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ARTICLE

"We almost had the whole block's phone number on the wall": A mixed methods investigation of informal helping in a predominantly rural sample

Matthew Hagler[1] | **Sherry Hamby**[2] | **Victoria Banyard**[3] | **John Grych**[4]

[1]University of Massachusetts Boston

[2]Life Paths Appalachian Research Center and Sewanee, the University of the South

[3]Rutgers University

[4]Marquette University

Correspondence
Email: Matthew.Hagler001@umb.edu

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Abstract

Community psychologists have noted the limitations of professional models of mental health treatment, demonstrating that people are more likely to use informal familial or community support during adversity. However, relatively little is known about the forms and functions of informal help seeking and provision. Semistructured interviews (N = 170), in which a sample of predominantly rural-dwelling adolescents and adults described significant life experiences, were coded for instances of receiving help. Codes thematically categorized the type of adversity, role of the helper, and nature of the help received. Most participants (67.64%) reported the presence of at least one informal helper; only 8.82% of participants discussed receiving professional help. Chi-square analyses suggested that the nature of the help received varied by the types of helper and adversity being experienced and that different helpers were more likely to aid with particular adversities. The presence of a nonfamilial, nonprofessional helper was associated with higher posttraumatic growth, generativity, and perceived social support.

The community psychology movement arose as scholars recognized the limitations of professional models of mental health treatment, noting that people are more likely to receive informal help within their families or communities. Cowen and colleagues (1982, 1979) documented that individuals frequently disclosed serious personal problems to bartenders, barbers, beauticians, cab drivers, lawyers, and supervisors, and Warren (1982) highlighted the accessibility and consistency of support from friends and family. These researchers attributed the relatively infrequent use of professional services to limited access, mistrust of professionals, culturally incompetent care, and modest effectiveness of formal interventions. Despite advances in clinical and counseling psychology, psychiatry, and public health, these criticisms remain relevant.

In particular, rural residents are vastly underserved by professional mental health services, and instead rely on informal support within families or communities (Jameson & Blank, 2007). However, little is known about the forms and functions of informal help seeking and provision in rural communities, and how these processes unfold during

significant moments in people's lives. To fill these gaps in knowledge, the current study conducted mixed methods analyses of data from a predominantly low-income, rural sample. We used thematic analysis of narrative interviews to construct typologies of the adversities for which participants received help, as well as the roles and functions of helpers. Additionally, we used quantitative analyses to examine the psychological outcomes associated with receiving informal help.

1.1 | Background

Contrary to some idyllic portrayals of rural life, state and local rural health leaders identified mental health as the fourth most pressing concern in rural areas, after access to services, oral health, and diabetes (Gamm, Stone, & Pittman, 2010). Evans (2003) found that poor rural children face high cumulative risk resulting from multiple chronic and acute stressors, ranging from housing problems, family turmoil and separation, poverty, and exposure to violence. Although the prevalence of mental illness is roughly equivalent across urban, suburban, and rural regions (Breslau, Marshall, Pincus, & Brown, 2014), rural residents are the least likely to receive treatment because of limited availability and awareness of services, mental health stigma, and mistrust of mental health care professionals (Gamm et al., 2010; Jameson & Blank, 2007; Nicholson, 2008).

Community psychologists have long recognized that the majority of adversities and mental health challenges never come to the attention of professional providers (Cowen et al., 1979; Gottlieb, 1978). This may be particularly true for rural residents, who more often turn to informal helping relationships in families and communities (Behringer & Friedell, 2006). In this article, we define an "informal helper" as any person without formal medical or mental health training who provides aid during times of adversity. We conceptualize these individuals as important sources of community and social support (i.e., the availability of tangible and intangible aid from the surrounding area and interpersonal relationships, respectively).

Although rural regions are vastly underserved by mental health professionals, the importance of informal support is not simply a matter of accessibility. Informal helpers make a qualitatively unique contribution to health and resilience. First, they tend to be more intimately known by informal helpers than by professionals, and thus informal helpers are able to provide more personalized assistance. Informal helpers and recipients likely share some commonalities of background, leading to greater trust, mutual identification, and empathy. Shared identities also diminish power differentials that sometimes inhibit working alliances in formal mental health services and may provide informal helpers with personal knowledge and experience with particular challenges and adversities (Heaney & Israel, 2008).

Informal help is less limited, more spontaneous, and present long before and after professional services typically are available (Budde & Schene, 2004). Further, unlike professional care, informal helping is partially driven by reciprocity and mutuality. Receiving assistance promotes a sense of obligation to provide later support for the original helper and/or other members of the family or community unit (Heaney & Israel, 2008). It also fosters a sense of social integration (Berkman, 2000), which in turn promotes altruistic behavior (Brañas-Garza et al., 2010). Thus, helping begets more helping, and the mutual provision of informal aid builds stronger families and communities.

Of course, it is important to explore distinctions among different types of informal helpers, who range in closeness, frequency of contact, accessibility, and degree of similarity. For example, family members tend to be the most available, long lasting, and frequently used sources of informal support (Heaney & Israel, 2008). However, researchers have noted some limitations of familial aid including potential redundancy of experiences, information, and resources within familial networks (Thoits, 2011). Thus, studies have also highlighted the unique contribution of more distal community ties, such as friends, neighbors, teachers, religious leaders, and coworkers, who may possess greater and/or more diverse resources, allowing them to provide novel forms of support for adversities with which family members are less experienced (Heaney & Israel, 2008; Kawachi & Berkman, 2001; Thoits, 2011).

Indeed, familial, nonfamilial, and community support are each positively and uniquely associated with mental and physical health, particularly in highly stressed rural populations (Hamby et al., 2015; Stain et al., 2008). Studies have shown that informal helpers are vital sources of support and care for individuals and families with a range of clinical concerns, such as the elderly (Sasso & Johnson, 2002), adults living with HIV/AIDS (Reynolds & Alonzo, 1998), and

families receiving child protective services (Manji, Maiter, & Palmer, 2005). Further, bystander intervention research has shown that responsive behavior by informal helpers is key to preventing various types of violence, such as childhood sexual abuse, peer bullying, and sexual assault (Banyard, Weber, Grych, & Hamby, 2016; Finkelhor, 2009; Lodge & Frydenberg, 2005). Informal helpers also provide support for victims of sexual violence, who may be reluctant to seek professional help because of fear and shame (Ansara & Hindin, 2010).

