An Information-Processing Model of the Decision to Seek Professional Help

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Despite the presence of quality mental health care in many communities, people tend to avoid seeking help and wind up languishing in their problems unnecessarily. For the professional to better understand how to reach these individuals, an information-processing model is presented that examines the effects of people's interpretation of their environment and their symptoms on their decision to seek mental health services. Using the model as a guide, suggestions are presented for practitioners who wish to provide services to those who are in need of professional help, yet are hesitant to obtain it.

Keywords: information processing, help seeking, mental health, professional help

One of the common frustrations of many mental health practitioners is the knowledge that many people are reluctant to seek professional help, even when they desperately need it. The extant literature on professional help seeking has made some progress in understanding the role of specific factors (e.g., public stigma, fears about emotional disclosure) that affect people's professional help-seeking attitudes and intentions. However, surprisingly few models have been developed that focus on the active decision-making processes that might encourage greater use of the available services. Relevant information-processing (Anderson, 1982) and social–cognitive (Bandura, 1997) theories have been available for some time, yet we are unaware of any research linking these concepts to the process of seeking professional help. Such a link would have the advantage of providing mental health professionals with a clearer understanding of the help-seeking process. This would allow them to both improve their ability to reach and serve diverse groups of clients and to provide needed information to the public.

Therefore, the goal of this article is to present an information-processing model of help-seeking decisions to provide a clearer understanding of people's decision to seek help from a mental health professional. We selected an information-processing model because it addresses how people interpret their environment and their ability to respond to that environment, encompassing both self-efficacy and social–cognitive theories. Because we believe that help-seeking decisions are based both on the perception of distress and on the belief in being able to cope (or not) with the distress, an information-processing model seemed the most comprehensive for understanding the process of seeking professional help. Although we present this as a step model, it should be noted that it is neither progressive (i.e., individuals may not experience the process in this exact order) nor inclusive (i.e., not all clients will experience these steps). Indeed, many individuals fall into a habitual pattern with regard to their decision-making. They decide something based not on an evaluation of information but on how they habitually react. This means that they effectively shortcut information processing. This model is, however, developmental, in that most potential clients will often begin at one point and move toward another point. By applying this model, we hope to better

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understand how one's decision to seek professional help might occur from a more unified perspective and offer suggestions based on each step regarding how mental health professionals might effectively reach out to those in need.

Information-Processing and Professional Help-Seeking Model

"How is it that people are able to make sense out of their world, to process information, and think logically, to make plans and act accordingly?" (Heppner & Krauskopf, 1987, p. 380). We believe that the answer to this question offers important knowledge about how best to reach out and serve clients. In marketing professional services to the public, the most important factor may be in understanding *how* an individual thinks about and decides to deal with the distress—be it by resolving a situation, dealing with the symptoms, or avoiding the issue (Heppner & Krauskopf, 1987). How an individual interprets his or her world and chooses to make a specific decision has been presented as a series of cognitive and affective steps (Crick & Dodge, 1994; see also Anderson, 1982). These information-processing steps suggest that individuals (a) encode and interpret internal and external cues, (b) generate and evaluate behavioral options, (c) decide on and enact a selected response, and finally (d) respond to personal and peer evaluations of selected behavior.

Encoding and Interpreting: Step 1

During Step 1, individuals selectively encode and interpret internal and external cues. Encoding, for the most part, refers to paying attention to relevant stimuli. For example, an individual may recognize one morning that he or she does not want to get out of bed or that he or she wants to cry. The person might realize behaviors that used to give pleasure no longer do so, and he or she has difficulty getting excited about previous interests. Regarding external cues, peers may tell an individual that something seems wrong or different about him or her or may get feedback from a supervisor that his or her performance at work is slipping. Interpretation means making sense of these stimuli by accessing a personalized schema from long-term memory and using the schema to make inferences about the encoded cues. In other words, this process "does not happen in a vacuum, but rather occurs in conjunction with the knowledge that one already possesses" (Heppner & Krauskopf, 1987, p. 385).

