network correlated very weakly with its density. If dense networks provide greater assistance one would expect a much stronger correlation. A methodological problem may explain this finding. Each respondent rated their network members on their "helpfulness" and these scores were averaged to determine the network's average degree of helpfulness. This procedure, however, may have underestimated the helpfulness of larger and denser networks. For example, a network consisting of one confidant with a helpfulness rating of seven (most helpful) was considered more helpful than a network of four confidants, two with ratings of seven and two with ratings of six (average helpfulness = 6.5). Intuitively, however, the second network should be more helpful overall. If denser networks are in fact more helpful than sparser networks, it is likely that this association would have been obscured or even reversed

because of the methodological problems with the measurement of network helpfulness. Given the data collected, there is no better scoring system available. In retrospect, however, respondents should have given one rating of their network's overall helpfulness.

The last possible explanation for the association between density and help seeking postulates that dense networks may accept deviant behavior, thereby alleviating the need for change. The present data cannot test this possibility. One could speculate, however, that cohesive networks may not only provide "treatment", but may also accept a member's problems without demanding change. In a sense, dense networks may function much like group therapy; providing not only treatment but also a sense of acceptance of both the individual and his or her problems. This does not imply that dense networks are always positive. Dense networks may dissuade individuals from making needed role changes and, by accepting problems, such networks may encourage the maintenance of emotional disorders.

It is noteworthy that men had denser networks than did women and older individuals had denser, more kin dominated networks than did younger people. Men through their work may belong to a tighter circle of friends or perhaps through sports or social contacts they engage in more group activities. Perhaps women engage in more one to one relationships. The greater density in the networks of older

people compared to younger ones may reflect their greater contact with kin and perhaps the greater number of years they have had available to develop friendship groups or belong to organizations.

Both men and older individuals were less likely to seek professional help than were women or younger people, raising the possibility that this relationship was partially accounted for by the differences in their network density. While speculative, men and older people may find greater acceptance of their problems within their networks and feel less pressure to change. They may also have access to more "treatment" through group cohesion and support. A group of men meeting for an evening at the bar, for example, may accept and even encourage behavior or attitudes within their group which appear problematic to their spouses. While a member might admit there are problems, the cohesive nature of the group may reduce the tension associated with the problem and decrease the probability of any member seeking help or even attempting change.

Implications: Gender, Age, and Network Perceptions

Men and older people's tendency to perceive therapists as directive and confrontive has several implications for public education programs. Perhaps men and older people might be re-educated to perceive therapy as an opportunity to enhance problem solving skills. This might counter their

expectations that therapists judge people and give directives to change. Treatment programs might also emphasize the educational or skill building aspects of their program. Men and older people might perceive such programs as less threatening to their self reliance or independence. They might also perceive less stigma in attending an educational program as opposed to "getting help".

Whereas it seems plausible that men might avoid seeking help for fear that therapists will be overly directive or confrontive, this explanation seems less applicable to older people. Unlike men, the older respondents reported a stronger willingness to seek help, than did younger respondents. They also expected more advice and explanation. These differences, combined with the older people's greater expectation for testing and diagnosis, suggests that they perceived therapy as quite medically oriented. It also suggests that older respondents may not have considered a directive or confrontive therapist as undesirable. Older respondents may have perceived therapists as expert helpers, who were perhaps authoritarian, but nonetheless helpful. If true, older people may have perceived therapists as similar to a traditional physician who diagnoses a problem, offers explanation and advice, and gives directives to change.

If older people perceive therapists as offering services similar to those offered by physicians, they may be

encouraged to seek help for emotional problems from their general practitioner. Older people may have established a caring and trusting relationship with their physician and see no advantage in seeking the same service from someone they know less well. They might also be reluctant to seek advice or guidance from a person younger than themselves, as would be the case with most mental health professionals. An older person's family physician would likely be of a similar age. Consequently, the physician might be perceived as having more life experience and more wisdom to offer. They might also prefer advice and directives from a peer as opposed to someone substantially younger than themselves. This hypothesis is supported by research indicating that 88% of the elderly would seek help for depression from their family physician, whereas only 40% would consider seeking help from mental health professionals, even when severely depressed (Waxman et al., 1984).

Perhaps older members of the public might benefit from educational programs about the nature of psychotherapy. If older people recognized the specific benefits of mental health services over traditional medical treatment, they might be more willing to utilize professional help.

It is tempting to assume that these findings have implications for therapists working with older clients or men. However, the age and gender differences identified were based on the sample of non-help seekers. It remains

unknown if age and gender differences in perceptions exist within a client population. Several researchers (Calhoun, Dawes, & Lewis, 1972; Lorion, 1974) have failed to find gender differences in clients' attitudes toward seeking help. This contrasts with the strong gender differences found in student and college populations (Fischer & Turner, 1970). Clearly the perceptions of men and older people in general may not represent the perceptions held by male clients or older help seekers.

While it remains unclear whether the age and gender differences found in the non-help seeking population apply to help seekers, the results suggest several possibilities that therapists should consider. First, men and older clients, especially those who have been pressured into getting help, may be more likely than their counterparts to expect testing, diagnosis, and directives regarding the changes they should be making. If true, men and older individuals may react more defensively to questions than do women or younger people. They may also be overly sensitive to challenges of their beliefs. Therapists might reduce such fears by recognizing and reinforcing their clients' adaptive beliefs or behaviors, while encouraging them to re-evaluate whether some beliefs or behaviors may be contributing to their problems.

As mentioned, there is a second interpretation of these results. Male clients, and older help seekers especially,

may actually expect and prefer an expert, directive therapist. If true, such clients might perceive a non-directive therapist as lacking in skills and generally unhelpful. Older people may also expect more explanation and advice than the therapist wishes to provide. If the therapist fails to deliver in these areas, clients might terminate therapy believing the therapist has little to offer.

The present data cannot clarify which, if either, of the above two hypotheses are true. Rather, the findings suggest that therapists carefully assess the expectations of male clients and older help seekers. The findings also underscore the need for further research examining age and gender differences in expectations within a help seeking population.

In this study, perceptions of mental health services failed to discriminate across socioeconomic status, suggesting that the classes surveyed have similar fears and concerns related to seeking help and similar knowledge about the process of therapy. Similarly, there was no evidence to support the hypothesis that different networks would hold specific fears or expectations regarding professional help. With the exception of the different help seeking norms held by men and women and across age groups, there was no evidence that normative expectations were unique to any other social group. Perhaps increased media attention to

mental health issues has ensured that most members of society have received similar information and have formulated similar opinions regarding mental health services. Perhaps mental health agencies have also succeeded in making their services more visible and more accessible to all social groups.

Limitations of this Research

This investigation is one of the first studies to tentatively identify the perceptions of mental health services held by both help seekers and the general public. It is also one of the few to investigate the relationship of perceptions to help seeking behavior. The results of this investigation, however, must be interpreted in light of the study's limitations.

The results are based on a questionnaire survey and the limits inherent in this design must be recognized. The return rate from the general public was reasonably good, suggesting the public sample is representative of the English speaking, literate population of Winnipeg. Like all mail surveys, however, the sample is likely over-representative of higher socioeconomic classes. Given the broad distribution of socioeconomic classes which did respond, and given the lack of association between perceptions and socioeconomic status, it is this researcher's opinion that the overall results have not been

unduly affected by this sampling bias. The perceptions of individuals at the very bottom of the social scale and of those who are illiterate or non-English speaking, however, remain unknown.

The help seekers' return rate was under 50%, raising concern that their results may not be highly representative of help seekers in general. The lack of follow-up likely accounts for the help seekers' lower return rates when compared to the general public. As returns were anonymous, there is no method of determining whether non-responders differed significantly from those who participated. It is difficult to speculate why some help seekers chose not to respond. Perhaps they were in greater distress or had greater fears about help seeking and did not wish to exacerbate them by dwelling on them. This questions whether the help seekers' generally positive views might not have been an artifact of a selection bias. Unfortunately, there is no way to verify this possibility without further research to compare the perceptions of responders and nonresponders. Until further research is completed, this factor limits the conclusiveness of these findings.

Questionnaire research presents a number of other limitations. The respondent could only rate the items presented and there was no opportunity to qualify one's response. Perceptions or views not listed could not be addressed. It is quite possible that the identified

perceptions may not be a complete representation of people's attitudes or expectations. Given the extensive pre-tests and interviews, however, it is this researcher's opinion that the research taps the public's most salient concerns and beliefs.

The possibility of an inflated experimentwise error rate has already been discussed. Also worrisome is the reliability and validity of the overall questionnaire. The stability and reliability of the factor structure and the construct validity of the factor scores remain unknown. The factor scores were based on factors consisting of three to nine items each and the coefficients of alpha ranged from a barely adequate .51 to a more reliable value of .85. Clearly, the present results must be considered tentative until further research confirms the validity and stability of these factors.

Similarly, the reliability and validity of indexes such as the preference for professional help scale and the indexes used to measure the network variables remains unknown. The valid measurement of network variables is difficult, even in face to face interviews. One must question the validity and reliability of network information collected through a written question and answer format, as was used in the present research.

There are, of course, other sources of possible bias, such as respondents misreading instructions or misunderstanding the meaning or intent of a statement. There is no evidence that this occurred extensively in the present study and the use of a pre-test sample eliminated most areas of confusion prior to the final survey.

The limitations of correlational versus causal research has been addressed throughout the discussion.

Future Research

Future research in this area might refine and validate the survey questionnaire. The present research has served a preliminary function of identifying possible fears and expectations which might influence help seeking behavior. Future research must develop more reliable and valid scales to measure these identified constructs. Redundant or non-discriminating items should be dropped from the questionnaire and new items should be generated to measure each factor. A more thorough item analysis needs to be conducted and the content validity of each scale examined. The factor structure should also be verified on several different populations. Once more reliable scales are developed, the construct validity of each scale can be examined.

Longitudinal research to better examine the causal role perceptions play in the help seeking process would clarify

the present findings. Although perceptions may correlate with help seeking, there is no direct evidence that perceptions are causally related to help seeking behavior. Perceptions might well change after a decision to seek help is reached. Longitudinal research could document the perceptions held by a randomly selected group of subjects whose future help seeking behavior could then be followed. This approach would directly identify perceptions likely to facilitate help seeking.

A second approach to longitudinal research might involve providing educational programs regarding mental health services. The help seeking behavior of the audience could be followed for several years time and compared to that of a control group. This approach would identify perceptions which are causally related to help seeking and test the feasibility of using educational programs to alter help seeking behavior.

A briefer and more valid instrument could also be used to document a new client's expectations of therapy. Such a questionnaire could examine the relationship between client perceptions and therapy outcome or premature termination. The present questionnaire may tap fears and concerns related to help seeking which earlier questionnaires (which focused more on expectations about therapists' orientations) have neglected. Perceptual differences across gender and age might also be documented on a client sample. The potential

benefits of specifically addressing clients' fears or expectations at the beginning of therapy could also be addressed.

Future research might also explore the actual behavioral correlates associated with various perceptions (e.g., do those expecting a medical focus in therapy seek help from general practitioner's rather than mental health professionals?). Once the role of perceptions in help seeking behavior is fully understood, professionals will be in a better position to ensure that services are available to all those in need and that therapy is responsive to a help seeker's expectations and concerns.

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Appendix A

A Literature Review of Attitudes Toward Help Seeking

The attitudes which an individual holds toward professional help are likely to reflect the probability of that person seeking help (although for severe problems or distress, almost all individuals may seek help and attitudes may have a lesser influence). Help seeking attitudes are evaluative judgements reflecting the sum total of an individual's beliefs, ideas or opinions about the process of seeking help. The understanding and measurement of people's attitudes can help to identify those beliefs or opinions which may deter certain groups or individuals from seeking help. This hypothesis led Fischer & Cohen (1970) to develop a standardized summated rating scale designed to measure the favourableness of one's attitudes toward seeking professional help (ATSPH scale). This scale consisted of 31 items reflecting possible attitudes or opinions about the help seeking process. Since the development of this scale, there have been a number of studies which have investigated whether there are attitudinal differences in various groups which differentially utilize helping resources. The studies by Fischer & Turner (1970) and Fischer & Cohen (1972) have been reviewed in greater detail in the introduction to this paper. Only brief mention was made of the later studies which extended Fischer and Turner's original work. The following review examines these studies and several others in greater detail.

To review, Fischer & Turner (1970) found that women and previous help seekers had significantly more favourable attitudes toward help seeking than did men or those with no previous contact with professional help. Authoritarianism and internal versus external locus of control were also correlated with attitude scores. Fischer & Cohen (1972) gave the ATSPH scale to 487 male and 502 female students and found that help seeking attitudes were independent of a student's social class of origin but did correlate with level of education (independent of age). The attitudes of third and fourth year university students were more favourable than first or second year students which in turn were more favourable than the attitudes of high school students. Jewish students had more favourable attitudes than Catholics or Protestants and psychology majors scored higher than other disciplines.