Although the importance and effectiveness of informal helping are clear, relatively less is known about the underlying mechanisms and processes. Social support theory highlights both direct and indirect pathways through which supportive relationships influence physical and mental health. For example, the presence of supportive others directly enhances one's sense of belonging, self-worth, and safety (Heaney & Israel, 2008; Kawachi & Berkman, 2001).

Further, social ties indirectly promote health by buffering the negative effects of stress. During times of adversity, social support can increase coping ability, promote psychological endurance, reduce stress load, and instill a sense of meaning (Grych, Hamby, & Banyard, 2015; Kawachi & Berkman, 2001; Thoits, 2011). Notably, longitudinal evidence demonstrates that social support during and after trauma promotes posttraumatic growth (i.e., positive change after a crisis or traumatic event; Tedeschi & Calhoun, 1996). Informal helpers might exert effects via both pathways, which are not mutually exclusive (Heaney & Israel, 2008). For example, informal support that is mobilized during a stressful life event might allow an individual to cope with the acute stressor and emerge with a greater sense of belonging and self-worth.

Turning to specific functions, the body of literature suggests three broad types of social support: emotional support (i.e., demonstrations of caring, value, appreciation, encouragement, reassurance, or sympathy); informational support (i.e., supplying knowledge, facts, or direct problem-solving assistance); and instrumental support (i.e., the provision of practical or material assistance; Thoits, 2011). Informal helpers could conceivably serve any or all of these functions, although existing literature suggests that emotional support is the most common (Patterson, Memmott, Brennan, & Germain, 1992; Warren, 1982).

1.2 | Research gaps and the current study

Previous studies have primarily investigated research questions regarding the prevalence and effectiveness of informal helpers (e.g., Warren, 1982) or the role of informal helpers in the context of specific clinical issues (e.g., Sasso & Johnson, 2002). However, relatively little is known about the forms and functions of informal helping in nonclinical community populations. Grounding in general social support theory is valuable, but considerable gaps in knowledge remain about the key features of social support seeking and provision (Feeney & Collins, 2014), such as the adversities for which people receive informal support, the nature of the help received, and differences among types of informal helpers. Mixed methods approaches are uniquely suited to fill these gaps in the literature. They allow researchers to examine larger quantitative patterns in data while providing rich, qualitative narratives that shed light on processes and participants' subjective experiences.

Thus, the current study used mixed methods data from a predominantly rural community sample of adolescents and adults to explore the role that informal helpers play in rural communities. First, we analyzed participants' narrative interviews using an inductive grounded theory approach. We constructed typologies of the adversities for which participants received support, the social roles of helpers, and the nature of the help received. Second, we explored quantitative associations among categories of adversity, helper, and help offered, allowing us to examine the likelihood of receiving different forms of support from particular helpers for each type of adversity. Consistent with the exploratory nature of this approach, we did not make a priori hypotheses for this portion of the study but pursued the following research questions: What are the types of adversities for which participants sought and received help? What are the social roles of the individuals who provided participants with aid during adversity? What is the nature of the help received? Does the nature of the help received tend to vary by the types of helper and adversity being experienced? Are different helpers more likely to aid with particular adversities?

Third, we examined quantitative associations among the presence of different types of helpers and measures of well-being and perceived social support. Based on previous research demonstrating the effectiveness of informal

helpers and the health-promoting effects of social support (e.g., Heaney & Israel, 2008; Kawachi & Berkman, 2001; Letvak, 2002), we hypothesized that participants who received support from any informal helper for an adversity would report greater subjective well-being, posttraumatic growth, and perceived social support compared with participants who did not report receiving any kind of informal help (Hypothesis 1).

Researchers have noted that informal support promotes reciprocity and altruism (Brañas-Garza et al., 2010; Heaney & Israel, 2008). Thus, we also expected receiving informal help to be associated with greater generativity (i.e., the desire to help others, particularly younger generations; Hypothesis 2). We believed that identifying an informal helper outside of the family would be indicative of a wider network of social support. Thus, we expected the utilization of nonfamilial, informal helpers, compared with the utilization of familial helpers, to be more strongly associated with well-being, posttraumatic growth, generativity, and perceived nonfamilial support (Hypothesis 3). Finally, we hypothesized that having a familial helper would be positively associated with a measure of perceived familial social support (Hypothesis 4).

2 | METHODS

2.1 | Participants

The sample consisted of 170 residents of southern Appalachia who completed a computer survey and a face-to-face, semistructured interview as part of a larger study on character development and resilience (see Hamby et al., 2015). The sample contained both adolescents and adults, ranging from age 12–66 years (mean [*M*] = 33.2, standard deviation [*SD*] = 12.5). The participants were 62.9% female and 37.1% male. In terms of race and ethnicity, 75.5% of the sample identified as White/European American (non-Hispanic), 13.8% as Black/African American (non-Hispanic), 3.8% as Hispanic (any race), 0.6% as Asian (non-Hispanic), and 6.3% as multiracial. The majority (63.9%) reported an annual household income of less than $30,000. Only 17.4% of the sample had obtained a degree beyond a high school diploma. The majority of the sample (88.2%) resided in counties designated as rural by the federal Office of Rural Health Policy; the Index of Relative Rurality for these counties ranged from .405 to .567.

2.2 | Procedure

We used a range of recruitment techniques. The majority (76%) of participants were recruited at local community events throughout the region, such as festivals and county fairs. Word of mouth was the second most productive strategy, producing 12% of participants, and the remaining 12% were recruited through other media including flyers, newspaper and radio ads, and direct mail. Interviewers met participants at locations throughout the community (e.g., community events, restaurants, our research center, and participants' homes) during daytime and evening hours and on weekdays and weekends. Because of limited cellular and Internet service in the region, we specifically selected a survey software that did not require Internet (i.e., Snap10), which was administered on laptops and electronic tablets.