One of the main factors in the encoding and interpretation process is therefore the personal significance an individual places on a symptom and what it means. Most psychologically relevant stimuli are subjective, and different attributions can be made regarding their importance (Lee, 1996). Not surprisingly, Kessler, Lloyd, Lewis, and Gray (1999) found that those who attributed commonsense explanations for their symptom(s) were less likely to seek professional services. Examples might include mistaking the symptoms of depression for a bad night's sleep, chronic marital difficulties as situational stress, or the symptoms of anxiety as excitement. Furthermore, in a qualitative study, Pill, Prior, and Wood (2001), found that participants who did not believe that symptoms of emotional distress comprised a "legitimate illness" tended to report their own symptoms of emotional distress as "trivial and an inevitable part of normal human existence" (p. 216). These findings may not be troubling for people with mild

problems whose concerns are likely to resolve without professional help. However, for people with more severe problems, interpreting distressing symptoms and cues as nonthreatening may lead to a deterioration in functioning that could be avoided. In effect, it seems that individuals can talk themselves into or out of seeking professional services.

Implications. Two main implications exist at this step. First, people may have difficulty making appropriate decisions about whether to seek professional help because they are not able to accurately recognize or understand what their symptoms mean (Pill et al., 2001). Heppner and Krauskopf (1987) identified this as an issue of "accuracy and completeness" (p. 389). For example, perhaps a person misunderstood his or her symptom(s), paid attention to the wrong symptom(s), or incorrectly identified the source of the symptom(s). The individual may not even recognize he or she is experiencing a symptom of a mental illness or that the symptom is changeable. One common misinterpretation is mistaking a panic attack for a heart attack, which leads people to excessively worry about their health and to ultimately seek medical as opposed to mental health services. Indeed, researchers have suggested that people often do not know a lot about mental health services or mental illness (Jorm et al., 1997; Jorm, 2000) and their perceptions are often based on inaccurate information gathered from media (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Lin, 2002; Wolff, Pathare, Craig, & Leff, 1996).

The second implication of this step involves the idea of short-cutting, which describes the process of responding automatically to stimuli that have been frequently experienced in the past to save cognitive effort (Anderson, 1983). These habitual responses may lead to problems and incorrect assumptions because they are based on limited information (or incomplete encoding). Based on their research with aggressive children, Crick and Dodge (1994) suggested that aggressive children often react aggressively to others because they pay attention only to the first 10% of the information presented them. Upon that limited knowledge, they make a conclusion about the other person (i.e., that they were acting aggressive) that often leads to their own aggression. Similarly, in the presence of psychological distress, maladaptive, rather than adaptive, interpretations are often made quickly in response to a specific stimulus (Beck, 1973).

To correct these problems, education programs that help the public learn how to identify the symptoms of mental illness and educate them as to what the symptoms mean need to be developed. Such efforts would empower the public to make informed judgments about their needs. These programs could directly address (a) the types of symptoms associated with different disorders, (b) the cause of different disorders, (c) the frequency of different symptoms and disorders, (d) the consequences and the causes of mental illness, and (e) the role of social and cultural norms on problem identification and interpretation. These types of programs would better inform the public and allow them to make more appropriate interpretations regarding their mental health. In doing so, the profession may be able to increase the public's awareness of mental issues and thereby minimize misperceptions and reduce the problems associated with misidentifying, mislabeling, or misinterpreting mental health symptoms.

Programs could also be developed to increase the identification or early detection of mental health concerns. Such programs have been used for a number of years for physical health concerns such