Calhoun, Dawes, & Lewis (1972) administered the ATSPH to 45 male and female adult outpatients at a university psychology clinic. The authors found no significant differences between the sexes which contrasts with the student sample investigated by Fischer & Turner (1970). Colhoun et al. also reported that severity of a client's disorder was negatively correlated with their attitudes. The more severe a person's disorder, the less favourable their attitude toward seeking professional help. This supports the hypothesis that as distress increases attitudes

likely play less of a role in the decision to seek help. Therefore, highly distressed help seekers are more likely to include individuals with more negative attitudes.

Wolkin, Moriwaki & Williams (1973) had 69 female college students complete the ATSPH. Their sample was comprised of three subsamples representing white middle class, black middle class, and black lower class subjects. Contrary to Fischer & Cohen's (1972) findings, middle class blacks had more favourable attitudes than did the lower class blacks. There were no significant differences between classes or races on any of the four factors (recognition of need for help, tolerance of stigma, interpersonal openness, confidence in mental health professionals) when they were analyzed separately. Of most interest was the finding that there were no differences in the attitudes of middle class blacks and whites suggesting that differential attitudes were independent of race. The addition of a lower class white sample would have substantially strengthened these conclusions.

Lorion (1974) had 90 applicants for outpatient treatment complete the ATSPH as well as the "Treatment Expectations Survey" (TES). The TES was a 29 item questionnaire which listed potential therapist behaviors and asked each respondent to indicate whether they expected such behavior (21 items were included from the original questionnaire developed by Overall & Aronson, 1963). Factor analysis of

the TES identified the following six factors: 1) Supportive-directive, 2) Treatment duration, 3) Dynamic, 4) Medical, 5) Passive therapist, and 6) Medical diagnosis (the literature utilizing the TES is explored in greater detail in Appendix B). Lorion concluded that a client's sex or socioeconomic level was unrelated to their help seeking attitudes as well as treatment expectations. He also found no correlation between favourableness of attitudes and any specific expectations about treatment. As all clients are likely to have generally positive attitudes toward help seeking, as well as similar expectations, it does not seem surprising that attitudes were found to be unrelated to treatment expectations. The selective effects of help seeking may also account for the failure to find a relationship between attitudes and gender or attitudes and socioeconomic status.

Rapoport (1976) gave the ATSPH to 90 lower class clients at a mental hygiene clinic. As in the previous studies, the lower class clients had generally favourable attitudes although of particular interest was the significant relationship between attitudes and continuation in treatment. Early dropouts had more negative attitudes toward therapy.

Cash, Kehr, & Salzbach (1978) examined the relationship between help seeking attitudes and perceptions of a therapist's expertise, trustworthiness, regard, empathy, genuineness, and helpfulness. A sample of 219 female

undergraduates completed the ATSPH and rated the behavior of a therapist based on audiotaped excerpts of an enacted counselling session. The results confirmed that the ATSPH discriminated those who had previous professional help from those who had not (significant differences were found on the whole scale score as well as each of the four factor scores). Favourable attitudes were also significantly associated with more positive ratings of the therapists on all six of the variables measured. The results suggest that a client's attitudes may influence their perceptions of their therapist which in turn (extrapolating from the data), might influence the outcome of therapy.

Zeldow & Greenberg (1979) asked 80 university students (40 male and 40 female) to complete the ATSPH and an "Attitudes Toward Women Scale". Previous help seeking was marginally correlated with attitudes but contrary to Fischer & Turner (1970), no sex differences were evident. Previous research had found that women with liberal sex role attitudes had negative perceptions of physicians and hospitals (Greenberg & Fischer, 1977) but contrary to expectations, liberal sex role attitudes were positively correlated with positive attitudes toward professional help. The authors speculated that liberal women may reject the passive patient role but perceive therapy as an active, collaborative venture which does not threaten individual autonomy.

Dadfor & Friedlander (1982) administered the ATSPH to 300 international students studying in the midwestern U.S.. Factor analysis identified three factors; 1) Appropriateness of seeking help, 2) Stigma-privacy, and 3) Preference to cope alone. European and Latin students held significantly more positive attitudes than did African and Asian students. The authors speculated that cultural differences in authoritarianism, restrictiveness, and acceptability of outside help may have accounted for the differences in attitudes. No sex or education differences were found although the range of education was very restricted. As in previous research, previous help seekers had the most positive attitudes on all three factors. Atkinson, Ponterotto, & Sanchez (1984) also reported that Vietnamese college students held more negative attitudes toward counselling than did Anglo-American students.

Scott, Balch, and Flynn (1983) administered an abbreviated 9 item version of the ATSPH to 403 members of the public in Tuscon Arizona. They reported that based on this public sample, higher socioeconomic classes had more positive attitudes toward seeking professional help. The limited number of items administered questions the validity of these findings.

Lastly, McLatchie & Draguns (1984) surveyed 152 protestant church members and students and reported that there was no correlation between attitudes measured by the

ATSPH and theological conservatism. More conservative members, however, preferred seeking help from clergy or professionals who held religious beliefs similar to themselves. They were suspicious that most mental health professionals were against their beliefs and would try to alter their beliefs in therapy.

Summary

The literature suggests that clients and students generally hold positive attitudes towards seeking professional help. These attitudes do not appear to correlate with social class in client and student samples although there is weak evidence that social class differences exist in the general public. Attitudes of clients and international university students do not appear to vary based on sex, yet other evidence suggests that sex differences do exist in a broader sample including high school and community college students (females holding the most positive attitudes). It appears that university males and those seeking help have attitudes similar to those of women in general. Men and women of the general public, however, likely differ in the attitudes they hold. The evidence also indicates that previous clients, regardless of sex, socioeconomic status, or culture, tend to have more positive attitudes than do non-help seekers. Whether help seekers sought help because they held positive attitudes or whether their positive attitudes are a result of seeking help is as yet unknown.

A major limitation of the research examining attitudes toward help seeking is that all but two of these investigations have utilized client or student samples. These populations limit the generalizability of the results. Clients have made the decision to seek help and hence are likely to all have reasonably positive attitudes. Students, especially university and college samples, tend to be upwardly mobile and from the higher socioeconomic strata. Their increased verbal skills and education may make psychotherapy more attractive and their attitudes more favourable. In fact, Fischer & Cohen (1972) have documented the positive correlation between attitudes and education. No studies have adequately examined how attitudes vary within a public sample and as a result, no definitive statements regarding the effects of socioeconomic, sex, or culture are possible. Nor is it clear exactly what beliefs or expectations contribute to positive or negative attitudes. Factor analyses have indicated that favourable attitudes include a belief that help is not a stigmatizing experience, a belief in the efficacy of therapy, a greater recognition of a need for help, and a greater willingness to discuss personal problems. Further research needs to identify more specifically what expectations or beliefs are related to positive attitudes toward help seeking. This is the focus of the present investigation.

Appendix B

A Literature Review of Client Expectations

Since the 1950's there has been substantial interest in the expectations which clients have about therapy and the possible effects of these expectations on premature termination, the process of therapy, or therapy outcome. During the 1950's there was considerable speculation that discrepancies between a therapist's actual behavior and the behavior expected by a client might lead to the client being confused, disappointed, and dissatisfied with therapy (Chance, 1957; Kelly, 1955). Many authors were concerned that disconfirmed expectations would lead to communication problems, premature termination, or poor therapy outcome. Goldstein (1962) reviewed the expectation literature up to that time and identified two types of expectations which he considered to be important variables; 1) prognostic expectations and 2) participant role expectations. The first related to the client's expectations about the efficacy of therapy (probability of success) and the second was defined as the expected behavior of client and therapist. Prognostic expectations have been widely studied as part of the literature on expectancy effects on the process and outcome of therapy (see Garfield & Bergin (1978) for a brief review of that literature). Of more relevance to the present research has been the studies of participant role expectations. This research has followed two tracts;

some investigators have examined the effects of disconfirmed expectations on therapy and others have simply documented expectations. The following discussion reviews the major studies which have identified specific client expectations. As the focus of this paper is the effect of expectations on the decision to seek help, the literature related to disconfirmed expectations will not be specifically reviewed.

In 1958, Apfelbaum published a study of the expectations held by clients at a university psychiatric clinic. Using a Q-sort technique, Apfelbaum identified three types of expectations: 1) the nurturant therapist; caring, protecting, and non-critical, 2) the critic; analytical, critical, and demanding, and 3) the model; well adjusted, diplomatic, but not protecting. Apfelbaum's work influenced the direction of research over the following decade. Most investigators directed their attention to identifying the type of therapist expected by various client groups. Most emphasis was on identifying the therapist's style or technique or the personal qualities of the therapist. Much of the research reflected the ongoing controversy within the mental health field regarding the appropriateness of directive versus non-directive therapy or an analytical versus behavioral approach.

Heine & Trosman (1960) had 46 psychiatric clients complete an attitude questionnaire about therapy. Those who terminated prematurely anticipated a passive-cooperative

role for themselves and expected medicine or diagnostic information. Continuers (over six weeks) expected active collaboration, advice, and help in changing behavior.

Overall & Aronson (1963) orally administered a 35 item "Treatment Expectations Survey" (TES) to 40 lower class outpatients at a university hospital. The items were chosen to represent five therapist orientations: 1) active-directive, 2) medical, 3) supportive, 4) passive, and 5) psychiatric-psychological. The questionnaire was administered to each client prior to therapy and then immediately after the first interview.

Clients were found to expect all five orientations from the same therapist but these results may well reflect a yes set by the respondents. The authors report that the clients generally expected a medical-psychiatric interview with the therapist assuming an active but permissive role. Comparison of pre and post interview expectations (visual examination) revealed that the greatest discrepancy between the expected behavior and the actual behavior of the therapist lay in the medical, active and supportive categories. The authors also found that clients with the largest discrepancy between expectations and actual treatment were the least likely to return.

Rapaport (1976) replicated Overall and Aronson's (1963) results on a sample of 90 lower class patients at a mental

hygiene clinic. Rapaport reported that there were larger discrepancies in expectations between therapists and drop-outs than between therapists and remainers. Again the drop-outs expected a more directive, supportive therapist and a stronger medical orientation.

In a follow-up to their original study, Aronson & Overall (1966) used the same questionnaire to compare the expectations of 79 lower and middle class clients from a psychiatric outpatient clinic. The authors concluded that the lower class clients expected a more medical, supportive, directive, and active therapist than did the middle class. Both groups, however, expected therapists to focus on psychological issues.

Using the TES (with five additional items), Williams & Williams (1967) studied 587 black and white outpatients from three hospital clinics. Rather than relying on the predetermined scales, the authors factor analyzed the TES and identified the following five factors: 1) diagnostic, 2) history of somatic illness, 3) active-medical, 4) supportive-optimistic, and 5) advice-guidance. Confirming earlier findings, the authors reported that lower socioeconomic status clients had significantly different expectations than did middle class clients on all but the first factor. All clients, however, had at least a superficial awareness that therapy was psychologically oriented.

Lorion (1974) examined the treatment expectations of 90 caucasian outpatients from three socioeconomic classes. Prior to treatment, each client completed a questionnaire consisting of 21 of the 29 items on the TES and an additional 8 items related to treatment duration. Factor analysis yielded six factors: 1) supportive-directive, 2) treatment duration, 3) dynamic orientation, 4) medical orientation, 5) passive therapist, and 6) medical diagnosis. Contrary to earlier findings, no socioeconomic differences were found. Gender was also unrelated to expectations except that middle class women anticipated less support and direction than did other groups. Overall, clients did not anticipate a highly active, supportive, problem solving therapist. Instead, they expected to discuss emotional problems with a therapist whose primary function would be to listen. The addition of an upper socioeconomic group would have strengthened the findings.

Balch et al. (1978) attempted to clarify the inconsistent findings regarding the relationship between socioeconomic status and expectations. The authors developed a questionnaire utilizing 16 items from the TES (three reworded) and added four of their own. The questionnaire was administered to 317 caucasian outpatients from a community mental health center, both prior to the initial intake interview and immediately after the first session. Factor analysis yielded four factors including: 1)

psychological-insight, 2) medical, 3) non-directive, and 4) supportive. The authors concluded that the same general factor structures were identified as in previous studies (which all used almost identical items) but they found no reliable association between expectations and social class, sex, marital status, or treatment progress (although males expected more advice and direction; a result consistent with Apfelbaum (1958). Discrepancy between pre and post expectations was not related to premature termination. All clients had strong expectations for a directive, advice oriented exchange.

Using their own questionnaire, Richards & Richards (1979) examined married individuals' expectations about marital counselling. The published report is very brief but the authors reported that 60 psychology and social work college students evidenced concrete expectations about the process and content of marital counselling. Two-thirds expected active guidance and skill training. Expectations were not found to differ based on sex or marital adjustment. The authors concluded that there was considerable discrepancy between the students' expectations and the practices of some contemporary marital therapists.

The research reviewed in this Appendix represents the major studies which have examined client expectations regarding the process of therapy or counselling. There have been many related studies which have specifically

investigated the effects of disconfirmed expectations on therapy but these studies are outside the mandate of this review. The types of expectations such studies have examined are generally similar to those reviewed in this paper.

