

Factors Influencing Willingness to Seek Help For Personal or Emotional Problems in Young People

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Contents

Thesis Abstract.....	1
Preface	2
CHAPTER 1: FACTORS INFLUENCING HELP-SEEKING FOR PERSONAL, EMOTIONAL & GENERAL MENTAL HEALTH PROBLEMS IN YOUNG PEOPLE: A REVIEW OF THE LITERATURE	3
Abstract.....	4
Introduction.....	5
A developmental stage for young people.....	5
Mental health problems in young people	5
Help-seeking as a protective factor	6
Models of help-seeking.....	7
Ways of conceptualising and measuring help-seeking.....	8
Aims and scope of current review	8
Method	9
Search terms	9
Exclusion criteria	10
Defining help-seeking	Error! Bookmark not defined.
Databases.....	12
Critical appraisal.....	12
Synthesis	12
Results.....	12
Study characteristics	25
Factors associated with young people's help-seeking.....	26
Demographic factors.....	26
Gender.	26
Age	27
Ethnicity.	28
Socio-cultural factors	28
Socio-economic status.	28
Media	28
Family factors.....	29
Social support.....	29
Contextual factors.....	29
Sources of help.....	29

Prior history.....	30
Wellbeing factors.....	32
Suicidal ideation.....	32
Distress.....	32
Hopelessness.....	33
Developmental and cognitive factors.....	33
Attitudes and beliefs.....	33
Emotional intelligence.....	35
Mental health literacy.....	35
Attachment style.....	36
Discussion.....	37
Summary of main findings.....	37
Demographic factors.....	37
Socio-cultural factors.....	37
Help-seeking contextual factors.....	38
Wellbeing factors.....	38
Developmental and cognitive factors.....	39
Strengths and limitations.....	40
Clinical implications.....	41
Research implications.....	42
Conclusion.....	43
References.....	45

CHAPTER 2: BELIEF BARRIERS, EMOTIONAL INTELLIGENCE, SUICIDAL IDEATION, MENTAL HEALTH LITERACY, GENDER, PAST HELP & WILLINGNESS TO SEEK PROFESSIONAL & NON-PROFESSIONAL HELP FOR PERSONAL & EMOTIONAL PROBLEMS IN YOUNG PEOPLE	59
Abstract.....	60
Introduction.....	61
Gender	62
Beliefs and attitudes	62
Mental health literacy.....	63
Emotional intelligence	63
Suicidal ideation.....	63
Aims and objectives	64
Method	64
Procedure.....	64

Participants	65
Measures.....	66
Help-seeking intentions	66
Gender	66
Emotional intelligence.	67
Belief based barriers	67
Suicidal ideation.....	67
Mental health literacy.....	68
Prior help.....	68
Results.....	68
Statistical analysis	68
Preliminary analysis	69
Multiple regression analysis	73
Regression model I: Formal GHSQ	73
Regression model II: Informal GHSQ.....	74
Regression model III: Informal GHSQ.....	76
Discussion.....	78
Summary of findings	78
Formal help-seeking.....	78
Informal help-seeking.	78
No help-seeking	79
Where this fits with the literature	79
Belief barriers.....	79
Reasons for living	80
Emotional intelligence	80
Gender	81
Previous help.....	81
Mental health literacy.....	82
Clinical implications	82
Limitations and future research.....	84
Conclusion	85
References.....	86
 CHAPTER 3: COMMENTARY & REFLEXIVE ANALYSIS OF THE RESEARCH PROCESS	 97
Abstract.....	98

Introduction.....	99
Reflective Commentary on the Research.....	100
Early considerations.....	100
Literature review.....	100
Methodological design.....	101
Ethical issues	101
Implications and application of research.....	102
Reflexive Analysis	103
Influence of researcher	103
Effects on researcher	104
Conclusion	106
References.....	107
 APPENDICES.....	 109
Appendix A: Summary of the strengths and weaknesses of review papers.....	110
Appendix B: Critical appraisal tool	120
Appendix C: Search terms, limiters and exclusion criterion	122
Appendix D: Participant information sheet	124
Appendix E: Consent form	129
Appendix F: Debrief sheet	130
Appendix G: The General Help-Seeking Questionnaire	137
Appendix H: The Bem Sex Role Inventory Short Form	138
Appendix I: The Schutte Emotional Intelligence Scale	139
Appendix J: The Brief Version of the Barriers to Adolescents Seeking Help Scale	141
Appendix K: Reason for Living for Adolescence	142
Appendix L: Mental Health Literacy Questionnaire.....	144
Appendix M: Demographic and prior help seeking questions.....	145
Appendix N: General Help-Seeking Questionnaire inter-item correlations	146
Appendix O: Results from standard multiple regression models using all variables	147
Appendix P: Letter of approval from Staffordshire University's Ethics Panel	150
Appendix Q: Letter of approval from the sixth form college.....	151
Appendix R: Evidence of permission to use measures.....	152
Appendix S: Excerpts from Journal of Educational and Psychological Consultation	159
Appendix T: Excerpts from Journal of Adolescence	161

Abstract

Young people face unique demands because of life transitions and developmental processes. Mental health problems are prevalent among young people as reflected by high levels of suicide in this age group. Yet young people are unlikely to seek help for their problems. To explore reasons for this reluctance, a literature review searched articles for factors inhibiting or promoting general mental health help-seeking among young people. Seventeen relevant articles emerged. Article findings were synthesised into 16 factors influencing help-seeking. Those promoting help-seeking: Being female, family involvement, social support, informal sources of help, prior help-seeking experience, emotional intelligence, mental health knowledge and secure attachment styles. Those inhibiting help-seeking: Suicidal ideation, hopelessness, and belief barriers. Factors with no direct influence: Ethnicity and media. Inconclusive factors: Age, socio-economic status and distress. Clinical implications of these factors were discussed. A limitation of the research field was a lack of clarity of how factors combined to influence help-seeking and which ones were most salient.

To empirically address this gap in the literature, a cross-sectional study was employed. The study used self-report surveys on 319 college students. Linear multiple regression was used to analyse results. Gender, mental health literacy, emotional intelligence, belief barriers, reasons for living and prior help were the predictor variables. Help-seeking intentions was the criterion variable. It was found the factors in combination predicted help-seeking to some extent, but belief barriers and reasons for living were predominant. This suggested services should attune more effectively to young people's beliefs and norms, adapting services accordingly, while reaching out to young people in the community. The study was limited by use of cross-sectional design and use of theoretical as opposed to real life help-seeking. A reflective commentary explored the research processes further, including a reflexive account of the relationship between researcher and research.

Preface

The first chapter of the thesis will be submitted for publication to the Journal of Educational and Psychological Consultation and the second chapter will be submitted to the Journal of Adolescence (see Appendix T). The third chapter is presented as a requirement of Keele and Staffordshire Universities and is not intended for publication. In order to promote consistency and ease of reading, formats of Chapter 1 and 2 differ slightly from the journals' formatting requirements (see Appendix S and U). The formats will be edited to journal requirement at the point of submission to publishers. The word count in Chapter 2 exceeds the journal requirements by 465 words. The extra words were used to provide extended details of results to promote greater technical understanding for the thesis. These extra details are not required by the journal and so will be edited out at the point of publication.

Chapter 1: Literature Review

Factors Influencing Help-Seeking for Personal, Emotional
and General Mental Health Problems in Young People: A
Review of the Literature

Abstract

Young people face unique developmental and social transitions, a life stage particularly vulnerable to distress, yet young people rarely seek help. This review aims to uncover factors inhibiting or promoting help-seeking for personal or emotional and mental health problems in young people. Unlike previous reviews, here the focus is directly on young people and not restricted to cognitive belief-based factors. Seventeen quantitative and qualitative studies were identified through a systematic search of EBSCO Host, Web of Knowledge and Cochrane Library search engines. After synthesising findings, 16 factors emerged. Those promoting help-seeking: Being female, family involvement, social support, informal sources of help, prior help-seeking experience, emotional intelligence, mental health knowledge and secure attachment styles. Those inhibiting help-seeking: Suicidal ideation, hopelessness, and belief barriers. Factors with no direct influence: Ethnicity and media. Inconclusive factors: Age, socio-economic status and distress. The review raised a number of clinical implications for services and professionals. Future research should consolidate our understanding of how factors combine to influence help-seeking.

Factors Influencing Help-Seeking for Personal, Emotional and General Mental Health Problems in Young People: A Review of the Literature

A Developmental Stage for Young People

An international definition for young people was offered by the United Nations who defined this age group as aged between 15 and 24-years-old (UNESCO, 2014). Adolescence is a distinct developmental stage marked by unique biopsychosocial changes (Offer, Schonert & Ostrov, 1991). During this transition from childhood into adulthood, young people often have to manage profound social, cultural and biological changes and expectation shifts.

As adolescents transition into adulthood they experience unique neurological and emotional developments (Arnett, 2000; Peterson, 2004). Adolescence is a time of heightened affect characterised by more polarised cognitive biases (Larson & Lampman-Petratis, 1989) and heightened self-consciousness compared to older age groups (Amato & Saunders, 1985; Nadler, 1986). Young people have their own socio-cultural norms with their own ways of expressing meaning and language, which might be quite different from other age groups, (McQueen & Henwood, 2002).

During adolescence people experience a developmental process called deindividuation, where they seek increasing control over their own lives as they become more autonomous and independent from parents (Adams & Marshall, 1996; Erikson, 1968). Activities and life events in youth contribute significantly to identity formation, hence events and actions incongruent to the current self-concept will feel threatening (Santrock, 1998; Nadler, 1986).

Due to the unique developmental characteristics of this life stage, environmental stressors and personal problems could potentially have a stronger impact on young people's wellbeing than in any other age group (Larson & Ham, 1993; Zivin, Eisenberg, Gollust & Golberstein, 2009). Indeed, young people are often faced with a catalogue of life changes such as leaving school, moving away from the family home and realising new sexual identities. Many life events in a short space of time have been shown to predict acute stress (Holmes & Rahe, 1967).

Mental Health Problems in Young People

Internationally, 20% of young people experience significant mental health problems (Belfer, 2008). One in four young people reported feelings of psychological

distress (Sawyer et al., 2000), 54% reported having had suicidal thoughts and 10% had attempted suicide at some point (Meehan, Lamb, Saltzman & O'Carroll, 1992). Indeed, evidence suggested 16 to 24-year-olds are particularly vulnerable to mental health difficulties (Slade, Johnston, Oakley-Browne, Andrews & Whiteford, 2009; Mind, 2009).

Mental health problems have a profound and enduring effect on young people as they enter adulthood (Belfer, 2008; Kessler, Berglund, Demler, Jin & Walters, 2005). The presence of depression and anxiety in adolescence is a significant risk factor for depression and anxiety in adulthood (Fergusson & Woodward, 2002). Fifty percent of adult mental health disorders commence by the age of 14-years-old (Belfer, 2008) and three quarters by the age of 24-years-old (Kessler et al., 2005). Having a mental health problem in adolescence can adversely affect employment, social skills, education and relationship formation (Wittchen, Nelson & Lachner, 1998; McGorry, Purcell, Hickie & Jorm, 2007). Worldwide, suicide is the third leading cause of death among 15 to 25-year-olds (Belfer, 2008).

Help-seeking can be conceptualised in many different ways (Rickwood et al., 2005). In keeping with previous literature (e.g. Gulliver et al., 2010; Zwaanswijk et al., 2003; Rickwood et al., 2005), this review will accept definitions that explore individuals' past, present or future intentions to seek help from someone or an organisation other than themselves, whether real or theoretical.

Help-Seeking as a Protective Factor

The ability to seek out help for personal or emotional difficulties has been found to be a protective factor against spiralling into poor mental health (Rickwood, Deane, Wilson & Ciarrochi, 2005). Engaging young people in treatment early creates favourable prognosis into adulthood and also provides long term cost-benefit gains for services (Kessler et al., 2005; McGorry et al., 2007). However, research shows young people are reluctant to ask for help for such problems (Sawyer et al., 2000, Zachrisson, Rodje & Mykletun, 2006). Indeed, this age group have been found to engage the least (Olfson & Klerman, 1992; Andrews, Issakidis & Carter, 2001). Only 17% of young people who scored clinically significant levels of distress on a questionnaire were willing to seek help (Rickwood & Braithwaite, 1994) and around 30% of those with a diagnosable disorder (Aalto-Setälä, Marttunen, Tuulio-Henriksson, Poikolainen & Lonnqvist, 2002; Kessler & Walters, 1998).

Models of Help-Seeking

Various help-seeking models have been proposed. Rickwood et al. (2005) suggested a four-step social transaction model. In the first step, the person appraises symptoms and conceptualises a problem. In the second step, the person has to be able to articulate their symptoms and needs. In the third step, sources of help must be physically available and accessible. In the last step, the person has to be willing to disclose their inner world. As the person moves through the steps, they go from an internal domain to an increasingly interpersonal one, and as such are more able to seek help.

Nadler (1991) conceptualised help-seeking as a cognitive process of problem solving. Help-seeking will be influenced by the interaction between the person's individual traits (for example motivation, locus of control and self-awareness), the type of help being sought and the characteristics of the help source. Before a person makes a help-seeking decision, a cost benefit analysis takes place; costs could equate to feelings of inferiority, damage to self-esteem or financial loss; benefits could equate to resolving the problem. When all factors are cognitively processed and problem-solving skills applied, a help-seeking decision is made.

These models have been supported by empirical research (Rickwood et al., 2005) but also attracted criticism for their simplistic and linear approaches (Biddle, Gunnell, Sharp & Donovan, 2004; Pescosolido & Boyer, 1999). Some argued the models focused on traits attributable to the help-seeker while ignoring contextual factors (Bebbington et al., 2000; Horwitz, 1996) and often disregarded the affective influence on cognition (Shad, Keshavan, Tamminga, Cullum & David, 2007; Saunders & Bowersox, 2007).

In response to the above criticisms, Biddle, Donovan, Sharp and Gunnell (2007) formulated a dynamic-interpretive model of help-seeking. The model described young people having polarised perceptions of mental distress; framed as either normal distress or real distress. Real distress was stigmatised with a host of negative narratives. Young people strive to maintain a self-perception of normal distress to avoid associating themselves with this stigma. As a young person's wellbeing decreases, they avoid defining themselves with real distress by comparing themselves to others who have more severe symptoms. Using cognitive biases they exaggerate areas of their life still

functioning adequately while understating evidence of non-functioning. Ultimately, help-seeking is perceived as an indicator of real distress so is avoided.

Biddle, et al.'s (2007) model has been commended for including different contextual variables such as cognitive processing, socio-cultural meanings and the nature of the problem (Gulliver, Griffiths & Christensen, 2010). However, this dynamic-interpretative model generally lacks empirical support (Pescosolido & Boyer, 1999).

Ways of conceptualising and Measuring Help-Seeking

In research there is a plethora of ways to conceptualise and measure help-seeking (Rickwood et al., 2005). One method involved asking respondents about current or recent help-seeking behaviour (Rickwood et al., 2005). This help-seeking measure is less sensitive though to nonclinical samples who may not have been receiving help (Rickwood et al., 2005).

An alternative, and popular conceptualisation of help-seeking, is to measure respondents' attitudes and intentions to help-seek in response to a theoretical problem or vignette (Wilson, Deane, Ciarrochi & Rickwood, 2005a; Rickwood et al., 2005). Such measures are underpinned by the theory that intentions are closely related to actual behaviour (Ajzen, 1991; Webb & Sheeran, 2006). Indeed, research has shown moderate correlations between willingness to seek help and actual help-seeking (Wilson, Deane, Ciarrochi & Rickwood, 2005; Rickwood et al., 2005). One help-seeking intentions measure, the General Help-Seeking Questionnaire (GHSQ; Wilson et al., 2005) has increasingly become the measure of choice due to its growing reliability and validity evidence-base (Rickwood et al., 2005).

However, such measures are regarded by some as a simplistic temporal snapshot in an otherwise complex help-seeking process that evolves over time (Biddle et al., 2007; Gulliver et al., 2010; Pescosolido, 1992). Such critics often conceptualise help-seeking as part of a broader, multifaceted psychosocial process. For these researchers, help-seeking is explored using in-depth qualitative approaches such as focus groups and interviews (Pescosolido, 1992; Dingwell, 1976).

Aims and Scope of Current Review

A growing pool of empirical research has explored factors influencing young people's help-seeking for personal or emotional and general mental health problems. As a consequence, a plethora of potential factors influencing help-seeking has been

identified. However there is a need to review these factors to gain an overview of how they influence help-seeking in young people.

Three previous review articles have only explored the cognitive barriers and facilitators to help-seeking, or were not solely focused on young people (Gulliver et al., 2010; Zwaanswijk, Verhaak, Bensing, Ende & Verhulst, 2003; Rickwood et al., 2005). Therefore, the current review aims to explore help-seeking for personal or emotional problems or general mental health problems exclusively in young people as a distinct age group. It will explore all types of potential factors influencing help-seeking not just internal cognitive ones. Systematic procedures will be adopted to uncover relevant research. The objective of the review is to inform mental health and community services to enable them to reach out more successfully to young people and promote help-seeking as a coping mechanism.

Method

This literature review aims to report and synthesise research that explored potential factors promoting or inhibiting young peoples' help-seeking for personal or emotional and general mental health problems. Even though a systematic review is beyond the scope of this paper, the methodology utilises systematic procedures (see Figure 1).

Search Terms

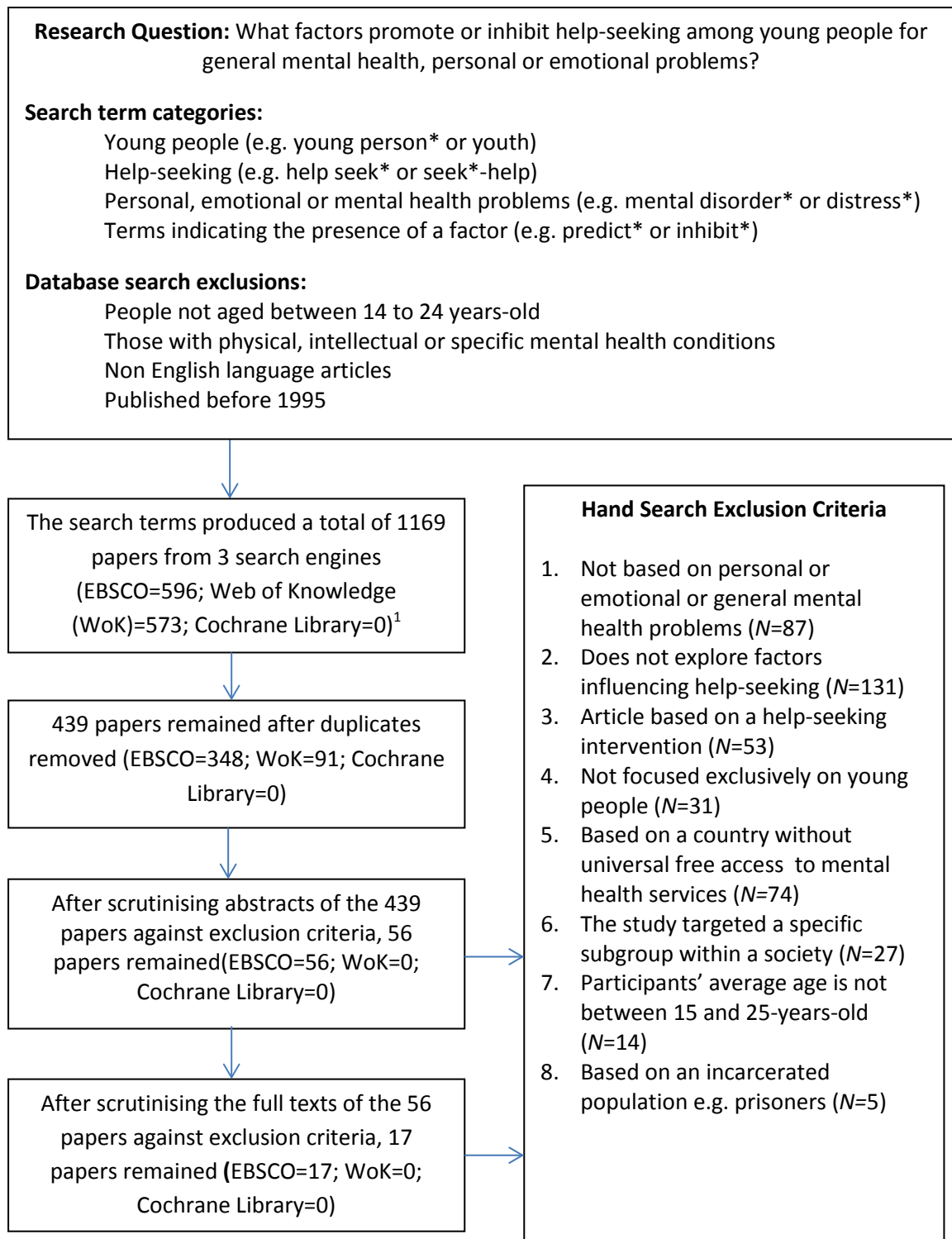
In order to explore the research question of 'what factors promote or inhibit help-seeking among young people for general mental health, personal or emotional problems', five sets of search terms were developed (see Appendix C). The first set were used to search for young people (e.g. young people or young person* or youth). The second set searched for help-seeking (e.g. help-seek* or help seek* or seek*-help). The third set searched for general mental health, personal or emotional problems (e.g. mental disorder* or mental* distress or psychological distress). The fourth set searched for terms indicating the presence of a factor (e.g. predict* or inhibit* or promot*). The fifth set introduced *not* terms to exclude younger children, older adults and problems based on physical conditions, intellectual impairments and specific complex mental health problems such as psychoses (e.g. old* or child* or psychos*). An abstract search was employed across databases.

