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Adolescent barriers to seeking professional psychololgical help for personal-emotional and suicidal problems

Coralie J. Wilson
University of Wollongong, cwilson@uow.edu.au

Debra Rickwood
University of Canberra

Joseph V. Ciarrochi
University of Wollongong, joec@uow.edu.au

Frank P. Deane
University of Wollongong, fdeane@uow.edu.au

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Abstract

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ACADEMIC PAPER

TITLE: Adolescent barriers to seeking professional psychological help for personal-emotional and suicidal problems.

AUTHORS: Coralie J. Wilson, Debra Rickwood*, Joseph Ciarrochi, & Frank P. Deane (Department of Psychology and Illawarra Institute for Mental Health, University of Wollongong, Wollongong, NSW.*Centre for Applied Psychology, University of Canberra, Belconnen, ACT).

CONTACT DETAILS: Coralie Wilson; C/o Illawarra Institute for Mental Health, Building 22, University of Wollongong, Wollongong, NSW 2522, Australia. Tel. +61 2 4221 4207, Fax. +61 2 4221 5585, Email. Coralie_Wilson@uow.edu.au.

ABSTRACT: A number of cognitive and affective barriers reduce the likelihood that young people will seek professional psychological help for either personal-emotional or suicidal problems. This paper describes a study that has examined the relationship between help-seeking barriers and intentions in a high school sample. Six hundred and eight high school students completed a questionnaire measuring help-seeking intentions and barriers to professional mental health sources. Barriers related to lower intentions to seek professional psychological help for suicidal and non-suicidal problems. Findings are discussed in terms of barrier reduction. Strategies for prevention and early intervention are suggested.

INTRODUCTION: Reluctance to seek help from formal medical or mental health sources provides a major obstacle for the prevention of suicide and self-harm (Kalafat, 1997). The Australian *National Survey of Mental Health and Wellbeing* (1999) reported that more than one in five of the 10,600 adults who participated in the study met the criteria for a mental health disorder. Only 38% of these adults sought professional help (Andrews et al., 1999). Of the 4,500 children and adolescents who took part in a similar survey, only 50% of those with a mental health problem attended any service during the previous 6 months, and only 17% attended a mental health service (Sawyer et al., 2000). In a Queensland study of 3,092 young adults aged 15 to 24 years (M = 18.55, SD = 2.77), Donald and colleagues (2000) found that 39% of the males and 22% of the females surveyed reported that they would not seek help from formal services for personal-emotional or distressing problems. Thirty per cent of the males and 6% of the females reported they would not seek help from anyone.

In their examination of barriers to medical service use, the Australian Access to Service and Evaluation Research Unit (SERU, 1999) found that young people identified cost, communication, compassion, confidentiality, and convenience as the major barriers to seeking help from General Practitioners. With regard to mental health services, Sawyer et al. (2000) found that parents cited practical barriers such as "the cost of attending services, not knowing where to get help, and long waiting lists" (p. 33). Donald et al. (2000) found that young people reported "the most common barrier to formal service utilisation was concern about confidentiality" (p. 44), followed by cost barriers and fear about what the service would do. In a study of Australian high school students' barriers to help-seeking, Wilson and Deane (2000) found that students emphasised the importance of fear, anxiety, shame, and adolescent

autonomy. Students also revealed that three important barriers to formal help-seeking related to beliefs that prior professional help had been of little use, limited knowledge about the help that professionals provide, and concerns about not having a relationship with available professional help-providers. Additional barriers included concerns about trust and confidentiality breach.

In terms of suicide prevention and early intervention, the barriers to young people seeking professional help for distressing personal-emotional or suicidal problems need further examination. Barriers and other variables that negatively influence intentions to seek professional help for personal-emotional and suicidal problems need to be identified then targeted for reduction. The goals of the current study were two-fold. First, to measure and prioritise barriers that relate to low intentions to seek professional help. Second, to explore the possibility that hopelessness and the perceived quality of prior professional help might account for the relationship between help-seeking barriers and intentions to seek professional help.