Summary

To summarize, early research concerning client expectations suggested that lower socioeconomic clients expected more active, supportive, and medically oriented therapy than did the higher socioeconomic clients. Later research has questioned whether such class differences still exist (at least within client populations). Recent research suggests that all clients recognize the psychological nature of therapy, although there is still a strong expectation for a directive, advice oriented exchange. Within client samples it appears that sex differences may be disappearing.

As mentioned previously, Duckro et al. (1979) reviewed the expectation literature and concluded that expectations have been imprecisely defined and globally assessed. The reliability of measures used to identify relevant dimensions has also been questioned and some studies have been vulnerable to a positive response bias.

Of greater importance to the present research is the relevance of these findings to the public's perceptions of therapy and the implications for help seeking. One problem

is that client expectations are unlikely to be representative of the public in general; afterall, clients have decided to seek therapy and likely have some information or knowledge which resulted in their seeking help. Consequently, the generalizability of these findings to the general public is unknown. Perhaps the greatest factor which limits the relevance of this literature to public expectations research is the different goals of the two areas. The client expectation research has traditionally focused on identifying those dimensions or expectations which are believed to hinder the continuation of therapy. Theoretical issues have also influenced many researchers to focus on expectations regarding the therapists' style, orientation, behavior, or personal qualities and in identifying and measuring various dimensions of the client-therapist relationship. While these expectations my influence the outcome of therapy, some of them may be less likely to strongly influence the public's help seeking behavior. It seems unlikely that the public would base their decision to seek help on issues such as their expectations about the therapists' style or theoretical orientation. The present research attempts to broaden this research by examining a wider range perceptions and expectations and investigating their relationship to help seeking behavior.

Appendix C

Student Perceptions of Counselling Centres

Student perceptions of counselling centres have some relevance to the present research, as student perceptions may be similar to the perceptions of mental health services held by the general public. Although much of the following research is in some ways an extension of the client expectation literature (the focus of the research was to develop a questionnaire for students seeking counselling), many of the perceptions examined and the findings reported have relevance to the present research.

Snyder, Hill, & Derksen (1972) administered a 70 item questionnaire to 181 undergraduate psychology students. Twenty-nine of the items were grouped based on homogeneity ratios to produce the following six scales: effectiveness of counselling, information about the counselling process (convenience of counselling would have been a more appropriate label), information about the centre, stigma of counselling, and counselling readiness. No between-group comparisons were reported and all interpretations were simply based on the extent to which each scale score deviated from its midpoint. The results suggested that students were not concerned about stigma, believed counselling to be effective, but had little knowledge of the facilities available or the process of counselling. Further results were not reported in the published article but

comparisons of help seekers with non-help seekers would have been helpful. Although methodological considerations limit the interpretability of this study, the investigation is noteworthy as one of the first to examine the perceptions of college counselling services held by non-help seeking students.

Several authors in the late seventies reviewed the expectation literature and concluded that most research had narrowly focused on only a few of the possible dimensions related to client expectancies (Duckro et al., 1979; Tinsley & Harris, 1976). To counter this problem, Tinsley & Harris (1976) designed the first extensive questionnaire to examine student expectations regarding a counsellor's behavior and style. Tinsley & Harris selected 73 items and assigned them to seven scales to represent expertise, genuineness, trust, acceptance, understanding, outcome, and directiveness. Nine items describing counselling procedures were also included. A total of 287 psychology undergraduates completed the questionnaire and their expectations were compared across gender and class year. The results indicated that students expected an experienced, expert, genuine, and accepting counsellor they could trust. Students were less certain whether the therapist would understand their problems or be able to help. These results raise the possibility that students' expectations about therapists' behavior may be fairly positive yet they may fail to seek help if they do not expect to be understood or helped.

The authors also found that the students' strongest expectation was to talk about their personal concerns and to see an experienced counsellor. There were moderate expectancies to understand the purpose of what happens in therapy and to discover the cause of their problems. Few expected homework or assignments.

Tinsley & Harris also reported that males were more likely to expect directiveness, whereas females expected more acceptance and a longer duration of therapy. Older students expected less experienced therapists and sophomores expected greater acceptance than did seniors.

Tinsley, Workman, & Kass (1980) developed an even more extensive questionnaire called the Expectancies About Counselling Questionnaire (EAC). It consisted of 135 items representing 17 hypothesized dimensions. Attempts were made to include items relating to (a) client attitudes and behaviors, (b) counsellor attitudes and behaviors, (c) counsellor characteristics, (d) characteristics of the counselling process, and (e) quality of outcome.

The authors had 446 psychology students complete the questionnaire and factor analyzed the results using the scores on each of the 17 dimensions as the factor items. Four factors were extracted representing: (a) personal commitment (client expects to be responsible, open, motivated); (b) facilitative conditions (expects counsellor

to be genuine, trustworthy, accepting, tolerant, concrete, confronting; (c) counsellor expertise (expects counsellor to be expert, empathic, directive); and (d) nurturance (expects counsellor to be accepting, self disclosing, nurturant, attractive). There were no between class differences but women were found to show greater personal commitment, expect more facilitative conditions, and expect less expert counsellors than did men. There was also a trend for women to expect more nurturance.

The respondents also rated their expectations on 13 items related to the process and outcome of counselling (e.g., take psychological tests, see a counsellor in training, receive information). These items were correlated with the identified factors to aid in the interpretation of the data. Personal commitment was positively related to the expectancy to take tests, do assignments, to understand the purpose of what happens in an interview, and to continue for more than three sessions. Those expecting facilitative conditions were more likely to expect to understand the purpose of what happens in an interview, to continue more than three sessions, and to believe that counselling involved more than just answering questions or receiving information. Those expecting expert counsellors also expected to only get help for serious problems, to only answer questions, to get help in one or two sessions, and to solve their problems once and for all. Lastly, those expecting a nurturant counsellor expected to get the help they needed after several sessions.

The same questionnaire was used by Ka-Wai, Yuen, & Tinsley (1981) who reported that compared to Chinese, African, and Iranian students, American college students expected a counsellor to be less directive and protective, and expected themselves to be more responsible for improvement. The non-American students expected a more passive role with a directive, nurturing authority figure.

Tinsley, Brown, de St. Aubin, & Lucek (1984) used the EAC questionnaire to compare 236 university students on their perceptions of different help givers. Students expected that in helping sessions with a psychologist or psychiatrist they would be more open and motivated and that the session would be more concrete, immediate, and beneficial than a session with a career or college counsellor.

The studies by Tinsley and colleagues have been a major step in examining a broader range of student perceptions of college counselling centres and in documenting gender differences in perceptions. It remains unclear, however, if student perceptions of such centres are similar to the public's perceptions of community clinics or hospitals. Most students perceive counselling centres as more appropriate for vocational or academic concerns than for personal or emotional difficulties (Geslo & Karl, 1974; Wilcove & Sharp, 1971), raising the possibility that results based on student populations may not generalize to the public at large. The present research explores this issue

further by examining a broad range of perceptions held by a sample of the general public. The relationship between perceptions and help seeking behavior is also investigated.

Appendix D

Covering Letters to PSC and K-W Client Samples

THE UNIVERSITY OF MANITOBA

PSYCHOLOGICAL SERVICE CENTRE

Winnipeg, Manitoba
Canada R3T 2N2
(204) 474-9222

Dear (Name of Client),

This survey is part of a program by the Psychological Service Centre, University of Manitoba, to improve our understanding of our client's viewpoints and opinions about mental health services. Knowledge of our client's perceptions and concerns can help us improve our services and make them more relevant to our client's needs.

This survey is also part of a larger research program which examines the general public's perceptions of mental health services. This research is being conducted by myself under the direct supervision of Dr. Lillian Esses, Department of Psychology, University of Manitoba. The research will help us better understand which beliefs or opinions encourage people to utilize our services and identify some of the concerns which discourage people from seeking assistance. This information can help us design better public information programs and make our services more available to those who need them.

As an individual who has decided to use our services, your ideas and beliefs can make a valuable contribution to this program. I know it is not a good time to ask you to complete a questionnaire and I am sure you have other concerns which are more important at this time. Unfortunately, an important aspect of our survey is to identify our client's concerns before their ideas are influenced by the actual experience of therapy or counselling. For these reasons we would be very grateful if you could spare the time and energy to complete the enclosed questionnaire.

The questionnaire is completely anonymous and confidential and you need not identify yourself on the questionnaire. Simply return it in the enclosed, stamped envelope. Completion of the survey is optional and your decision to participate will have no influence on the services you will be receiving.

Thank you for taking the time to read this letter and I hope you will be able to complete the survey. Should you have any questions or concerns regarding this survey please contact Christine Loff at 475-1280.

Sincerely,

David Ricketts, M.A.
Psychological Service Centre
University of Manitoba

THE UNIVERSITY OF MANITOBA PSYCHOLOGICAL SERVICE CENTRE Winnipeg, Manitoba
Canada R3T 2N2
(204) 474-9222

Dear (Name of Client),

This survey is part of a program by the Psychological Service Centre, University of Manitoba, to improve our understanding of our client's viewpoints and opinions about mental health services. Knowledge of our client's perceptions and concerns can help us improve our services and make them more relevant to our client's needs.

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I recognize that you and your family are seeking family therapy for help with family problems or with problems relating to one family member. Consequently some questions on this survey may be inappropriate for you as they reflect expectations about individual counselling. I would appreciate that when necessary, you answer the questions as though you yourself were seeking individual therapy. Please note that specific perceptions or expectations about family or group therapy have not been included in the survey.

The questionnaire is completely anonymous and confidential and you need not identify yourself. Simply return it in the enclosed, stamped envelope. Completion of the survey is optional and your decision to participate will have no influence on the services you will be receiving.

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Sincerely,

David Ricketts, M.A.
Psychological Service Centre
University of Manitoba

KITCHENER-WATERLOO HOSPITAL

835 King Street West, Kitchener, Ontario N2G 1G3. Telephone 742-3611

G. A. COX F.A.C.H.A.
EXECUTIVE DIRECTOR

Dear Sir/Madam,

This survey is part of a program by the Kitchener-Waterloo Hospital to improve our understanding of our client's viewpoints and opinions about mental health services. Knowledge of our client's perceptions and concerns can help us improve our services and make them more relevant to our client's needs.

This survey is also part of a larger research program which examines the general public's perceptions of mental health services. This research can help us better understand which beliefs or opinions encourage people to utilize our services and identify some of the concerns which discourage people from seeking assistance. This information can help us design better public information programs and make our services more available to those who need them.

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Thank you for taking the time to read this letter and I hope you will be able to complete the survey. Should you have any questions regarding the survey or if the survey raises any concerns please call Dr. Debby Zweig at 742-3611, Extension 4230.

Sincerely,

David Ricketts, M.A.
Outpatient Department
Kitchener-Waterloo Hospital

KITCHENER-WATERLOO HOSPITAL

835 King Street West, Kitchener, Ontario N2G 1G3. Telephone 742-3611

G. A. COX F.A.C.H.A.
EXECUTIVE DIRECTOR

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I recognize that you and your family are seeking family therapy for help with family problems or with problems relating to one family member. Consequently, some questions on this survey may be inappropriate for you as they reflect expectations about individual counselling. I would therefore appreciate, that when necessary, you answer the questions as though either yourself or a family member was seeking individual therapy. Please note that specific perceptions or expectations about family therapy or group therapy have not been included in this survey.

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Sincerely,

David Ricketts, M.A.
Outpatient Department
Kitchener-Waterloo Hospital

Appendix E

Information Provided to PSC and K-W Therapists

INFORMATION REGARDING RESEARCH AT THE P.S.C.

Dear Colleague,

I am conducting a research program at the P.S.C. which is part of my dissertation examining the public's perceptions of professional help and the implications for help seeking. The purpose of the research is to empirically identify and compare the perceptions and expectations of both help seekers and the general public regarding the process and outcome of therapy. Particular emphasis will be placed on identifying and comparing the perceptions people have of the procedures associated with professional help and the worries and concerns people have about seeking help from mental health professionals. Differences in the perceptions of help seekers (clients) and non-help seekers (the general public) may identify those expectations or beliefs which are likely to facilitate or hinder help seeking.

The research at the P.S.C. requires that adult clients seeking services be surveyed by a mail out questionnaire prior to their beginning therapy (either prior to their intake meeting or at least prior to their being seen in therapy). This means that many patients whom you see will have completed the questionnaire prior to their first appointment with you. While the research does not directly involve therapists, I thought you should be aware of the nature of this research and it's possible implications. Following is a brief summary of the research and the procedures utilized. A copy of the questionnaire and the lette is in each intake book. Included in the summary is a section discussing the possible implications of the research for therapists.

Summary of Research

The entire study entails a mail out questionnaire survey of 350 randomly selected members of the general public living in the city of Winnipeg. The general public's perceptions will be compared to the perceptions of first-time help seekers at both the P.S.C. and the Out-patient Department of the Kitchener-Waterloo Hospital. Approximately 40 clients will be surveyed from the P.S.C. The goal of this research is to identify those perceptions facilitative of help seeking. For this reason it is important that clients be surveyed before they begin therapy as the process of therapy itself may well influence a client's perceptions.