The survey contained a range of quantitative measures on character strengths, interpersonal resources, exposure to adversity, well-being, and demographics. A total of 2,565 individuals completed the survey, with an overall completion rate of 85% and a median completion time of 53 minutes. Survey participants received a $30 Walmart gift card and information on local resources. Additionally, survey participants were offered the opportunity to engage in narrative interviews. All survey participants were presented with this option and were able to contact the researchers to set up an interview until the target of 200 interviews was reached. Comparisons between participants who did and did not participate in interviews reveal few significant group differences. These groups did not significantly differ on any of the main study variables. Demographically, the interview sample tended to be slightly older ($M = 31.97$ vs. $M = 29.87$ years old) and more highly educated ($M = 4.42$ vs. $M = 4.04$ on a 10-point scale) compared with those who did not participate in the interview. There were no significant group differences in terms of race, gender, marital status, rurality, or income.

The interviews asked participants to discuss various facets of their life stories, including prominent moments (e.g., high, low, and turning points), past and current challenges, and coping strategies. The interviews were semistructured,

TABLE 1 Descriptive statistics and bivariate correlations for quantitative scales for the analytic sample

	Descriptive statistics			Bivariate correlations				
Scale	Mean (*SD*)	Median	Min–Max	1	2	3	4	5
1. Subjective well-being	0.00 (1.11)	0.34	−3.03–1.19	–	.63	.70	.59	.59
2. Posttraumatic growth	0.03 (1.00)	0.26	−2.78–1.12		–	.63	.39	.49
3. Generativity	0.04 (0.99)	0.34	−2.73–1.11			–	.46	.45
4. Social support (familial)	−0.08 (1.05)	0.12	−2.81–0.96				–	.56
5. Social support (non-familial)	−0.08 (1.06)	0.17	−3.30–0.86					–

Note. SD = standard deviation. Scale scores were mean-centered using means from the full survey sample. All bivariate correlations were significant at $\alpha = 0.01$.

requiring interviewers to follow a script but allowing them to tailor primary and follow-up questions to each participant. Interviews were conducted in a private location, typically in the research office or participants' homes. They were audio recorded and transcribed verbatim. Interview participants received an additional $50 gift card. All procedures were conducted according to the American Psychological Association's ethical principles and approved by the home institution's institutional review board.

2.3 | Measures

Given that our sample consisted of adolescents and individuals with limited educational attainment, we sought to develop scales that were brief and at an appropriate reading level. Thus, we selected and simplified items from existing scales. To facilitate progression through the survey and response consistency, scales were adapted, when necessary, to be on 4-point Likert-type scales ranging from 1 (*not true about me*) to 4 (*mostly true about me*). We established reliability and validity of new and existing items in a pilot study of 108 participants from the same community as the main sample. Psychometrics were further established in the main sample using factor analysis, reliability analysis, and correlations with related constructs (see Hamby, Grych, & Banyard, 2015). A scale score for each measure was created by taking a mean of the respective items. Each scale score was then mean-centered based on the mean of the full survey sample. Descriptive statistics and correlations among dependent variables are presented in Table 1.

2.3.1 | Subjective well-being

This 13-item scale, constructed based on factor analysis of several existing measures (Battista & Almond, 1973; Diener, Emmons, Larsen, & Griffin, 1985; Pearlin & Schooler, 1978; Rosenberg, 1965), assessed participants' subjective satisfaction with the quality of their lives. Participants rated their agreement with statements such as "In most ways, my life is close to ideal." The scale had an alpha of .94 and was strongly correlated with related constructs, such as mental health and spiritual well-being.

2.3.2 | Posttraumatic growth

This measure assessed strength, spiritual change, new life possibilities, and appreciation for life following adverse life events. It consisted of nine items adapted from Tedeschi and Calhoun's (1996) original 21-item scale. Participants were asked to think of the most stressful event they experienced within the past year and to rate their agreement with items such as "I have a greater appreciation for the value of my own life." The scale had an alpha of .90 and was strongly correlated with related constructs, such as psychological endurance, purpose, and subjective well-being.

2.3.3 | Generativity

This scale measured respondents' prosocial desire to help others by passing on knowledge and skills. Five items were selected from the six-item Loyola Generativity Scale (McAdams & de St. Aubin, 1992), and the wording was slightly

modified to be in first person, consistent with the survey's other scales. Participants rated their agreement with statements such as "I like to teach things to people." The scale's alpha was .88, and it had moderate to strong correlations with related constructs, such as compassion and other-oriented meaning making.

2.3.4 | Perceived social support (familial)

This six-item scale (adapted from Turner, Finkelhor, & Ormrod, 2010; Zimet, Dahlem, Zimet, & Farley, 1988) assessed perceived availability of support within participants' immediate families. Participants were asked to rate the extent to which they agreed with statements such as "I can talk about my problems with my family." The scale's alpha was .88, and it was significantly correlated with measures of related constructs, such as community support and subjective well-being.

2.3.5 | Perceived social support (nonfamilial)

This six-item scale (adapted from Turner et al., 2010; Zimet et al., 1988) assessed participants' perceived ability to rely on support outside of their immediate family (e.g., friends, nonparent adults). Participants were asked to rate the extent to which they agreed with statements such as "I can count on my friends when things go wrong." The scale's alpha was .90. Validity was established with moderate to strong correlations with related constructs, such as community support and subjective well-being.

2.4 | Coding and analysis

We used a grounded theory approach (Corbin & Strauss, 1990; Walker & Myrick, 2006) to derive thematic codes. This is an inductive approach that builds themes from participants' words rather than applying preexisting categories and frameworks. It should be noted that participants were not asked specifically about receiving help from others. Rather, they were asked about significant life events, including experiences with adversity, and analyses were conducted on interview segments in which participants spontaneously discussed receiving help from another person. Broadly, the analytic team examined types of adversities, types of helpers, and the nature of the help provided.