as heart disease, diabetes, and cancer (Smedley & Syme, 2000; Truman et al., 2000). Similar campaigns have been implemented in the screening of specific psychological health concerns. For example, the National Depression Screening Days and the subsequent National Anxiety Disorders Screening and National Alcohol Screening Days represent efforts focused on identifying individuals in the community who either have an identified disorder or are at risk for developing a specific disorder (Greenfield et al., 2000, 2003). Some of these programs have been reported to be very successful, identifying thousands of individuals at risk for developing problems and linking them with professional services (Greenfield et al., 2000; Magruder, Norquist, Fiel, Kopans, & Jacobs, 1995). For example, studies following the effectiveness of the National Depression Screening Day have found that up to 65% of those recommended to seek additional evaluations actually do so (Greenfield et al., 1997, 2000). One study found that over 80% of these individuals go on to receive treatment (Greenfield et al., 2000). Similarly, a study on screening for the risk for alcohol abuse and dependence found that 66.9% of a community sample and 9.5% of a college population reported that they had sought additional evaluations after the initial screening (Greenfield et al., 2003). The great potential of these programs is that they are a feasible and cost-effective way to provide individuals with accurate and useful information for the decision-making process.

Furthermore, because many individuals' first contact with a professional is through medical services rather than mental health services (Andrews, Issakidis, & Carter, 2001), it may be important to conduct screenings and provide educational information in general medical practices (Dew, Bromet, Schulberg, Parkinson, & Curtis, 1991). Examples of simple screening tools are becoming more numerous, such as the Alcohol Use Disorders Identification Test (AUDIT; Bohn, Babor, & Kranzler, 1995) and the World Health Organization Well Being Index (WHO-5; Bech, Gudex, & Johansen, 1996). Screening for mental health concerns through general medical practitioner's offices has been shown to be helpful in identifying individuals dealing with mental health concerns (i.e., generalized anxiety disorder and depression; Ansseau, Fischler, Dierick, Mignon, & Leyman, 2005). For example, one study examining the effectiveness of screening for maternal depression by pediatricians found that both paper-based and interview screenings enhanced the detection of mothers at risk for depression (Olson et al., 2005). These types of screenings may also be particularly important for the identification of mental health concerns of minorities. Past researchers have found that individuals of color tend to access mental health services through medical services more often than White individuals (Bhui & Bhugra, 2002; Morgan et al., 2005). However, researchers have also found that individuals of color are less likely to be identified as having a mental health issue by medical personnel than White individuals (Bhui & Bhugra, 2002). As such, multiculturally sensitive screening tools need to be developed and used to help assist in the identification of different disorders.

Generating Options: Step 2

During Step 2, individuals generate behavioral options based on both their previous interpretation of cues and their current goals. First, an individual must decide a problem exists that needs to be addressed. For example, if the original symptom is not interpreted as severe enough, something that will go away on its own, or unchangeable, then no response may be generated. However, if one's interpretation is that he or she is experiencing distress and he or she can do something about this distress, then his or her goal may be psychological relief and he or she may seek help. Consistent with this, Cameron, Leventhal, and Leventhal (1993) found that the presence of a new symptom by itself was not enough, the person had to interpret his or her symptom as severe enough to warrant seeking help. Those who generated care seeking as a viable option were more likely to have interpreted their symptoms as being a specific disorder (68%) than those who did not see professional help as a viable option (46%). In addition, those who sought care were more likely to rate their symptoms as severe and reported greater pain associated with their symptoms (Cameron et al., 1993). The perceived consequences of the symptoms also differed; those who sought help were more likely to consider their symptoms as limiting their activities, being less in their control, and more likely to need treatment (Cameron et al., 1993).

Once a symptom is interpreted as needing attention, behavioral options are generated based on the individual's goals. This process has been referred to as *goal setting* and it is "the process of establishing, with varying degrees of specificity, a possible solution that is aimed at responding to one's internal and external demands" (Heppner & Krauskopf, 1987, p. 396). In other words, once individuals decide on their ultimate goals they must break them down into manageable tasks (Heppner & Krauskopf, 1987). Problems can occur if an individual has difficulty breaking down goals or generating adaptive ways of meeting the goals. For example, one of the reasons that socially anxious individuals may act introverted in social situations is because they have deficits in their ability to generate alternative options and therefore see avoidance as the only way to keep from being ridiculed. Applying this to help seeking, an individual may not generate seeking professional help as an option or choice because of a number of factors, such as limited knowledge about the effectiveness of therapy, the types of professional resources available or what will happen if he or she sought treatment. The challenge to the profession, at this step, may be awareness of how an individual decides on specific goals, and how he or she develops behavioral options to meet these goals. Unfortunately, the professional help-seeking literature has not focused on how options are generated.