In regards to the research at the P.S.C., the clients surveyed will be those over 18 years of age. For adolescents under 18 and who are seen with their families, the questionnaire will be sent to one of their parents.

Seriously disturbed patients or patients in crisis will be excluded to avoid undue pressure from being exerted on a help seeker in a time of crisis.

The questionnaire and covering letter will be mailed to consenting clients who will be asked to return them in an enclosed, stamped envelope. As the questionnaire is anonymous, there would be no follow-up or reminder letters for the client sample.

Questionnaire and Covering Letter Design

The questionnaire consists of five sections and is attached to this summary.The major section consists of statements representing opinions and beliefs about what might happen in psychotherapy or counseling. Clients are asked to rate on a 7-point scale how strongly they agree or disagree with each statement. The randomly ordered statements have been chosen to reflect possible expectations about the procedures or process of therapy as well as possible concerns about seeking help. The statements have been chosen to reflect the following categories (four or five statements per category): embarassment, lack of interest by the therapist, confidentiality, cost, availability of services, loss of self reliance, and fear of receiving negative feedback. Items reflecting the process of therapy include beliefs about the duration of therapy, the type of person who seeks therapy, and the techniques or procedures associated with therapy. The techniques will be grouped a priori to reflect the following categories: medical, supportive-philosophical, advice-guidance, behavioral, collaborative exploration, causal-insight, and testing-diagnosis. Factor analysis will eventually determine the underlying factors represented by these items.

The covering letter is also attached. It explains to the clients the purpose of the research and informs them that the questionnaire is completely anonymous and that completion of the questionnaire is optional. Clients are assured that their decision to respond will in no way influence the services provided. The letter also gives my assistant's name and telephone number should they require additional information or have any concerns or questions regarding the research. The front page of the questionnaire should also answer any questions not answered in the covering letter.

Implications for Therapists

It is possible that the questionnaire might increase a new client's concerns about the nature of therapy or the consequences of seeking help. I have tried to minimize this problem by ensuring that the wording of items is balanced for both positive and negative wording. Clients also have a name and telephone number to call should they have any concerns.

Clients will also be told to feel free to discuss any therapy related issues or concerns raised by the questionnaire with their therapists. It may be useful, therefore, for you to watch for specific concerns of your clients and be aware of the nature of this research. Any client's questions regarding the actual research (ie. purpose, logistics,etc.) should of course be referred back to my research assistant, Christine Loff. Clients might, however, have other concerns relating to the natur therapy that would be better addressed by their own therapist.

Benefits to Clients and the P.S.C.

I hope this research will prove useful to clients as well as staff at the P.S.C. In completing the questionnaire, clients will have an opportunity to consider the implications of therapy and it should help, them to verbalize and recognize their own beliefs and attitudes. Hopefu this will give them the opportunity and stimulus to discusss these issue with their therapists. Dealing with such issues may make therapy more productive and effecient. I think the P.S.C. staff will also find the study's results beneficial and I will be providing the P.S.C. with a copy of the results. This research should identify some of the preconc clients have about therapy and document their concerns. Such informatic may help therapists provide more accurate information during the first interviews and perhaps allay the client's concerns.

I hope this brief summary adequately explains the nature of this research. Should you have any further questions please contact Christine Loff at the P.S.C. or Psych Dept. Should your clients make any comments or have any concerns about the research I would also appre you passing this information on to Christine.

Sincerely,

David Ricketts

Information Regarding Research at the K-W Hospital

June 1, 1984

I am conducting a research program here at K-W Hospital which is part of a dissertation examining the public's perceptions of professional help and the implications for help seeking. The purpose of the research is to empirically identify and compare the perceptions and expectation of both help seekers and the general public regarding the process and outcome of therapy. Particular emphasis will be placed on identifying and comparing the perceptions people have of the procedures associated with professional help and the worries and concerns people have about seeking help from mental health professionals. Differences in the perceptions of help seekers (clients) and non-help seekers (the general public) may identify those expectations or beliefs which are likely to facilitate or hinder help seeking.

The research at the hospital requires that adult patients seeking services from the OPD adult and adolescent teams be surveyed by a mail out questionnaire prior to their beginning therapy (either before being seen at intake or at least prior to their being seen by their therapist). This means that many patients whom you pick up after June 10 will have completed the questionnaire prior to their first appointment with you. While the research does not directly involve therapists, I thought you should be aware of the nature of this research and it's possible implications. Attached is a brief summary of the research and the procedures utilized. The questionnaire and covering letter are also attached. Included in the summary is a section discussing the possible implications of the research for therapists.

Summary of Research

The entire study entails a mail out questionnaire survey of 350 randomly selected members of the general public living in the city of Winnipeg. The general public's perceptions will be compared to the perceptions of first-time help seekers at the Psychological Service Centre, University of Manitoba, and at the Outpatient Department of the K-W Hospital. It is proposed that approximately 35 clients be surveyed from the K-W Hospital. The goal of this research is to identify those perceptions which are facilitative of help seeking. For this reason it is important that clients be surveyed before they actually begin therapy as the process of therapy itself may well influence a client's perceptions.

In regards to the research here at K-W Hospital, the clients surveyed will be those seeking help from the adult and adolescent teams. For adolescents under the age of 18 and who are being seen with their families, the questionnaire will be sent to one of their parents.

Potential clients will be identified in consultation with Gary and Pam who will be asking clients for their consent to participate. Any seriously disturbed patients or patients in crisis will be excluded to avoid undue pressure from being exerted on a help seeker in a time of crisis.

The questionnaire and covering letter will be mailed to consenting clients who will be asked to return them in an enclosed, stamped envelope. As the questionnaire is anonymous, there would be no follow-up or reminder letters for the client sample.

Questionnaire and Covering Letter Design

The questionnaire consists of five sections and is attached to this summary.The major section consists of statements representing opinions and beliefs about what might happen in psychotherapy or counseling. Clients are asked to rate on a 7-point scale how strongly they agree or disagree with each statement. The randomly ordered statements have been chosen to reflect possible expectations about the procedures or process of therapy as well as possible concerns about seeking help. The statements have been chosen to reflect the following categories (four or five statements per category): embarassment, lack of interest by the therapist, confidentiality, cost, availability of services, loss of self reliance, and fear of receiving negative feedback. Items reflecting the process of therapy include beliefs about the duration of therapy, the type of person who seeks therapy, and the techniques or procedures associated with therapy. The techniques will be grouped a priori to reflect the following categories: medical, supportive-philosophical, advice-guidance, behavioral, collaborative exploration, causal-insight, and testing-diagnosis. Factor analysis will eventually determine the underlying factors represented by these items.

The covering letter is also attached. It explains to the clients the purpose of the research and informs them that the questionnaire is completely anonymous and that completion of the questionnaire is optional. Clients are assured that their decision to respond will in no way influence the services provided. The letter also gives my name and telephone number should they require additional information or have any concerns or questions regarding the research. The front page of the questionnaire should also answer any questions not answered in the covering letter.

Implications for Therapists

It is possible that the questionnaire might increase a new client's concerns about the nature of therapy or the consequences of seeking help. I have tried to minimize this problem by ensuring that the wording of items is balanced for both positive and negative wording. Clients also have my name and telephone number to call should they have any concerns.

Clients will also be told to feel free to discuss any therapy related issues or concerns raised by the questionnaire with their therapists. It may be useful, therefore, for you to watch for specific concerns of your clients and be aware of the nature of this research. Any client's questions regarding the actual research (ie. purpose, logistics etc.) should of course be referred back to myself. Clients might, however, have other concerns relating to the nature of therapy that would be better addressed by their own therapist. I would also appreciate any feedback on any comments or concerns raised by your clients.

Benefits to the K-W Hospital

I hope this research will prove beneficial to the staff at the hospital. I will of course provide the hospital with a final copy of the study as well as specific information and results regarding the perceptions of outpatients at the hospital. The implications of these findings will be discussed. The results should identify some of the preconceptions which clients have about therapy as well as documenting their possible worries and concerns. Such information may help therapists provide more accurate information during the first interviews and perhaps allay the client's concerns. The identification of those perceptions which hinder or hamper help seeking by the general public may also help to orient education campaigns or suggest changes to make services more accessible to those in need.

I hope this brief summary adequately explains the nature of this research. Should you have any further questions please contact me at extension 3159.

Sincerely,

David Ricketts
Psychology Intern
Outpatient Dept.

Appendix F

Covering Letter and Reminder Letters Sent to Public

HE UNIVERSITY OF MANITOBA

PSYCHOLOGICAL SERVICE CENTRE

Winnipeg, Manitoba
Canada R3T 2N2

(204) 474-9222

Dear (Name of Respondent),

The enclosed survey is part of a research program by the University of Manitoba designed to improve our understanding of the general public's perceptions and viewpoints of mental health services. This research is being conducted by myself under the direct supervision of Dr. Lillian Esses, Department of Psychology, University of Manitoba.

In order to provide the best service possible it is necessary for professionals to accurately understand the general public's perceptions of services such as psychotherapy or counselling. Unfortunately, very little is known about the public's viewpoint at this time. The current research program was undertaken to help remediate this situation. The results of this study will help professionals to change their services to make them more relevant to the needs of the general public. The results will also help professionals design better educational programs regarding their services. Such programs would ensure that people make informed choices whether counselling or psychotherapy is appropriate for themselves or their families.

Your name is one of 350 chosen by chance from a list of all residences in the City of Winnipeg. I would be very grateful if you could spare the time and effort to complete the enclosed survey. I appreciate the difficulties in finding the time to complete a questionnaire, but the survey should only take about one-half hour and I think you will find the questions quite interesting. Even if you are unfamiliar with the subject or even if you have reservations about the value of psychotherapy, your viewpoint and contribution is extremely important.

Further information and directions are printed on the questionnaire. Once completed, please return it in the stamped and addressed envelope provided. I can assure you that your reply is strictly confidential. Please note that the return envelopes are numbered only to allow follow-up of any missing returns.

Thank you for taking the time to read this letter and I hope you will find the opportunity to participate in this research. Should you have any questions or concerns please contact Christine Loff at 475-1280.

Sincerely,

David Ricketts, M.A.
Psychological Service Centre
University of Manitoba

Last week a questionnaire seeking your opinions and perceptions of mental health services was mailed to you. Your name was drawn by chance from a list of all households in the City of Winnipeg.

If the survey has already been completed and returned, please accept our sincere thanks. If you plan to participate but have yet to complete the questionnaire, please do so at your earliest convenience. If you have any questions, or if you did not receive the questionnaire, please contact Christine Loff at 475-1280.

Sincerely,

David Ricketts, M.A.
University of Manitoba

THE UNIVERSITY OF MANITOBA

PSYCHOLOGICAL SERVICE CENTRE

Winnipeg, Manitoba
Canada R3T 2N2

(204) 474-9222

Dear (Name of Respondent),

Several weeks ago you were mailed a questionnaire seeking your opinions and perceptions of mental health services. This research is designed to help professionals better understand the public's viewpoints so that services such as counselling can be made more relevant to the public's needs.

Questionnaires are often lost in the mail, misplaced, or perhaps forgotten, so I have taken this opportunity to remind you of this research and have enclosed an extra copy of the survey along with another stamped, self addressed envelope.

I recognize the difficulties in finding the time and energy to reply to mail surveys and I am sure your time is both limited and valuable. However, for scientifically accurate results, a very high return rate is necessary. We need everyone's opinions if at all possible. Should you be hesitating because you are unfamiliar with the subject, or because you have negative perceptions, please be assured that your contribution is both necessary and highly valued.

Your assistance will be greatly appreciated and I trust you will find the time to participate. Please feel free to call Christine Loff at 475-1280, should you have any further questions or concerns.

Sincerely,

David Ricketts, M.A.
Psychological Service Centre
University of Manitoba

Appendix G

Questionnaires Sent to the Public, PSC and K-W Samples

**

PERCEPTIONS OF MENTAL HEALTH SERVICES

QUESTIONNAIRE

The accompanying letter describes the purpose of this survey and explains why you have been asked to participate. The following information should answer some of the other questions you may have.

Who is being asked to participate?	Three hundred households were randomly selected from the Winnipeg City Directory.
What happens to my returned questionnaire?	All the information you provide is strictly confidential. All survey research at the University of Manitoba is supervised by an ethical review board to protect your privacy. The information from the surveys will be grouped or "pooled" together. Neither your name nor individual answers will appear in any results or reports. Please note that the return envelopes are numbered to facilitate follow up of missing returns.
Who will be able to see my questionnaire?	
Will I get a copy of the results?	Yes, but only if you enclose a slip of paper with your name and address. We will gladly mail you a summary report.

**
Note: The original questionnaire was printed in booklet form.

Why should I participate?

Your participation is of course optional but, if our research is to be accurate and useful, a very high participation rate is essential. As the number of individuals surveyed is limited, your opinion is very important to us.

What if I know very little about psychotherapy or mental health services?