Analysis was conducted in three phases (Walker & Myrick, 2006). In the "open phase," three research coordinators (including the first author) reviewed 10 randomly selected transcripts, taking extensive notes, and developing preliminary ideas for codes. In the second phase, the "axial phase," these initial codes were discussed with other investigators (the second through fourth authors) along with exemplifying quotations and interviews. The research team collaborated to make connections between categories and create a more condensed coding scheme. In the third or "selective" phase, these codes were applied to a randomly selected subset of 20 interviews, and the research team further discussed codes and reached consensus, integrating and combining codes to create the final coding scheme.

Next, the research coordinators trained four undergraduate research assistants in the coding scheme. After showing adequate interrater reliability in the 30-interview preliminary subsample, the research assistants independently applied the coding scheme to the remaining 170 interviews. Codes were not considered to be mutually exclusive, and participants could report multiple instances and types of adversity, helpers, and help received. Every interview was coded by at least two coders, and mean pairwise agreement ranged from 87% to 93%. Discrepancies were discussed among the research team until consensus was reached.

The subsample of 170 independently coded interviews was used for quantitative analysis. Specifically, we examined percentages of participants who reported each type of helper, each type of adversity, and each type of help. We then conducted chi-square analyses to examine associations among helping codes, and multivariate analyses of covariance (MANCOVAs) to examine psychological outcomes associated with receiving informal help.

To explore associations among type of adversity, type of helper, and type assistance received, chi-square analyses were run between each type of adversity and each type of helper, between each type of adversity and each type of assistance, and between each type of helper and each type of assistance. For ease of interpretation, odds ratios were calculated from the chi-square analyses.

Three MANCOVAs were run. Each MANCOVA had five dependent variables: subjective well-being, posttraumatic growth, generativity, familial social support, and nonfamilial social support. In the first MANCOVA, a dichotomous variable indicating whether participants discussed the presence of any informal helping in their interview was included as the primary independent variable. In second MANCOVA, a dichotomous variable indicating whether participants discussed the presence of a nonfamilial informal helper was entered as the primary independent variable. In the third MANCOVA, a dichotomous variable indicating whether participants discussed the presence of a familial informal helper was used as the primary independent variable. For significant MANCOVAs, separate ANCOVAs were conducted to identify the dependent variables on which groups differed. All MANCOVA and ANCOVA analyses co-varied age and sex.

3 | RESULTS

3.1 | Thematic analysis and coding

3.1.1 | Types of adversity

Participants reported receiving help with a range of adversities. Some participants described exposure to domestic violence, including witnessing violence between parents or directly experiencing abuse from a spouse, parent, and other family member. Others discussed exposure to violence at school or in the community including being bullied by peers, witnessing gang violence, and being mugged or robbed. Some interviewees identified substance abuse as a major adversity, describing how addiction to alcohol, stimulants, or opiates negatively affected the personal and professional lives. Several participants discussed experiences with health problems including acute injuries and illnesses as well as chronic disability or disease.

As would be expected in a low-income sample, several participants reported having financial difficulties, either in the past or ongoing, and discussed how combinations of low wages, underemployment, and unexpected financial burdens resulted in struggles to make ends meet. Some interviewees also reported other nonfinancial vocational difficulties at school or work, such as struggles to complete significant projects or assignments, receiving poor grades or performance reviews, and dissatisfaction with their occupation or area of study.

Many participants also described adversities that were more interpersonal in nature. Some discussed having relationships problems with romantic partners, friends, or family members including significant conflict, break-up, or estrangement. Several participants identified the death of a loved one as a significant adversity and described both immediate and long-term bereavement over the loss of a grandparent, parent, sibling, child, friend, or romantic partner.

Finally, we created two additional categories that included various other adversities not captured by the other codes. Some participants described family adversities other than bereavement and relationship problems, such as health problems of family members, caregiver burden, and familial fragmentation. Some interviewees also identified other, noninterpersonal adversities, such as natural disasters, property loss, and changes in residence. The prevalence of these codes and exemplary quotes are presented in Table 2.

3.1.2 | Types of helpers

Most frequently, participants reported receiving help from one or both of their parents. Notably, parental assistance was not limited to childhood; many participants described how their parents helped them as adults. Other relatives also were identified as helpers including grandparents, uncles, aunts, cousins, and siblings. Often, participants described close, reciprocal relationships with extended family members, many of whom served as primary or important secondary caregivers. Older adolescent and adult participants sometimes identified spouses or romantic partners as important helpers. Participants frequently highlighted the introduction of an important romantic partner as a significant turning point in their lives, which helped them overcome significant adversities.

TABLE 2 Percentage of participants who reported receiving help for each type of adversity and exemplary quotes