Implications. A clear implication of this second step is that professional mental health services need to establish into the normal lexicon of options generated by members of the public. One way to do so may be to better inform the public about (a) what therapy is, (b) when it should be used, and (c) where one can seek services. As mentioned, often the public is not well informed about mental health services (Jorm et al., 1997; Jorm, 2000) and as such, they may be unsure of what their options are. Such information can be presented at number of levels. On one level, individual mental health professionals can work to make mental health services better known in their communities. This could be through outreach efforts in which they talk about mental health services with underserved groups (e.g., at a local school, community group, or church) or through the creative use of personal advertisements designed to promote mental health services (e.g., flyers, Web pages). These issues could also be effectively addressed at the group level. For example, one study that focused on improving the health of African American women targeted churches with large

minority memberships (see Fox, Pitkin, Paul, Carson, & Duan, 1998). These outreach efforts could discuss what types of therapy are conducted, what types of issues and symptoms could be effectively addressed in therapy, and where one can find the services. Deane, Spicer, and Leatham (1992) proposed using videotaped orientation programs in a prison setting to familiarize inmates with therapy and when to seek it. Similar orientation programs might be used in other settings such as schools or workplaces, where a specific audience exists that one wants to reach (Battaglia, Coverdale, & Bushong, 1990; Esters, Cooker, & Ittenbach, 1998). Joyce, Diffenbacher, Greene, and Sorokin (1984) also recommend that large-scale community-based discussion and educational groups for mental health issues be developed to better inform people about when it is appropriate to obtain treatment. Augmenting the public's awareness of these issues might increase the likelihood that seeking professional help would become a more typical response to psychological distress. Importantly, this has the effect of empowerment in that it makes the public more informed, active participants in the decision-making process.

These outreach programs could also be enhanced by including mental health professionals, as well as community and cultural role models (Wills & Depaulo, 1991). The use of prominent sports figures to address male erectile dysfunction (e.g., Addis & Mahalik, 2003) is a recent example, as are using teens to counsel teens and former gang members to reach current gang members. All have been successful at establishing relationships between professionals and group members, and by extension, ensuring that messages about mental health services are heard. Therefore having popular and easily identifiable figures (at the national, state, and local levels) who have experienced different types of psychological distress talk about their experiences can be a key way to reach underserved populations. These individuals could be seen in prepared public service announcements, television programming, or they could work directly with communities, schools, and other local resources to promote mental health services and educate potential clients about the importance of mental health services.

Decision Making: Step 3

During Step 3, individuals decide on a response (from the options generated in the previous step) and implement it. In effect, individuals examine the conditions and actions required of the given situation and decide on a plan to handle it (Anderson, 1983). This process entails a direct evaluation of the potential response(s), with a particular focus on what will happen if the individual were to enact that behavior. It is at this point in the process where individuals begin to increasingly evaluate the costs and benefits of their generated option(s), vis-à-vis their preferred goal, and make a judgment regarding the best course of action. Thus individuals will enact the response that appears to have the highest benefits relative to the costs.

Obstacles can occur if an individual is unable to evaluate fully what the best course of action is or misinterprets the relative costs and benefits. Thus this evaluation process can be hampered by a number of factors such as anxiety (i.e., the individual wanting to make a quick decision to lessen uncertainty), stigma (i.e., the fear of what others will think if the individual chooses a certain behavior), lack of sufficient information (i.e., the individual does not have enough information about the costs and benefits to make