Even if you know very little about psychotherapy, have few strong feelings, or even very negative perceptions, your reply is equally important and useful.

How should I complete the questionnaire?

Please complete it truthfully and without discussing it with other people. Do not spend too much time on any one question as your first answer or feeling is usually correct. There are no right or wrong answers and this is not a test of any kind.

What is "psychotherapy" or "counselling"?

Psychotherapy (also called counselling or professional help) is a service provided by mental health professionals to help people with personal or family problems. This may include emotional, behavioral, or relationship problems or any other problems resulting in worry, stress or unpleasant feelings.

What are "mental health professionals"?

These are professionally trained individuals who provide psychotherapy or counselling. For the purpose of this survey, they should be considered to include psychologists, psychiatrists, social workers, and psychiatric nurses.

QUESTIONNAIRE

I. Below is a list of opinions and beliefs about what might happen in psychotherapy or counselling. Please circle the number which describes how strongly you agree or disagree with each statement.

Circle "1" if you STRONGLY DISAGREE
Circle "2" if you DISAGREE
Circle "3" if you SOMEWHAT DISAGREE
Circle "4" if you NEITHER AGREE NOR DISAGREE
Circle "5" if you SOMEWHAT AGREE
Circle "6" if you AGREE
Circle "7" if you STRONGLY AGREE

Each statement begins:

"IF I RECEIVED PSYCHOTHERAPY OR COUNSELLING....."

	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE		SOMEWHAT AGREE	AGREE	STRONGLY AGREE
my friends and relatives would admire me for seeking help.....	1	2	3	4	5	6	7
I would learn a new life philosophy to help me look at the brighter side of life.....	1	2	3	4	5	6	7
the therapist would explain why I have certain problems.....	1	2	3	4	5	6	7
the therapist would focus on how to change my behavior.....	1	2	3	4	5	6	7
the therapist would tell me what's wrong with me.....	1	2	3	4	5	6	7
the therapist would analyse my personality and point out areas I needed to change.....	1	2	3	4	5	6	7
the therapist would mostly listen while I did most of the talking.....	1	2	3	4	5	6	7
the therapist would think I was weak or lacked common sense.....	1	2	3	4	5	6	7
I doubt I would be able to talk about my true feelings or even admit them to myself.....	1	2	3	4	5	6	7
I would learn to be less emotional.....	1	2	3	4	5	6	7
each appointment I would spend a lot of time waiting for my therapist..	1	2	3	4	5	6	7
the therapist would likely be well adjusted and have few emotional problems of his or her own.....	1	2	3	4	5	6	7
I would be asked to give extensive details about past medical problems.	1	2	3	4	5	6	7
I would get a lot of advice on how to solve my problems.....	1	2	3	4	5	6	7
the therapist would recommend hobbies or books to take my mind off my worries.....	1	2	3	4	5	6	7
the therapist would try to cheer me up by pointing out things I do well	1	2	3	4	5	6	7

	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE		SOMEWHAT AGREE	AGREE	STRONGLY AGREE
I might feel worse at times if I talked about the things that worry me.	1	2	3	4	5	6	7
I would worry that I was being disloyal to my family.....	1	2	3	4	5	6	7
my religous faith and beliefs would be strengthened and encouraged.....	1	2	3	4	5	6	7
I would be afraid that I was admitting defeat.....	1	2	3	4	5	6	7
the therapist would tell me what to do or show me a new way to solve my problem.....	1	2	3	4	5	6	7
the therapist would identify my character traits which contributed to my problems.....	1	2	3	4	5	6	7
the therapist would measure my brain waves to identify any mental problems.....	1	2	3	4	5	6	7
I would very likely receive a drug prescription.....	1	2	3	4	5	6	7
the therapist would give me sympathy, encouragement and reassurance....	1	2	3	4	5	6	7
it would be easy to find a therapist I could afford to see.....	1	2	3	4	5	6	7
I would worry about how my relatives and family would feel or react if I made real changes in my life.....	1	2	3	4	5	6	7
The therapist would tell me to do things I'd rather not do.....	1	2	3	4	5	6	7
the therapist would be very interested in me as a person.....	1	2	3	4	5	6	7
I would learn to increase my will power so I could better control my behavior.....	1	2	3	4	5	6	7
the therapist might change me without me even knowing how it happened..	1	2	3	4	5	6	7
I might be asked to give up some of my moral beliefs and principles....	1	2	3	4	5	6	7
the therapist might be too well off financially to understand or "tune in" to my problems.....	1	2	3	4	5	6	7
I would be reassured that there was nothing wrong with my mind.....	1	2	3	4	5	6	7
the therapist would point out the differences between what I am and what I want to be.....	1	2	3	4	5	6	7
the therapist would give me assignments to do outside of the therapy sessions.....	1	2	3	4	5	6	7

	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE		SOMEWHAT AGREE	AGREE	STRONGLY AGREE
the therapist would point out how I should behave.....	1	2	3	4	5	6	7
I would discover how my problems relate to my upbringing.....	1	2	3	4	5	6	7
the therapist would encourage me to take chances and be less fearful...	1	2	3	4	5	6	7
the therapist would be sure to recognize the important role my family and friends play in my problems and worries.....	1	2	3	4	5	6	7
I would be embarassed to tell my family and friends.....	1	2	3	4	5	6	7
the therapist would analyse my dreams to discover the cause of my problems.....	1	2	3	4	5	6	7
I might be told I needed electro-shock treatment.....	1	2	3	4	5	6	7
the therapist would try to convince me to change my mind about some things.....	1	2	3	4	5	6	7
the therapist would take all of my problems seriously.....	1	2	3	4	5	6	7
I would always be able to trust my therapist.....	1	2	3	4	5	6	7
the therapist would fully understand and value my cultural or traditional beliefs.....	1	2	3	4	5	6	7
the therapist would try to help me put my feelings into words so that I could understand them.....	1	2	3	4	5	6	7
I might get too embarassed to talk about extremely personal problems...	1	2	3	4	5	6	7
the therapist would give me tests to identify my disorder.....	1	2	3	4	5	6	7
I would be afraid that what I say might get back to others such as my boss.....	1	2	3	4	5	6	7
it would be easy to talk to the therapist and explain why I am upset...	1	2	3	4	5	6	7
the therapist would help me practice what I need to learn.....	1	2	3	4	5	6	7
I would learn to meditate to increase my peace of mind.....	1	2	3	4	5	6	7
the therapist would discuss his or her own life experiences and relate them to my problems or situations.....	1	2	3	4	5	6	7
the therapist would have values similar to my own.....	1	2	3	4	5	6	7
others might be disappointed that I didn't talk to them instead of a therapist.....	1	2	3	4	5	6	7

	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE		SOMEWHAT AGREE	AGREE	STRONGLY AGREE
finding a therapist, making an appointment, and getting to each appointment would create a lot of hassles and difficulties.....	1	2	3	4	5	6	7
the therapist would teach me new skills such as assertiveness or relaxation.....	1	2	3	4	5	6	7
I would never be afraid of being told I needed to stay in a hospital for awhile.....	1	2	3	4	5	6	7
a therapist of any age would be just as helpful to me.....	1	2	3	4	5	6	7
it would take a great deal of effort and time to make any real changes in my life or situation.....	1	2	3	4	5	6	7
I would only seek psychotherapy if my problems were extremely serious..	1	2	3	4	5	6	7
the therapist would expose things I'd rather forget or not know.....	1	2	3	4	5	6	7

Below is a list of opinions or beliefs about psychotherapy or counselling. As in the previous section, please circle the number which describes how strongly you agree or disagree with each statement.

	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE		SOMEWHAT AGREE	AGREE	STRONGLY AGREE
A person with a strong character can get over mental conflicts on their own and would have little need for professional help.....	1	2	3	4	5	6	7
Although there are clinics for people with mental troubles, I do not have much faith in them.....	1	2	3	4	5	6	7
I would want to get professional help if I was worried or upset for a long period of time.....	1	2	3	4	5	6	7
A person with a serious emotional disturbance would probably feel most secure in a good mental hospital.....	1	2	3	4	5	6	7
Emotional difficulties, like many things, tend to work out by themselves.....	1	2	3	4	5	6	7

	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE		SOMEWHAT AGREE	AGREE	STRONGLY AGREE
If I believed I was having a mental breakdown, my first inclination would be to get professional help.....	1	2	3	4	5	6	7
If a good friend asked for my advice about a mental problem, I might recommend that he or she seek professional help.....	1	2	3	4	5	6	7
The idea of talking about problems with a mental health professional strikes me as a poor way to get rid of emotional conflicts.....	1	2	3	4	5	6	7
A person with emotional problems is not likely to solve them alone; he or she is likely to solve them with professional help.....	1	2	3	4	5	6	7
At some time in the future I might want to have psychological counselling.....	1	2	3	4	5	6	7
I would rather be advised by a close friend than by a mental health professional, even for a serious emotional problem.....	1	2	3	4	5	6	7
If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in counselling or psychotherapy.....	1	2	3	4	5	6	7
There are times when I have felt completely lost and would have welcomed professional help with a personal or emotional problem...	1	2	3	4	5	6	7
A person should work out his or her own problems; getting psychological counselling would be a last resort.....	1	2	3	4	5	6	7
I would rather live with certain mental conflicts than go through the ordeal of getting professional help.....	1	2	3	4	5	6	7
Psychotherapy would have doubtful value for a person like myself.....	1	2	3	4	5	6	7

III. Below is a list of problems people might need help with. Mental health professionals may or may not be qualified or trained to help people with each of these problems. Please circle the number which indicates how well qualified or trained, you believe mental health professionals are to help people with each of these problems.

	VERY UNQUALIFIED		UNQUALIFIED		SLIGHTLY UNQUALIFIED		SLIGHTLY QUALIFIED		QUALIFIED		VERY QUALIFIED
Fears and anxieties	1		2		3	4	5		6		7
Bad habits such as smoking, overeating, or drinking	1		2		3	4	5		6		7
Backaches or headaches	1		2		3	4	5		6		7
Financial problems and worries	1		2		3	4	5		6		7
Criminal or unlawful behavior	1		2		3	4	5		6		7
Children's misbehavior	1		2		3	4	5		6		7
Legal questions or concerns	1		2		3	4	5		6		7
Neurological (Brain) disorders	1		2		3	4	5		6		7

IV.

a) A friend of yours is feeling very depressed and sad and there seems to be no clear reason why. Your friend has felt this way for several months. How helpful to your friend would the following people be? (please circle the appropriate number)

	NOT AT ALL HELPFUL				HELPFUL		VERY HELPFUL
Social worker	1	2	3	4	5	6	7
General Practitioner (family physician)	1	2	3	4	5	6	7
Psychologist	1	2	3	4	5	6	7
Clergyman	1	2	3	4	5	6	7
Psychiatrist	1	2	3	4	5	6	7
Non-professional helpers (eg. faith healer, psychics)	1	2	3	4	5	6	7
Other family or friends	1	2	3	4	5	6	7

b) For no apparent reason, a friend of yours is so anxious, nervous and tense that he or she can no longer sleep at night. How helpful to your friend would the following people be?

	NOT AT ALL HELPFUL						VERY HELPFUL
Other family or friends	1	2	3	4	5	6	7
Social worker	1	2	3	4	5	6	7
General practitioner (family physician)	1	2	3	4	5	6	7
Clergyman	1	2	3	4	5	6	7
Psychiatrist	1	2	3	4	5	6	7
Non-professional helpers (eg. faith healer, psychic)	1	2	3	4	5	6	7
Psychologist	1	2	3	4	5	6	7

c) A married couple you know is having marriage problems they just can't seem to solve. How helpful to the couple would the following people be?

	NOT AT ALL HELPFUL						VERY HELPFUL
Non-professional helpers (eg. faith healer, psychic)	1	2	3	4	5	6	7
Other family or friends	1	2	3	4	5	6	7
Social worker	1	2	3	4	5	6	7
General practitioner (family physician)	1	2	3	4	5	6	7
Psychologist	1	2	3	4	5	6	7
Clergyman	1	2	3	4	5	6	7
Psychiatrist	1	2	3	4	5	6	7

V.

a) Please list the initials of all adult persons (friends, relatives, spouse and family) who are important to you and with whom you discuss personal problems or worries. It might be helpful to recall a recent emotional crisis and recall who you spoke to or would have liked to have spoken to. If you would prefer not to list initials, any letter or symbols will do so long as you recognize who that person is. You may have only one or two names on your list, or you may have quite a few. There is no correct number.

Initials	Relation to Yourself (circle one)	How helpful is this person's support and advice? NOT AT ALL HELPFUL 1 2 3 4 5 6 7 VERY HELPFUL	How many other people on your list does this person know and visit?
_____	Family/Relative Friend	1 2 3 4 5 6 7	_____
_____	Family/Relative Friend	1 2 3 4 5 6 7	_____
_____	Family/Relative Friend	1 2 3 4 5 6 7	_____
_____	Family/Relative Friend	1 2 3 4 5 6 7	_____
_____	Family/Relative Friend	1 2 3 4 5 6 7	_____
_____	Family/Relative Friend	1 2 3 4 5 6 7	_____
_____	Family/Relative Friend	1 2 3 4 5 6 7	_____
_____	Family/Relative Friend	1 2 3 4 5 6 7	_____

b) Please review your list and in the second column circle either "Family/Relative" or "Friend", to indicate each person's relation to yourself.

c) In the third column, please circle the number which describes how helpful you find each person's support or advice.

d) Lastly, please review your list again and for each person indicate, in the far right column, how many of the other people on your list that person knows and visits even when you are not with them.