Exclusion Criteria

Limiters were added to the database search (see Appendix C): English language due to lack resources to translate); 15 to 24-years-old age range (United Nations' definition of a young person); papers published after 1995 (the year UK's current child and adolescent services were conceptualised; Health Advisory Service, 1995).

In line with the aims and objectives of the current review, a set of exclusion criteria were developed to guide the hand search of database results (see Figure 1 and Appendix C). In particular, articles were excluded if:

- The problem was not general mental health, personal or emotional in nature
- Factors potentially influencing help-seeking were not explored
- The emphasis of the research was evaluating an intervention
- Participants were not exclusively young people
- The study was based in a country without universal free access to mental health services
- The study focused on a specific subgroup (e.g. refugees in London)
- The study used participants whose average age fell outside the 15 to 25-year-old range
- The participants were incarcerated (e.g. prisoners).

Figure 1: A Flow Diagram Showing the Literature Search Procedure

Notes: ¹ Databases included: Web of Science, BIOSIS, Current Contents Connect, Data Citation Index, Journal Citation Reports, Academic Search Complete, GreenFILE, AMED - The Allied and Complementary Medicine Database, Medline, PsycINFO, CINAHL, Teacher Reference Center

Databases

Three database host searches were carried out. An EBSCO Host search (Academic Search Complete, GreenFILE, AMED - The Allied and Complementary Medicine Database, Medline, PsycINFO, CINAHL, Teacher Reference Center), a Web of Knowledge (WoK) search (Web of Science, BIOSIS, Current Contents Connect, Data Citation Index, Journal Citation Reports) and a Cochrane Library search.

Critical Appraisal

The studies in this review used a variety of designs, so for efficiency, a bespoke appraisal checklist was developed which had the flexibility to appraise all methodologies (see Appendix B). A recent review found no single preferred appraisal method (Katrak, Bialocerkowski, Massy-Westropp, Kumar & Grimmer, 2004) so the current checklist was created by combining and synthesising popular appraisal tools that focused on the different methodologies represented within the review studies, including Randomly Controlled Trials and Qualitative Methods Critical Appraisal Skills Programme checklists (CASP; 2010), the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE; von Elm, Altman Egger, Gøtzsche & Vandenbroucke, 2008) and checklists by Young and Solomon (2009), Greenhalgh (1997a), Greenhalgh and Taylor (1997), Greenhalgh (1997b) and Greenhalgh (1997c). A thematic analysis of these tools was carried out (Braun & Clarke, 2006) which was used to develop the current appraisal checklist (see Appendix B for an example of how this was done).

Synthesis

The characteristics of the selected papers, including methodology, design, findings and implications were summarised and synthesised below. Where papers reported findings beyond the current research question, these were not synthesised. As the research question is focused on factors influencing help seeking in young people, findings will be synthesised under factor headings.

Results

The database search yielded 1169 potentially relevant papers which reduced to 439 once duplicates were removed (See Figure 1). After analysing the abstracts of these papers against the exclusion criteria, 56 papers remained. A further examination of the full texts of these 56 papers identified 17 relevant papers (see Table 1).

Table 1

A Summary of Papers Exploring Factors Influencing Mental Health, Personal or Emotional Problem Help-Seeking in Young People Identified Through the Literature Search

Authors	Age	N	Sample	Method	Factors explored	Help-seeking measure	Other measures	Summary of select key statistical findings
1. Carlton & Deane (2000)	14-18 (<i>M</i> =15.63)	221 (51% females, 49% males)	New Zealand High school students	In class self-report questionnaire	<ul style="list-style-type: none"> • Distress • Gender • Help-seeking attitudes • Prior help • Suicidal ideation • Treatment fearfulness 	Novel measure: Help-seeking intention for personal or emotional problems and suicidal thinking (No validity or reliability data presented)	Attitudes towards help seeking: ATSPPHS (reliability and validity evidence from Fischer & Turner, 1970) Fears about treatment: TAPS (Cronbach's alphas from .70 to .93; validity evidence from Spielberger, 1983; Deane & Chamberlain, 1994) Psychological distress: HSCL-21 (validity and reliability evidence from Spielberger, 1983 and Deane, Leathem & Spicer, 1992) Suicidal ideation: SIQ (reliability and validity evidenced from Reynolds, 1988a; Beaumont, 1994)	Attitudes to help-seeking, fears of treatment, distress, suicidal ideation and prior help significantly predicted help-seeking for emotional and personal problems, accounting for 22% of the variance (R^2), with help-seeking attitudes the only independent predictor ($p < 0.001$)

							Prior help seeking: novel items (no reliability or validity data reported)	
2. Ciarrochi & Deane (2001)	No age range (<i>M</i> =20.58)	300 (77% females, 23% males)	Australian undergraduate psychology university students	In class self-report questionnaire	<ul style="list-style-type: none"> Emotional intelligence Hopelessness Prior help 	GHSQ with personal or emotional problems and suicidal thinking (no reliability or validity data presented)	Emotional competence: SEIS (Cronbach's alpha= .86; validated by Ciarrochi, 2000; Petrides & Furnham, 2000; Schutte et al., 1998). Hopelessness: the BHS (Cronbach's alpha=.93; validated by Metalsky & Joiner, 1992; Beck et al., 1974) Prior help seeking: items from the GHSQ (no reliability or validity data reported)	Those with previous professional help expressed greater help seeking from mental health professionals for personal and emotional problems ($r=0.14, p<.050$). Perceiving emotions was not associated with help-seeking. Managing self-emotions ($r=.27, p<.005$) and other's emotions ($r=.24, p<.005$) was related to increased help-seeking from family
3. Tishby et al. (2001)	13-18 (No mean)	1415 (49% females, 51% males)	Israeli high school students	In class self-report questionnaire	<ul style="list-style-type: none"> Age Distress Gender Help-seeking attitudes Suicidal ideation Type of problem 	Novel measure: Help-seeking responses to variety of problems (No validity or reliability data reported)	Emotional distress: Beck's Depression Scale (no reliability or validity data reported) Suicidal ideation: a novel question (no reliability and validity data reported) Type of problem, help	Race, socio-economic status, parental marital status and birth order were not associated with help-seeking. Males (22%) were more likely to state they would not seek help from anyone ($p<.010$) than

seeking attitudes, age, gender: an adapted version of the Minnesota Adolescent Health Survey (no reliability or validity data reported)	females (14%). Students in grades 7-8 (5%) expressed greater willingness to seek help from professionals than grades 9-10 (2%) and grades 11-12 (1%). Students in grades 11-12 (61%) had greater help-seeking intentions from friends than those in grades 7-8 (41%). Those with depression were less likely to want to seek help from anyone for depressed mood (17%) than nondepressed participants (13%). Those who had previously attempted suicide were more likely to not want to seek help from anyone for depressed mood (45%) than non-suicidal participants (16%)
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Factors Influencing Help-Seeking for Personal or Emotional Problems in Young People

4. Wilson & Deane (2001)	15-17 (No mean)	23 (52.2% females, 47.8% males)	Australian high school students	Semi-structured interview and focus group	<ul style="list-style-type: none"> • Barriers • Distress • Influencing factors • Sensitive issues • Service engagement 	Focus groups, semistructured interviews	NA	Qualitative findings only
5. Ciarrochi, Deane, Wilson & Rickwood (2002)	16-18 (<i>M</i> =16.9)	137 (44.5% females, 45.5% males)	Australian high school students	In class self-report questionnaire	<ul style="list-style-type: none"> • Emotional intelligence • Hopelessness • Problem type • Social support • Source of help 	GHSQ with personal or emotional problems and suicidal thinking (validity data reported from Ciarrochi & Deane, 2001a; Deane, Wilson & Ciarrochi, 2001; no reliability data reported)	Hopelessness: BHS (Cronbach's alpha=.82; validity data from Metalsky & Joiner, 1992) Emotional competence: SEIS (Cronbach's alpha=0.78; validity data from Schutte et al., 1998; Schutte et al., 2001); LEAS (Cronbach's alpha=.89, test-retest reliability, $r=.66$; validity data from Ciarrochi, Chan & Bajgar, 2001; Lane et al., 1990); TAS-20 (Cronbach's alpha=.79, test and retest validity, $r=.77$; validity data from Taylor, 2000; Bagby et al., 1994) Social support: SSQ	Help-seeking associated with emotional awareness ($F(10, 120)=3.35, p=.001$), identifying emotions ($F(10, 116)=2.40, p=.010$), describing emotions ($F(10, 116)=2.29, p=.020$), managing own emotions ($F(10, 115)=2.0, p=.04$) and managing others' emotions ($F(10, 115)=3.12, p=.002$). More positive relationships found between emotions and informal help-seeking than emotions and formal help-seeking ($\chi^2(1)=9.68, p<.005$).

(Cronbach's alpha=.85; no validity data reported)

Help source and problem:
Items embedded in GHSQ

6. Biddle, Gunnell, Sharp & Donovan (2004)	16-24 (No mean)	1276 (56.1% females, 43.9% males)	Young people randomly selected from registered Avon (UK) population	Self-report postal questionnaire	<ul style="list-style-type: none"> • Suicidal ideation • Wellbeing • Socio-economic status • Social support • Prior help 	Novel measure: Current and past 4 weeks of help-seeking for psychological and emotional problems (No reliability or validity data)	<p>Psychological health: GHQ-12 (no reliability and validity data reported)</p> <p>Suicidal thinking: Items from GHQ-28 (no reliability and validity reported)</p> <p>Socio-economic status and help-seeking history: Novel questions (no reliability and validity data reported)</p> <p>Social Support: Duke UNC Functional Social Support Questionnaire (no reliability and validity data reported)</p>	Greater Help-seeking in females than males (difference=9.4%, 95% CI=5.5 to 13.3, $p<.001$). Distress (GHQ) was strongest predictor of help seeking (the OR between GHQ scores of 4-6 and 10-12 was 13.4 (95% CI=5.3-33.9, $p<.001$). Males had greater thresholds of distress before seeking help than females (difference=1.5, 95% CI=-0.2 to 3.1, $p=.070$)
7. Sheffield, Fiorenza & Sofronoff (2004)	15-17 ($M=16.03$)	254 (51.2% females, 48.8% males)	Australian high school students	In class self-report questionnaire	<ul style="list-style-type: none"> • Attitude to help-seeking • Mental health literacy • Distress 	Novel measure: Help-seeking responses to depression and depression with suicidal thoughts vignettes	<p>Attitudes towards mental health: OMI (no reliability or validity data reported)</p> <p>Knowledge of mental illness: Novel measure (no</p>	Adolescents with greater adaptive functioning, fewer perceived barriers to help seeking, and higher psychological distress were

					<ul style="list-style-type: none"> • Perceived barriers • Social support • Prior history 	No reliability or validity data	reliability or validity data reported)	more willing to seek help from formal help sources ($F(7, 246)=5.56$, $p<.001$) explaining 13.7% of the variance (R^2), and informal sources of help ($F(7, 246)=9.99$, $p<.001$) explaining 22.1% of the variance (R^2)
							Psychological Functioning: DASS-21 (no reliability or validity data reported) Perceived barriers to help-seeking: Novel measure (no reliability or validity data reported) Social support: Novel measure (no reliability or validity data reported) Prior help-seeking: Novel measure (no reliability or validity data reported)	
8. Moran (2007)	14-15 ($M=15$)	112 (35% females, 65% males)	London (UK) high school students	In class self-report questionnaire	<ul style="list-style-type: none"> • Age • Attachment style • Emotional and behavioural problems • Ethnicity • Gender • Prior help 	GHSQ with personal or emotional problems (reliability and validity data reported from Ciarrochi & Deane, 2001; Deane et al., 2001)	Age, gender and ethnicity: Demographic questions Attachment style: Bartholomew and Horowitz's (1991) categories (reliability and validity evidenced by Bartholomew & Harrowitz, 1991; Shaver & Hazan, 1993) Emotional and behavioural	Significantly more help-seeking found for females than males ($t=2.01$, $df=105$, $p<.050$), for secure attachment compared to insecure attachments ($t=-2.04$, $df=96$, $p<.050$) and previous professional help compared to informal help ($t=-2.19$, $df=90$, $p<.050$).

							difficulties: SDQ (reliability and validity evidenced by Goodman 1997)	Ethnicity and level of emotional and behavioural problems had no effect
9. Biddle, Donovan, Sharp & Gunnell (2007)	16-24 (No mean)	23 (56.5% females, 43.5% males)	Young people purposively selected from Biddle et al.'s (2004) original sample	Semi-structured interview	<ul style="list-style-type: none"> • Distress • Normalising and coping • Perceptions of help source • Self-diagnosis 	Semi-structured interviews	NA	Qualitative findings only
10. Raviv, Raviv, Vago-Gefen & Fink (2009)	15-18 (No mean)	662 (54.1% females, 45.9% males)	Israeli high school students	In class self-report questionnaire	<ul style="list-style-type: none"> • Belief barriers • Benefit of help-seeking • Coping ability • Gender • Perceived problem severity • Prior help • Satisfaction of prior help 	Novel measure: Help-seeking responses to depression vignettes (no reliability and validity data reported)	Belief barriers: BASH (test retest reliability, $r=.65$; Cronbach's $\alpha=.89$) Perceived coping, psychological benefit, problem severity, comparative coping and prior help seeking and prior help seeking satisfaction: Novel items (no reliability or validity data reported)	Females seek help from friends more than males ($F(1, 654)=20.46, p<.010$). For help-seeking from a psychologist, participants referred others for help more than themselves ($F(1, 654)=179.22, p<.010$). Males believed they could cope better with problems than females ($F(1, 654)=43.80, p<.010$) as did older adolescents compared to young ones ($F(1, 654)=3.99, p<.050$).

								Past help correlated with willingness to seek help from a psychologist ($r=.32$, $p<.010$)
11. Morgan & Jorm (2009)	12-25 ($M=18.23$)	3746 (52.1% females, 47.9% males)	Australian young people randomly selected from registered telephone numbers	Telephone structured interview	<ul style="list-style-type: none"> Recall of news's stories Age Gender Personal experience of mental distress Mental health literacy 	Items on Mental Health Literacy Questionnaire (Jorm et al, 1997): Vignette of a young person with mental illness (no reliability or validity data reported)	Recalled stories from media: Novel scale (no reliability or validity data reported) Mental health problem recognition: Novel measure (no reliability or validity data reported) Psychological distress: K6 Questionnaire (no reliability or validity data reported)	Recalled news stories and prior personal experience did not predict help-seeking. Being female ($OR=0.90$) and older ($OR=1.30$) significantly predicted greater help-seeking
12. Wilson (2010)	15-25 ($M=18.47$)	109 (33% females, 67% males)	Australian university students	In class self-report questionnaire	<ul style="list-style-type: none"> Distress Belief barriers 	GHSQ with personal or emotional problems and suicidal thinking (no reliability or validity data reported)	Belief barriers: BASH-B (Cronbach's $\alpha=.88$) Psychological distress: HSCL-21 (Cronbach's $\alpha=.92$)	Higher distress associated with no help ($r=.34$, $p<.001$) and weaker informal help-seeking ($r=-.20$, $p=.037$). Stronger belief barriers associated with no help ($r=.28$, $p=.003$) and weaker formal help-seeking ($r=-.28$, $p=.010$)

Factors Influencing Help-Seeking for Personal or Emotional Problems in Young People

13. Smith and Shochet (2011)	17-26 (<i>M</i> =19.39)	150 (78.7% females, 21.3% males)	Australian psychology university students	Internet based self-report questionnaire	<ul style="list-style-type: none"> • Mental health literacy • Attitudes to help-seeking • Belief barriers 	GHSQ with mental illness (reliability data reported from Smith & Shochet, 2011; no validity data reported)	Mental health literacy: Mental Health Literacy Questionnaire (Cronbach's alpha=.81) Attitudes to mental illness: Novel scale (Cronbach's alpha=.81) Knowledge about the importance of help seeking: Novel items (Cronbach's alpha=.60) Confidentiality and affordability: Novel items (no reliability or validity data reported)	Mental health literacy components accounted for 27% of the help-seeking variance (R^2). Knowledge about interventions (β =.20), affordability (β =.28), confidentiality (β =.17) and beliefs about mental illness (β =.17) were independent predictors of help-seeking (p <.01)
14. Klineberg, Biddle, Donovan & Gunnell (2011)	16-24 (No mean)	1276 (57.2% females, 42.8% males)	Young people randomly selected from registered Avon (UK) population	Postal self-report questionnaire	<ul style="list-style-type: none"> • Distress • Socio-economic status • Mental health literacy 	Novel measure: Help-seeking responses to general anxiety-depression and acute depression-suicidal thoughts (no reliability and validity data reported)	Psychological distress: GHQ-12 (no reliability and validity data reported) Socio economic status: the Townsend postcode score and parental occupation coding (no reliability or validity data reported)	Participants who identified a mental health problem in a vignette, 64.7% suggested the character should seek help from a GP, whereas 16.4% said they actually would see a GP. No gender difference was observed for recommending help for perceived mild depressive

									symptoms. For severe depressive symptoms, more females (71.5%) than males (53.7%) suggested the character should see a GP ($p=.001$) and more females (19.2%) than males (11.8%) said the character would see a GP ($p=.0009$)
15. Wilson, Rickwood, Bushnell, Caputi & Thomas (2011)	18-25 ($M=19.39$)	641 (74.4% females, 25.6% males)	Australian psychology university students	Internet based self-report questionnaire	<ul style="list-style-type: none">• Informal help-seeking• Need for autonomy• Type of problem	GHSQ-V with general anxiety and depression and suicidal thoughts (no reliability data; validity reported via factorial analysis within the paper)	Need for autonomy: BASH-B (Cronbach’s alpha=.78; validity evidence from Wilson & Deane, 2010b) Informal help seeking and problem type: GHSQ-V (reliability data not reported; validity data reported via factorial analysis within the paper)	Factors when combined significantly predicted help-seeking for general anxiety and depression ($R^2=.13$) with seeking previous help from family ($R^2=.22$), need for autonomy ($R^2=-.14$) and desire not to seek help ($R^2=-.12$) as independent predictors of help-seeking	
16. Wilson & Deane (2012)	13-21 ($M=16.88$)	1037 (58.5% females,	Australian university and college students	In class self-report questionnaire	<ul style="list-style-type: none">• Age• Gender• Help-seeking	GHSQ with personal or emotional and suicidal thoughts (Cronbach’s	Need for autonomy and help seeking fears: BASH-B (Cronbach’s alpha=.84,	Lower need for autonomy ($\beta=-.24$, $p<.001$), believing prior mental health care	

Factors Influencing Help-Seeking for Personal or Emotional Problems in Young People

		41.5% males)			fears	alpha=.83; validity data reported from Deane et al., 2001)	validity data from Wilson et al., 2005 and factorial analysis in their own study)	was helpful ($\beta=.27, p<.001$) predicted professional help-seeking ($F(5, 267)=16.56, p<.001$). Males had significantly greater need for autonomy than females ($F(1, 1030)=5.31, p=.021$). Need for autonomy was not different across age ranges yet help-seeking fears was (males: $F(2, 427)=4.62, p=.010$; females: $F(2, 603), p<.001$)
					<ul style="list-style-type: none">• Need for autonomy• Prior help			Prior help seeking: Items from the GHSQ Age and gender: demographic questions (no reliability or validity data reported)
17. Wright, Jorm & Mackinnon (2012)	12-25 (M=18.23)	3746 (52.1% females, 47.9% males)	Australian young people randomly selected from registered telephone numbers	Telephone structured interview	<ul style="list-style-type: none">• Mental health literacy• Type of mental health problem	Items from Mental Health Literacy Questionnaire (Jorm et al., 1997) with depression, depression with alcoholism, psychosis, and social phobia vignettes. (reliability and validity reported)	Perception of helpfulness of help: Novel questions (no reliability or validity data reported) Knowledge of help and treatment, and how problem labelled: Novel measure (no reliability or validity data reported)	Accurate identification of depression predicted belief in usefulness of counsellor ($OR=1.76$) and psychologist ($OR=1.83$). Accurate identification of psychosis predicted belief in helpfulness of psychiatrist ($OR=1.86$) and GP ($OR=2.07$). Identification of social phobia predicted belief in helpfulness of psychologist ($OR=3.67$)