the best decision), feeling of self-efficacy (i.e., the individual has a sense of previous failure or success in dealing with this issue), and previous experience (i.e., whether or not a specific behavior worked for the individual in the past). These decisions are also affected to a large degree by racial, cultural, and gender role norms (i.e., external expectations about how we should behave). Societal, cultural, and gender norms teach us, from an early age, who is an appropriate person to talk to and what we can expect from different types of assistance (Eckenrode, 1983). These lessons can then affect where one decides to seek help when a problem arises. Scholars writing in the area of psychotherapy for men have written of the risks (i.e., sense of failure, loss of control, perception of weakness) posed to men by admitting the need for and seeking mental health services (Addis & Mahalik, 2003; Vogel & Wester, 2003). As such, the potential benefits of professional help might be, in some men's minds, outweighed by the perceived costs of going against their gender role by obtaining the help. Therefore although recognizing that one is distressed is likely to increase a person's consideration of mental health services, it may not lead him or her to actually seek such care (Cohen, Barbano, & Locke, 1976; Silverman, Eichler, & Williams, 1987).

Implications. The implications of this third step need to be considered at the public level (i.e., how mental health professionals describe their services), as well as the potential individual client level (i.e., reaching out to specific groups or individuals). For example, one implication of this step is that mental health providers should try to increase the public's ability to fully evaluate their options. In particular, a need exists to address the *true* relative costs and benefits of seeking help (Fisher, Nadler, & Whitcher-Alagna, 1982). This can be particularly important, because people seem to underestimate the effectiveness of mental health services and overestimate the costs. As with many social behaviors, seeking help may be based more on the perceived costs (e.g. "It will be uncomfortable if I have to tell someone about my pain, and I do not want to be uncomfortable") than a full assessment of the relative benefits (e.g., "I will feel less distress"; Vogel, Wester, Wei, & Boysen, 2005). Consistent with this, researchers have found that concerns about the costs of seeking help outweigh the perceived benefits (Vogel & Wester, 2003; Vogel et al., 2005), and that for many individuals the risks are perceived as large enough that help seeking is seen as a last resort (Hinson & Swanson, 1993).

To counteract these perceptions, mental health professionals may need to accurately inform the public of the true costs and benefits of seeking professional help. This work might include preparatory education and information to (a) reduce the stigma associated with mental illness (Bennett & Lehman, 2001), (b) to reduce the initial anxiety of opening up to another person (Vogel & Wester, 2003), and (c) provide information to increase accurate expectations about what therapy can accomplish (Deane et al., 1992). This type of information could be provided through outreaches and workshops, as well as through other types of educational efforts including informational pamphlets, books, videotapes and audiotapes, posters, Web pages, advertisements, and even commercials. This type of educational effort has the potential to truly affect the lives of those considering seeking professional help, because even brief educational programs can have at least short-term effects on peoples' attitudes (Pinfold et al., 2003).

One particularly important message that may need to be addressed in these efforts may be the reduction in the stigma, the

most cited cost associated with seeking professional help (see Corrigan, 2004). Consistent with this, perceptions of the stigma associated with mental services have been linked to negative attitudes about seeking professional help (Komiya, Good, & Sherrod, 2000; Vogel et al., in press), to a decrease in treatment adherence (Sirey, Bruce, Alexopoulos, Perlick, Friedman, & Meyers, 2001), to the discontinuation of treatment (Sirey, Bruce, Alexopoulos, Perlick, Raue, et al., 2001), and to a lower likelihood of help-seeking behaviors (Cooper, Corrigan, & Watson, 2003). However, the stigma associated with mental health services can be reduced through interventions designed to help individuals see that their problems are (a) not their fault (Schreiber & Haretick, 2002), (b) reversible (Rosen, 2003), (c) will improve through treatment, or (d) a combination of these factors (Mann & Himelein, 2004). Workshops could also be developed that help individuals increase their ability to manage and cope with the stigma associated with mental health services. For example, Enright (1997) suggested cognitive–behavioral strategies to build the necessary skills to manage stigma (see also Holmes & River, 1998). Similarly, Griffiths, Christensen, Jorm, Evans, and Groves (2004) recently implemented a Web-based cognitive–behavioral intervention to reduce the stigma felt by individuals experiencing depression (see http://www.bluepages.anu.edu.au).