ADDITIONAL INFORMATION

Age: _____

Sex: _____

Your Occupation: _____

Spouse's Occupation: _____

If presently retired or unemployed, please indicate previous occupation.

Marital Status:
( ) Single
( ) Married
( ) Living as Married
( ) Separated or Divorced
( ) Widowed

Number of Children: _____

Religous Affiliation: _____

Ethnic Background or Origin: _____

1) Have you previously received psychotherapy or counselling for a personal problem? ( ) YES ( ) NO

2) If you answered NO to the last question then please answer the next question. Have you ever had a personal problem for which you might have used psychotherapy or counselling? ( ) YES ( ) NO

3) Do you have any friends or relatives who have sought psychotherapy or counselling? ( ) YES ( ) NO

4) How long do you think psychotherapy or counselling lasts? Please guess if unsure.

( ) ONE TO THREE SESSIONS

( ) EIGHT TO TWELVE SESSIONS (2 - 4 months)

( ) MORE THAN TWENTY-FOUR SESSIONS (more than six months)

This is the end of the survey. I would like to thank you for your time and energy in completing this questionnaire. Your help is very much appreciated. Remember, if you would like a copy of the results of the overall survey be sure to enclose a note with your name and address. Additional comments are welcomed and space is available on the next page.

Do you have any comments you would like to add?

PERCEPTIONS OF MENTAL HEALTH SERVICES**

QUESTIONNAIRE

The accompanying letter describes the purpose of this survey and explains why you have been asked to participate. The following information should answer some of the other questions you may have:

When should I return the questionnaire?	Please complete and return it as soon as possible. It is important that it be returned before your first appointment.
Who is being asked to participate?	All individuals making an appointment at the Psychological Service Centre, University of Manitoba. This survey program will continue for several months.
Why should I participate?	Your participation is optional but, if our research is to be accurate and useful, we need a very high participation rate. As the number of individuals surveyed is limited, your response and opinion is very important to us.

** Note: The original questionnaire was printed in booklet form.

What happens to my returned questionnaire? Who will be able to see my questionnaire?	Your questionnaire is anonymous and your identity cannot be determined. All survey research at the University of Manitoba and the Psychological Service Centre is supervised by an ethical review board. The information from all questionnaires will be grouped or "pooled" together. Neither your name nor your individual answers will appear in any of the results.
Will I get a copy of the results?	Yes, but only if you enclose a slip of paper with your name and address. We will gladly mail you a summary of the results!
How should I complete the questionnaire?	Please complete it truthfully and without discussing it with other people. Do not spend too much time on any one question as your first answer or feeling is usually correct. There are no right or wrong answers and this is not a test of any kind.
After completing the questionnaire should I discuss it with my therapist or counsellor?	It is not necessary but if the survey raises any concerns or questions about therapy then feel free to discuss them with your therapist.
What if I know nothing about psychotherapy?	Even if you know nothing about psychotherapy or have few strong feelings, your reply is just as important and useful.
What is "psychotherapy" or "counselling"?	Psychotherapy (also called counselling or professional help) is a service provided by mental health professionals to help people with personal or family problems. This may include emotional, behavioral or relationship problems or any other problems resulting in worry, stress or unpleasant feelings.
What are "mental health professionals"?	These are professionally trained individuals who provide psychotherapy or counselling. For the purpose of this survey, they should be considered to include psychologists, psychiatrists, social workers, and psychiatric nurses.

QUESTIONNAIRE

Below are a list of opinions and beliefs about what might happen in psychotherapy or counselling. Please circle the number which describes how strongly you agree or disagree with each statement.

Circle "1" if you STRONGLY DISAGREE
Circle "2" if you DISAGREE
Circle "3" if you SOMEWHAT DISAGREE
Circle "4" if you NEITHER AGREE NOR DISAGREE
Circle "5" if you SOMEWHAT AGREE
Circle "6" if you AGREE
Circle "7" if you STRONGLY AGREE

Each statement begins:
"WHEN I RECEIVE PSYCHOTHERAPY OR COUNSELLING....."

	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE		SOMEWHAT AGREE	AGREE	STRONGLY AGREE
my friends and relatives will admire me for seeking help.....	1	2	3	4	5	6	7
I will learn a new life philosophy which will help me to look at the brighter side of life.....	1	2	3	4	5	6	7
the therapist will explain why I have these problems.....	1	2	3	4	5	6	7
the therapist will focus on how to change my behavior.....	1	2	3	4	5	6	7
the therapist will tell me what's wrong with me.....	1	2	3	4	5	6	7
the therapist will analyse my personality and point out areas I need to change.....	1	2	3	4	5	6	7
the therapist will mostly listen while I do most of the talking.....	1	2	3	4	5	6	7
the therapist may think that I am weak or lack common sense.....	1	2	3	4	5	6	7
I doubt I will be able to talk about my true feelings or even admit them to myself.....	1	2	3	4	5	6	7
I will learn how to be less emotional.....	1	2	3	4	5	6	7
each appointment I will spend a lot of time waiting for my therapist..	1	2	3	4	5	6	7
my therapist will likely be well adjusted and have few emotional problems of his or her own.....	1	2	3	4	5	6	7
I will be asked to give extensive details about past medical problems.	1	2	3	4	5	6	7
I will get a lot of advice on how to solve my problems.....	1	2	3	4	5	6	7
the therapist will recommend hobbies or books to take my mind off my worries.....	1	2	3	4	5	6	7
the therapist will try to cheer me up by pointing out things I do well	1	2	3	4	5	6	7

	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE		SOMEWHAT AGREE	AGREE	STRONGLY AGREE
I might feel worse at times if I talked about the things that worry me	1	2	3	4	5	6	7
I will worry that I am being disloyal to my family	1	2	3	4	5	6	7
my religous faith and beliefs will be strengthened and encouraged	1	2	3	4	5	6	7
I will be afraid that I am admitting defeat	1	2	3	4	5	6	7
the therapist will tell me what to do or show me a new way to solve my problem	1	2	3	4	5	6	7
the therapist will identify my character traits which contribute to my problems	1	2	3	4	5	6	7
the therapist may measure my brain waves to identify any mental problems	1	2	3	4	5	6	7
I will very likely receive a drug prescription	1	2	3	4	5	6	7
the therapist will give me sympathy, encouragement and reassurance	1	2	3	4	5	6	7
it will be easy to find a therapist whom I can afford to see	1	2	3	4	5	6	7
I will worry about how my relatives and family will feel or react if I make real changes in my life	1	2	3	4	5	6	7
the therapist will tell me to do things I'd rather not do	1	2	3	4	5	6	7
the therapist will be very interested in me as a person	1	2	3	4	5	6	7
I will learn to increase my will power so I can better control my behavior	1	2	3	4	5	6	7
the therapist might change me without me even knowing how it happened.	1	2	3	4	5	6	7
I may be asked to give up some of my moral beliefs and principles	1	2	3	4	5	6	7
my therapist may be too well off financially to understand or "tune in" to my problems	1	2	3	4	5	6	7
I will be reassured that there is nothing wrong with my mind	1	2	3	4	5	6	7
the therapist will point out the difference between what I am and what I want to be	1	2	3	4	5	6	7
my therapist will give me assignments to do outside the therapy sessions	1	2	3	4	5	6	7

	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE		SOMEWHAT AGREE	AGREE	STRONGLY AGREE
my therapist will point out how I should behave.....	1	2	3	4	5	6	7
I will discover how my problems relate to my upbringing.....	1	2	3	4	5	6	7
my therapist will encourage me to take chances and be less fearful...	1	2	3	4	5	6	7
my therapist will be sure to recognize the important role my family and friends play in my problems and/or worries.....	1	2	3	4	5	6	7
I will be embarassed to tell my family and friends.....	1	2	3	4	5	6	7
my therapist will analyse my dreams to discover the cause of my problems.....	1	2	3	4	5	6	7
I may be told I need electro-shock treatment.....	1	2	3	4	5	6	7
my therapist will try to convince me to change my mind about some things.....	1	2	3	4	5	6	7
my therapist will take all of my problems seriously.....	1	2	3	4	5	6	7
I will always be able to trust my therapist.....	1	2	3	4	5	6	7
my therapist will fully understand and value my cultural or traditional beliefs.....	1	2	3	4	5	6	7
my therapist will try to help me put my feelings into words so that I can understand them.....	1	2	3	4	5	6	7
I may get too embarassed to talk about extremely personal problems...	1	2	3	4	5	6	7
my therapist will give me tests to identify my disorder.....	1	2	3	4	5	6	7
I will be afraid that what I say may get back to others such as my boss.....	1	2	3	4	5	6	7
it will be easy to talk to my therapist and explain why I am upset...	1	2	3	4	5	6	7
my therapist will help me practice what I need to learn.....	1	2	3	4	5	6	7
I will learn to meditate to increase my peace of mind.....	1	2	3	4	5	6	7
my therapist will discuss his or her own life experiences and relate them to my problems or situation.....	1	2	3	4	5	6	7
my therapist will have values similar to my own.....	1	2	3	4	5	6	7
Others may be disappointed I didn't talk to them instead of a therapist.....	1	2	3	4	5	6	7

	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE		SOMEWHAT AGREE	AGREE	STRONGLY AGREE
finding a therapist, making an appointment, and getting to each appointment will create a lot of hassles and difficulties.....	1	2	3	4	5	6	7
my therapist will teach me new skills such as assertiveness or relaxation.....	1	2	3	4	5	6	7
I would never be afraid of being told I needed to stay in the hospital for awhile.....	1	2	3	4	5	6	7
a therapist of any age would be just as helpful to me.....	1	2	3	4	5	6	7
it will take a great deal of effort and time to make any real changes in my life or situation.....	1	2	3	4	5	6	7
I would only seek psychotherapy if my problems were extremely serious	1	2	3	4	5	6	7
my therapist would expose things I'd rather forget or not know.....	1	2	3	4	5	6	7
my therapist would identify my character traits which contribute to my problems.....	1	2	3	4	5	6	7

II Below is a list of problems people might need help with. Mental health professionals may or may not be qualified or trained to help people with each of these problems. Please circle the number which indicates how well qualified or trained, you believe mental health professionals are to help people with each of these problems.

	VERY UNQUALIFIED	UNQUALIFIED	SLIGHTLY UNQUALIFIED		SLIGHTLY QUALIFIED	QUALIFIED	VERY QUALIFIED
Fears and anxieties.....	1	2	3	4	5	6	7
Bad habits such as smoking, overeating, or drinking.....	1	2	3	4	5	6	7
Backaches or headaches.....	1	2	3	4	5	6	7
Financial problems and worries.....	1	2	3	4	5	6	7
Criminal or unlawful behavior.....	1	2	3	4	5	6	7
Children's misbehavior.....	1	2	3	4	5	6	7
Legal questions or concerns.....	1	2	3	4	5	6	7
Neurological or brain disorders.....	1	2	3	4	5	6	7

III

a) A friend of yours is feeling very depressed and sad and there seems to be no clear reason why. Your friend has felt this way for several months. How helpful to your friend would the following people be? (please circle the appropriate number)

	NOT AT ALL HELPFUL			HELPFUL			VERY HELPFUL
Social worker	1	2	3	4	5	6	7
General Practitioner (family physician)	1	2	3	4	5	6	7
Psychologist	1	2	3	4	5	6	7
Clergyman	1	2	3	4	5	6	7
Psychiatrist	1	2	3	4	5	6	7
Non-professional helpers (eg. faith healer, psychics)	1	2	3	4	5	6	7
Other family or friends	1	2	3	4	5	6	7

b) For no apparent reason, a friend of yours is so anxious, nervous, and tense that he or she can no longer sleep at night. How helpful to your friend would the following people be?

	NOT AT ALL HELPFUL			HELPFUL			VERY HELPFUL
Other family or friends	1	2	3	4	5	6	7
Social worker	1	2	3	4	5	6	7
General Practitioner (family physician)	1	2	3	4	5	6	7
Clergyman	1	2	3	4	5	6	7
Psychiatrist	1	2	3	4	5	6	7
Non-professional helpers (eg. faith healer, psychic)	1	2	3	4	5	6	7
Psychologist	1	2	3	4	5	6	7

c) A married couple you know is having marriage problems they just can't seem to solve. How helpful to the couple would the following people be?