Notes: *CI*, Confidence intervals; *OR*, Ordinal Ratio; HSCL-21, Hopkins Distress Symptom Check-list with 21 items (Green, Walkey, McCormick & Taylor, 1988); GHSQ, General Help-Seeking Questionnaire (Wilson, Deane, Ciarrochi & Rickwood, 2005); GHSQ-V, General Help-Seeking Questionnaire Vignette version (Wilson, Rickwood, Bushnell, Caputi & Thomas, 2011) based on GHSQ (Wilson, Deane, Ciarrochi & Rickwood, 2005); BASH, Barriers to Adolescents Seeking Help scale (Kuhl, Jarkon-Horlick & Morrissey, 1997); BASH-B, The Brief Version of the Barriers to Adolescents Seeking Help Scale (Wilson, Deane & Ciarrochi, 2005b; Kuhl et al., 1997); K6 Questionnaire (Kessler, Andrews, Colpe, et al., 2002); The Mental Health Literacy Questionnaire (Jorm, Korten, Jacomb, Christensen, Rodgers & Pollitt, 1997); Townsend postcode score (Townsend, Phillimore & Beattie, 1988); SIQ, Suicidal Ideation Questionnaire (Reynolds, 1988a); Occupational coding into manual or non-manual (Office of National Statistics, 2000); GHQ-12, General Health Questionnaire with 12 questions (Goldberg & Williams, 1988); Duke UNC Functional Social Support Questionnaire (Broadhead, Gehlbach, De Gruy & Kaplan); OMI, Opinions about Mental Illness scale (Cohen & Struening, 1962); DASS-21, Depression Anxiety Stress Scale with 21 items (Lovibond & Lovibond, 1995); Minnesota Adolescent Health Survey (Blum & Bearinger, 1990); Beck's Depression Scale (Beck, Ward, Mendelson, Mock & Erbaugh, 1961); SEIS, Schutte Emotional Intelligence Scale (Schutte, Malouff, Hall, Haggerty, Cooper, Golden & Dornheim, 1998); BHS, Beck hopelessness scale (Beck, Weissman, Lester & Trexler, 1974); LEAS, Levels of Emotional Awareness (Lane, Quinlan, Schwartz, Walker & Zeitlin, 1990); TAS-20, Toronto Alexithymia Scale with 20 items (Bagby, Taylor & Parker, 1994); SSQ, Social Support Questionnaire (Sarason, Levine, Basham & Sarason, 1983); ATSPPHS, Attitudes Toward Seeking Professional Psychological Help Scale (Fischer & Turner, 1970); TAPS, Thoughts about Psychotherapy Survey (Kushner & Sher, 1989) derived from Thoughts about Counselling Survey (Pipes, Schwartz & Crouch, 1985); SDQ, Strengths and Difficulties Questionnaire (Goodman, 1997)

Study Characteristics

Each paper reported a research study, the methodologies they used and help-seeking factors explored are summarised in Table 1. As the majority of studies aimed to extend findings from previous research, papers in the tables are presented in chronological order.

Fifteen studies used cross-sectional methodology, two of which conducted structured telephone interviews (Wright, Jorm & Mackinnon, 2012; Morgan & Jorm, 2009). The other 13 used questionnaires; two were administered by post (Biddle et al., 2004; Klineberg, Biddle, Donovan & Gunnell, 2011), two were administered online (Smith & Shochet, 2011; Wilson, Rickwood, Bushnell, Caputi & Thomas, 2011), seven were administered face-to-face at an education establishment (Wilson, 2010; Raviv, Raviv, Vago-Gefen & Fink, 2009; Moran, 2007; Sheffield, Fiorenza & Sofronoff, 2004; Carlton & Deane, 2000; Tishby et al., 2001; Wilson & Deane, 2012) and a further two did not specify how they were administered (Ciarrochi & Deane, 2001; Ciarrochi, Deane, Wilson & Rickwood, 2002). Two studies used qualitative methodology, utilising focus groups and semi-structured interviews which were analysed through grounded theory principles (Biddle et al., 2007; Wilson & Deane, 2001).

The majority of studies sampled student populations. Seven studies used school populations selected for convenience, one was based at a high school in London (Moran, 2007), another one in New Zealand (Carlton & Deane, 2000), two in Israel (Tishby et al., 2001; Raviv et al., 2009), and three in Australia (Wilson & Deane, 2001; Ciarrochi et al., 2002; Sheffield et al., 2004). Five Australian studies used university or college students. One of these studies was based at Nowra and Wollongong Universities (Wilson & Deane, 2012), one at Queensland University (Smith & Shochet, 2011), two did not specify the university (Wilson et al., 2011; Ciarrochi & Deane, 2001) and another used unspecified universities and colleges in Nowra, Wollongong and Brisbane (Wilson, 2010). Three of these university-based studies used psychology undergraduate students who received course credits for participation (Ciarrochi et al., 2001; Smith & Schochet, 2011; Wilson et al., 2011).

Four studies randomly sampled specific geographical regions, three of which shared the same sample selected from the Bristol area (Biddle et al., 2004; Klineberg et al., 2011; Biddle et al., 2007). Two further studies sampled Australian households by

randomly generating telephone number sequences (Morgan & Jorm, 2009; Wright et al., 2012).

Factors Associated with Young People's Help-Seeking

Demographic factors.

Gender. Three studies found females had significantly greater help-seeking intentions than males (Morgan & Jorm, 2009; Ciarrochi & Deane, 2001; Tishby et al., 2001). One study found males reported greater intentions not to seek help from anyone (Tishby et al., 2001). Three studies found females had more favourable attitudes and beliefs towards help-seeking (Sheffield et al., 2004; Wilson, 2010; Raviv et al., 2009). On the other hand, two studies found males had a greater need for autonomy and perceived they could cope alone (Raviv et al., 2009; Wilson & Deane, 2012).

Two studies found females had greater help-seeking scores than males for informal help but found no significant gender differences with formal help-seeking (Biddle et al., 2004; Raviv et al., 2009). Three further studies found no gender differences in help-seeking (Ciarrochi et al., 2002; Carlton & Deane, 2000; Smith & Shochet, 2011).

Even though studies above offer a mixed picture of how gender influences help-seeking, the individual studies do not have parity across methodologies, making them difficult to compare. For instance, evidence suggesting no gender influence on help-seeking was based on studies with modest sample sizes (Ciarrochi et al., 2002, $N=137$; Carlton & Deane, 2000, $N=221$; Smith & Shochet, 2011, $N=150$). Evidence suggesting a significant gender influence was based on relatively large samples (Morgan & Jorm, 2009, $N=3746$; Ciarrochi & Deane, 2001, $N=300$; Tishby et al., 2001, $N=1415$), therefore offering more robust evidence.

Three further studies explored the influence of gender in more nuanced ways. Klineberg et al. (2011) found no gender differences when using a depression vignette with mild symptoms, but discovered greater female help-seeking intentions when using a vignette with severe symptoms. These findings were significant at a .0001 probability level and based on a sample of 1125, thus offering relatively strong statistical evidence.

Findings from Moran's (2007) study suggested no gender differences for past help-seeking but females gave significantly greater future help-seeking intention than

males. Even though males sought help less than females, when they did seek help, they were more likely to opt for help from mental health workers, counsellors, phone lines, religious leaders or psychologists whereas females favoured friends. However, this gender effect is probably less relevant than initially suggested. When placed into a regression equation, gender only predicted help-seeking when entered alongside other predictor variables with no independent effect.

Biddle et al. (2004) found scores indicating mental distress were the best predictor of actual help-seeking from a GP; as distress levels increased so did help-seeking. Males were observed needing a higher distress threshold before seeking help from a GP than females. However, the authors' conclusions might be misleading as conclusions were based on a probability level of .070; much higher than most commentators would accept (Dancey & Reidy, 2008).

Age. In Morgan and Jorm's (2009) study, being an older young person predicted greater help-seeking intentions. Wilson and Deane (2012) found help-seeking fears became significantly weaker with older participants, yet the need for autonomy did not change across age groups. However, both these studies used restricted help-seeking measures causing problems extrapolating findings. In particular, Morgan and Jorm measured help-seeking by only providing dichotomous yes/no responses to help-seeking items and choosing to explore formal help-seeking thus ignoring informal help-seeking.

In contrast, Tishby et al. (2001) found for a range of stated problems, older participants rated themselves as less likely to seek help than young participants. This difference was greatest for social problems, where 14% of the younger group said they would seek-help compared to 7% in the older group. An advantage of this study over others was the authors split young people into three age groups to assess differences between help-seeking means. This enabled researchers to carry out an inferential statistical test of difference to establish cause and effect, providing a more nuanced overview of age effects with the introduction of a middle age band.

No age differences were found in Raviv et al.'s (2009) study for seeking help from a psychologist. When it came to seeking help from friends, older participants had greater help-seeking intentions than younger ones. However, Raviv et al.'s findings have limited scope, as they did not present significance data on age differences, leaving

readers to guess statistical strengths by visual inspections of means. Also they only presented data on psychologists which may have limited generalisability.

Ethnicity. No association between different ethnic groups and past or future help-seeking was found by Moran (2007). However, this single study with a modest sample ($N=112$) drawn from a deprived area of London provides specific data which may not be generalisable to other populations.

Socio-cultural factors.

Socio-economic status. The findings from Biddle et al. (2004) study suggested males from manual occupation families were more likely to seek help from a GP than those with non-manual backgrounds. For females the same was true but in the opposite direction. The advantage of Biddle et al.'s findings is they were based on random sampling selection procedures, thus increasing the generalisability of results. However, these particular results were based on weak statistical probabilities ($p=.090$ and $p=.080$). Additionally, as there is an increased statistical chance of making a type one error in this study with nine predictor variables utilised (Dancey & Reidy, 2008), caution is therefore needed when interpreting findings.

In Tishby et al.'s (2001) study, young people's socio-economic status and their father's level of education were not associated with help-seeking intentions. Formal and informal help-seeking intentions were compared in Raviv et al.'s (2009) study between two socio-economic categories and no difference was found. However the researchers never fully described how they measured socio-economic status, thus making it difficult to ascertain the validity of findings.

Media. In Morgan and Jorm's (2009) study, they asked participants to recall media stories about mental illness in the last 12 months. From this, ten narrative themes emerged; the most common were violence within mental illness and crime. They found recalled stories were not predictors of help-seeking intentions but influenced stigma attitudes. Recalled stories about a prominent figure disclosing a mental disorder predicted a belief that those with a mental illness were sick not weak, whereas recalled stories about mental illness, violence and crime predicted a reluctance to disclose own mental health issues. This study offered a unique insight into the influence of media on help-seeking; a factor most other studies did not consider. However, the study had some limitations. In particular, the study asked participants to recall a maximum of three stories which could have stifled further responses.

Additionally, they were only asked to recall stories from news programmes. Young people may have more affinity and exposure to television dramas, documentaries, soap operas and children's programmes, but these were not analysed. In their focus groups, Morgan and Jorm's findings were further supported by Wilson and Deane (2001) who found media influenced students' conceptualisation of mental health and help-seeking.

Family factors. Findings from Tishby et al.'s (2001) study showed parents' marital status and participants' birth order within the family were not associated with help-seeking. Participants' living arrangements (living with parents, partner/spouse, friends, living alone or other) were observed by Biddle et al. (2004) not to predict actual help-seeking.

Wilson et al. (2011) discovered seeking previous help from family was the best predictor of mental health professional help-seeking. In contrast, previous help from friends and intimate partners did not predict help-seeking. They concluded families act as important gatekeepers into mental health services so this study offered important clinical implications for mental health services. However, the variables together only explained 13% of the help-seeking statistical variance, indicating conclusions maybe somewhat over stated.

Social support. A focus group study by Wilson and Deane's (2001) found students gained help-seeking knowledge by word-of-mouth from their social circle and used this knowledge to match help-seeking sources with their perceived problem. This qualitative research provided a rich understanding of young people's help-seeking experience. One flaw though, was the researcher and participants within the focus groups were acquainted. This could have further encouraged participants' responses to converge towards a group norm according to normative social influences (Asch, 1951), thus potentially reducing the validity of data.

There was no relationship with perceived social support and formal help-seeking found in studies by Sheffield et al. (2004) and Biddle et al. (2004). However, Sheffield et al. found social support predicted informal help-seeking. Both studies used either novel or adapted social support scales, but the rationale and evidence for developing these measures was not clear, thus reducing the studies' reliability and validity.

Contextual factors.

Sources of help. Seven studies found participants preferred to seek-help from informal sources such as friends and family rather than professionals such as

psychologists and GPs (Wilson, 2010; Raviv et al., 2009; Tishby et al., 2001; Biddle et al., 2004; Wilson et al., 2011; Ciarrochi et al., 2002; Moran 2007; Sheffield et al., 2004). Three studies found young people preferred no help than professional help (Tishby et al., 2001; Ciarrochi et al., 2002; Klineberg et al., 2011). One study even found “think about/attempt suicide” (Klineberg et al., 2011) was preferred over seeking-help from a mental health worker.

Findings from Wilson et al.’s (2011) study suggested intimate partners were the preferred informal help source, closely followed by friends and family. Four studies found GPs were the preferred formal help source (Klineberg et al., 2011; Sheffield et al., 2004; Biddle et al., 2004; Moran, 2007). Sheffield et al. (2004) found psychologists and psychiatrists were rated second and third. School counsellors and telephone-helplines were rated least preferred help source (Tishby et al., 2001; Sheffield et al., 2004; Biddle et al., 2004; Moran, 2007; Ciarrochi et al., 2002).

However, Sheffield et al. (2004) found for those who had actually sought previous help, school counsellor became the preferred formal help source; thus highlighting the problem of drawing conclusions from theoretical help-seeking studies. Additionally, all the above studies measured preferred sources of help by presenting fixed choices with an option of ‘other sources of help’ presented at the end. Data on what the ‘other sources’ were, were either not collected or not presented in their findings, thus important information about additional help sources may have been missed.

In Wilson and Deane’s (2011) qualitative study, young people’s perceptions of the help source seemed to influence their help-seeking decisions. They were more likely to help-seek if they perceived the source was listening, validating, empowering and normalising of problems. They placed importance on being able to trust the helper. The validity of these findings were strengthened by the researchers’ crystallisation techniques which is where researchers use deeper descriptions, greater attention to complexity of interpretations, use of more than one line of inquiry and reflexivity throughout (Ellingson, 2009).

Prior history. Those who had previously sought professional help in Ciarrochi and Deane’s (2001) study expressed more help-seeking intentions for mental health workers, GPs and helplines but fewer help-seeking intentions for informal sources. Ciarrochi and Deane used a volunteer student based sample, providing course credit

incentives for participation. This may have led students to provide responses aiding what they perceived the aims of research were.

Those with mental health problems who had a past help-seeking experience in Biddle et al.'s (2004) study, were four times more likely to have sought help from GPs and seven times more likely to have sought help from friends and family in the past four weeks. Biddle et al. used a random sampling method taken from a community-wide population, increasing the validity and generalisability of findings. Moreover, the validity of Biddle et al.'s findings were strengthened by the fact they measured real life help-seeking as opposed to theoretical help-seeking which is the case in most other studies.

Two studies found associations between satisfaction of prior help experiences and help-seeking intentions. Ciarrochi et al. (2002) found perceived usefulness of previous professional help-seeking predicted greater intentions to seek help, but only from mental health workers. Even though Raviv et al. (2009) found a weak relationship between past and future help-seeking from a psychologist; they found this relationship became stronger when participants expressed satisfaction for their previous psychological help. Ciarrochi et al. and Raviv et al.'s prior help-seeking findings came from subsamples in their main study so analysis was based on small samples (e.g. Ciarrochi et al. had 38 participants in their subsample). Data analysis based on small numbers will have low statistical power reducing usefulness of these results.

Four studies found an indirect relationship between prior help-seeking and help-seeking intentions. Sheffield et al. (2004) found past help-seeking predicted more favourable attitudes towards mental health problems. Moran (2007) found past help-seeking predicted help-seeking when placed alongside predictor variables of attachment style and gender. Wilson and Deane (2012) found, when paired with reduced desire for autonomy, prior help-seeking predicted greater help-seeking intentions. Ciarrochi and Deane (2001) found having prior help seeking experiences increased the strength of the relationship between higher emotional intelligence and more help-seeking intentions. However, it should be noted, none of these studies found a direct relationship between prior help and help-seeking intentions. This suggested prior help is a factor with minimal influence which was not often reflected in conclusions drawn by these studies.

Wellbeing factors.

Suicidal ideation. In Tishby et al.'s (2001) study, those who had previously attempted suicide expressed a 45% preference for no help for depressed mood compared to 16% of non-suicidal participants. Suicidal attempters had lower help-seeking intentions across all help sources compared to non-suicidal participants. The validity of these results was increased by assessing those who had previously experienced real life suicidal behaviour. However, considering this, clinical safeguarding procedures were not discussed in Tishby et al.'s article, leaving unanswered questions surrounding their ethical procedures.

Findings from Carlton and Deane (2000) showed those with higher suicidal ideation scores was associated with decreased help-seeking for suicidal thinking problems. However, in this study suicidal ideation did not independently predict help-seeking for personal and emotional problems.

In Biddle et al. (2004) study, participants with high distress scores were compared with those with suicidal thoughts. They found GP help-seeking in the last four weeks was greater for those with suicidal ideation than for mental distress. However, Biddle et al. classified clinically distressed participants as scoring four or more on the General Health Questionnaire (GHQ-12; Goldberg & Williams, 1988), but it was not clear why this cut-off was chosen when a threshold of 1 or 2 is recommended by the measure's authors (Goldberg & Williams, 1988). If Biddle et al.'s threshold had been set to these recommended levels, results would have undoubtedly facilitated quite different conclusions, thus questioning the utility of findings. Additionally, it is not clear the justification of why Biddle et al. used this measure on young people when it is recommended only for adults (Goldberg & Williams, 1988). Nevertheless, the fact they measured real life distress and help-seeking increased the validity of these findings.

Distress. Greater distress levels were found to predict more help-seeking intentions in Sheffield et al.'s (2004) and Raviv et al.'s (2009) studies. When help from GPs were analysed separately, Biddle et al. (2004) found the strongest predictor of GP help-seeking was high distress scores. In contrast, four studies found distress levels had no association with help-seeking (Wilson, 2010; Klineberg et al., 2011; Carlton & Deane, 2000; Moran, 2007). Another study found distressed young people showed greater preference for no help than non-distressed participants (Tishby et al., 2001).

There are problems with comparing this research since each study used different distress measures. For instance, Raviv et al. (2009) asked participants to rate the level of distress of a vignette character, whereas Sheffield et al. (2004) used the validated Depression Anxiety Stress Scale (Lovibond & Lovibond, 1995). In addition there were some methodological weaknesses among measures. In Moran's (2007) study distress scores were converted into dichotomous categories using a cut off score of 17 but did not provide a rationale for this threshold. Consequently, differences in findings may have resulted from variation in the internal validity of measures, thus cohesive conclusions are difficult to draw.

Hopelessness. Findings from Ciarrochi and Deane (2001) showed greater hopelessness correlated with lower help-seeking intentions. However, they used psychology university students receiving credits for participation. This coercion may have created more demand characteristic among participants, leading them to give responses they thought would aid research aims.

Hopelessness in Ciarrochi et al.'s (2002) study was also found to predict less intention to seek-help from parents, relatives, teachers, pastors, youth workers but did not correlate with help-seeking from mental health professionals or telephone help-lines. However, conclusions were based on low to modest coefficients (r values ranging from $-.18$ to $-.32$) suggesting Ciarrochi et al. may have over stated conclusions.

Developmental and cognitive factors

Attitudes and beliefs. Findings from Smith and Shochet's (2011) study suggested negative beliefs about confidentiality, interventions and inaccurate beliefs about affordability of services predicted less help-seeking intentions. In Wilson and Deane's (2012) study, help-seeking fears predicted reduced levels of help-seeking, but beliefs on treatment efficacy did not influence help-seeking. Conversely, Raviv et al. (2009) found belief in treatment efficacy predicted greater help-seeking from psychologists. Wilson and Deane (2001) observed when young people perceived help sources as useful, they gave favourable descriptions of those sources. Wilson (2010) found belief barriers, not distress, predicted low professional help-seeking.