Type of adversity	Percent of sample	Exemplary quote
Domestic or family violence	4.12	"[My husband] … beat the hell out of me. I called [my friend] … and he came. He had gotten me an apartment, paid for me an apartment. So I could move out … I was so glad that somebody was finally helping me … get away from him because I really just didn't feel like I could … I was relieved." (31-year-old female)
Peer or community violence	4.12	"I was in third grade, I was having a rough time with bullies…. I had friends who stuck up for me…. Sometimes it doesn't work … but it can make a difference because at least you know that someone's actually there…standing up for you." (12-year-old female)
Substance abuse	7.65	"I used to drink a lot…. I got two D.U.I.s…. I was at a bar … and the owner of the bar … looked at me and he said, 'I've got a question. How in the world do you do this, man? You are here seven days a week. You leave here at two in the morning … drunker than crap. You come in … and drink some more…. How are you doing that?' And … I got to thinking … this man's right…. I was like, 'Okay man, something's gotta give … you could wind up killing yourself or hurting somebody….' So, the turning point in my life." (46-year-old male)
Health problems	10.59	"Well, when I was sixteen … I went totally blind for a month…. It was a tumor on my brain … I didn't think I was going to get my vision back…. My cousin, he's a preacher … he came to my house every night, and he prayed over me every night…. He said, 'I have faith that God is going to bless you with your sight soon.' He did it for like a week, and that weekend I started … to see…. I got my sight back." (27-year-old female)
Financial difficulties	9.41	"I've been homeless … I lived in a tent for four months and I lived in a car for two…. I was … out of work, basically … my lowest point…. It started turning around right after … I came to live with my dad, me and my fiancé did, and … they were helping me out…. It just turned around from there because I got hired on and then we got into these apartments." (20-year-old male)
Professional or academic issue	8.24	"In the eighth grade, I was making just terrible, terrible grades. Like, I thought I wasn't going to pass the eighth grade or something. And [my dad] … gave me a talking to…. That pretty much turned me around. And I made really good grades in high school … enough to … go to college…. I feel like if he hadn't done it, I would have probably just flunked…. He just made it clear to me that it was very important to work hard. And school and education is very important." (19-year-old male)
Relationship problems	6.47	"I was in a very committed relationship with a woman several years … and she broke the relationship off. At the time, it was absolutely devastating…. That's where I had to reevaluate … how I handled my relationships with women…. I was very close with … some of her family. Her brother-in-law and her sister. And they were very supportive of me during that time." (36-year-old male)
Bereavement	12.35	"[My cousin] had got caught in the sink hole…. That was just like a changing point in my life because he was born in '86 and I was born in '86…. I just kind of blocked everybody out. Kind of stuck to myself for a while…. I stayed with [my girlfriend]…. She helped me a lot cope with it…. I was glad she was there to help me cause she helped me through it a lot…." (27-year-old male)
Other family adversity	10.59	"When my dad left … I was mad at him forever…. I don't really cope with stuff easily… it takes me a long time to process, but I eventually got there…. My youth leader was saying how if you were to do something terrible, that God would always forgive you and that you should forgive people because that's what He would want." (15-year-old female)
Other adversity (noninterpersonal)	4.12	"We almost had the whole block's phone number on our wall…. I had a fire in my home…. I ran across the street to get some help, and he come over and put the fire out, and, like I say, it was just a helping hand." (39-year-old male)

Beyond romantic and familial relationships, several participants also reported help from friends or peers, who often provided help in contexts or situations during which familial assistance was unavailable. Others discussed receiving assistance from school personnel, such as teachers and school administrators. These participants described receiving help from school personnel both within and outside the classroom, with both academic and nonacademic difficulties. Further, religion was salient for many participants, and some identified ministers, preachers, reverends, and priests as significant sources of help during adversity. A small but notable group of participants noted that they received help from complete strangers, often describing it as an unexpected but vital lifeline during difficult times.

A small subsample (8.82%) reported receiving help from someone in a formal helping role including doctors, nurses, therapists, and other health professionals, who provided specialized knowledge and expertise and helped when participants' informal helping networks were inadequate or overwhelmed. Comparatively, 67.64% of participants reported the presence of an informal helper; 37.01% reported having any informal helper who was a family member or romantic partner, and 29.41% identified any nonfamilial, nonprofessional informal helper. The prevalence of these codes and exemplary quotes are presented in Table 3.

3.1.3 | Types of help

Three primary themes emerged regarding the function of the help received. Over half of all participants reported receiving emotional support or guidance. For example, they described helpers who listened to them, talked through their problems, gave guidance or advice, provided encouragement, or expressed love. Qualitatively, participants emphasized the constancy and unconditionality of this support, which helped them weather significant adversities. Helpers ranged in the degree to which they provided direct advice versus nondirective support, but participants often were not specific enough to make this distinction.

Other participants also discussed material or financial support. This included directly receiving cash gifts or loans as well as food, shelter, transportation, and other necessities, often during times of significant need. Participants viewed this type of assistance as a vital lifeline and often emphasized the profound relief and emotional impact of experiencing such generosity. A relatively small number of participants described receiving information or instruction (i.e., the direct transmission of facts, knowledge, or skills). This informational support often came at key moments and helped participants make important decisions about their lives. Finally, a small number of participants reported receiving help that was unspecified or uncategorized. The prevalence of these codes is presented in Table 4 with exemplary quotes.

3.2 | Associations among categories of adversity, helper, and help received

Chi-square analyses were conducted among binary variables indicating the presence or absence of each type of adversity, helper, and help received; odds ratios from chi-square analyses are presented in Tables 5–7. These analyses suggested several notable patterns among these variables. For example, participants who received assistance from familial helpers tended to bring up health problems, bereavement, and other family adversities. Receiving help from a professional helper (e.g., therapists, doctors) was associated with reports of domestic/family violence and health problems. Participants who experienced peer/community violence or professional/academic issues tended to identify school personnel as helpers. Reports of receiving help from a stranger were associated with experiencing financial problems.

Participants often received emotional support or guidance in the context of domestic/family violence, peer or community violence, health problems, and bereavement. Those who identified having a familial, professional, friend, or peer as a helper tended to report receiving emotional support. The transmission of skills or information was associated with professional or academic issues, as well as receiving help from school personnel or therapists or medical professionals. Material or financial support was associated with reporting financial difficulties and family adversity other than bereavement, as well as receiving help from a family member or stranger.

TABLE 3 Percentage of participants who reported each type of helper and exemplary quotes