METHOD: Six hundred and eight students recruited from high schools in NSW and QLD took part in the study. Students ranged in age from 12 to 21 years (M = 15.64, SD = 1.69) and represented high school grades 8 to 12. Students completed self-report questionnaires that measured barriers to professional help-seeking, intentions to seek professional help for personal-emotional problems and suicidal thoughts, the quality of prior professional help, and hopelessness. Barriers were measured by a brief version of the Barriers to Adolescents Seeking Help survey (BASH-B; Kuhl et al., 1997). Help-seeking intentions and prior help were measured by a high school focused version of the General Help-Seeking Questionnaire (GHSQ; Deane et al., 2001). Hopelessness was measured by the Beck Hopelessness Scale (BHS; Beck et al., 1974).

RESULTS: BASH-B mean scores are presented in descending order, along with standard deviations, in Table 1. As expected, the belief that one should solve their own problems was the most important barrier to adolescents seeking professional psychological help.

Table 1. Means (M) and standard deviations (SD) of high school student barriers to seeking professional psychological help (BASH-B).

Barrier	M	SD
I would solve my problem myself.	4.30	1.16
I think I should work out my own problems.	4.03	1.37
I'd be too embarrassed to talk to a counsellor.	3.58	1.54
Adults can't understand adolescent problems.	3.40	1.52
Even if I wanted to, I wouldn't have time to see a counsellor.	3.37	1.44
A counsellor might make me do what I don't want to.	3.23	1.59
I wouldn't want my family to know I was seeking a counsellor.	3.09	1.58
I couldn't afford counselling.	3.07	1.57
Nothing will change the problems I have.	2.78	1.44
If I go to counselling, I might find out I'm crazy.	2.60	1.52
If I went for help, the counsellor would not keep my secret.	2.54	1.57

n = 608. Note. Evaluations were made on a 6 point scale (1 = strongly agree to 6 = strongly disagree). Items were reverse scored so that higher mean scores reflect higher barriers to professional psychological help-seeking.

Correlational analyses were conducted between each barrier item and professional help-seeking intentions for personal-emotional and suicidal problems. As presented in Table 2, a number of significant correlations indicated that higher barriers to professional help-seeking related to lower adolescent intentions to seek professional help for suicidal and non-suicidal problems. Particularly noteworthy are the associations between intentions to seek help for suicidal problems and barriers related to autonomy and the belief that nothing will help.

Table 2. Correlations (r) between high school student barriers to seeking professional psychological help (BASH-B) and intentions to seek professional psychological and medical help for suicidal and non-suicidal problems (GHSQ).

	Psychological help		Medical help	
Barrier	Sui.	N-Sui.	Sui.	N-Sui.
I would solve my problem myself.	-.16**	-.14**	-.12**	-.09*
I think I should work out my own problems.	-.21**	-.19**	-.21**	-.19**
I'd be too embarrassed to talk to a counsellor.	-.15**	-.18**	-.16**	-.21**
Adults can't understand adolescent problems.	-.04	-.04	-.17**	-.14**
Even if I wanted to, I wouldn't have time to see a counsellor.	-.13**	-.09*	-.13**	-.10*
A therapist might make me do what I don't want to.	-.10*	-.06	-.08	-.14**
Wouldn't want my family to know I was seeking a counsellor.	-.11**	-.05	-.21**	-.19**
I couldn't afford counselling.	-.06	-.01	-.10*	-.08*
Nothing will change the problems I have.	-.17**	-.11**	-.17**	-.14**
If I go to counselling, I might find out I'm crazy.	-.04	-.01	-.04	-.07
If I went for help, the counsellor would not keep my secret.	-.07	-.03	-.04	-.08*

n = 608. **p < .001, *p < .05. Note. Negative correlations indicate that higher barriers to professional help-seeking associated with lower intentions to seek professional help.

Correlational analyses were also conducted between each barrier item, and hopelessness, and between each barrier item and quality of prior professional help. As presented in Table 3, significant correlations indicated that higher levels of student hopelessness and poor quality prior help related to higher barriers to professional help-seeking. Of particular note, are the significant associations between hopelessness and the individual barriers related to time and money constraints, not wanting family to know about seeking professional help, and the belief that nothing will help. Equally noteworthy are the significant associations between poor quality prior help and the individual barriers related to embarrassment, confidentiality breach, coercion, the belief that nothing will help, and autonomy. (Note: reduced samples sizes due to not all participants receiving the hopelessness measure and not all participants rating prior professional help).