Another particularly important cost to address at this step is the fear of having to self-disclose emotional or personal information to a mental health professional. Individuals considering seeking help may fear having to experience painful effect (Vogel & Wester, 2003) and may believe that the therapist will force them to tell all of their deepest thoughts, feelings, and secrets (i.e., that they will be "put on the hot seat"). To address these concerns, it may be important for education and outreach efforts to address why discussing emotional material is beneficial in therapy (Hanna, 2002). For example, most therapists try to create and maintain a safe, confidential environment in which self-disclosures are treated with respect and caring. The goal is not to have a person rehash painful emotions but to help the individual learn how to effectively handle difficult or painful experiences or feelings. In addition, it may be important to inform the public that in therapy the client typically controls what, how much, and when to share emotional information. In fact, a few studies have suggested that "keeping some secrets" is beneficial for clients (Kelly, 1998); thus educating the public that they do not have to reveal everything could be helpful.

A third important cost to address at this step is the negative expectations a person has about therapy. Initial expectations can strongly influence an individual's decision about whether to seek professional help (Tinsley, Brown, de St. Aubin, & Lucek, 1984). Several researchers (Bayer & Peay, 1997; Kelly & Achter, 1995; Takeuchi, Leaf, & Kuo, 1988), for example, have found that individuals who do not seek mental health services have lower expectations about the benefits of seeking help. To address these expectations, education and outreach programs should overtly discuss how therapy works, what is expected of clients, and what types of behaviors they should expect from a therapist. Programs including audiotaped or videotaped information about therapy, for example, have been developed to change individuals' expectations about therapy (see Tinsley, Bowman, & Ray, 1988, for a review). These programs have included role induction, defined as a process through which a person is prepared for psychotherapy by having it described for them (Nelson & Neufeldt, 1996), vicarious training,

and cognitive–experiential exercises to understand the process and rationale for therapy (Battaglia, Coverdale, & Bushong, 1990; Deane, Spicer, & Leatham, 1992; Esters, Cooker, & Ittenbach, 1998; Walitzer, Dermen, & Connors, 1999). Some evidence suggests that these programs increase participants' knowledge about mental health services (Rosen, Walter, Casey, & Hocking, 2000).

Furthermore, mental health professionals should consider developing interventions that normalize the therapeutic process. Recently, Addis and Mahalik (2003) noted how "any strategy that increases the normativeness for particular problems should be effective in facilitating help seeking" (p. 12). Thus help seeking is increased when people see the problem they are dealing with as common (Snyder & Ingram, 1983). Normalizing issues may make seeking treatment less threatening and more typical. Outreach interventions and public marketing could therefore discuss the commonness of mental illness and therapy. Similarly, Heesacker and Pritchard (1992) noted that describing or framing therapy that is consistent with a person's way of viewing the world could increase potential clients' belief that therapy could be helpful to them. For example, Robertson and Fitzgerald (1992) described how practitioners might be able to increase the numbers of male clients who sought treatment by merely relabeling their services as consultation or professional coaching rather than therapy or counseling. Even this relatively simple change in how mental health services are labeled has been demonstrated to play a role in overcoming how the service is perceived (Witt, Moe, Gutkin, & Andrews, 1984) and how the treatment is evaluated (R. C. Woolfolk & Woolfolk, 1979; A. E. Woolfolk, Woolfolk, & Wilson, 1977). Thus reframing mental health services as education, consultation, or coaching may significantly reduce some individual's perceptions of the anticipated costs associated with talking to that professional (Komiya et al., 2000).