Three of these studies (Raviv et al., 2009; Wilson, 2010; Wilson & Deane, 2012) used a standardised measure supported by validity and reliability evidence, increasing the findings internal and external validity. In contrast, Smith and Shochet (2011)

created a novel measure, with only moderate reliability (Cronbach's alphas starting at .60).

In Sheffield et al.'s (2004) study, young people were asked to consider belief barriers to different sources of help. For school counsellors, the barrier "prefer to handle the problem myself" was dominant, followed by "not confidential" and "Don't think they can help". For psychologists and psychiatrists the inaccurate barrier "too expensive" was dominant, followed by "don't know where to find one" and "prefer to handle it myself". The advantage of this study was that it provided a unique insight into beliefs surrounding specific help sources. However, Sheffield et al.'s findings were measured using a non-validated tool which collected binary responses (yes or no) to fixed items. There was no way of elaborating responses, or adding additional beliefs of their own, and therefore data had limited scope.

Wilson and Deane (2001) extracted a theme labelled "attitudes" from qualitative analyses. Within this theme, participants expressed belief that help-seeking should be encouraged as a good way to solve problems. Help-seeking was also regarded as non-typical for their age group, not always necessary and could sometimes be used by professionals in an attempt to change their minds. As these findings were based on qualitative designs, participants' responses were not constrained by closed-ended questions as they were in Sheffield et al.'s (2004) study. Hence Wilson and Deane's findings provided greater insight into real life experiences, increasing the ecological validity of their findings.

Autonomy. Higher need for autonomy predicted lower professional help-seeking intentions (Wilson & Deane, 2012; Wilson et al., 2011). However, these conclusions were based on weak statistical results, with Wilson et al. (2011) finding only 13% of the help-seeking variance was accounted for by need for autonomy and in Wilson and Deane's (2012) study it was 24%. This suggested need for autonomy offers at best, a partial explanation of help-seeking, which was not fully reflected in the studies' conclusions.

Stigma. In a qualitative study, Biddle et al. (2007) discovered participants' definition of their own distress dictated whether they sought help or not. Participants understood distress in polarised ways; defining it as either 'normal' or 'real'. A range of stigmatising attitudes were assigned to real distress, and considered a state to be avoided at all costs, using descriptors such as "ill in the head", "freak" and "nutcase in a

padding cell". Negative narratives were also assigned to those perceived having normal distress but who sought help; they were described as, "attention seeking", "non-genuine" or "hypochondriac". Thus, participants invested attention on their beliefs and activities associated with normal distress in order to keep real distress at bay. As help-seeking was associated with real distress it was considered a taboo activity and avoided.

The methodology in Biddle et al.'s (2007) study was enriched by inductively driven research strategies designed to better conceptualise participant's real life help-seeking experience. Firstly, unlike previous research, Biddle et al. selected young people experiencing real distress. Secondly, researchers used purposive sampling to increase homogeneity among participants in terms of distress and help-seeking. Additionally, true to the inductive method, Biddle et al. were the first to use their findings to create a help-seeking model which has helped advance the help-seeking research field.

Emotional Intelligence. Emotional intelligence was measured using three emotional skills: managing self-emotion, managing others' emotion and perceiving emotion. It was found abilities to manage self and others' emotions predicted increased informal help-seeking but was not related to formal help-seeking (Ciarrochi & Deane, 2001; Ciarrochi et al., 2002). No correlation was found between perceiving emotions and help-seeking (Ciarrochi & Deane, 2001). These relationships remained even after accounting for hopelessness, gender and prior help-seeking.

Caution is needed drawing conclusions from these findings. Ciarrochi and Deane (2001) sampled psychology students who may be more emotionally reflective than other young people (Camarano, 2011). Students received course credit incentives for taking part which could have caused demand characteristic. Ciarrochi et al. (2002) also used an unrepresentative sample from a private Christian school, and as they volunteered to participate in research, they may have been more pro-social and inclined to seek help. These methodological problems reduce the validity and generalisability of results.

Mental health literacy. Smith and Shochet (2011) found mental health literacy (Knowledge of mental illness, interventions, help-seeking, confidentiality and affordability) accounted for 27% of help-seeking variance. However, they used the term 'mental illness' in their help-seeking measure instead of the more common term

‘personal or emotional problem’. This phrasing might have led to the distress sounding more severe, influencing participants to respond differently compared to other studies.

Findings from Wright et al. (2012) showed those who accurately identified a depression, psychosis and social phobia vignette (according to Diagnostic Statistical Manual of Mental Disorders-IV (American Psychiatric Association, 2000) criteria) expressed greater preferences for professional help sources and predicted better outcomes when using those sources. They also found non-technical labels such as shy, stressed, paranoid significantly predicted reluctance to seek professional help. However when presented with vignettes, participants were asked a leading question “what, if anything, do you think is wrong with John?”, potentially biasing participants into thinking John had a problem. In addition, the study surveyed participants’ attitudes to mental health using telephone ‘cold calling’ techniques which raised issues of ethics, clinical safeguarding and validity of participants’ responses. Nevertheless, this study was a part of a large scale national survey collecting data from 3 746 participants, thus providing statistically strong results which cannot be easily discounted.

Findings from Klineberg et al. (2011) showed there was a discrepancy in participants’ treatment expectations of what they thought would occur as opposed to what they thought should happen. Of the participants who correctly identified the depression vignette, only 16.4% stated the character would see their GP, but 64.7% stated the vignette’s character should ideally see their GP. This study provided a unique insight into the potential difference between idealised and actual help-seeking.

Attachment style. Young people in Moran’s (2007) study who were securely attached gave significantly higher help-seeking intentions than insecurely attached individuals. When attachment as a single variable was entered into a regression equation, it predicted help-seeking only when placed alongside gender and prior help-seeking predictors. Attachment styles have been found to be sensitive to cultural variations (Van Ijzendoorn & Krommberg, 1988). As Moran purposively sampled an ethnically diverse population, attachment styles observed here may not be representative of other ethnic and cultural groups.

Discussion

Summary of Main Findings

Demographic factors. There was mixed evidence of how gender influenced help-seeking. Some studies found females had more help-seeking intentions (e.g. Morgan & Jorm, 2009), some found with actual help-seeking, females seek more help only from informal sources (Biddle et al., 2004) and others found no gender difference (e.g. Ciarrochi et al., 2002). Further studies found greater polarisation in male and female help-seeking for more severe problems (Klineberg et al., 2011). Even though males seek help less than females, when they did, they were more likely to access professional help compared to females while females were more likely to access informal sources (Moran, 2007). Males needed greater levels of distress before considering seeking help compared to females (Biddle et al., 2004). In spite differing findings, common to all studies was males do not seek help more than females. However, gender can be defined as a biological sex or identification to a gender role (Bem, 1974). All the above studies measured gender using biological terms, so may lack sensitivity to the psychosocial and cultural influences on gender.

How age influenced help-seeking was not clear; one study, with an age range of 12 to 15-years-old, found older young people sought help more (Morgan & Jorm, 2009), one study reported 16 to 18-year-olds seek-help less than 12 to 13-year-olds (Tishby et al., 2001), and others reported no age differences (e.g. Klineberg et al., 2011). Inconsistencies could be a result of different approaches to measuring help-seeking and categorising age groups.

There was no evidence that ethnicity played a role in help-seeking (Moran, 2007). However this conclusion was based on a single study with a modest sized unrepresentative sample.

Socio-cultural factors. One study found females with lower socio-economic backgrounds and males from higher socio-economic backgrounds seek-help more for milder depression (Klineberg et al., 2011). In contrast, another study found no relationship between socio-economic status and help-seeking (Tishby et al., 2001). However, findings were based on weak statistical probabilities and unclear socio-economic measures, thus drawing meaningful conclusions were difficult.

Exposure to news stories was shown not to influence help-seeking per se, but did influence mental health and help-seeking attitudes (Morgan & Jorm, 2009; Wilson & Deane, 2001). However, conclusions were constrained by methodological limitations.

Research indicated social support provided young people with mental health knowledge and increased informal help-seeking without affecting formal help-seeking (Sheffield et al., 2004; Biddle et al., 2004). Young people's living arrangements or family structure did not impact on help-seeking (Tishby et al., 2001; Biddle et al., 2004), but seeking help from family members predicted later professional help-seeking (Wilson et al., 2011). However, as the statistical power of these results was low, conclusions may be overstated.

Help-seeking contextual factors. Evidence overwhelmingly suggested informal sources of help were preferred over formal ones (e.g. Wilson, 2010). GPs were the preferred formal help source and intimate partners the preferred informal one, whereas school counsellors and telephone help lines were the least preferred (e.g. Wilson et al., 2011; Klineberg et al., 2011). Young people described how they would be more inclined to seek help from someone perceived as trustworthy, validating and empowering. However, the bulk of research asked participants to choose help sources based on theoretical problems which may not reflect real life experiences.

Some research suggested prior help-seeking and satisfaction with previous help was related to higher help-seeking intentions, especially for formal sources of help (e.g. Biddle et al., 2004; Ciarrochi et al., 2002). It was also suggested prior help-seeking increased favourable mental health attitudes (Sheffield et al., 2004). Much of this evidence was based on small subsamples obtaining weak statistical power, so caution is needed drawing conclusions.

Wellbeing factors. Findings on the effects of distress were mixed. Some studies showed greater distress predicted increased help-seeking (e.g. Raviv et al., 2009), some showed it had no effect (e.g. Wilson, 2010), while another study found it increased the wish for no help (Tishby et al., 2001). These mixed conclusions may be due to inconsistent ways of conceptualising and measuring distress or methodological flaws in studies.

Evidence suggested greater hopelessness predicted lower help-seeking from most sources, except telephone help-lines and mental health professionals (Ciarrochi &

Deane, 2001; Ciarrochi et al., 2002). However, clear validity issues arose from sampling techniques thus weakening generalisability.

Suicidal ideation was found to suppress help-seeking intentions (Tishby et al., 2001; Carlton & Deane, 2000). This negative effect was stronger for higher suicidal ideation than for greater distress (Biddle et al., 2004). However, concerns were raised over the lack of transparent ethical and clinical safeguarding practices in these studies and cohesion in measures of suicidal ideation.

Developmental and cognitive factors. Young people were observed using stigmatising narratives to describe real distress (Biddle et al., 2007). Yet, help-seeking was described by some as a ‘good thing’ that should be encouraged as long as it was not coercive (Wilson & Deane, 2001). Those with favourable attitudes and beliefs towards mental health and help-seeking had greater help-seeking intentions (e.g. Smith & Shochet, 2011). Need for autonomy was related with lower help-seeking rates (e.g. Wilson & Deane, 2012). Other emergent help-seeking beliefs barriers centred on the utility of help-seeking, need for autonomy, misconception of affordability and confidentiality (Sheffield et al., 2004). However, variations among belief measures and methodological designs meant it was difficult to draw cohesive conclusions.

One study found how young people perceived their own distress influenced help-seeking. Young people stigmatised the idea of real distress, and avoided labelling themselves as such (Biddle et al., 2007). As help-seeking was associated with real distress it was also avoided.

Greater emotional intelligence was found to predict greater help-seeking for informal but not formal sources (Ciarrochi & Deane, 2001; Ciarrochi et al., 2002). However, these studies lacked generalisability due to flaws in sampling techniques.

The evidence suggested accurate mental health literacy led to greater and more appropriate help-seeking (Smith & Shochet, 2011; Wright et al., 2012). There were some discrepancies though, between ability to identify appropriate treatments and wanting to utilise them (Klineberg et al., 2011).

The study investigating attachment, suggested young people with secure attachment styles had greater help-seeking intentions than those with insecure attachment styles (Moran, 2007). However, attachment style only predicted help-seeking intention when placed as a covariate in a regression model.

Strengths and Limitations

All but two studies used cross-sectional designs, which gave a snap shot of young people's lives. However, help-seeking is probably a complex longitudinal process with stages evolving over time (Wills & Gibbons, 2009; Rickwood, Deane & Wilson, 2007). Such research may not capture the true nature of help-seeking. Indeed, participants not willing to engage now may in fact seek help later on in their journey.

The bulk of studies used regression and chi square statistical analysis. Such designs can highlight predictions and associations between factors and help-seeking but do not show causation (Dancey & Reidy, 2008). Inappropriately, researchers have sometimes described cause and effect in relationships investigated, so conclusions should sometimes be considered cautiously.

Most studies reported moderate to low correlation co-efficients, statistical variance, probability levels and none provided data on Cohen's effect sizes (Cohen, 1988). They frequently relied on unrepresentative moderate samples, and novel or adapted measures without data on reliability or validity. These factors raise questions about the validity, reliability and generalisability of findings and reduce the ability to draw conclusions from the research.

Two qualitative studies made efforts to increase rigour in data analysis while attempting to extract deeper interpretation from the data. By using such methods as crystallisation techniques (Ebbingson, 2009), conclusions were based on reflexive, rich and meaningful interpretations (Ebbingson, 2009).

Fourteen studies presented theoretical problems asking participants for speculative help-seeking responses. This method is appropriate due to ethical issues, safeguarding and with evidence suggesting current attitudes predict future help-seeking (Wilson, Deane, Ciarrochi & Rickwood, 2005). Nevertheless, non-clinical participants are likely to have little experience of mental health issues so may respond differently compared to distressed participants. Even if findings based on theoretical help-seeking differ slightly from real life help-seeking, it could increase the probability of type one or two errors in the research, especially where small statistical associations exist.

All but two studies featured self-report questionnaires or structured interviews which are sensitive to bias (Clark-Carter, 2010). Those declining or less motivated to complete questionnaires may be those less likely to seek-help. Measures frequently utilised fixed responses with likert scales, which limits data only to what is asked and

sensitive only to the points on the scale. In contrast, two qualitative studies used semi-structured interviews and focus groups with open-ended questions, which provided in-depth understanding of help-seeking and facilitated theory construction (Biddle et al., 2007).

Three studies had relatively large samples using random methods which increased the statistical power, validity and generalisability of findings. However, other studies used modest samples selected for convenience from educational facilities. A number of studies recruited psychology students providing course credits for participation. These samples could be susceptible to demand characteristics and investigator effects, especially where lecturers were assisting data collection. Such participants may be more motivated to engage and probably more orientated to seek help.

Clinical Implications

Evidence suggested males have lower help-seeking intentions than females (e.g. Ciarrochi & Deane, 2001). Additionally, suicidal ideation was observed negating help-seeking among young people (e.g. Tishby et al., 2001), mirroring patterns in adult populations (Clark & Fawcett, 1992; Rudd, Joiner & Rajab, 1995). This implies mental health services should invest resources in reaching out to young people in the community, especially males, who may be distressed, even suicidal, yet invisible to services.

Research indicated young people prefer to seek help from partners, friends and family rather than professional sources (e.g. Wilson, 2010). Young people experiencing mental health problems may have formed informal relationships based on conflict, cognitive distortion or poor social-cognitive reasoning (Coles, Protinsky & Cross, 1992; Sarbornie & Kauffman, 1985). Hence, the informal sources may not supply the appropriate support needed. This implies the importance for mental health services to work closely with family and friends, providing support, information and training. Indeed, this need was reinforced by research indicating families act as gatekeepers to professional services (Wilson et al., 2011).

Those with insecure attachment styles had lower help-seeking intentions (Moran, 2007), mirroring wider research on the general lack of positive engagement found in those with insecure attachments (e.g. Mikulincer & Nachshon, 1991; Larose &

Bernier, 2001). Unfortunately, it is those with insecure attachments who probably need greatest support (Herbert, 1998). Consequently, when clinicians work with young people with insecure attachments, such as in care settings, they need to be mindful of their clients' lack of help-seeking inclination.

Satisfaction with prior help predicted future willingness to engage (e.g. Biddle et al., 2004). It is therefore important mental health services invest in making their first contact with young people a positive experience, increasing greater future engagement. Research suggests this can be achieved by validating young people, normalising their experiences and building relationships based on openness and trust (Wilson & Deane, 2011).

Stigmatising attitudes contributed to young peoples' reluctance to admit they had a problem and engage in help (Biddle et al., 2007). It is imperative then, for clinicians and services to attempt to reduce mental health stigma. Research suggests one effective method has been to use media sources (Morgan & Jorm, 2009).

Greater need for autonomy and independence was found to inhibit help-seeking (e.g. Wilson & Deane, 2012). These findings are consistent with literature on developmental processes within young people, especially the need for autonomy, self-determination and deindividuation (Adams & Marshall, 1996; Erikson, 1968). It is therefore important for clinicians to inform young people that services will facilitate choice and self-management of treatment.

Accurate mental health literacy was found to facilitate help-seeking (e.g. Smith & Shochet, 2011), which implies that services should promote mental health knowledge in young populations, by providing teaching resources to schools and colleges.

In this review, the GHSQ (Wilson et al., 2005) has emerged as the preferred measure of help-seeking, allowing different factors across studies to be more easily compared. Also, continued use of the GHSQ has increased available data on its reliability and validity, thus enhancing its clinical utility.

Research Implications

Research uncovered a range of factors which potentially inhibit or promote help-seeking among young people. However, there is a general lack of unified understanding of how factors combine to influence help-seeking or which are more pertinent than others (Rickwood et al., 2005). Future research should attempt to consolidate our

understanding of help-seeking, exploring how factors work together and which ones are most salient. With this knowledge, services can focus resources more efficiently on predominant factors influencing service engagement.

As findings on the influence of social support, ethnicity, media, age and socio-economic status on young peoples' help-seeking were not clear, future research is urgently needed to clarify these relationships.

Youth help-seeking research to-date has merely explored how biological gender influenced help-seeking. However, in doing so it has failed to explore how psychosocially defined gender roles influence help-seeking. Future research would benefit from investigating different ways to conceptualise gender.

Research on young peoples' help-seeking has featured a number of studies with flawed methodologies. For instance, some studies provided course credit incentives to volunteers (Ciarrochi & Deane, 2001; Smith & Shochet, 2011; Wilson et al., 2011) potentially increasing demand characteristics among participants. Some methodologies raised potential ethical concerns while failing to describe safeguarding procedures (Tishby et al., 2001; Wright et al., 2012; Wilson & Deane, 2012; Biddle et al., 2004; Biddle et al., 2007). Therefore, to increase the overall validity and reliability of this research field, it is imperative future studies employ more stringent scientific rigour with greater care in reporting safeguarding procedures.

Conclusion

A number of factors were found to influence young people's help-seeking for personal or emotional and general mental health problems. Young people overwhelmingly preferred to seek help from friends, family and intimate partners and would rather have no help than seek-help from professionals. Being female, family involvement, social support, informal sources of help, prior help-seeking experiences, emotional intelligence, mental health knowledge and secure attachment style were found to predict help-seeking in young people. Suicidal ideation, hopelessness and belief barriers were found to inhibit help-seeking. No direct influence was found for ethnicity and exposure to media. Findings on age, socio-economic status and distress were too varied for any conclusions to be drawn.

This research provides mental health and community services with clinically useful evidence on help-seeking and provides clues on how to successfully reach out to

young people. However, many of the research papers reviewed had methodological flaws and questionable validity. It was often difficult to draw cohesive conclusions due to variations in chosen measures and research procedures. Future research should extract salient factors from previous research to explore how these predict help-seeking both individually and in combination. This would provide mental health services with a more accurate understanding of why young people are reluctant to engage with their services.

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Chapter 2: Empirical Paper

Belief Barriers, Emotional Intelligence, Suicidal Ideation,
Mental Health Literacy, Gender, Past Help and Willingness
to Seek Professional and Non-Professional Help for
Personal or Emotional Problems in Young People

Abstract

The study aimed to explore the combined and individual predictive power of factors on help-seeking for personal or emotional problems in young people. Cross-sectional self-report surveys were administered to 319 students, recruited from a UK college.

Multiple regression analysis was employed. Factors when combined provided a better explanation of informal and no help-seeking than formal help-seeking. Belief based barriers, emotional intelligence, reasons for living, gender, feminine gender role identification, prior help and mental health literacy predicted help-seeking. Belief barriers and reasons for living emerged as predominant predictors. Findings suggested organisations should integrate young people's beliefs and norms into planning service provision. A range of other clinical implications were discussed. Research was limited by cross-sectional survey methodology and the use of theoretical help-seeking. Future research possibilities were discussed.