Table 3. Correlations (r) between high school student barriers to seeking professional psychological help (BASH-B), hopelessness (BHS), and the quality of prior professional help (GHSQ).

Barrier	Hopelessness$_a$	Prior Help$_b$
I would solve my problem myself.	.23**	-.27*
I think I should work out my own problems.	.20**	-.28*
I'd be too embarrassed to talk to a counsellor.	.23**	-.36**
Adults can't understand adolescent problems.	.30**	-.20*
Even if I wanted to, I wouldn't have time to see a counsellor.	.31**	-.25*
A therapist might make me do what I don't want to.	.27**	-.34**
Wouldn't want my family to know I was seeking a counsellor.	.35**	-.17*
I couldn't afford counselling.	.48**	-.14
Nothing will change the problems I have.	.31**	-.29**
If I go to counselling, I might find out I'm crazy.	.26**	-.17*
If I went for help, the counsellor would not keep my secret.	.26**	-.35**

$_a$n = 354, $_b$n = 140. **p < .001, *p < .05. Note. Quality of prior professional help was rated on a 5 point scale (1 = not useful to 5 = extremely useful). Negative correlations between Barriers and Prior Help indicate that higher barriers were associated with poor quality prior help.

To examine the possibility that hopelessness and quality of prior help would contribute to the negative relationship between professional help-seeking barriers and intentions, four GLM MANCOVAs were conducted. Models 1 and 2 used professional help-seeking intentions for suicidal thoughts as dependent variables. Models 3 and 4 used professional help-seeking intentions for personal-emotional problems as dependent variables. Barriers were collapsed as a single scale (α = .83) then used to predict professional help-seeking intentions while controlling for hopelessness (Models 1 & 3), then hopelessness and quality of prior help (Models 2 & 4). As shown in Table 4, with hopelessness controlled, barriers significantly predicted lower professional psychological help-seeking intentions for suicidal but not personal-emotional problems, and lower professional medical help-seeking intentions for suicidal and personal-emotional problems. However, once quality of prior help was controlled with hopelessness, barriers could no longer predict help-seeking intentions for either problem-type. (Note. There was substantial loss of power with reduced sample size for the prior help analyses.)

To examine the impact of prior help further, two additional GLM MANCOVAs were conducted. The first model (Model 5) used intentions to seek professional help for suicidal thoughts as dependent variables. The second model (Model 6) used intentions to seek professional help for personal-emotional problems as dependent variables. Barriers were used to predict professional help-seeking intentions while controlling for quality of prior help. As shown in Table 4, barriers were unable to predict professional help-seeking intentions for either suicidal or personal-emotional problems, indicating that the quality of prior help could explain the negative relationship between barriers and help-seeking intentions, over and above the impact of barriers. However, barriers and quality of prior help could not account for more than 18% of the variance in intentions to seek help for suicidal thoughts from mental health professionals or more than 10% of the variance for suicidal thoughts from physical health professionals. Similarly, barriers and quality of prior help could not account for more than 24% of the variance in intentions to seek help for personal-emotional problems from mental health professionals or more than 6% of the variance for personal-emotional problems

from physical health professionals, indicating that additional factors influence intentions to seek help from professional sources (Table 4).

Table 4. Summary of MANCOVA analyses for barriers (BASH-B) predicting help-seeking intentions with hopelessness (BHS) controlled, then hopelessness and quality of prior help (GHSQ) controlled.

	Help-seeking Intentions							
	Suicidal Thoughts[a]				Non-sui problems[b]			
Source of Help	B	SE	R^2	Adj. R^2	B	SE	R^2	Adj. R^2
Hopelessness Controlled (Models 1 & 2)								
Mental Health Professional	-.32*	.12	.048	.041	-.12	.08	.014	.007
Physical Health Professional	-.17*	.08	.033	.026	-.19**	.05	.072	.066
Hopelessness and Quality of Prior Professional Help Controlled (Models 3 & 4)								
Mental Health Professional	-.01	.25	.177	.139	.20	.18	.241	.201
Physical Health Professional	-.17	.18	.102	.060	-.12	.12	.061	.011
Quality of Prior Professional Help Controlled (Models 5 & 6)								
Mental Health Professional	-.01	.24	.175	.150	.20	.17	.241	.215
Physical Health Professional	-.16	.17	.101	.074	.01	.11	.056	.024

[a]df (Models 1 & 2) = 1, 304; [a]df (Models 3 & 4) = 1, 65; [a]df (Models 5 & 6) = 1, 66.
[b]df (Models 1 & 2) = 1, 299; [b]df (Models 3 & 4) = 1, 57; [b]df (Models 5 & 6) = 1, 58.
**$p < .001$, *$p < .05$ significantly different from zero.