	NOT AT ALL HELPFUL			HELPFUL			VERY HELPFUL
Non-professional helpers (eg. faith healer, psychic)	1	2	3	4	5	6	7
Other family or friends	1	2	3	4	5	6	7
Social worker	1	2	3	4	5	6	7
General Practitioner (family physician)	1	2	3	4	5	6	7
Psychologist	1	2	3	4	5	6	7
Clergyman	1	2	3	4	5	6	7
Psychiatrist	1	2	3	4	5	6	7

IV

a) Please list the initials of all adult persons (friends, relatives, spouse and family) who are important to you and with whom you discuss personal problems or worries. It might be helpful to recall a recent emotional crisis and recall who you spoke to or would have liked to have spoken to. If you would prefer not to list initials, any letters or symbols will do so long as you recognize who that person is. You may have only one or two names on your list, or you may have quite a few. There is no correct number.

Initials	Relation to Yourself (circle one)	How helpful is this person's support and advice? NOT AT ALL HELPFUL — HELPFUL — VERY HELPFUL	How many other people on your list does this person know and visit?
_____	Famiy/Relative Friend	1 2 3 4 5 6 7	_____
_____	Family/Relative Friend	1 2 3 4 5 6 7	_____
_____	Family/Relative Friend	1 2 3 4 5 6 7	_____
_____	Family/Relative Friend	1 2 3 4 5 6 7	_____
_____	Family/Relative Friend	1 2 3 4 5 6 7	_____
_____	Family/Relative Friend	1 2 3 4 5 6 7	_____
_____	Family/Relative Friend	1 2 3 4 5 6 7	_____
_____	Family/Relative Friend	1 2 3 4 5 6 7	_____

b) Please review your list and in the second column circle either "Family/Relative" or "Friend" to indicate each person's relation to yourself.

c) In the third column, please circle the number which describes how helpful you find each person's support or advice.

d) Lastly, please review your list again and for each person indicate, in the far right column, how many of the other people on your list that person knows and visits even when you are not with them.

ADDITIONAL INFORMATION

Age: _____

Sex: _____

Your Occupation: _____

Spouse's Occupation: _____

If presently retired or unemployed, please indicate previous occupation.

Marital Status:
( ) Single
( ) Married
( ) Living as Married
( ) Separated or Divorced
( ) Widowed

Number of Children: _____

Religous Affiliation: _____

Ethnic Background or Origin: _____

1) Have you previously received psychotherapy or counselling for a personal problem? ( ) YES ( ) NO

2) Do you have any friends or relatives who have sought psychotherapy or counselling? ( ) YES ( ) NO

3) How long have you been considering psychotherapy or counselling before you decided to make an appointment?

( ) ONE WEEK
( ) TWO TO FOUR WEEKS
( ) ONE TO SIX MONTHS
( ) SIX MONTHS TO ONE YEAR
( ) ONE TO TWO YEARS
( ) MORE THAN TWO YEARS

4) How hesitant or reluctant were you to make an appointment for psychotherapy or counselling?

( ) EXTREMELY HESITANT
( ) VERY HESITANT
( ) HESITANT
( ) SLIGHTLY HESITANT
( ) NOT HESITANT AT ALL

5) Who referred you for psychotherapy or counselling?
(please check one or more)

( ) SELF
( ) RELATIVE OR FAMILY MEMBER
( ) MEDICAL DOCTOR
( ) FRIEND
( ) OTHER (Please specify: _____)

6) Did the person who referred you for help have any previous personal experience in seeking psychotherapy or counselling?

( ) YES
( ) NO
( ) DON'T KNOW

7) How long do you expect your counselling to last? Please guess if unsure.

( ) ONE TO THREE SESSIONS
( ) EIGHT TO TWELVE SESSIONS (2 - 4 months)
( ) MORE THAN TWENTY-FOUR SESSIONS (more than six months)

Do you have any comments you would like to add?

This is the end of the survey. I'd like to thank you for your time and energy in completing the questionnaire. Your help is very much appreciated. Remember, if you would like a copy of the results of the overall survey be sure to enclose your name and address.

PERCEPTIONS OF MENTAL HEALTH SERVICES

QUESTIONNAIRE

The accompanying letter describes the purpose of this survey and explains why you have been asked to participate. The following information should answer some of the other questions you may have.

When should I return the questionnaire?	Please complete and return it as soon as possible. It is important that it be returned before your first appointment.
Who is being asked to participate?	All individuals making an appointment at the K-W Hospital Out Patient Department. This survey program will continue for several months.
Why should I participate?	Your participation is optional but, if our research is to be accurate and useful, we need a very high participation rate. As the number of individuals surveyed is limited, your response and opinion is very important to us.

Note: The original questionnaire was printed in booklet form.

Appendix H

Covering Letter and Preliminary Questionnaire

April 4, 1984

Dear Homeowner,

I am a graduate student in clinical psychology and, as part of my doctorate degree, I am conducting research on the public's opinion and viewpoints about mental health services. Understanding the public's expectations or perceptions of psychotherapy and counseling can help professionals to design better public information programs. The results of this research may also help to make services more accessible to the public and more relevant to the public's needs. Surprisingly, there is very little known about the public's perceptions of mental health services.

At present, I am developing a questionnaire which will eventually be used in a large scale survey of the general public. In order to develop this final questionnaire I am presently asking a small, randomly chosen group of homeowners to assist me by completing the enclosed questionnaire, which is a preliminary version. Your house was one of 50 chosen by chance and I would be very grateful if you could spare the time and effort to complete the questionnaire. I appreciate the difficulties in finding time to complete a questionnaire but the survey should only take about one-half hour and I think you will find the questions quite interesting. Even if you know very little about therapy or counseling your opinion is equally valuable.

The survey is completely anonymous and confidential and you need not identify yourself. I will be calling on you next Sunday to inquire whether you wish to participate and, if possible, to collect the completed questionnaire. If you prefer not to be disturbed perhaps you could leave the completed questionnaire i your mailbox or on your front porch next Sunday? Should you like a copy of the final results of this research please enclose a slip of paper with your name and address.

Thank you for taking the time to read this letter and I hope you will be able to complete this survey. Should you have any questions or concerns please feel free to call me in the evening at 743-4238.

Sincerely.

David S. Ricketts, M.A.
415-57 Union St. East
Waterloo, Ontario
N2J 1B9

PERCEPTIONS OF MENTAL HEALTH SERVICES*

QUESTIONNAIRE

The accompanying letter describes the purpose of the survey and explains why you have been asked to participate. The following information should answer some of the other questions you may have.

Who is being asked to complete this preliminary questionnaire?	Fifty randomly chosen homeowners or residents in the Waterloo area.
What if I know absolutely nothing about psychotherapy or counseling and have never needed or wanted mental health services?	Even if you know nothing about psychotherapy, have few strong feelings, or even if you have negative perceptions of counseling, your opinion and viewpoint is just as important and useful.
Why should I participate?	Your help is of course optional, but if this research is to be accurate and useful I need a very high participation rate. As the number of individuals surveyed is very limited, your opinion is very important to me.
What happens to my returned questionnaire? Who will be able to see my questionnaire?	Your answers are confidential and you need not give your name. No one except myself will see your individual answers. Neither your name nor any identifying information will appear in any published or printed reports.
How should I complete the questionnaire?	Please complete it truthfully and without discussing the answers with other people. There are no right or wrong answers and this is <u>not</u> a test of any kind.
What is psychotherapy or counseling?	Psychotherapy (also called counseling or professional help) is a service provided by mental health professionals to help people with personal or family problems. This may include emotional, behavioral, or relationship problems or any other problems resulting in worry, stress or unpleasant feelings.
What are "mental health professionals"?	These are professionally trained individuals who provide psychotherapy or counseling. For the purpose of this questionnaire, they should be considered to include psychologists, psychiatrists, social workers, and psychiatric nurses.
Do I have to write comments?	Additional written comments are not necessary but I would be extremely pleased if you jotted down any impressions, concerns, criticisms or suggestions regarding this research and questionnaire. As this is a preliminary draft of the final questionnaire your comments can be useful in improving the final version. There is space on the last page for comments if you would like to add any.

*Note: The original questionnaire sent to respondents was printed in larger type on legal size paper. This copy has been reduced to 75% size for inclusion in the appendix.

QUESTIONNAIRE

I Below are a list of opinions and beliefs about what might happen in psychotherapy or counseling. Please circle the number which describes how strongly you agree or disagree with each statement.

Circle "1" if you STRONGLY DISAGREE
Circle "2" if you DISAGREE
Circle "3" if you SOMEWHAT DISAGREE
Circle "4" if you NEITHER AGREE NOR DISAGREE
Circle "5" if you SOMEWHAT AGREE
Circle "6" if you AGREE
Circle "7" if you STRONGLY AGREE

Each statement begins: "IF I RECEIVED PSYCHOTHERAPY OR COUNSELING....."

	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE		SOMEWHAT AGREE	AGREE	STRONGLY AGREE
friends and relatives would admire my courage in seeking help	1	2	3	4	5	6	7
I'd learn new ideas or philosophy so that I could look at the bright side of life	1	2	3	4	5	6	7
the therapist would devise a detailed plan for me to follow	1	2	3	4	5	6	7
I'd probably get the "same old advice"	1	2	3	4	5	6	7
the therapist would explain why I have these problems	1	2	3	4	5	6	7
the therapist would try to persuade me to change my personality	1	2	3	4	5	6	7
the therapist would expect me to be brief and to the point	1	2	3	4	5	6	7
the therapist would focus on how to change my behavior	1	2	3	4	5	6	7
I would discover that my problems are due to my upbringing	1	2	3	4	5	6	7
I'd probably waste the therapist's time with my problems	1	2	3	4	5	6	7
the therapist would help me to identify what I do that is part of the problem	1	2	3	4	5	6	7
I'd see the therapist for more than 20 sessions	1	2	3	4	5	6	7
the therapist would analyse my personality and point out areas I need to change	1	2	3	4	5	6	7
I would find the cause of my problems and this would help me to solve them	1	2	3	4	5	6	7
the therapist would mostly listen while I did most of the talking	1	2	3	4	5	6	7
the therapist would think that I was weak or lacked common sense	1	2	3	4	5	6	7
I'd be too embarassed to talk to the therapist about any personal problems	1	2	3	4	5	6	7
I'd learn how to forget about my problems	1	2	3	4	5	6	7
my problems would involve things I could never talk about or even admit to myself	1	2	3	4	5	6	7
I'd learn how to control my emotions better	1	2	3	4	5	6	7
I'd discover new ways of looking at my problems	1	2	3	4	5	6	7
I doubt the therapist could be counted on to help in a crisis	1	2	3	4	5	6	7
I would spend a lot of time waiting for my appointments	1	2	3	4	5	6	7
I would be asked to talk about past illnesses and medical problems	1	2	3	4	5	6	7
I would get a lot of advice on how to solve my problems	1	2	3	4	5	6	7
the therapist would recommend hobbies or books to take my mind off my worries	1	2	3	4	5	6	7
I'd see the therapist for 3 to 20 sessions	1	2	3	4	5	6	7
a lot of time would be spent in therapy identifying what my problems are	1	2	3	4	5	6	7
the therapist would try to cheer me up by pointing out things I do well	1	2	3	4	5	6	7
I'd feel stronger and more self reliant	1	2	3	4	5	6	7
I'd probably feel worse if I was forced to talk about things that worry me	1	2	3	4	5	6	7
the therapist would likely use hypnosis to help me solve my problems	1	2	3	4	5	6	7
I would be forced to talk about others behind their back	1	2	3	4	5	6	7
the therapist would expose things I would rather forget or not know	1	2	3	4	5	6	7
I'd see the therapist for 1 or 2 sessions	1	2	3	4	5	6	7
I'd feel like I was admitting defeat	1	2	3	4	5	6	7
I would find out that I can never solve my problems	1	2	3	4	5	6	7
the therapist would tell me what to do or show me a new way to solve my problems	1	2	3	4	5	6	7
I'd be responsible for solving my own problems	1	2	3	4	5	6	7
the therapist would measure my brain waves to identify any mental problems	1	2	3	4	5	6	7
I would be very likely to receive a drug prescription	1	2	3	4	5	6	7
the therapist would give me sympathy, encouragement, and reassurance	1	2	3	4	5	6	7
the therapist would tell me to do things I'd rather not do	1	2	3	4	5	6	7
I could easiy find a therapist whom I could afford to see	1	2	3	4	5	6	7
the therapist would be very interested in my problems	1	2	3	4	5	6	7
my friends and relatives would be happy that I was getting some help	1	2	3	4	5	6	7
I would never worry about the therapist talking behind my back	1	2	3	4	5	6	7
I would learn to increase my will power so I could better control my behavior	1	2	3	4	5	6	7
the therapist would try and trick me into changing even if I didn't really want to	1	2	3	4	5	6	7