Word Count = 7 601

Belief Barriers, Emotional Intelligence, Suicidal Ideation, Mental Health Literacy, Gender, Past Help and Willingness to Seek Professional and Non-Professional Help for Personal or Emotional Problems in Young People

Adolescence is a unique developmental stage where young people seek their own self-identities while navigating often difficult life transitions (Erikson, 1968; Dubrow, Lovko & Kausch, 1990; Sheffield, Fiorenza & Sofronoff, 2004). It is a life stage marked with pronounced vulnerability to distress (Sheffield et al., 2004). Eighteen to 24-year-olds have a 27% prevalence rate of mental health difficulties (Andrews, Hall, Teesson & Henderson, 1999). Half of all major mental health conditions start by the age of 14-years-old and three quarters by the age of 24 (Kessler et al., 2005). In a review of UK suicides, it was found 4% of suicides were committed by young people and of these, 93% occurred between the ages of 15 and 19-years-old (Windfuhr et al., 2013).

As young people take on increased levels of autonomy, help-seeking can be seen as a developmental skill enabling them to maintain wellbeing (Wilson, Deane & Ciarrochi, 2005; Wilson, Bushnell & Caputi, 2011). Indeed, without self-help, young peoples' distress may be invisible to others who have the power to intervene (Windfuhr et al., 2013). It was found the majority of young suicide victims were living at home, attending full time education, whilst unknown to mental health services (Windfuhr et al., 2013).

Regardless of help seeking benefits, research shows young people are unlikely to seek-help for emotional and mental health issues (Rickwood, Deane, Wilson & Ciarrochi, 2005; Vaswani, 2011). Among approximately 10 000 young people surveyed, and even at the highest levels of mental health difficulty, only a third sought help (Zachrisson, Rodje & Mykletun, 2006). Furthermore, 39% of males and 22% of females categorically stated they would never seek-help (Donald, Dower, Lucke & Raphael, 2001). Only 14% of children who died from suicide were actually engaged with mental health services (Windfuhr et al., 2013). When young people do seek help, it is more likely to be with their peers who might provide inappropriate support and advice (Wilson & Deane, 2001; Kelly, Jorm & Rodgers, 2006). It was found male friends aged 18 to 24-years-old were more likely to tell a friend suffering distress to "pull yourself together" than any other age group (Mind, 2009).

The availability of young people's professional support has increased in quantity and quality in recent years, yet service utilisation has not proportionately risen (Wilson

& Deane, 2001). This suggests the key to understanding help-seeking reluctance lies beyond situational factors but with individual psychosocial ones (Wilson & Deane, 2001).

Gender

Research showed young males were more vulnerable to mental health problems, self-harm and suicide than females (Windfuhr et al., 2013; Vaswani, 2011), yet males were less likely to seek-help for mental health problems than females (Morgan & Jorm, 2009; Ciarrochi & Deane, 2001). Young males had higher distress thresholds needed before help was sought (Biddle, Gunnell, Sharp & Donovan, 2004). Males and females preferred help from friends, although males preferred some professional help for inter-personal and social problems (Tishby et al., 2001; Donald et al., 2001). Males expressed greater inclination for no help across all problems and stronger beliefs in needing autonomy (Tishby et al., 2001; Raviv, Raviv, Vago-Gefen & Schachter Fink, 2009).

To date, gender in help-seeking research was conceptualised in biological terms. However, Vaswani (2011) argued young people's identification to culturally defined gender roles was a better prediction of help-seeking than binary sex. Addis (2009) claimed help-seeking reluctance in males is attributed to beliefs men should hold a "stiff upper lip and handle all of his problems on his own" (Addis, 2009, p.1). McQueen and Henwood (2002) suggested young men's identification to a masculine self-image has an impact on how they attend to their mental health distress. They painted a picture of how masculine self-identities have rapidly changed over the last two decades in-line with shifting culturally defined gender roles.

Beliefs and Attitudes

Favourable beliefs about help-seeking for personal or emotional problems predicted greater help-seeking intentions in young people (Carlton & Deane, 2000; Wilson, 2010). Indeed, beliefs were found to be a better predictor of help-seeking than levels of distress (Wilson, 2010). Sheffield et al. (2004) found predominant belief barriers to professional help centred on issues of confidentiality, efficacy of help, access uncertainty and need for autonomy. Other research found need for autonomy and belief in ability to cope alone were significant independent predictors of help-seeking (Wilson & Deane, 2012; Wilson et al., 2011).

Mental Health Literacy

More accurate technical knowledge about mental health problems and treatment predicted greater professional help-seeking in young people (Wright, Jorm & Mackinnon, 2012; Klineberg, Biddle, Donovan & Gunnell, 2011). In contrast, those using lay labels to define mental health problems had significantly fewer help-seeking intentions (Wright et al., 2012).

Emotional Intelligence

It was found young people with less emotional intelligence were more reluctant to seek help (Ciarrochi, Wilson, Deane & Rickwood, 2003; Wilson et al., 2011). When these findings were age adjusted, difficulty describing emotions were associated with lower help-seeking intentions in older adolescents but higher help-seeking intentions among younger adolescents (Ciarrochi et al., 2003). In contrast, Ciarrochi, Deane, Wilson & Rickwood (2002) found that, although emotional competencies predicted informal help-seeking, it had no association with formal help.

Suicidal Ideation

Even though those with higher levels of distress were more likely to seek help (Sheffield et al., 2004; Raviv et al., 2009), those with suicidal ideation have been found to seek help less (Deane, Wilson & Ciarrochi, 2001; Wilson, Rickwood, Deane & Ciarrochi, 2001). This suicidal negation effect remained stable even when hopelessness and previous experience of professional help had been factored out (Rickwood et al., 2005; Wilson, Deane & Ciarrochi, 2005). Tishby et al. (2001) found those who had previously attempted suicide expressed a 45% preference for no help, compared to 16% of non-suicidal participants. However Biddle et al. (2004) found actual help-seeking in the last four weeks from a GP was greater in those with suicidal ideation than those with mental distress.

Prior History

Those who have sought help previously for personal or emotional problems had greater future help-seeking intentions (Biddle et al, 2004; Moran, 2007) and more favourable attitudes towards mental health issues (Sheffield et al, 2004). Satisfaction with past help also predicted future help-seeking (Ciarrochi et al., 2002; Raviv et al., 2009).

Aims and Objectives

Help-seeking is a crucial part of the process of accessing help for personal or emotional problems so it is important for mental health services to invest resources in promoting help-seeking. This may be particularly important for young people (Rickwood et al., 2005; Windfuhr et al., 2013).

Research has identified numerous significant factors which potentially influence young people's help-seeking for personal or emotional problems (Rickwood et al, 2005). However, to-date, research has not combined these factors into one study to explore how they collectively influence help-seeking in young people, and which factors are most salient. Moreover, studies have used different methodologies with inconsistent levels of control, making comparison of findings problematic (Windfuhr et al., 2008).

The current study seeks to explore how factors when combined influence help-seeking. Principle factors identified from previous research will be investigated in one study and the main aims will be to find out the extent to which these factors together influence youth help-seeking, and to identify the strongest predictors.

In order to investigate these aims, two research questions were generated:

1. What is the combined predictive power of gender, sex role identification, prior help experiences, belief barriers, emotional intelligence, mental health literacy and suicidal ideation on students' help-seeking intentions for emotional-personal problems?
2. Which of the above factors predict students' help-seeking for emotional and personal problems the most?

Method

Procedure

The study received ethical approval from Staffordshire University Research and Ethics Committee. To protect confidentiality and safeguard participants, questionnaires were anonymised using a coding system. A code on the questionnaires linked to the corresponding consent form, allowing students to be referred to the pastoral team if risks were identified in responses. All students, regardless of participation, were given information about college, local and national support services (see Appendix F). Informed consent was sought directly from students, and as they were over 16-years-

old, consent was not sought from parents in accordance with college policy and British Psychology Society (BPS) ethical guidelines (BPS, 2010).

A Sixth Form College in the UK granted permission to access students. A research request was sent to all subject managers resulting in Psychology, Health and Social Care, Extended Project, Latin and Physical Education departments volunteering to assist with research. Students received information sheets in the first week of participation (see Appendix D). The following week, the researcher re-entered lessons, reiterated research aims and parameters of consent and confidentiality, handing out consent forms (see Appendix E) and questionnaires. Students were invited to complete questionnaires, or alternatively complete college work if they did not wish to participate. No time constraints were set. On completion, a debrief sheet was given out including details of support services available (see Appendix F).

Participants

An a-priori power calculation using Statistics Calculators (Statistics Calculators Version 3.0; Soper, 2012) was undertaken to determine the required sample size for the multiple regression analyses. In line with previous research (Rickwood et al, 2005) a medium effect size (0.15) was set, with power set at 0.80 (Cohen, 1988), and alpha at the traditional .05 level, a minimum sample size of 92 participants were required. A total of 319 participants were recruited and of these, 221 were females (69.3%) and 98 were males (30.7%). Participants were A-level and GCSE students from Psychology, Health and Social Care, Latin, Physical Education or Extended Qualification Projects classes. All teaching groups within these subjects were surveyed. The majority were 17-years-old ($N=238$), with an age range of 16 to 19 years (Mean=17, $SD=0.56$). No other demographic data were collected, but recent statistics indicated the local population was 91% British white, 3% other-white, 1% Asian, 0.2% Chinese and 0.5% black (ONS, 2012) and a recent Office for Standards in Education (Ofsted) report stated demographics at the college mirrored that of its local community (Ofsted, 2008). The college is the only free to access sixth form provision in this city and surrounding rural areas and provides sixth form education to around 16 state schools (Ofsted, 2004).

Measures

The questionnaire consisted of eight measures, selected for their reliability and validity evidence. Priority was given to measures used in previous help-seeking research to promote comparability.

Help-Seeking Intentions. The General Help Seeking Questionnaire (GHSQ; Wilson, Deane, Ciarrochi & Rickwood, 2005; see Appendix G) measures help-seeking intentions for a theoretical problem, stated as a “personal or emotional problem”. Participants are asked their willingness to seek help across ten help sources, four of which are informal sources (partner, friend, parent, other relative/family member), six are formal sources (mental health professional, phone line, family doctor/GP, teacher, pastor/priest, youth worker). Two more items enquire about not seeking help and an option of rating “someone else not listed here”. A seven-point rating scale is used (1=extremely unlikely; 7=extremely likely). The measure produces a GHSQ score (the mean) as well as formal, informal and No help-seeking sub-scores. Higher scores indicate higher help-seeking intentions. The GHSQ has high internal reliability (Cronbach’s $\alpha=.85$; Wilson, Deane, Ciarrochi et al., 2005) high test-retest reliability over three weeks ($r=.92$; Wilson, Deane, Ciarrochi et al., 2005) and good face validity with help-seeking intentions found to relate to actual help-seeking over a three week period (Wilson, Deane, Ciarrochi et al., 2005). The Cronbach’s α in the current study was .81.

Gender. Gender was measured in two ways: biological sex (see Appendix M) and gender role identification as measured using the Bem Sex Role Inventory (BSRI) Short Form (Bem, 1974; Bem, 1981; see Appendix H). The BSRI Short Form consists of 30 words or phrases; ten categorised masculine, ten feminine and ten filler items. Participants rate how much they identify with items using a seven-point scale (1=never or almost never true; 7=always or almost always true). A masculine and feminine mean score is generated. The BSRI has good internal reliability (masculinity $\alpha=.86$; femininity $\alpha=.80$; Bem, 1974) and good test-retest reliability over four weeks (masculinity, $r=.90$; femininity, $r=.90$; Bem, 1974). The Short Form was found to strongly correlate with the original version ($r=.90$, Bem, 1981). The measure has good validity with sex-typed participants scoring higher on corresponding sex-typed behaviour (Bem, 1975; Bem & Lenney, 1976; Bem, Martyna & Watson, 1976). Holt and Ellis (1998) found gender stereotypes conceptualised in Bem’s survey had remained stable over the 20

year period following her research. In the current study, Masculine items had a Cronbach's alpha of .83 and Feminine items .86.

Emotional Intelligence. The Schutte Emotional Intelligence Scale (SEIS; Schutte et al., 1998; see Appendix I) measures emotional intelligence as a trait measure of the construct (Petrides & Furnham, 2000). Thirty three items are scored on a five-point scale (1=strongly disagree; 5=strongly agree) to produce an overall SEIS score (the sum); high scores indicate greater emotional intelligence. The measure has good internal reliability for an adolescent sample (Cronbach's alpha=.84; Ciarrochi, Chan & Bajgar, 2001) and was found to have good test-retest reliability over two weeks ($r=.78$, Schutte et al., 1998). Research indicated SEIS has good validity with scores correlating to a measure of alexithymia ($r=.65$), attention to feelings ($r=.63$), clarity of feelings ($r=.52$), and mood repair ($r=.68$; Schutte et al., 1998). In the current study, the Cronbach's alpha was .78.

Belief Based Barriers. The brief version of the Barriers to Adolescents Seeking Help Questionnaire (BASH-B, see Appendix J; Wilson, Deane & Ciarrochi, 2005) measures belief barriers to help-seeking. The brief version was extracted from the original (Kuhl, Jarkon-Horlick & Morrissey, 1997). Eleven items are rated on a six-point scale (1=strongly disagree; 6=strongly agree) producing a BASH-B score (total sum). Higher scores indicate stronger belief barriers to help-seeking. The BASH-B has high internal reliability (Cronbach's alpha of .84; Wilson, Deane & Ciarrochi, 2005). Evidence suggests BASH-B has good validity, correlating with low help-seeking scores on the GSHQ (Wilson, Deane, Ciarrochi et al., 2005) and correlating with greater negative Attitudes Towards Seeking Professional Psychological Help Scale scores (Fischer & Turner, 1970; Wilson et al., 2005). In the current study, the Cronbach's alpha was .81.

Suicidal ideation. The Reasons for Living Inventory for Adolescents (RFL-A; see Appendix K; Osman et al., 1998) measures reasons for living to indirectly assess suicidal ideation (Osman et al., 1998). This version was adapted for adolescents from the original scale (Linehan, Goodstein, Nielson & Chiles, 1983). Thirty two items are rated with a six-point scale (1= not at all important; 6= extremely important) producing a RFL-A score (the mean). Higher scores indicate lower suicidal ideation. The RFL-A has good internal consistency (Cronbach's alpha of .97; Osman et al., 1998). It has been suggested RFL-A has good validity, with the RFL-A positively correlating with Suicidal Behaviours Questionnaire (Linehan & Nielson, 1981; $r=-.48$) and Beck Hopelessness

Scale (Beck, Weissman, Lester & Trexter, 1974; $r = -.55$). In the current study, the Cronbach's alpha was .95.

Mental Health Literacy. The Mental Health Literacy Questionnaire (Jorm et al., 1997a, see Appendix L) measures mental health knowledge. The measure features two vignettes based the diagnostic criteria for depression and schizophrenia (Diagnostic Symptom Manual Forth Edition (DSM-IV); American Psychiatric Association (APA), 2000). For each vignette, two open-ended questions about the nature of the problem and how it could be best helped are presented. Participants' answers are coded using 12 categories for the first question and nine for the second (Jorm et al., 1997a; Reavley & Jorm, 2011). Category coding was previously shown to have good reliability with high inter-rater reliability ($\kappa = 0.8$; Wright et al., 2012). Participants score 1 for each appropriate problem and help-source accurately identified (DSM-IV; National Institute for Health and Clinical Excellence, 2005; Wright et al., 2005; Eckert, Kutek, Dunn, Air & Goldney, 2010). Higher scores represent greater mental health literacy. The measure was shown to have good validity with mental health workers receiving greater mental health literacy scores than lay participants (Caldwell & Jorm 2000; Jorm et al., 1997b). The Cronbach's alpha was .53 in the current study which may have indicated low reliability (Kline, 1999). However, Cronbach's alpha is sensitive to the number of items present (Field et al., 2013; Cortina, 1993); as this measure only had four items, a lower Cronbach's alpha was not unexpected, so the measure was retained.

Prior Help. Prior help was measured using a yes/no question asking if help had ever been sought before, for a personal or emotional problem (see Appendix M). Participant were then asked to specify the help used. Responses were categorised into formal and informal help sources or other. These questions were adapted from previous help-seeking studies (e.g. Wilson, Deane & Ciarrochi, 2005; Deane, Wilson & Ciarrochi, 2001).

Results

Statistical Analysis

Data were analysed using SPSS statistical software, version 20 (IBM, 2012). The proportion of missing data on each measure fell below 2%. This was below a suggested 5% threshold when missing data is considered inconsequential, as such, missing data were not corrected (Schafer, 1999). Multiple linear regression was used to explore the

variables predictive power on help-seeking. Prior to analysis, data were screened against statistical assumptions of multiple regression. Using Casewise Diagnostics, and Cook's and Mahalanobis Distance, no influential outliers were detected (Field, 2013; Tabachnick & Fidell, 1997). Collinearity statistics (Tolerance and Variance Inflation Factor) suggested no collinearity of variables (Kutner, Nachtsheim & Neler, 2004). Visual displays (Probability-Probability Plots, Plots of Standardised Residuals against Predicted Values and Histograms) suggested homoscedasticity and the distributions of residuals between the model's prediction and observed data were normal for the Informal GHSQ linear model but indicated heteroscedasticity for the Formal GHSQ and No Help GHSQ linear models. This indicated Formal and No Help GHSQ models were falling short of multiple regression assumptions (Field, 2013; Fox, 1991). To counteract this violation and increase accuracy of confidence intervals and significance calculations, Bootstrapping was employed for these two models (Efron & Tibshirani, 1993; Field, 2013).

Preliminary Analysis

As can be seen in Table 1, the Informal General Help Seeking Questionnaire (GHSQ) received the highest scores among criterion variables ($M=4.48$, $SD=1.19$), followed by No Help GHSQ ($M=2.75$, $SD=1.77$) and Formal GHSQ ($M=2.19$, $SD=0.94$). This indicated participants preferred to seek informal help over no help and formal help, and formal help was the least favoured. Predictor variables with continuous numerical data were BSRI Feminine ($M=4.95$, $SD=0.86$), BSRI masculine ($M=4.45$, $SD=0.83$), SEIS ($M=114.09$, $SD=9.95$), BASH-B ($M=36.39$, $SD=8.55$), MHL ($M=2.08$, $SD=1.23$), RFL-A ($M=4.82$, $SD=0.75$). Predictors using dummy variables were Prior Formal Help (27.3% prior formal help, 82.7% no prior formal help), Prior Informal Help (41.1% prior informal help, 58.9% no prior informal help), Biological Gender (69.3% female, 30.7% male).

Table 1:

Descriptive statistics and Pearson's correlations between criterion variables (Formal Help-seeking, Informal Help-Seeking and No Help-Seeking) and predictor variables (Biological Gender, Feminine and Masculine Sex role Identification, Prior Formal and Informal Help, Emotional Intelligence, Belief Barriers, Mental Health Literacy and Reasons for Living)

	GHSQ-F	GHSQ-I	GHSQ-N	Gender	BSRI-F	BSRI-M	PH-F	PH-I	SEIS	BASH-B	MHL	RFL-A
Mean	2.19	4.48	2.75	1.31	4.95	4.45	.27	.41	114.09	36.39	2.08	4.82
SD	.94	1.19	1.77	.46	.86	.83	.45	.49	9.95	8.55	1.23	.75
GHSQ-F	1.00											
GHSQ-I	.45***	1										
GHSQ-N	-.23***	-.53***	1									
Gender	.03	-.18**	.09	1								
BSRI-F	.14**	.29**	-.27***	-.27***	1							
BSRI-M	.01	.08	.03*	.09	-.05*	1						
PH-F	-.04	-.12*	.05	-.12*	.12*	.02	1					
PH-I	.10	.21***	-.18***	-.20***	.22***	.03	.20***	1				
SEIS	.21***	.39***	-.29***	-.09	.43**	.20***	.05	.15**	1			
BASH-B	-.26***	-.33***	.39***	-.11*	-.07	-.02	.01	-.07	-.34***	1		
MHL	-.06	-.05	.10	-.11*	.11*	-.02	.13*	.11	-.08	-.06	1	
RFL-A	.22***	.46***	-.39**	-.10	.21***	.13**	-.10	.09	.42***	-.37***	-.08	1

*p <.05; **p<.01; ***p<.001

Note: GHSQ-F, General Help-Seeking Questionnaire (GHSQ) Formal Help Sources (Wilson, Deane, Ciarrochi et al., 2005); GHSQ-I, GHSQ Informal Help Sources (Wilson, Deane, Ciarrochi et al., 2005); GHSQ-N, GHSQ No Help (Wilson, Deane, Ciarrochi et al., 2005); BSRI-F, Bem's Sex Role Inventory (BSRI) Feminine (Bem, 1974); BSRI-M, BSRI Masculine (Bem, 1974); PH-F, Prior Formal Help; PH-I, Prior

Informal Help; SEIS, Schutte Emotional Intelligence Scale (Schutte et al., 1998); BASH-B, Barriers to Adolescents Seeking Help Scale Brief Version (Wilson, Deane & Ciarrochi, 2005; Kuhl et al., 1997); MHL, Mental Health Literacy Questionnaire (Jorm et al., 1997); RFL-A, Reason for Living Adolescent version (Osman et al., 1998).