DISCUSSION: BASH-B means and standard deviations showed that the largest barriers to students seeking professional health care reflected autonomy (Table 1). Other important barriers reflected anticipated shame and embarrassment, fear of not being understood or being pressured by professional health providers, and anticipated time or money constraints. All barriers related negatively to professional help-seeking intentions for suicidal and non-suicidal problems, indicating that higher barriers related to lower help-seeking intentions. Hopelessness and quality of prior help related to all individual help-seeking barriers (Table 3), however, only quality of prior help was able to explain the negative relationship between barriers and help-seeking intentions (Table 4). Consistent with previous research that exmained treatment fearfulness (Deane & Chamberlain, 1994; Kushner & Sher, 1989), quality of prior help associated most strongly with barriers that described embarrassment, concerns about confidentiality breach, and concerns about coercion (Table 3).

The current study was limited in that at best, only 24% of the variance in professional help-seeking intentions was explained by the variables included in the study. Certainly, there are barriers that have not been identified but which reduce young peoples' intentions to seek professional help. However, despite this limitation, the results of the currently study highlight at least three issues that suicide prevention and early intervention programs would do well to address.

First, programs should target each of the individual barriers measured, particularly those related to autonomy and independence. Although autonomous problem-solving is commonly seen as a desirable goal for good mental health (e.g., D'Zurilla, 1986), it is

important that young people understand that professional help-seeking is often the best way to manage distressing personal-emotional problems and certainly, the best way to manage problems related to suicide (Kalafat, 1997; Wilson & Deane, 2002). Help-seeking messages need to convey the notion that part of being independent and self-directed is knowing when to seek help and support (e.g., "Standing on your own two feet includes knowing when to lean on others"). Programs need to include aspects that match different types of problems to different help-sources (e.g., Wilson, 2000). Programs also need to include practice elements, whereby young people are provided the opportunity to develop personal pathways to care before they become distressed and less likely to seek help from any source, particularly formal help-sources (Deane et al., 2001; Wilson & Deane, 2002; Wilson et al, 2002a,b).

Second, programs need to impart a sense of hope in the promotion of professional help-seeking. While it is important that young people have clear and realistic expectations about the help that professional sources provide, it is also important that young people have the basic understanding that professional help can actually be helpful (Wilson & Deane, 2002). Programs should include information about the ways in which different professionals can assist with different problems. Providing young people with statistics about the efficacy of professional treatment may be of benefit. Professionals should talk with young people about the benefits of the help that they can provide. Through prevention programs and personal contact with professional health care providers, it is important that young people know that no problem is insignificant if it causes distress and that professional help is a good way to start reducing that distress (Wilson & Deane, 2001, 2002).

Third, programs need to explore and address young peoples' negative attitudes and beliefs about the quality of previous professional helping episodes (Carlton & Deane, 2000; Deane & Todd, 1996). From a behavioural perspective, there is evidence that attitudes and beliefs proximate intentions and behaviours (e.g., Ajzen, 1991). From a prevention perspective, there is evidence that negative attitudes and beliefs about prior professional help-seeking may reduce the likelihood that young people will seek professional help in the future (Wilson & Deane, 2000). However, there is also evidence that negative attitudes and beliefs which young people can associate with prior professional help-seeking might be modified favourably in two steps. First, by exploring young peoples' previous professional help-seeking experiences with them. Second, by involving young people in programs that generate new help-seeking experiences with professional health care providers (Wilson & Deane, 2002). At a minimum, prevention programs should include aspects that provide opportunity for young people to reassess their attitudes and beliefs about professional help-seeking (Wilson & Deane, 2001).

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