the therapist would want to change my morals and values.....	1	2	3	4	5	6	7
I'd be reassured that there was nothing wrong with my mind.....	1	2	3	4	5	6	7
I'd find out that my problems are not my own fault.....	1	2	3	4	5	6	7
the therapist would point out the difference between what I am and what I want to be.....	1	2	3	4	5	6	7
the therapist would give me assignments to do outside the therapy sessions.....	1	2	3	4	5	6	7
the therapist would identify my character traits which contribute to my problems;.....	1	2	3	4	5	6	7
the therapist would encourage me to take chances and be less fearful.....	1	2	3	4	5	6	7
the therapist would try to help me uncover things about myself which I am unaware of.....	1	2	3	4	5	6	7
friends and relatives would think I am crazy.....	1	2	3	4	5	6	7
the therapist would teach me to be more responsible for myself and my own needs.....	1	2	3	4	5	6	7
the therapist would try to analyse my dreams to discover my problems.....	1	2	3	4	5	6	7
I might be told I needed electro-shock treatment.....	1	2	3	4	5	6	7
the therapist would try to convince me to change my mind about some things.....	1	2	3	4	5	6	7
the therapist would take all of my problems seriously.....	1	2	3	4	5	6	7
I would be sure I could trust my therapist.....	1	2	3	4	5	6	7
the therapist would try to help me put my feelings into words so that I understand them...	1	2	3	4	5	6	7
the treatment would be a shared responsibility between the therapist and myself.....	1	2	3	4	5	6	7
the therapist would give me tests to identify my disorder.....	1	2	3	4	5	6	7
it would be easy to talk to the therapist and explain why I was upset.....	1	2	3	4	5	6	7
I would be afraid that what I say might be told to others.....	1	2	3	4	5	6	7
the therapist would advise me to relax more, maybe take a holiday to get away.....	1	2	3	4	5	6	7
the therapist would help me practice the things I need to learn.....	1	2	3	4	5	6	7
I would learn to meditate to increase my peace of mind.....	1	2	3	4	5	6	7
I'd probably be able to find a therapist with values similar to my own.....	1	2	3	4	5	6	7
I would know how to find a good therapist.....	1	2	3	4	5	6	7
others would be disappointed I didn't talk to them instead of a therapist.....	1	2	3	4	5	6	7
I might find out too much about myself and my weaknesses.....	1	2	3	4	5	6	7
I'd probably end up arguing with the therapist.....	1	2	3	4	5	6	7
finding a therapist, making an appointment and getting there would be too much trouble....	1	2	3	4	5	6	7
the therapist would teach me how to better control my friends and family.....	1	2	3	4	5	6	7
I would never be afraid of being sent to a hospital by my therapist.....	1	2	3	4	5	6	7
I would think less of myself for having had to seek help.....	1	2	3	4	5	6	7
the therapist would probably understand and accept my type of lifestyle.....	1	2	3	4	5	6	7

II. Below is a list of opinions or beliefs about psychotherapy or counseling. As in the last section, please circle the number which describes how strongly you agree or disagree with each statement.

	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE		SOMEWHAT AGREE	AGREE	STRONGLY AGREE
A person with a strong character can get over mental conflicts on their own and would have little need for professional help.....	1	2	3	4	5	6	7
Although there are clinics for people with mental troubles, I do not have much faith in them.....	1	2	3	4	5	6	7
Psychotherapy is mostly for people who like to talk a lot and who talk well.....	1	2	3	4	5	6	7
I would want to get professional help if I was worried or upset for a long period of time.	1	2	3	4	5	6	7
A person with a serious emotional disturbance would probably feel most secure in a good mental hospital.....	1	2	3	4	5	6	7
Psychotherapy is mostly for people with lots of friends and relatives.....	1	2	3	4	5	6	7
Emotional difficulties, like many things, tend to work out by themselves.....	1	2	3	4	5	6	7
If I believed I was having a mental breakdown, my first inclination would be to get professional help.....	1	2	3	4	5	6	7
Most therapists are too educated or "out of touch" to help with most people's problems....	1	2	3	4	5	6	7
If a good friend asked for my advice about a mental problem I might recommend that he or she seek professional help.....	1	2	3	4	5	6	7

	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE		SOMEWHAT AGREE	AGREE	STRONGLY AGREE
The idea of talking about problems with a mental health professional strikes me as a poor way to get rid of emotional conflicts	1	2	3	4	5	6	7
A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help	1	2	3	4	5	6	7
Most therapists would have trouble understanding common, everyday problems	1	2	3	4	5	6	7
At some time in the future I might want to have psychological counseling	1	2	3	4	5	6	7
Mental health professionals seldom have their own mental or emotional problems	1	2	3	4	5	6	7
I would rather be advised by a close friend than by a mental health professional, even for a serious emotional problem	1	2	3	4	5	6	7
Therapy is mostly for the rich or well educated	1	2	3	4	5	6	7
If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy	1	2	3	4	5	6	7
There are times when I have felt completely lost, and would have welcomed professional advice for a personal or emotional problem	1	2	3	4	5	6	7
A person should work out his or her own problems; getting psychological counseling would be a last resort	1	2	3	4	5	6	7
I would rather live with certain mental conflicts than go through the ordeal of getting professional help	1	2	3	4	5	6	7
Psychotherapy would have doubtful value for a person like myself	1	2	3	4	5	6	7
I would only seek psychotherapy if my problems were extremely serious	1	2	3	4	5	6	7

III Below is a list of eight possible problems people might need help with. Mental health professionals might or might not be qualified or trained to help with each of these problems. Please circle the number which indicates how well qualified or trained you believe mental health professionals are to help people with each of these problems.

Circle "1" if you think they are VERY UNQUALIFIED
Circle "2" if you think they are UNQUALIFIED
Circle "3" if you think they are SLIGHTLY UNQUALIFIED
Circle "4" if you think they are NEITHER QUALIFIED NOR UNQUALIFIED
Circle "5" if you think they are SLIGHTLY QUALIFIED
Circle "6" if you think they are QUALIFIED
Circle "7 if you think they are VERY QUALIFIED

	VERY UNQUALIFIED	UNQUALIFIED	SLIGHTLY UNQUALIFIED		SLIGHTLY QUALIFIED	QUALIFIED	VERY QUALIFIED
Nervousness or anxiety	1	2	3	4	5	6	7
Bad habits such as smoking, overeating, or drinking	1	2	3	4	5	6	7
Backaches or headaches	1	2	3	4	5	6	7
Financial problems and worries	1	2	3	4	5	6	7
Anger outbusts, bad temper	1	2	3	4	5	6	7
Children's misbehavior	1	2	3	4	5	6	7
Legal questions or concerns	1	2	3	4	5	6	7
Strange thoughts or ideas	1	2	3	4	5	6	7

IV Pretend you had a friend who was feeling very depressed and sad and no matter what you or your friend did that friend still felt miserable. Your friend asks where he or she should go for help. How likely would you be to suggest that the friend seek help from a.....

	VERY UNLIKELY						VERY LIKELY
Social worker	1	2	3	4	5	6	7
General Practitioner (medical doctor)	1	2	3	4	5	6	7
Psychologist	1	2	3	4	5	6	7
Clergyman	1	2	3	4	5	6	7
Psychiatrist	1	2	3	4	5	6	7
Other (please specify)_	1	2	3	4	5	6	7

Pretend you had a friend who for several months has been so anxious, nervous and tense that he or she could no longer sleep at night. Nothing you or your friend does seems to help and your friend is not even sure why he or she is so anxious. Your friend asks where he or she should go for help. How likely would you be to suggest that the friend seek help from a .....

	VERY UNLIKELY						VERY LIKELY
Psychiatrist.....	1	2	3	4	5	6	7
Social worker.....	1	2	3	4	5	6	7
General Practitioner (medical doctor).....	1	2	3	4	5	6	7
Psychologist.....	1	2	3	4	5	6	7
Clergyman.....	1	2	3	4	5	6	7
Other (please specify)_____.....	1	2	3	4	5	6	7

A married couple you know is having marriage problems that they just can't seem to solve. They ask you where they should go for help. How likely would you be to suggest that this couple seek help from a.....

	VERY UNLIKELY						VERY LIKELY
Clergyman.....	1	2	3	4	5	6	7
Psychiatrist.....	1	2	3	4	5	6	7
Social worker.....	1	2	3	4	5	6	7
General Practitioner (medical doctor).....	1	2	3	4	5	6	7
Psychologist.....	1	2	3	4	5	6	7
Other (please specify)_____.....	1	2	3	4	5	6	7

V a) Please list the initials of all adult persons (friends, relatives, and family) who are important to you and with whom you discuss personal problems or worries. If you would prefer not to list their initials, any letters or symbols will do so long as you can recognize who that person is. You may have only one or two names on your list, or you may have quite a few. There is no correct number.

Initials	Relation to Yourself (please circle one)	How helpful is this person's support and advice? VERY UNHELPFUL 1 2 3 4 5 6 7 VERY HELPFUL	How many other people on your list does this person know and visit?
_____	Family Relative Friend	1 2 3 4 5 6 7	_____
_____	Family Relative Friend	1 2 3 4 5 6 7	_____
_____	Family Relative Friend	1 2 3 4 5 6 7	_____
_____	Family Relative Friend	1 2 3 4 5 6 7	_____
_____	Family Relative Friend	1 2 3 4 5 6 7	_____
_____	Family Relative Friend	1 2 3 4 5 6 7	_____
_____	Family Relative Friend	1 2 3 4 5 6 7	_____
_____	Family Relative Friend	1 2 3 4 5 6 7	_____

b) Please review your list and in the second column circle either "Family", "Relative", or "Friend" in order to indicate each person's relation to yourself.

c) In the third column, please circle the number which describes how helpful or unhelpful you find each person's support or advice.

d) Lastly, please review your list again and for each person indicate, in the far right column, how many of the other people on your list that person knows and visits even when you are not with them.

ADDITIONAL INFORMATION

Age: ____ Your Occupation: _____ (If presently unemployed and looking for work please indicate previous occupation).

Sex: ____ Spouse's Occupation: _____

Marital Status: ( ) single
( ) married or living together
( ) separated or divorced

Number of children: _____

Religous Affiliation: _____

Ethnic Background or Origin: _____

1) Have you previously received psychotherapy or counseling for personal problems? ( ) YES
( ) NO

2) If you answered NO to the last question then please answer the next question. Have you ever had a personal problem for which you might have used psychotherapy or counseling? ( ) YES
( ) NO

3) Do you have any friends or relatives who have sought psychotherapy or counseling for an emotional problem? ( ) YES
( ) NO

Do you have any comments you would like to add? Were particular questions or sections too confusing or difficult to answer? Do you have any other beliefs or perceptions of mental health services which were not identified by this questionnaire?

Thank you very much for your time and energy in completing this questionnaire.
Your help is greatly appreciated.

This is an additional section of the questionnaire. If you have the time I would appreciate you completing this one as well.

Listed below are a number of statements concerning personal attitudes and traits. Please read each item and decide whether the statement is "true" or "false" as it pertains to you personally. Please circle the correct answer.

Before voting I thouroughly investigate the qualifications of all candidates	TRUE	FALSE
I never hesitate to go out of my way to help someone in trouble...	TRUE	FALSE
It is sometimes hard for me to go on with my work if I am not encouraged.....	TRUE	FALSE
I have never intensely disliked anyone.....	TRUE	FALSE
On occasion I have had doubts about my ability to succeed in life.	TRUE	FALSE
I sometimes feel resentful when I don't get my way.....	TRUE	FALSE
I am always careful about my manner of dress.....	TRUE	FALSE
My table manners at home are as good as when I eat in a restaurant	TRUE	FALSE
If I could get into a movie without paying and be sure I was not seen, I would probably do it.....	TRUE	FALSE
On a few occasions, I have given up doing something because I thought too little of my ability.....	TRUE	FALSE
I like to gossip at times.....	TRUE	FALSE
There have been times when I've felt like rebelling against people in authority even though I knew they were right.....	TRUE	FALSE
No matter who I am talking to, I'm always a good listener.....	TRUE	FALSE
I can remember "playing sick" to get out of something.....	TRUE	FALSE
There have been occasions when I took advantage of someone.....	TRUE	FALSE
I'm always willing to admit it when I make a mistake.....	TRUE	FALSE
I always try to practice what I preach.....	TRUE	FALSE
I don't find it particularly difficult to get along with loud mouthed, obnoxious people.....	TRUE	FALSE
I sometimes try to get even rather than forgive and forget.....	TRUE	FALSE
When I don't know something I don't mind admitting it.....	TRUE	FALSE

I am always courteous, even to people who are disagreeable..... TRUE FALSE

At times I have really insisted on having things my own way..... TRUE FALSE

There have been occasions when I felt like smashing things..... TRUE FALSE

I would never think of letting someone else be punished for my wrong-doing..... TRUE FALSE

I never resent being asked to return a favour..... TRUE FALSE

I have never been irked when people expressed ideas very different from my own..... TRUE FALSE

I never make a long trip without checking the safety of my car.... TRUE FALSE

There have been times when I was quite jealous of the good fortunes of others..... TRUE FALSE

I have almost never felt the urge to tell someone off..... TRUE FALSE

I am sometimes irritated by people who ask favours of me..... TRUE FALSE

I have never felt that I was punished without cause..... TRUE FALSE

I sometimes think when people have a misfortune they only got what they deserve..... TRUE FALSE

I have never deliberately said something that hurt someone's feelings..... TRUE FALSE

THANK YOU.