Type of helper	Percent of sample	Exemplary quote
Parent	21.76	"It was a challenge…. All I've done … day and night was sports…. And going from sports to the real world … working … was a big challenge. My mom … helped me a lot…. She helped me realize … there's more to life than this…. She pretty much helped me a lot." (30-year-old male, discussing debilitating sports injury)
Other relative	19.41	"At 19 … I was just a first-time momma and I was like, 'How am I going to do this?' Having my grandmother being there for me telling me everything was going to be alright … kept me going. She and my grandpa … helped me buy diapers and stuff for my son and everything." (20-year-old female)
Spouse or romantic partner	8.24	"I have been clean from methamphetamines for almost seven years because of [my fiancé]…. It was my family…. I was in the middle of a meth lab growing up half my life…. If it was not for her, I would not have been able to get out…. I would never have been able to climb that mountain…. She has made me realize you cannot let people push you over … and there is more to life than just drugs and having fun…. She has turned me into a better person, a better man…. And she has made me open up my eyes to life. " (26-year-old male)
Friend or peer	19.41	"When I lost [custody of] the baby… that was the hardest thing I think I've ever had to do…. I stayed with a friend. She's a great person and I stayed with her and she actually came to all my … court dates with me … and was there for me because I didn't have any family in [state]. I didn't have anybody." (25-year-old female)
School personnel	4.12	"The toughest … time I've ever had was going through school…. I always got made fun of…. I had an aid to read my work off and … she's about the only one that … helped me…. She … told me to try to walk away from them and … just blow them off…. She kind talked me through the stuff." (21-year-old male with visual impairment)
Religious or community leader	5.29	"When my mom and dad, were turning around and doing drugs and stuff … my pastor helped me and get me into a shelter and stuff. I went to the shelter so that I didn't have to follow in their footsteps and doing what they were doing." (24-year-old female)
Stranger	3.53	"[My friend] was in the hospital out of town, and I didn't have no way of getting there…. A stranger … took me … and they didn't charge me gas, bought me dinner, breakfast." (45-year-old female)
Therapist or medical professional	8.82	"It was a kind of all-encompassing depression. And … I started frequently having … anxiety-induced seizures…. I took a medical leave. I went to a … psychiatric center, and I lived there for a month doing kind of intensive therapy….. My wife and I realized that this was larger than either of us could control." (35-year-old male)

TABLE 4 Percentage of participants who reported receiving each type of help and exemplary quotes

Type of help	Percent of sample	Exemplary quote
Emotional support, advice, or guidance	51.76	"My mom and dad had a fight about them divorcing … it was pretty rough…. I talk to my mom a lot, most of the time, cause that's who I'm closest to … so yeah, I talk to my mom a lot about it…. My mom makes me feel better about stuff…. She just knows what to say to me. She knows how to make me feel better, how to tell me to calm down…. She makes me feel a lot better when I'm upset." (12-year-old male)
		"My daughter's death was the low point. She was killed at a railroad crossing.… I got through it with friends who just let me grieve…There were people that were really uncomfortable when they saw me…. If I started talking about [my daughter], they'd change the subject…. And there were people who just let me do what I needed to do, cry when I needed to cry and just fall apart when I needed to fall apart. Those are the people who are still in my life and really important to my life." (66-year-old female)
		"I was involved with a married man…. We were really in love and he was separating from his wife. And she found out about it…. She went ballistic … tried to hit me with a car, asked me to leave the church I was in…. And I lost him…. He chose her at the end and … there were times I just wanted to die…. It's been really hard to forgive myself … for doing that…. I got through it because a lot of friends helped me. Good friends who knew me, who loved me for who I was … that's the only way I got through it." (43-year-old female)
Transmission of information or skills	6.47	"I was in art class and I was a shy student, and I was struggling…. I had all these bunch of my classmates came over there and help me. I was like in tears because I didn't know what I was doing…. When they came over, I was like 'Why are they helping me?'… but then I just got more frustrated. I was like, 'Well maybe they can help me figure out a better way'…. So I guess those people being there and at first being frustrated with them but then accepting their help … it makes you feel great." (20-year-old female)
		"One of the best professors I had … he was an English teacher…. We wrote papers and essays, and he helped me become a great writer. If I wanted to pursue my career in writing, I know that I could because he was a very good professor, and he's the reason why I got to English because in high school I struggled with English a lot…. I thought I'd never be able to do it." (27-year-old female)
		"My GPA was a 1.8. And didn't even know what a GPA was … so my sophomore year, and I … asked [my former Head Start teacher], "What's a GPA?" and I found out this was for college…. [She] told me, 'You gotta make something of yourself.' And I just worked harder on stuff." (37-year-old female)
Material or financial support	17.65	"My mother abandoned me. She was an alcoholic…. My father was strictly army. This is the way we were going to do it…. It's my way or the highway. And then at 18 … he kicked me out of the house…. So I grab two garbage bags and I'm hiking it down the road thinking where am I going to go? I was lost completely. Overwhelmed. Here I got nobody that cares about me. Where am I going to go? What am I going to do? My girlfriend's parent's took me in." (53-year-old female)
		"The church helped me…. I let them know that … [my mother] didn't have insurance. She did die of cancer…. They gave her two weeks. She ended up living another two or three months…. [Church members] helped me gather what they had, plus what I had." (38-year old female)
		"[My truck] had been towed … and they say it's going to be two hundred dollars to get your truck out. I was like, 'Right now I have two hundred and twenty dollars to my name'…. And, so [my neighbor] takes me up to this church…. The guy … walks out. [My neighbor] tells him … everything that was going on … and he goes in and comes out…. He says, 'Usually we just help out with food and stuff … but here's a check for two-hundred dollars from the Benevolence Fund'…. I was really thankful. I was honestly like in shock…. I was just blown away…. I said, 'I can't allow all these negative emotions and negative situations to get in my head right now…. I'm going to have to take these negative situations and turn it into fuel to start a positive fire.'" (27-year-old male)

TABLE 5 Odds ratios from chi-square analyses of associations among types of adversities and helpers

	Parent	Spouse or partner	Other family	Friend or peer	School personnel	Community or religious leader	Stranger	Therapist or medical professional	All family or partner	All nonfamily or nonprofessional
Domestic or family violence	0.59	—[a]	1.93	3.33	4.36	—[a]	—[a]	18.42**	1.01	3.29
Peer or community violence	1.46	—[a]	0.77	3.33	12.64**	—[a]	—[a]	1.78	1.01	6.36*
Substance abuse	1.67	3.98	—[a]	1.96	—[a]	1.55	2.53	0.85	1.79	2.13
Financial difficulties	2.38	1.69	1.64	0.57	—[a]	—[a]	11.62**	0.67	2.68	1.07
Relationship problems	2.18	—[a]	0.45	3.90*	—[a]	4.83	—[a]	2.50	1.24	3.04
Health problems	2.59	6.11**	0.55	0.49	—[a]	—[a]	1.73	3.66*	4.46**	–0.43
Bereavement or death	1.14	3.27	4.57**	2.37	1.19	2.14	1.44	1.90	2.70*	1.91
Other family adversity	1.95	2.56	3.57*	0.81	—[a]	2.59	1.73	—[a]	4.46**	1.19
Professional or academic issue	1.49	—[a]	0.34	2.54	20.40**	1.42	—[a]	—[a]	0.80	7.01**
Other noninterpersonal adversity	1.46	—[a]	1.93	6.16*	—[a]	3.23	—[a]	—[a]	1.10	3.29

[a]Odds ratios are not provided when there were cell sizes of zero.
*$p < .05$. **$p < .01$.