As can be seen in Table 2, compared to males, females were associated with greater numerical scores on Informal GHSQ, SEIS, BASH-B, MHL, RFL-A, BSRI Femininity and lower scores on Formal GHSQ, No Help GHSQ and BSRI Masculinity. To test whether females and male means were statistically different, an independent samples *t*-test was performed. The female and male distributions were sufficiently normal for the purposes of conducting a *t*-test (i.e. skew <2.0 and kurtosis <9.0; Schmider, Ziegler, Danay, Beyer & Buhner, 2010) and homogeneity of variance was tested and satisfied with Levene's *F* test (Field, 2013). For Informal GHSQ, significantly more ($t=3.19$, $df=317$, $p=.002$, two-tailed) females ($M=4.62$, $SD=1.17$) were willing to seek help than males ($M=4.17$, $SD=1.16$). For BSRI Femininity, significantly more ($t=5.03$, $df=317$, $p<.001$, two-tailed) females ($M=5.10$, $SD=0.83$) identified with femininity sex roles than males ($M=4.60$, $SD=0.82$). For BASH-B, significantly more ($t=2.04$, $df=317$, $p=.043$, two-tailed) females ($M=37.04$, $SD=8.77$) had greater belief based barriers to help-seeking than males ($M=34.94$, $SD=7.88$). For MHL, significantly more ($t=2.03$, $df=317$, $p=.044$, two-tailed) females ($M=2.17$, $SD=1.23$) had greater mental health literacy scores than males ($M=1.87$, $SD=1.20$). However, Formal GHSQ, No Help GHSQ, SEIS, RFL-A and BSRI Masculinity were not found to have significant gender differences. Thus, being female was associated with significantly greater willingness to seek informal help, greater identification with a feminine sex roles, greater belief-based barriers to help-seeking and greater mental health literacy compared to males.

Table 2:

T-Tests, Means (M) and Standard Deviations (SD) on Formal Help-seeking, Informal Help-Seeking and No Help-Seeking, Feminine and Masculine Sex role Identification, Emotional Intelligence, Belief Barriers, Mental Health Literacy and Reasons for Living for females and males

	Female M		Male		<i>t</i> -value	<i>p</i> -value
	<i>N</i> =221		<i>N</i> =98			
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
GHSQ-F	2.18	0.94	2.23	0.95	-0.47	.639
GHSQ-I	4.62	1.17	4.17	1.16	3.19	.002
GHSQ-N	2.65	1.67	2.98	1.93	-1.51	.133
BSRI Feminine	5.10	0.83	4.60	0.82	5.03	<.001
BSRI Masculine	4.40	0.85	4.57	0.79	-1.63	.104
SEIS	114.65	10.13	112.83	9.46	1.51	.132
BASH-B	37.04	8.77	34.94	7.88	2.04	.043
MHL	2.17	1.23	1.87	1.20	2.03	.044
RFL-A	4.87	0.72	4.70	0.80	1.81	.072

Among predictor variables moderate correlations emerged (see Table 1) for Reasons For Living Adolescent version (RFL-A) and Schutte Emotional Intelligence Scale (SEIS; $r=.42$, $p<.001$), RFL-A and Barriers to Adolescents Seeking Help Brief Version (BASH-B; $r=-.37$, $p<.001$), SEIS and BASH-B ($r=-.34$, $p<.001$), and Bem Sex Role Inventory Femininity (BSRI-F) and SEIS ($r=.43$, $p<.001$). This means those with more reasons for

living had greater emotional intelligence and fewer belief barriers. Those with greater emotional intelligence had fewer belief barriers and higher femininity scores.

Weaker correlations were found for BSRI-F and Prior Informal Help ($r=-.22$, $p<.001$), Prior Informal Help and Prior Formal Help ($r=.20$, $p<.001$), Biological Gender and BSRI-F ($r=-.27$, $p<.001$) and BSRI-F and RFL-A ($r=.21$, $p<.001$). This means those with previous informal help were slightly more likely to have had formal help and be feminine. Those who were feminine were slightly more likely to be biologically female and have more reasons for living.

Inter-item GHSQ correlations (see Appendix N) suggested formal GHSQ items correlated more with other formal items and less with informal ones. Analysis of difference between subsection means (Wilcoxon Signed Rank test, two-tailed) showed strong significant differences between Formal and Informal GHSQ ($z=-15.31$, N -Ties=316, $p<.001$), Formal and No Help GHSQ ($z=-3.65$; N -Ties=303, $p<.001$) and Informal and No Help GHSQ ($z=-9.82$, N -Ties=306, $p<.001$). This suggested meaningful differences between help sources, so following GHSQ guidelines, the measure was split into three separate criterion variables; Formal, Informal and No Help GHSQ (Deane & Wilson, 2007).

Multiple Regression Analysis

All predictor variables were entered into standard regression models. Predictor variables included: Biological Gender, BSRI Feminine, BSRI Masculine, Prior Formal and Informal Help, SEIS, BASH-B, MHL and RFL-A. Three multiple regression models were performed, one for each criterion variable of Formal, Informal and No Help GHSQ.

Regression Model I: Formal GHSQ. All predictor variables, together with Formal GHSQ as the criterion variable, were entered into a standard regression model using 1 000 bootstrap samples (See Appendix O). A significant model emerged ($F(9, 309)=4.20$, $p<.001$). The model explained 10.9% (R^2) of the Formal GHSQ variance, 8.3% when adjusted.

BASH-B was the only significant (negative) predictor of Formal GHSQ with RFL-A approaching significance ($p=.057$). Higher belief barriers predicted lower formal help-seeking and more reasons for living slightly influenced higher formal help-seeking scores.

The model was computed again using only the significant and near significant variables of BASH-B and RFL-A, results of which are presented in Table 3. This model was significant ($F(2, 316)=14.63, p<.001$), explaining 8.5% (R^2) of the variance, 7.9% when adjusted. BASH-B and RFL-A were both significant predictors of Formal GHSQ, with BASH-B having the greatest significance, independently contributing 21% (β) to the Formal GHSQ variance.

Table 3

Summary of linear model using Formal Help-Seeking as the criterion variable and Belief Barriers and Reasons for Living as predictor variables: Unstandardised, standardised coefficients with standardised errors, probability and 95% confidence intervals (reported in parentheses) based on 1 000 Bootstrap samples

	<i>B</i>	<i>SE B</i>	β	<i>p</i>
Constant	2.15 (1.33, 3.10)	0.42		.001
BASH-B	-0.02 (-0.03, -0.01)	0.01	-.21	.001
RFL-A	0.18 (0.07, 0.29)	0.061	.14	.004

Note: $R^2=.09$; Adjusted $R^2=.08$

Regression Model II: Informal GHSQ. All predictor variables and Informal GHSQ as the criterion variable, were entered into a standard regression model (see Appendix O). A significant model emerged ($F(10, 308)=15.66, p<.001$), explaining 33.7% (R^2) of the Informal GHSQ variance, 31.6% when adjusted. Biological Gender, SEIS, BASH-B, RFL-A, BSRI Feminine, Prior Formal and Informal Help were found to be significant predictors. These six significant predictor variables were re-entered into a second standard regression model, the results of which are presented in Table 4. The new

model was significant ($F(7, 311)=22.43, p<.001$), explaining 33.5% (R^2) of the Informal GHSQ variance, 32.0% when adjusted.

Table 4

Summary of linear model with Informal Help-Seeking as the criterion variable and Biological Gender, Femininity, Prior Formal and Informal Help, Emotional Intelligence, Belief Barriers and Reasons for Living as predictor variables: Unstandardised and standardised coefficients, standard errors and probability values

	<i>B</i>	<i>SE B</i>	β	<i>P</i>
Constant	1.00	0.89		.258
Biological Gender	-0.30	0.13	-.12	.018
BSRI Femininity	0.16	0.08	.12	.034
Prior Formal Help	-0.40	0.13	-.15	.002
Prior Informal Help	0.33	0.12	.14	.006
SEIS	0.02	0.02	.14	.013
BASH-B	-0.03	0.01	-.18	.001
RFL-A	0.42	0.09	.27	<.001

Note: $R^2=.34$; Adjusted $R^2=.32$

BASH-B, Biological Gender and Prior Formal Help predicted Informal GHSQ with negative relationships, meaning those with greater belief barriers, who had formal help in the past and were biologically male were less willing to seek help from informal sources. BSRI-F, Prior Informal Help, SEIS and RFL-A predicted Informal GHSQ with positive relationships, meaning those with greater reasons for living, emotional intelligence, in receipt of previous informal help and identified with femininity were more willing to seek help from informal sources. RFL-A was found to be the most significant predictor, independently contributing 26.7% (β) to the Informal GHSQ variance.

Regression Model III: No Help GHSQ. All predictor variables, with No Help GHSQ as the criterion variable, were entered into a standard regression model using 1 000 bootstrap samples (see Appendix P). The model was found to be significant ($F(9, 302)=13.40, p<.001$), explaining 28.5% (R^2) of the No Help GHSQ variance and 26.4% when adjusted. Prior Informal Help, BASH-B, MHL, BSRI-F and RFL-A emerged as significant predictors. These five significant predictors were entered into a second standard regression, with results presented in Table 5. The new model emerged as significant ($F(5, 306)=23.51, p<.001$), explaining 27.8% (R^2) of the No Help GHSQ variance, 26.6% when adjusted.

Table 5

Summary of linear model with No Help-Seeking as the criterion variable and Belief Barriers, Mental Health Literacy, Reasons for Living, Femininity and Prior Informal Help as predictor variables: Unstandardised and standardised coefficients, with standard errors, 95% confidence intervals (reported in parentheses) and probability values based on 1 000 Bootstrap samples

	<i>B</i>	<i>SE B</i>	β	<i>p</i>
Constant	4.75 (2.84, 6.93)	1.04		<.001
Prior Informal Help	-0.38 (-0.72, -0.03)	0.18	-.11	.035
BASH-B	0.06 (0.04, 0.08)	0.01	.29	<.001
MHL	0.18 (0.03, 0.32)	0.07	.13	.010
RFL-A	-0.51 (-0.82, -0.22)	0.14	-.22	<.001
BSRI Femininity	-0.39 (-0.59, -0.20)	0.11	-.19	<.001
<i>Note: R^2=.28; Adjusted R^2=.27</i>				

In the new model, Prior Informal Help, RFL-A and BSRI-F significantly predicted No Help GHSQ with negative relationships, meaning those with greater reasons for living, in receipt of previous informal help and more feminine were less likely to state they would not seek help. BASH-B and MHL significantly predicted No Help GHSQ with positive relationships, meaning those with greater belief barriers and greater mental health literacy were more likely not to seek help. BASH-B, RFL-A and BSRI-F were the

most significant predictors, with BASH-B contributing the most to No Help GHSQ variance ($\beta=0.29$), followed by RFL-A ($\beta=.22$) and BSRI-F ($\beta=.19$).

Discussion

Summary of findings

Students had greater intentions to seek help for personal and emotional problems from informal sources of help, such as friends and family, than professional ones, such as GPs. Indeed, not seeking any help at all was favoured over formal help.

For students' intentions to seek help from formal sources, the predictor variables combined accounted for 11% of students' help-seeking. However, belief based barriers was the only variable independently predicting formal help-seeking. For students' intentions to seek help from informal sources, the predictor variables combined account for 34% of students' help-seeking. Gender, feminine sex role identification, prior help experiences, emotional intelligence, belief based barriers and reasons for living all independently predicted students' informal help-seeking, with reasons for living the strongest predictor followed by belief based barriers. When it came to student's intentions not to seek help, predictor variables combined accounted for 29% of students' help-seeking. Gender, feminine sex role identification, prior informal help, belief based barriers, mental health literacy and reasons for living all independently predicted students' desire not to seek help, with belief based barriers as the strongest predictor followed by reasons for living. Across all help sources, belief barriers and reasons for living emerged as the two strongest predictors of help-seeking.

Formal Help-Seeking. Belief barriers was the strongest, and indeed only factor independently predicting formal help-seeking, although reasons for living approached significance. All other factors, including biological gender, feminine and masculine sex role identification, prior formal and informal help experiences, emotional intelligence and mental health literacy had no association. Among help sources, formal help-seeking had the least association with the combined predictor variables, suggesting factors extracted from the literature were less relevant to professional help-seeking.

Informal Help-Seeking. Reasons for living was the predominant predictor for informal help-seeking, followed by belief barriers. Indeed, among the three help

sources, informal help-seeking had the greatest association with reasons for living. Biological gender and feminine sex role identification independently, yet modestly, predicted informal help-seeking, accounting for the same amount of variance as each other. In contrast, masculine sex role identification had no association. Both prior formal and informal help predicted informal help-seeking, with their predictive power greater here than for the other two help-seeking sources. Emotional intelligence had a modest association with informal help even though remaining unrelated to formal and no help-seeking. Among help sources, informal help-seeking had the strongest association with the combined variables, suggesting factors extracted from the literature had the greatest impact on informal help-seeking.

No Help-Seeking. For no help-seeking, belief barriers was the strongest predictor, followed by reasons for living. Indeed, among the three help sources investigated, no help-seeking had the strongest association with belief barriers. Feminine sex role identification was the third strongest predictor of no help-seeking, yet biological gender and masculine sex role identification had no association. Indeed, feminine sex role identification had the greatest predictive power with no help-seeking compared to formal and informal help-seeking. Mental health literacy had no predictive power on formal and informal help-seeking but was a relatively strong predictor (the fourth strongest) for no help-seeking. However, contrary to expectations (Smith & Shochet, 2011; Wright et al., 2012), superior mental health knowledge actually increased a preference for no help not decreased it. When it came to past help, prior informal help modestly predicted no help-seeking, whereas prior formal help had no association. Emotional intelligence also had no association with non help-seeking.

Where this fits with the literature

Belief barriers. In this study, belief barriers emerged as one of the strongest predictors of help-seeking intentions, supporting past research, indicating a relationships between beliefs and help-seeking (Carlton & Deane, 2000; Cooper, Corrigan & Watson, 2003). Previous research suggested beliefs were even greater predictors of help-seeking than distress (Wilson, 2010).

Findings supported Biddle, Donovan, Sharp and Gunnell's (2007) help-seeking model, which suggested young people fear classifying themselves as having real distress because of a host of negative beliefs attributed to this type of distress. Thus, help-

seeking is avoided as it is associated with, and may be considered an indicator of real distress. Findings also support linear cognitive help-seeking models, such as Nadler (1991) who suggested help-seeking involved a cognitive problem solving process; young people identify a problem, assess their abilities and use a cost-benefit analysis to make a reasoned help-seeking decision.

The predictive power of belief barriers could be explained by developmental processes in young adults. Adolescents seek to develop self-identities during a process known as deindividuation (Santrock, 1998; Nadler, 1986). A sense of independence and control over their lives is sought, often in opposition to parents and authority figures (Adams & Marshall, 1996; Erikson, 1968). This developmental process is likely to produce negative beliefs about help-seeking (Rickwood et al., 2005).

Reasons for living. Current findings found reasons for living was a dominant predictor of help-seeking, suggesting suicidal ideation reduces help-seeking, consistent with previous findings (Sheffield et al., 2004; Raviv et al., 2009). Suicidal ideation negation effect has been found even when hopelessness and prior help-experience were factored out (Wilson, Deane & Ciarrochi, 2005). Wilson et al (2005) suggested the suicidal ideation negation effect could be linked to negative beliefs associated with suicidal ideation. However, the current study does not support this, as both suicidal ideation and belief barriers were independent predictors. The observed effect might instead be associated with impoverished social and cognitive problem solving skills resulting from a suicidal ideation (D’Zurilla, Chang, Nottingham, & Facini, 1998). Such skills are likely to be integral to the help-seeking process (Nadler, 1991; Rickwood et al, 2005).

Emotional Intelligence. Emotional intelligence only predicted informal help-seeking, supporting Ciarrochi et al. (2002) who found emotional intelligence influenced informal, not formal help-seeking. However the current study does not support other research which found emotional intelligence could predict all types of help-seeking (Ciarrochi et al., 2003; Wilson et al., 2011; Vaswani, 2011).

Emotional intelligence’s predictive effect could be explained in part by research on neurological development. The prefrontal cortex is implicated in rationalising and regulating emotions and processing social complexities (Goleman, 1996; Turner, 2000). Young people who have experienced attachment difficulties, trauma or distress in early years are likely to have developed less optimal prefrontal cortex functioning (Chugani et

al., 2001; Gerhardt, 2004). These young people are probably least cognitively equipped to seek out help yet likely most in need of it (Gerhardt, 2004). This could partially explain why students in this study with lower emotional intelligence, were less willing to seek help from friends and family.

Gender. The current study found females and those with feminine identities were more likely to seek help, supporting previous research (Morgan & Jorm, 2009; Donald et al., 2001). Feminine sex role identification provided greater individual contributions to help-seeking variance than biological gender, suggesting culturally defined gender roles have greater impact on help-seeking than biological gender, mirroring findings from a previous adult study (Vasmani, 2011). However, contrary to expectations (Tishby et al., 2001; Raviv et al., 2009) masculine role identification had no predictive power on any help-seeking.

These findings offer a new perspective in understanding gender differences in help-seeking. Young people's reluctance to seek help is more attributable to cultural defined sex roles than biological gender. Their sense of masculinity is unlikely to affect their help-seeking decisions, but rather their inability or reluctance to identify with feminine traits is key. As femininity sex role identification strongly correlated with biological gender in this study, this alternative perspective can explain why research consistently finds males seek help less (Tishby et al., 2001; Raviv et al., 2009).

These findings highlight an advantage of using the BSRI (Bem, 1974), as it can measure femininity and masculinity as independent factors co-existing in the same person. The bulk of previous research though (e.g. Tishby et al., 2001), has utilised biological definitions which are likely less nuanced and sensitive to social and cultural contexts (Hoffman & Border, 2001; Bem, 1974). However some research has indicated BSRI maybe actually measuring cognitive traits functioning independently of gender (Hoffman & Borders, 2001; Ang, Lim, Tin & Yau, 2004).

Previous help. It was found receiving prior help predicted greater help-seeking, congruent with previous research (Biddle et al., 2004; Moran, 2007). However, prior help had no bearing on formal help-seeking intentions, contradicting research by Ciarrochi and Deane (2001) who found having received previous professional help increased formal help-seeking while having little effect on informal help.

In the current study, prior informal help reduced a desire for no help, suggesting friends and family can act as gatekeepers into professional services. This supported

Wilson et al. (2011), who found past help from friends and family was the greatest predictor of professional help-seeking.

Mental health literacy. Mental health literacy had no effect on purposive help seeking but increased a wish for no help, contrary to previous research suggesting mental health literacy predicted greater help-seeking (Wright, Jorm & Mackinnon, 2012; Klineberg, Biddle, Donovan & Gunnell, 2011). Findings from the current study probably highlight important differences between knowledge about how to act and motivation to act (Miller & Rollnick, 2002). Previous literature suggested young people with mental health problems who need help the most, have often developed pessimistic, fatalistic and avoidant coping styles (Seligman, 2007; Herbert, 1998). Thus, increasing knowledge for these young people might not be enough to change habitual maladaptive coping styles (Seligman, 2007; Herbert, 1998). Moreover, gaining mental health knowledge could inhibit help-seeking, for example knowing professionals will become involved might be perceived as threatening to vulnerable young people. Stösser and Klosinski (1995) found young people expressed more fears about engaging with psychiatric services when they gained more knowledge of those services.

Clinical Implications

As no help was preferred over professional help, clinicians need to be sensitive to young people's apprehension towards mental health services. It can be assumed most young people will not refer themselves to services. Professionals need to find more effective ways to reach out to young people in the community.

Tonin (2007) argued mental health services have found themselves in a position where young people are expected to adapt to norms and expectations of the organisation. As beliefs were found to highly influence help-seeking, clinical services need to reverse this position. Resources should invest in understanding the cultural norms, language and beliefs young people assign to distress and help-seeking (McQueen & Henwood, 2002). Armed with this knowledge, professionals should better tailor services to fit specific needs, norms and expectations of young people (Tonin, 2007).