An added way to deal with this issue may not be to rename the treatment but to instead describe treatment in ways that would reframe how treatment is perceived (i.e., describe it in ways that would be perceived positively by the individual). Framing therapy as a type of empowerment (e.g., "It takes courage to face one's problems"), rather than something that is perceived as a weakness (e.g., "I could not handle this on my own"), may increase service use. The National Institutes of Health (NIH), for example, has an educational program focused on depression in men, and it describes seeking treatment as taking courage (e.g., "It takes courage to ask for help. These men did"). NIH has an online Web site where this statement is advertised followed by pictures of men who sought treatment and links to their stories as well as information about depression (see NIH, n.d.). Of course, it is important to note that reframing therapy in these ways may not always be appropriate. A mental health professional, for example, would not want to mislead the individual (i.e., call the treatment education and then provide interpersonal counseling); thus the professional may need to alter what he or she does with clients if someone were to seek treatment from these advertising efforts. It may also be important to take into account insurance reimbursement issues, because some types of treatment may or may not be reimbursable. This would need to be discussed with the individual seeking treatment before the treatment begins.

Another implication of this step seems to be that mental health professionals may need to reach beyond traditional methods of providing services to access specific groups or individuals most

reluctant to seek their services. If traditional methods are perceived as involving high risks, then finding alternative methods of treatment, perceived as less threatening, may be a way to reach underserved populations. Those who write about conducting therapy with minorities, for example, suggest that many minorities may be resistant to mental health services because traditional mental health services are perceived as inconsistent with the cultural norms of that group (Padilla, Carlos, & Keefe, 1976; Root, 1985). To avoid these inconsistencies, many minority individuals simply avoid mental health services. One of the most basic ways to make services more appealing to underserved groups may include, but is not limited to, providing culturally sensitive services; providing physical access to those with disabilities; and being sensitive to variations in age, socioeconomic status, political orientation, sexual orientation, and subscription to gender roles. Despite efforts to date, many individuals still see the mental health profession as insensitive to them, their issues, and their needs (Bui & Takeuchi, 1992). Adoption of a more sensitive stance and communication of these changes to the public, might do a lot to increase the use of mental health services and access to members of traditionally underserved populations. Specifically, outreach efforts by staff who are sensitive to these issues and who target specific groups may promote perceived accessibility of mental health services (Akutsu, Snowden, & Organista, 1996).

Mental health professionals seeking to reach a specific audience may need to consider innovative methods to reach those individuals, perhaps by extending beyond the comfort of convention and offering nontraditional services in nontraditional ways. Kiselica (1999) asserted that mental health professionals considering work with a specific population that does not normally seek treatment may need to be prepared to earn their individuals' trust by, for example, abandoning their offices and meeting them in their own space (e.g., meeting a child on the playground rather than in an office). Wester and Lyubelsky (2005) further discussed how those working with members of law enforcement need to alter their therapeutic techniques to better serve such individuals by making them instrumental, solution focused, and accepting of institutional coping styles. Roffman et al. (1989), in turn, found that some people who did not want to seek professional help in person were willing to talk to someone over the phone. Furthermore, with the expansion of the Internet, many people are looking online for mental health services (Mallen & Vogel, 2005). Although many issues connected with the practice of online counseling need to be addressed, some services could be provided to potential clients over the Internet (see Mallen & Vogel, 2005; Mallen, Vogel, & Rochlen, 2005; and Mallen, Vogel, Rochlen, & Day, 2005). These Web-based services may not only provide some needed relief but also provide a gateway into more traditional services once a positive experience or connection has been established.

Evaluation of Behavior: Step 4

During Step 4, individuals evaluate and consider the outcomes of their behavior. These evaluations then lead to new decisions about what to do next. Although not as commonly discussed in the help-seeking literature, we believe this is an important factor in understanding the professional help-seeking process—what Heppner and Krauskopf (1987) called *self-appraisal* (p. 423). After all, individuals tend not to choose mental health services as a first

choice (Hinson & Swanson, 1993; Lin, 2002) but only after other sources of help have been attempted (Wills, 1992). Thus professional help seeking may often occur only after other sources of help have failed and the consequences of not seeking help from a mental health professional have increased. Consistent with this, Cameron et al. (1993) found that those who ultimately sought help for a problem reported actively attempting to deal with the problem, but that those efforts had not been very successful. Thus those who ultimately seek professional help are likely to have tried several other strategies that did not work or fully work to their satisfaction. As a result, an individual's evaluation of his or her previous attempts to deal with the problem may be one of the key factors to understanding those who seek professional help and those who do not. Those who do not seek professional help may perceive (accurately or not) that earlier attempts were successful or successful enough to not warrant additional action at that time.