TABLE 6 Odds ratios from chi-square analyses of associations among types of adversities and help received

	Emotional support or guidance	Transmission of skills or Information	Material or financial support
Domestic or family violence	—[b]	—[a]	0.84
Peer or community violence	—[b]	—[a]	0.84
Substance abuse	3.38	1.23	0.40
Financial difficulties	0.70	—[a]	17.73**
Relationship problems	4.57	—[a]	1.14
Health problems	5.41*	3.60	—[a]
Bereavement	11.01**	—[a]	0.23
Other family adversity	2.67	0.84	3.97**
Professional or academic issue	2.50	8.51**	0.83
Other noninterpersonal adversity	1.25	—[a]	4.14

[a]Odds ratios are not provided when there were cell sizes of zero.
[b]In these cases, odds ratios were not calculated because every participant who reported receiving help for exposure to domestic or familial violence or peer or community violence said that they received emotional support or guidance.
*$p < .05$. **$p < .01$.

TABLE 7 Odds ratios from chi-square analyses of associations among types of helper and help received

	Emotional support or guidance	Transmission of skills or information	Material or financial support
Parent	3.19**	0.79	3.37
Spouse or romantic partner	14.04**	—[a]	0.83
Other relative	3.79**	0.45	1.34
Friend or peer	5.61**	0.92	1.87
School personnel	2.41	6.84*	0.00
Community or religious leader	3.46	1.88	1.48
Stranger	0.93	—[a]	5.56**
Therapist or medical professional	4.16*	4.59*	—[a]
All family members or partner	5.52**	0.53	2.68*
All nonfamilial or nonprofessional	4.03**	2.05	1.98

[a]Odds ratios are not provided when there were cell sizes of zero.
*$p < .05$. **$p < .01$.

3.3 | Associations with well-being and perceived social support

The first MANCOVA analysis revealed that, contrary to hypotheses 1 and 2, there were no significant group differences on subjective well-being, posttraumatic growth, generativity, perceived familial social support, and perceived nonfamilial social support, based on whether participants reported the presence of any informal helper.

The second MANCOVA analysis revealed that there were significant group differences between participants who nominated a nonfamilial, nonprofessional helper and those who did not, $F(5, 147) = 2.50$, $p < .05$, Wilks' $\Lambda = .922$, partial $\eta^2 = .08$. Follow-up ANCOVAs revealed that individuals who identified the presence of a nonfamilial, nonprofessional helper, compared with those who did not identify the presence of a nonfamilial, nonprofessional helper, reported significantly higher posttraumatic growth, $F(1, 151) = 4.88$, $p < .05$, partial $\eta^2 = .03$; generativity, $F(1, 151) = 4.69$, $p < .05$, partial $\eta^2 = .03$; and perceived nonfamilial social support, $F(1, 151) = 5.94$, $p < .05$, partial $\eta^2 = .04$. Thus, these findings provide partial support of Hypothesis 3. In contrast, the third MANCOVA revealed that the presence of a familial helper was not associated with significant differences on the dependent variables, contrary to Hypothesis 4.

4 | DISCUSSION

These mixed methods analyses provided a rich, unique examination of the prevalence, forms, and functions of informal helping in a predominantly rural sample. When discussing significant challenges and adversities in their life stories, fewer than 10% of participants reported help from therapists, doctors, or other health professionals. In contrast, the majority of participants (67.64%) reported the presence of informal helpers, who provided support for a range of adversities. Chi-square analyses suggest that the nature of the help received varied by the types of helpers and adversity being experienced and that different helpers were more likely to provide assistance during particular adversities. We expected the presence of any informal helper to be associated with higher perceived social support and other psychological outcomes, but this hypothesis was not supported. However, the presence of a nonfamilial, nonprofessional helper was positively associated with several psychological outcomes.

Consistent with previous studies (Gottlieb, 1978; Warren, 1982), the most common informal helpers were family members including parents, spouses or partners, grandparents, and others. Familial helpers were particularly likely to provide aid during more private adversities, such as health problems, bereavement, and other family adversities, and they tended to offer both emotional and material support. Previous research has shown that family members often lean on one another for mutual support following significant crises (Murphy, Johnson, Lohan, & Tapper, 2002). Qualitatively, quotes emphasized the constancy and unconditional love of family members or the life-changing influence of supportive relationship partners.

Surprisingly, the presence of a familial helper was not associated with any of the psychosocial outcomes we investigated including perceived familial social support. Rural Appalachian populations are characterized by strong kin networks (Behringer & Friedell, 2006; Keefe, 1988), and familial support may have been a normative experience for most of our sample, whether or not they specifically discussed familial helpers in their interviews. Alternatively, the same stressors that prompted help from family members (e.g., bereavement, divorce) may have threatened the overall integrity of their family support networks. Further, familial relationships are complex, and the positive impact of familial support can be moderated by the simultaneous experience of relational strain (Fuller-Iglesias, Webster, & Antonucci, 2015).

Many participants reported having an informal helper outside the family, including friends, teachers, ministers, community members, and even strangers. These nonfamilial helpers provided essential, supplementary support, particularly with problems experienced outside the home (e.g., peer or community violence, professional and academic issues). Qualitatively, our participants highlighted nonfamilial support as a vital and sometimes unexpected lifeline, especially when family members were unavailable or unable to help. These results reflect Thoits's (2011) theory of social support, which emphasizes the importance of more distally located helpers, who may be more experienced and better positioned to assist with some adversities and less likely to be directly suffering from the same adversity (or be the cause of it). Similarly, theories of social capital highlight the importance of both bonding ties within close-knit in-groups and bridging ties to more distant others (Ferlander, 2007; Granovetter, 1973).