As informal help was preferred by young people, it should be a priority to providing support, training and information to families, friends and community members to empower them to support their young people and enable them to signpost

them to professionals where appropriate. Indeed, maintaining strong community contact has been shown to aid recovery from trauma based problems (Bracken & Petty, 1998).

Mental health knowledge did not increase help-seeking, and in some instances inhibited it. This suggested promotional campaigns designed to increase mental health knowledge with the view of improving service engagement are likely not to succeed. To achieve greater service engagement, such campaigns should focus on changing prevailing beliefs and attitudes, which were found to predict help-seeking in the current study.

Previous research suggested attachment difficulties and early trauma can impair cognitive processes (Chugani et al., 2001; Gerhardt, 2004) which could explain why cognitive based factors in the current study influenced help-seeking. Seligman (2007) proposed all young people, even those with poor early experiences, can be socialised into having more constructive, optimistic and healthy cognitions through focused dialogue techniques. If such techniques could be taught to schools, carers and parents to use with children, even before they reach adolescence, it could increase the wellbeing and help-seeking tendencies of young people (Seligman, 2007).

Prior help influenced future help-seeking intentions, demonstrating the importance of making young people's first point of contact with services a positive experience. It is imperative clinicians are trained in facilitating a welcoming, validating, and non-stigmatising atmosphere (Wilson & Deane, 2001).

The current findings suggested the influence of gender on help-seeking is complex and goes beyond simple biological definitions. Thus it is important clinicians not make assumptions based purely on biological gender. Indeed, using a working hypothesis that males are reluctant to seek help is less helpful than considering the extent to which clients identify with culturally defined feminine traits.

The sex role identification findings provided useful indications on how to increase young peoples' help-seeking skills. Focusing on reducing traits associated with Bem's masculine scale (Bem, 1974), such as independence and aggression, are likely to be less successful than developing skills associated with Bem's femininity scale (Bem, 1974) such as compassion and sympathy.

Limitations and Future Research

Cross-sectional research is able to collect multiple data sets with relative ease but only provides a snap shot in time of someone's life. However, help-seeking is probably a cognitive behavioural process progressing over time (Rickwood et al., 2005). Changes in help-seeking may occur as young people grow older and develop greater problem solving skills and emotional intelligence (Gerhardt, 2004; Ciarrochi et al., 2003). The current cross-sectional design is not sensitive to these temporal and developmental processes. Future research would benefit from longitudinal methodology.

In the current study, students voluntarily completed surveys, potentially filtering out more apathetic participants or those averse to engaging with adults, potentially biasing the sample towards more pro help-seeking participants. Future research would benefit from purposively targeting hard-to-engage youth populations.

The current study measured help-seeking intentions as opposed to actual help-seeking. Even though such approaches have been validated (e.g. Wilson, Deane, Ciarrochi et al., 2005) and sensitive to non-clinical samples (Rickwood et al., 2005), it is still not assessing real distress and help-seeking. Therefore, caution may be needed extrapolating findings to real life. It would be useful for future research to access clinical populations, measuring real life help-seeking.

As this research utilised regression analysis, causal relationships cannot be inferred. Additionally, even though strong significant relationships were observed, regression models sometimes accounted for modest variances in the data, this was especially true for students' formal help-seeking. This suggested there may be factors influencing help-seeking that are still relatively unknown and highlights the need for more explorative research.

As beliefs and other cognitive processes were implicated in the help-seeking process, it would be worthwhile future research deconstruct these beliefs and cognitions into component parts to explore which ones are most salient. In addition, exploring elements potentially influencing beliefs, such as cultural differences, would further enrich our understanding of help-seeking.

Conclusion

This study aimed to explore how factors, identified from literature, combined to predict young people's help-seeking intentions for personal and emotional problems, and which factors had the strongest predictive power. Factors combined did predict help-seeking, but with a much greater power for informal sources, such as friends and family and a desire for no help, compared to help from professionals, such as GPs.

It was found belief based barriers and suicidal ideation as measured by reasons for living, were the strongest help-seeking predictors. Other factors investigated, including emotional intelligence, biological gender, sex role identification, prior help experiences and mental health literacy, had weaker associations with help-seeking and their effects differed according to the help source.

Previous research has focused on investigating gender differences using biological definitions. The current study demonstrated potential flaws in this approach. Males sought help less than females, yet identification with masculinity had no influence. Identification with femininity offered greater predictive power than biological gender. This suggested the effects of gender are far more complex than previously indicated.

The study uncovered important implications for young people's mental health services. Most importantly, it indicated the importance of increasing services' understanding of young people's cultural norms and expectations to help them design strategies to meet and satisfy these and help them.

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Chapter 3: Reflective Review

Commentary and Reflexive Analysis of the Research Process

Abstract

The aim of research was to explore factors promoting or inhibiting help-seeking for personal or emotional problems in young people. In Chapter 1, a review of the literature found a range of potential influencing factors, but how factors combined and which ones were most salient, was not clear. Chapter 2 aimed to empirically test the predictive value of combined and individual factors on help-seeking. A cross-sectional questionnaire was administered to 319 sixth form college students. Multiple regression statistical analysis was employed. Belief barriers, reasons for living, emotional intelligence, gender and feminine sex role identification, mental health literacy and prior help predicted help-seeking. Belief barriers and reasons for living emerged as the predominant predictors. Limitations and implications of findings were discussed. This chapter offers further reflective commentary on the design, methodology and analysis of research, followed by a critical personal reflexive account of the relationship between the research and researcher.

Commentary and Reflexive Analysis of the Research Process

Young adulthood is a time of acute vulnerability to psychological distress due to unique developmental and psychosocial transitions (Offer, Schonert & Ostrov, 1991). Indeed, this age group is characterised by high rates of personal, emotional and mental health problems (Sawyer et al., 2001). Suicide is a leading cause of death among young people (Belfer, 2008). An ability to seek help for problems is a crucial skill young people can develop to navigate themselves through this turbulent time (Rickwood, Deane, Wilson & Ciarrochi, 2005). Yet, research shows young people rarely seek help (Zachrisson, Rodje & Mykletun, 2006) and the question remains why.

Chapter 1 reviewed the literature to explore which factors have been found to influence young people to seek help. Being female, family involvement, social support, informal sources of help, prior help-seeking, emotional intelligence, mental health knowledge and secure attachment styles were found to promote help-seeking. Suicidal ideation, hopelessness and belief barriers were found to inhibit help-seeking. Ethnicity and media were shown to have no effect, whereas age, socio-economic status and distress drew conclusive results. However, it was not clear how factors combined to influence help-seeking and which ones were most salient.

Chapter 2 reported a study based on positivist principles aimed to test how factors combine to predict help-seeking intentions among college students and which factors were the best predictors of help-seeking. Belief based barriers to help-seeking and reasons for living were found to be predominant predictors of help-seeking. The research had important implications for mental health services, suggesting the need to adapt service provision to accommodate young people's prevailing beliefs and cultural expectations.

The aim of this chapter is to offer further commentary and reflexive analysis on the research to facilitate greater contextual understanding. The first half of the chapter will use third person reflective commentary to critically reflect on the research. The second half will offer first person reflexive analysis to explore the relationship between the researcher and research and its subsequent effects on both. First person tense was chosen to create more human rich accounts of these relationships.

Reflective Commentary on the Research

Early considerations

The ideas of the current research were born from a previous service evaluation the researcher led on behalf of an independent service-user involvement group. Focus groups were used to explore which services young people valued and what factors encouraged them to use or not use them. It was found young people highly valued local services but rarely accessed them. Young people gave different reasons for this, from fear of confidentiality breaches to not knowing how to use them. Interestingly though, many were not able to fully account for the reluctance to use services and concluded future research would be beneficial. Therefore, this experience naturally informed the direction of the current research.

Planning a study so it maintained good ethical standards and clinical safeguarding was challenging, especially for such a complex research project as this. As such, time and effort was invested to investigating and planning the research proposal. When the study's procedures were questioned, criticised and ultimately returned with modifications at its first ethics panel submission, it was a sore point. However, this process brought with it an invaluable learning curve. It demonstrated the importance not to assume procedures are ethical, based on one person's judgement, but to constantly gain wider advice and supervision.

Literature Review

For the literature search, developing search terms was challenging as the help-seeking research field involves quite generic phrases such as "help-seeking" and "mental health". When these phrases were placed into an EBSCO search it produced over 300 000 hits. The sheer volume of papers meant slight changes in search terms, such as adding or removing a truncation mark, changed results by thousands. Consulting key papers helped formulate more focused terms and the use of limiters enabled the search become more manageable.

To focus the search further a set of exclusion criteria were applied. One dilemma was whether to include papers from countries where mental health care was either absent or not free, such as the USA. In such countries, issues of insurance and finance may confound help-seeking decisions and not generalisable to a UK system. On the other hand, American authors may have produced some highly relevant research

which would be missed. With supervisory advice, a decision was taken to exclude these papers so search results could maintain its relevance to the UK.

Methodological design

A power calculation suggested a minimum of 92 participants were needed for the current study. Five subject departments at the college offered access to their students. To maintain a sample similar to the power calculation would have meant some teaching groups within these departments being excluded. However, this was ethically problematic as student may have wondered why they were excluded while others included. For ethical reasons then, all students within these departments were surveyed which had the unanticipated consequence of inflating the numbers. Such a larger sample had benefits though, as it increased the statistical power of the results making them easier to generalise.

The benefit of using established measures was they come with validity and reliability evidence already in place, improving internal validity of the study. However, using these measures brought problems too. Each measure had its own likert scale; as participants moved from one measure to the next, they were faced with different scales. Confusion may have ensued, for instance students might have carried on rating a new measure with a past likert scale in mind. To placate this risk, clear instructions were given and students were invited to ask questions throughout. Anecdotally though, only around 15 students were observed asking for clarification over likert scales.

Multiple regression was used to analysis the results. However, the measures produced a large amount of data with many possibilities of further analysis, such as mediation or hierarchical regression. Additionally, many of the measures had subscales and individual items; the predictive qualities of these could also be explored further. Unfortunately, the limited word count hindered further data analysis in this thesis but there is scope for further analysis in the future.

Ethical Issues

There was potential risk asking young people to respond to items connected to personal or emotions problems could cause distress due to personal predispositions or experience. To reduce this risk, participants were provided information about the study a week prior to conducting research, allowing participants time to reflect on their

consent. It was made clear throughout, participants had the right to withdraw at any point without having to give a reason and have all related data destroyed.

The Reasons for Living measure (Osman et al., 1996) assessed suicidal ideation. There was a risk such items could have caused distress. However, literature suggested no negative effects from completing suicidal ideation items and they actually increased mood if framed positively, as was the case in this study (Deeley & Love, 2010). To help placate any risk of distress, information regarding college, local and national support services were given out after questionnaires were returned. They were given to all, even students not participating in research.

To promote safeguarding, a coding system was implemented, with a code number on the questionnaire linked to a corresponding consent form. If any responses caused concerns, the coding system was used to identify students and pass their details onto the pastoral team at the college. Also, when students approached the researcher directly with a disclosure, again details were passed onto the pastoral team. This safeguarding process was made explicit to students before consent was sought.

A risk of conducting research within lessons was students participating in research were visible to their peer group, creating an unavoidable confidentiality breach. This potential risk was highlighted to students before consent was sought so they could make informed choices. However, students commonly participate in similar written activities as part of everyday lessons, so it was not anticipated students would feel anxious about this and indeed no student was observed voicing concerns over confidentiality.

Participants who have learning difficulties or special needs may have found questionnaires difficult and/or stressful to complete. To minimise this risk, the researcher liaised with teachers to ensure any special requirements, such as using special coloured paper, was in place before entering classes. Students also complete numerous questionnaires throughout their college career, so it was hoped the research questionnaire would not cause additional anxiety than they would face in their everyday lives.

Implications and application of research

A number of clinical implications were discussed as a result of the current research. Findings provided valuable clues into how to engage young people more

effectively in mental health services. It provided further understanding of why young people may be reluctant to seek-help and what help-seeking promotional strategies might or might not work.

However, the generalisability and application of these implications was limited by a number of factors. The college was based in a community with a relatively non-diverse population. In addition, compared to other parts of the region, and indeed other parts of the country, the local community had relatively high levels of affluence.

Conclusions were based on multiple regression analysis. The inherent problem with this method is that it does not establish cause and effect relationships, limiting the usefulness of conclusions.

Even though findings were strengthened by a relatively large sample with strong statistical significance, the statistical variance and standardised coefficients were still moderate to weak. Caution is therefore needed in drawing firm conclusions from the findings. Indeed, much of the help-seeking variance is still unaccounted for within this study. Future research would benefit from additional explorative studies, perhaps using qualitative methodologies, allowing previously unforeseen factors to come to the fore.

Reflexive Analysis

Influence of researcher

Throughout my adult life I have worked with young people as a teacher, youth worker and now as a trainee clinical psychologist. In my journey I have come to appreciate young peoples' problems are often marginalised or ignored. For instance, when young people experience a distressing problem, such as breaking up with a boyfriend or girlfriend, adults around them often trivialise or dismiss their issues with such narratives as "they are just teenagers" or "they will get over it". From my work experience, I am conscious young people, especially young men, tend to hide problems from adults and I have wondered if not feeling validated by adults contributes to this. As a result, developing this research project was satisfying my own curiosity and came naturally to me.

Undoubtedly, the fact I used to work as a teacher in the sixth form college where my research took place, enabled receiving permission to access students easier. As part of the recruitment process a request was sent out to subject managers asking for volunteers to assist in my research. Psychology and Health and Social Care subjects

were the first to volunteer, not surprisingly as these were the departments I used to work in. My research was only made possible by the kind support of the college and these subject departments. This experience reinforced the importance of fostering good working relationships, and maintaining these relationships even when moving onto another position or profession. It can certainly make achieving goals easier, and in clinical settings this could make the difference between success or failure when implementing new clinical systems or conducting research.

As an ex-teacher it was possible students may have heard about me from other teachers or older siblings for instance. It is possible this may have unduly influenced their decision to take part or whether they gave socially desirable answers. It was anticipated the informed consent process and other ethical consideration could placate this. However, when considering this possibility, I reflected on the power researchers can have over participants even if an indirect link exists between them.

Effects on researcher

Since conducting my research I have reflected on my own help-seeking responses, and have come to realise, like many of my male participants, I would not have sought help for emotional problems as a young man or even now as an adult. When I reflect on the reasons for this, I cannot pin point a single logical explanation, but only that it feels anxiety provoking to do so. When I have shared emotions and feelings within various reflective groups I have noticed I am more likely to receive practical advice whereas female colleagues are more likely to receive sympathy and validation of their feelings. I have wondered, whether this subtle difference could be as a result of my gender and I have wondered if males in general, receive similar reactions while growing up. These reflections make me appreciate the complexity of my research findings, especially those around gender differences. It has also made me acutely aware of how I might be unconsciously responding to clients based on their gender and I now make efforts to reflect on this in clinical supervision.

While conducting research I had to balance three different conflicting motivations. As a researcher I had an instinct to protect the interests of my study, increase rigour and maximise control. As a clinician, I am aware of safeguarding my participants, being sensitive to their needs and wanting to help and support. As an ex-teacher I had an instinct to attuned to the atmosphere and behaviour of students in the

class and direct them accordingly. It was sometimes difficult to balance these instincts. For instance, in one class the teacher left for 10 minutes and students started to talk. As a researcher I was worried they would confound each other's responses. As a trainee psychologist I wanted them to feel comfortable with the task, and if that meant quietly talking then that was OK. As an ex-teacher I had an urge to "shhh" them and direct them back to the task at hand. In the end, I balanced my conflicting urges by explained to students the importance of maintaining silence for the purpose of research and that we could talk again after completion. I have often experienced similar conflicting dilemmas while training as a clinical psychologist and have reflected on this issue. I have come to realise that my teaching background can complement and add value to my clinical and research work and does not necessarily have to compete. I believe the same can be true for researchers and clinicians.

The findings in my research surprised me. I did not expect to see such clear differences between formal and informal help-seeking intentions. It was also surprising to see participants rated no help as preferable to formal help. These findings have made me reflect on my own position as an emerging psychologist. If young people hold such negative perceptions about engaging with professionals, then I have to learn to go beyond my basic clinical training to find ways of reaching out to them. Indeed, I have come to realise working at an organisational level, influencing service provision, may be the best way to affect greatest change and help the greatest number of young people. Providing one-on-one interventions within a traditional service model is certainly not enough if I want to make a difference.

While conducting this research I have seen the birth of my two children. Balancing commitments of my personal life, research and clinical training have been no mean feat. Even though it is an experience I would not want to repeat, I have developed new skills as a result. I have learned to utilise mindfulness techniques to help reduce stress and anxiety, a technique I have now began to use in my clinical practice. I have come to appreciate the importance of reflection and supervision at deeper levels. And above all, it has made me appreciate the importance of placing brackets around segments of my life, knowing in the future I need to protect family time.

Conclusion

The current research emerged from the researcher's own background of working with young people. Each stage of the research procedure had to be carefully considered. Within the literature review, search terms, limiters and exclusion criteria were carefully designed to gain the most appropriate and manageable search results. Due to the nature of participants, extra care was taken over tackling ethical issues when designing research procedures; safeguarding young people was a priority. The empirical research found gender, feminine sex role identification, prior help, emotional intelligence, belief barriers, reasons for living and mental health literacy could predict help-seeking intentions. Belief barriers and reasons for living emerged as predominant predictors. It implied mental health organisations should listen and adapt services to young peoples' beliefs and norms. This research has highlighted the complexities of help-seeking for psychological distress in young people but also the complexities of the relationship between the researcher and the research. The findings not only had clinical implications for services but also influenced personal practice and aspirations of the researcher.