Implications.   Primarily this fourth step suggests people may not seek professional help or choose to continue therapy if they have not fully examined their previous behavior or misinterpreted the consequences. Individuals may miss opportunities to evaluate their behavior because they do not want to feel responsible for choices or do not want to re-experience a painful decision. Individuals may also have difficulty making new decisions as the result of an underestimate or overestimate of the effectiveness, costs, or both, of past behavior. For example, an individual who has been depressed for a few weeks and chose to keep it a secret, may wake up on a particular day and feel a little better. His or her immediate pain is lessened, so the individual assumes that he or she is better and that avoiding the issue was the best solution. Having decided to not take any action in the hope that the symptom would go away is still a decision (one which is less likely to help), and assisting an individual to recognize this process may allow him or her to make a different decision in the future that better reaches the desired goal. Indeed, a good chance exists that the individual will re-experience the feelings of depression, because he or she has not made any changes to his or her life or learned any adaptive ways to handle negative feelings.

The major implication of this step for mental health professionals is the awareness that a client will still be evaluating his or her decision to seek professional help even after he or she made the initial decision. Although outreach programs may be able to discuss this step, the major benefits may come from examining with actual clients how concerns about the process affects them even after they enter therapy (Kushner & Sher, 1989; Vogel & Wester, 2003). The high percentage of clients who drop out of therapy (Baekeland & Lundwall, 1975) suggests that concerns about therapy do not just go away after the initial visit and may even intensify for some individuals if their fears are realized. Some clients, even after deciding to try therapy, may still feel uncertain or fearful, and therapists may need to acknowledge these negative expectations about what therapy is like before they will be able to work with clients experiencing these concerns. Therefore desensitizing clients to the concerns that they may have about mental health services and discussing what will happen in the sessions may increase service utilization and decrease premature termination (Giles & Dryden, 1991). Furthermore, mental health professionals may want to work with clients to (a) systematically identify the previous results of their decision making, (b) learn how these decisions met or did not meet their desired goals, and (c) provide

ways to increase the clients' accurate expectations about what different decisions might accomplish. In addition, feeling a lack of control over the duration of therapy has been implicated as a reason for not continuing counseling (Harris, Tessler, & Potter, 1977). Similarly, clients who were able to choose the type of therapy have been found to have the best results (Miller, 1985). Increasing the client's feelings of control may, therefore, lessen their fears and increase treatment duration. Although this idea is still speculative, openly talking with clients about their fears of losing control and increasing clients' sense of power in the treatment may foster increased use and decrease premature termination of mental health services.

Conclusions

By understanding the act of seeking professional help from an information-processing perspective, mental health professionals may be better positioned to develop interventions designed to overcome specific barriers. This differs from existing work, in that it not only presents a way to disseminate information through outreach programs and increased contact with the community but also empowers individuals to make informed choices. Importantly, an information-processing model offers the profession several potential avenues of intervention, rather than being restricted to intervening only at the level of the individual who actually walks through the office door. Mental health professionals can intervene at the community, family, and societal levels to help individuals make the best choices for themselves when a symptom occurs. We believe that mental health professionals will be more effective at helping people overcome the barriers to seeking professional help if they have an awareness of the overall process people engage in to arrive at such a decision. They will be able to focus their efforts and interventions on certain aspects of information processing depending on the needs of their target populations. We recognize that more research is required to determine which of our suggestions is the most effective at increasing the use of professional services—in effect, an empirical test of our model in this context. The potential costs of such programs, for example, and the degree to which third-party payers might not reimburse for such services, might mean that mental health professionals modify our suggestions for their own specific circumstance. At the same time, however, we believe that our ideas represent an informed approach based on the help-seeking and information-processing literatures. Although reducing the hesitancy to seek professional help is a large task, therapists and other mental health workers can help by using interventions guided by theory.

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