This diverse network may lead to a greater perception of social support and resilience following significant adversities (Thoits, 2011; Thompson, Flood, & Goodvin, 2015). Thus, partially consistent with our third hypothesis, the presence of an informal helper outside of the family was associated with higher levels of posttraumatic growth and perceived nonfamilial social support. As discussed above, reporting a nonfamilial helper might represent a broader, more varied social support network, allowing participants to receive help with a wider range of challenges. Reflective of previous research linking social support to altruism (Brañas-Garza et al., 2010), participants who have had a nonfamilial helper demonstrated a greater desire to provide help and guidance to others. However, having a nonfamilial helper was not related to subjective well-being, possibly because the positive effects of that support were counteracted by the deleterious effects of the adversity that prompted it.

A relatively small proportion (8.82%) of participants discussed receiving professional help, likely reflecting the limited access and utilization of formal mental health care found in rural health research (Gamm et al., 2010; Letvak, 2002). However, both quantitative and qualitative results showed that professional helpers provided aid during significant hardships and traumas for which specialized training is needed, such as exposure to domestic violence and serious physical or mental illness.

Although our thematic typology of support functions was generated inductively, our categories were broadly consistent with those found in wider social support theory (i.e., emotional, informational, and instrumental/material support; Thoits, 2011). However, we added to this literature by unpacking subjective experience and impact of receiving these types of support during key moments in participants' life stories. Like previous investigations of informal helping and social support, we found that emotional support was the most commonly discussed function of informal helpers (Patterson et al., 1992; Thoits, 2011; Warren, 1982). Still, it is possible that incidences of other types of support were underestimated because of limited specificity of participants' responses. Further, participants may be more likely to receive informational and instrumental or material support for day-to-day issues, rather than significant adversities, making them less likely to report these support functions spontaneously during interviews.

4.1 | Strengths, limitations, and future directions

The current study has several strengths. Its mixed methods approach was particularly well-suited for developing a richer, more nuanced understanding of the prevalence, form, and function of informal helping. The inductive coding scheme was built upon participants' own words, rather than preexisting hypotheses, which is beneficial when approaching a relatively unexplored area of research. While the themes and quotations provided details and nuance, the quantitative analysis allowed us to identify patterns and associations in the data. It is noteworthy that we examined spontaneous descriptions of receiving informal help rather than asking participants directly, avoiding potential demand characteristics and social desirability bias. The frequency and sincerity of these spontaneous discussions highlight the centrality of informal support during key life moments. Another strength of the study is its sample, which is large, particularly for a mixed methods study, and drawn from a rural Appalachian population that has been excluded from most psychological research.

Several limitations of the study should also be acknowledged. First, our data are cross-sectional, making us unable to draw definitive causal conclusions. In particular, we used participants' retrospective accounts of receiving help during adversity to create predictor variables and ratings of their current condition and well-being as outcomes. Participants were asked to select experiences to share during the interviews based on salience rather than timing, so we were unable to systematically account for the role of timing (i.e. how long ago and at what developmental stage each episode of adversity and helping occurred), which is an important area of future research, especially longitudinal investigations. Further, experimental and quasi-experimental studies are needed to make inferences of causality.

It should also be noted that our interviews were not specifically developed to examine helping and help seeking. Although it is notable that so many participants brought up informal helping spontaneously, interviews intentionally designed to examine these phenomena could generate additional information, particularly regarding the nature of the help received. Additionally, we examined only informal helping from the recipients' perspective; giving voice to helpers' perspectives will be an important area of future investigation.

Further, it should be noted that our analyses of associations among types of adversities, helpers, and help received were exploratory in nature. Because there is a lack of previous studies that have conducted in-depth investigations of the role and functions of informal helpers, we ran a large number of chi-square analyses without specific hypotheses in mind. This raises the possibility of type I errors (i.e., false-positives). As a result, statistical significance of these results should be interpreted with caution, and future investigations should attempt to replicate the patterns suggested in this study. Finally, although the distinctive regional and demographic profile of our sample is a strength, our findings might not generalize to other regions and sociocultural groups. Future research should examine informal helping in both diverse and targeted samples.

4.2 | Implications for practice and policy

The current study demonstrates the prevalence and importance of informal helping, reiterating that most of life's challenges are dealt with beyond the offices of doctors and therapists. Recognizing the enormous potential of informal helpers, community psychologists have developed community-based interventions. For example, lay helper

interventions provide training and support for informal helpers; they are taught "microcounseling" skills to support others through a variety of difficulties (e.g., Kabura, 2005) or receive specialized training for working with specific clinical problems (e.g., Montgomery, Kunik, Wilson, & Stanley, 2010). These programs often seek to build coalitions among informal helpers and professional practitioners, combining their diverse strengths and expertise (Eng & Parker, 2002). Although findings on the efficacy of these community-based interventions are promising, large-scale implementation and long-term sustainability are difficult to achieve (Stith et al., 2006). Thus, rural communities would benefit from the development, implementation, and maintenance of community-based prevention efforts that promote the availability and potential of informal helpers.

Further, our findings show that professional helpers can play a key role in health promotion and intervention. The participants who discussed receiving professional help identified this help as a vital lifeline when coping with major issues that had overwhelmed the capacities of their informal support networks. This stated importance of professional help and the low frequency at which it was discussed reiterate the need to expand the accessibility of professional care, particularly in rural regions.

4.2.1 | Conclusion

This mixed methods study provides an empirical demonstration of the strength of human altruism, connection, and community. To further promote these powerful vehicles of resilience, researchers need to better understand the form, function, and availability of the informal provision of help during the experience of both day-to-day and acute adversities. The current study makes a significant contribution to this understudied aspect of social support and sets the stage for future investigations.

ORCID

Matthew Hagler http://orcid.org/0000-0003-4004-7412
Victoria Banyard http://orcid.org/0000-0002-9645-5055

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