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Appendices

Appendix A: Table briefly summarising some of the literature review's selected papers' strengths and weaknesses

Authors	Strengths	Weaknesses
1. Carlton and Deane (2000)	<ul style="list-style-type: none"> • Reliability and validity of measures evidenced well • Transparency over procedure and statistical analysis • Clinical implications thoroughly discussed • Ethical issues thoroughly considered • Methods section clearly detailed procedure enabling replication 	<ul style="list-style-type: none"> • Findings state ATSPPHS predicts help-seeking but not which direction • Modest self-selected unrepresentative sample • An additional benign condition added to measures which might have wasted participant's time for little benefit • Only measured professional help-seeking. It did not take into account informal help-seeking nor looked at different types of professional help-seeking • Cause and effect relationships suggested even though results based on regression analysis. • The null results findings were not fully considered in conclusions and clinical implication
2. Ciarrochi and Deane (2001)	<ul style="list-style-type: none"> • Good reliability and validity evidence provided for measures • A clearly focused research questions underpinned by literature leading to a clearly defined design • Sample selection transparent 	<ul style="list-style-type: none"> • Unbalanced gender ratio, with 230 females vs 70 males • Biased sample - psychology university students receiving course credit for participation • Sample for mediation analysis very small and could have suffered a loss of power • The mediation analysis only

	<ul style="list-style-type: none"> Fairly large sample As many variables were used, probability threshold adjusted to reduce type one errors 	explored help-seeking for professional sources and ignored informal help-seeking
3. Tishby, Turel, Gumpel, Pinus, Lavy, Winokour and Sznajderman (2001)	<ul style="list-style-type: none"> An attempt to explore difference between help-seeking for themselves and others – creates clarification over previous findings An attempt to explore help-seeking for actual clinical subgroup Large sample increasing generalisability Use of t tests and chi square so an attempt to look at cause and effect Measured help-seeking for a range of problems, not just emotional ones Confidentiality and anonymity considered 	<ul style="list-style-type: none"> Vignette creates hypothetical situation which young people may not relate Items were either adapted or novel – no reliability or validity data discussed Suicide measured using one question so maybe limited scope/validity Sample from middle class school causing bias Some findings presented in discussion section which were not presented in findings section. Some participants were the researcher's own clients indicating bias? Safeguarding not considered in ethics
4. Wilson and Deane (2001)	<ul style="list-style-type: none"> A clear account of background literature given and used as foundation for research questions Use of semi-structured interview schedule which was transparently 	<ul style="list-style-type: none"> Sample is self-selected so probably more pro-social and help-seeking orientated biasing results The focus group facilitator known to students causing possible demand characteristics Those in focus group were friends with each other so social group

	<p>presented in article</p> <ul style="list-style-type: none"> • Rigour increased by the use of a second checker, immersion, crystallisation processes and five scheduled readings • Depth of data increased by use of quotes • Research grant explicitly stated to show any conflicts of interest • A range of ethical issues considered • Honest acknowledgement of bias in sample 	<p>influences could have influenced responses</p> <ul style="list-style-type: none"> • Data analysis not taken back to participants to check for grounding • Process of saturation and recruitment not transparent • Authors have conducted previous research which this study supported- could this have been influenced by researcher bias or conflict of interest?
5. Ciarrochi, Deane, Wilson and Rickwood (2002)	<ul style="list-style-type: none"> • Extended Ciarrochi and Deane's (2001) previous work by introducing social support as explanatory factor • Controls put into place to limit impact of type 1 errors • Reliability and validity evidence for each measure presented • Fully acknowledge cause and effect cannot be concluded 	<ul style="list-style-type: none"> • Introduction copied word-for-word from previous article (Ciarrochi & Deane, 2001) • Lack of detail in method section, e.g. no information on sampling and procedures • Biased ungeneralisable sample – 137 students from private Christian school in Australia • Subsample for prior help seekers very small with 38 participants reducing statistical power • Authors described null results for social support as a limitation, the important implications of these findings on help-seeking research ignored

6. Biddle, Gunnell, Sharp and Donovan (2004)	<ul style="list-style-type: none"> • A relatively large random sample of 3004 increases generalisability and validity • First UK study exploring help-seeking in distressed young adults • Response rates and drop outs were made explicitly clear increasing transparency • Gender differences explored through all the different variables creating more nuanced findings • Looked at nine different predictive variables- recognising the complexity of help-seeking 	<ul style="list-style-type: none"> • Sent out an eight page questionnaire – acts as a barrier to those inclined not to be motivated, not wanting to engage, not pro-social–those likely not wanting to seek help • No reliability or validity data given for chosen measures in method section – some on GHQ given in discussion later on • Not clear why a score of 4 was considered threshold for clinical ‘caseness’ in the GHQ-21 • Conclusions were made on findings with weak probability levels and many non-significant results were not considered within clinical implications • Ethical issues of sending sensitive questionnaires out to participants not discussed
7. Sheffield, Fiorenza, Sofronoff (2004)	<ul style="list-style-type: none"> • Sampling transparent • Attempt to differentiate types of problems and different types of help sources • Attempt to differentiate clinical and non-clinical participants to create more validity 	<ul style="list-style-type: none"> • Lack of rationale for chosen design and measures • Research aims and questions not fully congruent with chosen design and measures • Used “mental illness” in measure which may have cued participants to perceive the problem more severe than other measures • Did not explore implications of non-significant results

8. Moran (2007)	<ul style="list-style-type: none"> • Thorough consideration of background literature which used to inform research question • An attempt to explore cultural and ethnic variations within help-seeking and to differentiate UK help-seeking norms from American research • Chosen measures were based on good reliability and validity evidence • Authors acknowledged limitations within their research • Variety of ethical issues thoroughly considered • Implications of null findings discussed as well as significant ones 	<ul style="list-style-type: none"> • 48% of participants had sought help in the past which is well above average, suggesting an unrepresentative sample • Modest unrepresentative sample of 112 people • From 16 ethnic groups they collapsed them into 5 categories – not clear how categories chosen, e.g. Chinese and Asian were separate categories, yet Chinese collapsed into ‘others’ and Asian collapsed into ‘other Asians’ • Attachment was measured using self-categorisation, but those with insecure attachments might have poorer self-insight and/or insecure more likely to have low mood and low mood is associated with faulty negative self-perceptions which could have distorted their self-categorisation • Continuous SDQ data was converted into dichotomous data by introducing a 17 point cut off which was an arbitrary threshold not based on clinically data
9. Biddle, Donovan, Sharp and Gunnell (2007)	<ul style="list-style-type: none"> • Clear aims and rational for design • Effort to sample a distressed non-help-seeking population to 	<ul style="list-style-type: none"> • The sampling and inclusions process was not clear • Codes not checked with participants (grounded in the data) • Purposive sampling managed by

	<p>increase validity</p> <ul style="list-style-type: none"> • An attempt at rigour with coding checked by a colleague and triangulation • Conclusion firmly based in the data 	<p>one researcher – possible lack of reliability</p> <ul style="list-style-type: none"> • Possible invested interest or epistemological bias present (study's aim was to create interpretive dynamic model from findings which came to pass) • Ethical issues of psychological harm, safeguarding not discussed
10. Raviv, Raviv, Vago-Gefen and Fink (2009)	<ul style="list-style-type: none"> • An attempt to examine the difference between referring others to help seeking and themselves • Relatively large sample with balance of genders increasing generalisability • Ethical considerations considered 	<ul style="list-style-type: none"> • Vignette taken from previous study but not clear how it was created or its validity • No validity or reliability evidence provided for chosen measures except for the BASH measure • It only focused on help-seeking for psychologist and friend and ignores all other sources • Unrepresentative sample as Israeli middle class school students • Some new data was presented in discussion section without being in the results • One conclusion was based on differences that were not significant and then implications were drawn based on this weak evidence
11. Morgan and Jorm (2009)	<ul style="list-style-type: none"> • Large sample increasing generalisability • Used $p < .01$ probability to counter negative effect of many variables in the 	<ul style="list-style-type: none"> • Only asked for max 3 news stories so not measuring extent or number of news stories • Maybe young people focus on light entertainment, drama and fiction

	<p>formula to decrease chances of type 1 errors</p> <ul style="list-style-type: none"> • First to attempt to explore in detail in effects of media on help-seeking • Use of real life media exposure increasing validity of findings 	<p>shows more than news stories which means the method is not valid for youth</p> <ul style="list-style-type: none"> • No validity or reliability data presented for measures
12. Wilson (2010)	<ul style="list-style-type: none"> • Strong foundation in literature and solid justification for research • Good ethical considerations such as debrief sheet and anonymity • Validity and reliability of measures considered • Invested interest statement given 	<ul style="list-style-type: none"> • Small university sample causing bias • Distress scale may not measure all types of distress or longevity of it • Distress scale only measures 7 days so overly sensitive to minor distress and not sensitive to long term stress • The no correlation between distress and formal help-seeking interpreted as active avoidance – faulty conclusion as assumes cause and effect where there is no relationship • Only small correlations available
13. Smith and Shochet (2011)	<ul style="list-style-type: none"> • They provided validity and reliability data for their measures • Clear sampling procedures presented • Clear focused research questions • Some limitations of the study discussed by authors 	<ul style="list-style-type: none"> • Used GSHQ measure using phrase mental illness. This wording may lead to perceptions of more serious or medically based problems • They used the full GHSQ yet only explored professional sources (ignoring informal sources) creating a waste of data and raises ethical issues • Sample university students studying

		<p>psychology – lack of generalisability</p> <ul style="list-style-type: none"> • Small sample dominated by females – lack of representation • Students given course credit for participation causing bias in responses • All measures were novel or adapted and no validity evidence
<p>14. Klineberg, Biddle, Donovan and Gunnell (2011)</p>	<ul style="list-style-type: none"> • Vignette-based research allows participants to express opinions on mental health and help-seeking in a safe way, encouraging greater openness • Open-ended questions were coded and inter-rater reliability checked 	<ul style="list-style-type: none"> • Only data on seeking help from a doctor presented. All other types of help-seeking not presented • Based on a postal survey with a low response rate which could have created a response bias • As over a third scored the maximum 4 on the GHS-21 it suggests an over representation of distressed individuals in sample • The authors proposed a dynamic interpretive model in another paper and the current research supports this model was there research bias?
<p>15. Wilson, Rickwood, Bushnell, Caputi and Thomas (2011)</p>	<ul style="list-style-type: none"> • Chosen measures were backed by sound reliability and validity evidence • A relatively large sample of 641 participants increased generalisability • Ethical issues were considered, such as a safeguarding and confidentiality 	<ul style="list-style-type: none"> • Participants were psychology students from a single university in Australia receiving course credit for participation, so limiting generalisability • There was an imbalance in gender within the sample, 25.6% were males and 74.4% were females • There were some discrepancies with what appeared on tables and

	<ul style="list-style-type: none"> • An online survey was used which created greater confidentiality and less investigator effects • A more stringent probability level of 1% was used to reduce type I errors • The first time informal-help seeking was used to predict formal help-seeking • A range of clinical implications for family work were discussed and disputing expectations of economic influence on help-seeking 	<p>how the data was described. In particular the relationship between sources of help with suicidal thinking</p> <ul style="list-style-type: none"> • The use of theoretical vignettes is not true to life and does not capture participants real distress and their reactions to their own real distress • Data based on weak statistical variance and correlations interpreted in parity with other more significant data • Gender was stated as a separate variable, but not mentioned in the results
16. Wilson and Deane (2012)	<ul style="list-style-type: none"> • Large sample, with good gender balance • Clear and concise background of research with research question clearly presented and justified • Factor analysis data used to support the development and use of measures • Thorough consideration of clinical implications of results • Transparency in conflict of 	<ul style="list-style-type: none"> • Lack of detail over how survey administered and how sample selected • Potential problem with investigator effects • Lack of tabular presentation of findings so difficult to follow results • Safeguarding was not considered in ethics • Measures are self-report and based on theoretical help-seeking so lacks validity

	<p>interest with funding body named</p> <ul style="list-style-type: none"> • A range of ethics issues considered 	
17. Wright, Jorm and Mackinnon (2012)	<ul style="list-style-type: none"> • Vignette age controlled to reduce participant's age confounding responses • Sampling process clear and transparent • Clear rational and literature base to justify study's aims • Very large sample of 3,746 (2802 after exclusions) increasing generalisability • Clear statement of interests both financially and use of a research company • Effect sizes reported 	<ul style="list-style-type: none"> • The phrase "What, if anything, do you think is wrong with John?" could cause leading question • Telephone survey could create unmotivated flippant responses and those least likely to seek help decline invitation • Cold calling telephone technique could cause ethical issues • A private research company was contracted out to collect data which could have caused bias • Only measures intentions to seek-help not actually seeking help so lacking validity • Unable to fully define the sample as only know information asked over the telephone

Appendix B: Critical appraisal questions used within the literature review

1. Was the study's research question clearly focused and relevant?
2. Was the study's design appropriate for the aims of the research?
3. Were the methods described in enough detail?
4. Did the study's methods address the most important potential sources of bias?
5. Were outcomes, exposure, predictor, potential confounder, and effect modifier variables clearly defined?
6. Was the study's sampling clearly defined and appropriate to research aims?
7. Were all of the participants who entered the study accounted for at its conclusion?
8. For each variable (cross-sectional) was chosen measure critically considered?
9. Were the data collected and analysed in a way that addressed the research aims?
10. Was the data accurately analysed with sufficient rigour?
11. Was there a clear statement of findings?
12. Did the data justify the conclusions?
13. How clinically valuable were the results?
14. Were all important outcomes considered so the results can be applied?
15. Were there any conflicts of interest?
16. Have ethical issues been considered and minimised?
17. Have possible limitations, including potential sources of bias or imprecision been discussed?

Note: Above questions were adapted and synthesised from Critical Appraisal Skills Programme (CASP; 2010); The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE; von Elm, Altman Egger, Gøtzsche & Vandenbroucke, 2008); Young and Solomon (2009); Greenhalgh (1997a); Greenhalgh and Taylor (1997); Greenhalgh (1997b); Greenhalgh (1997c)

Example of using thematic analysis (Braun & Clarke, 2006) to develop an appraisal item

Theme: Research Question

Items placed into this theme:

1. Did the study ask a clearly-focused question? (Randomly Controlled Trial CASP, 2010)
2. Was there a clear statement of the aims of the research? (Qualitative CASP, 2010)
3. Is the study question relevant? (Young & Solomon, 2009)
4. Did the paper describe an important clinical problem addressed via a clearly formulated question? (Greenhalgh & Taylor, 1997)
5. State specific objectives, including any prespecified hypotheses (STROBE; von Elm, Altman Egger, Gøtzsche & Vandenbroucke, 2008)

Adapted critical appraisal question based on this theme:

Was the study's research question clearly focused and relevant?

Appendix C: Search terms, limiters and exclusion criteria used in the literature search

Search terms for the database searches:

1. AB: young people* or youth or young adult* or adolescen* or student* or undergraduat*
2. AB: AND help-seek* or help seek* or seek*-help or seek* help
3. AB: AND mental health or emotional W3 problem* or emotional W3 difficult* or personal-emotional W3 problem* or mental disorder* or mental distress or psychological distress or mental* ill* or psychological problem*
4. AB: AND predict* or influenc* or facilitate* or relat* to or associate* or less likely or more likely or less willing or more willing or negate* or effect* or inhibit* or promote*
5. AB: NOT old* or young* child* or medic* or injur* or biolog* or physical* or aut* or learning disabilit* or intellectual disabilit* or HIV or care giver* or care-giver* or caregiver* or insur* or eating disorder* or substance or drug* or smok* or alcohol* or prison* or dent* or neuro* or overweight or obes*

Limiters applied to the database searches:

1. Papers from 1995 to 2013
2. limited to age range of 14 to 24-years-old
3. English Language paper only

Exclusion criteria for the hand search of the literature results:

1. The papers were excluded if they were not focused on problems of general mental health issues, wellbeing, general distress, emotional problems, anxiety or depression. Hence papers focused on biological or specific psychiatric conditions such as eating disorders, psychosis or alcohol abuse, were excluded.
2. Papers that did not explicitly make conclusions about factors potentially inhibiting or facilitating help-seeking behaviour were excluded.
3. Papers based on exploring an intervention, such as a campaign to improve service engagement, were excluded.
4. Papers were excluded if they were not focused exclusively on young people, for instance papers exploring the help-seeking of care-givers, teachers, parents or other parties connected to young people were not included.
5. Papers were excluded if the findings were not generalisable to a population with free to access mental health services, for example papers originating from the USA were excluded.
6. Papers were excluded if the focus of the paper was on an explicitly distinct cultural subgroup, such as refugees in London or Mexican Americans living in New York.
7. Papers were excluded if the focus of the paper was not on ages of 15 to 24-years-old (UN definition of young people). In particular, papers were removed if 25% or more of their participants fell outside this age range (Gulliver et al., 2010), the sample's mean age fell outside this range (Gulliver et al., 2010) or the sample was explicitly labelled "adults" or "children" without further details (Gulliver et al., 2010).
8. Papers were excluded if the focus was on an incarcerated population, e.g. prisoners

Appendix D: Participant Information Sheet

The following information is what was initially presented to participants:

Study Title

Exploring factors that predict help-seeking intention in young people

Invitation

I would like to invite you to take part in a research study. Please take time to read the following information carefully and if you wish, talk to others about it. If there is anything that is not clear or you would like more information, do not hesitate to ask.

What is the purpose of the study?

Young people are faced with many unique challenges in life as they make the transition into adulthood and increased independence. It is also a time when many challenges (e.g. new friends, different environments) and new experiences (e.g. drugs and alcohol) occur. Such challenges and experiences can result in some young people experiencing emotional and mental health problems". However, previous research has shown that young people, and particularly young men, are often reluctant to seek help for these problems. This is especially true for seeking help from mental health professionals and services.

The purpose of this study is to gain a better understanding of what influences young people to seek or, indeed not to seek-help for mental health and emotional problems.

What will happen to me if I take part?

You will be asked to fill-in a questionnaire where all but two questions have fixed-choice answers that will take about 20 to 30 minutes to complete.

The questions are centred on help-seeking, your beliefs and understanding of mental health services, and your own self-perceptions. You will not be asked to share accounts of actual personal experiences.

Do I have to take part?

No; It is up to you to decide. You do not have to take part, and if at first you decided to get involved but then changed your mind, you are also free to withdraw at any time. Even if you took part and later regretted it, you can ask for your questionnaire to be removed from the study and destroyed. Whatever you decide, I will not ask you to give reasons for your decision.

Confidentiality

You will be asked to sign and write your name on a consent form saying you have agreed to take part in the study.

You will not be asked to put your name on the questionnaire and all information in it will be kept confidential.

There is one important exception to the rule of confidentiality. If responses on the questionnaire cause concern (for example it indicates depression) the researcher will pass details (including the student's name) onto the Director of Studies who may wish to contact you, your family or other people. This is important as it ensures the health and safety of students taking part in this study.

There is a number code on the questionnaire that matches to a code on the consent form which would be used to identify the respondent if a concern is raised. This scenario is the only time anonymity will be broken.

The questionnaires will be kept separately from the consent forms to help protect confidentiality.

All consent forms and questionnaires will be kept in a folder in a locked office.

Statistical data drawn from them will be on password protected electronic files. They will be kept for ten years following Staffordshire University rules. After ten years, all raw data will be destroyed. Only the researcher and his supervisor will have access to this information.

What are the possible disadvantages and risks of taking part?

The questionnaire will be filled-in during class time causing you to miss up to 30 minutes of your lesson. However, I have worked closely with your teacher to reduce disruption.

Even though your questionnaire will be anonymous, it could be possible people in your class might tell others you have taken part.

The questionnaire will explore help-seeking for mental health and emotional problems. If you have personal experiences in this area, it is possible questions could cause anxiety. However, questions will not ask for specific personal accounts and if you are concerned about becoming anxious, please feel to opt out of doing the questionnaire at any time.

If at any point it is believed a student is in danger of harm or risk, this information including the name of the student, will be immediately passed on to the Directors of Studies as per college policy. If there is anything you wish to disclose regarding harm or risk please come and speak to the researcher, one of your teachers or your Director of Studies.

If you have any worries or concerns about this study, or any issues it raises, you can talk directly to the researcher, the researcher's supervisor, your teacher or your Director of Studies. Also, you may wish to speak to your personal tutor, parents or the management team at the college. I will be giving out information about college, community services and useful websites you can access for further help and advice for emotional problems.

What are the possible benefits of taking part?

This study will not benefit you directly. However it is hoped that the research topic will spark some interesting ideas and thoughts. It will give you some insight in how a doctorate research project is carried out which could help spark ideas for your own EPQ (Extended Project Qualification) if you are doing one. You will also receive an information sheet detailing services available at college, in the community and online that can help with emotional and personal problems.

What happens when the research study stops?

Questionnaire responses will be converted into numerical data and analysed and then written up as a doctoral thesis and a publishable journal article. The results will not identify any single person.

The results from this study will be mentioned in the college bulletin between 6 months to a year's time. However, feel free to contact the researcher or his supervisor at any point if you would like to discuss the research further.

Who has reviewed the study?

All research at Staffordshire and Keele Universities is scrutinised by an independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by Staffordshire University Research Ethics Committee.

Complaints

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions (contact details below). Alternatively, you can contact the researcher's supervisor (contact details below). If you remain unhappy and wish to complain formally, you can do this through the Staffordshire University Clinical Psychology Department (see below).

Further information and contact details**1. General or specific information about research:****Researcher's Contact Details:**

Andrew Turner (Trainee Clinical Psychologist)

Clinical Psychology Professional Doctorate

Faculty of Sciences

Staffordshire University

Stoke-on-Trent

ST4 2DE

t: 01782 294007

f: 01782 295785

e: DClinPsy@staffs.ac.uk

Researcher Supervisor's Contact Details:

Prof. Helen Dent (Professor of clinical Psychology)

Clinical Psychology Professional Doctorate

Faculty of Sciences

Staffordshire University

Stoke-on-Trent

ST4 2DE

t: 01782 294007

f: 01782 295785

e: DClinPsy@staffs.ac.uk

2. Advice as to whether they should participate.

Andrew Turner (Researcher): See contact details above.

Prof. Helen Dent (Research Supervisor): See contact details above.

Director of Studies at the college: Visit them at the Director of Studies Offices in the Main Building of the College.

3. Who they should approach if unhappy with the study.

Andrew Turner (Researcher): See contact details above.

Prof. Helen Dent (Research Supervisor): See contact details above.

Department of Clinical Psychology at Staffordshire University: See contact details above.

Director of Studies the College: Visit the Director of Studies Offices in the Main Building of the College or call xxxxx.

Appendix E: Consent form used in the study

Number

:

CONSENT FORM

Title of Project: Factors affecting help-seeking in young people: Exploring how gender and different variables predicts help-seeking intention for mental health and emotional problems in college students

Name of Researcher: Andrew Turner

Please initial box if you agree

- ☐ 1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- ☐ 2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my education or legal rights being affected.
- ☐ 3. I understand that some information about my demographic background will be collected during the study, and may be looked at by individuals from Staffordshire and Keele Universities.
- ☐ 4. I understand that if the researcher has any reason to suspect any harm or risk to myself he will pass all relevant information, including your name, onto the Director of Studies.
- ☐ 5. I agree to take part in the above study.

Name of Participant

Date

Signature

Appendix F: Debriefing Information given out to all students in the study

Debrief Sheet

Thank you for taking part in this study.

The purpose of this study was to explore factors that influence young people to seek or not seek help for emotional and psychological problems.

You filled out a questionnaire which measured gender role identities, knowledge of mental health, attitudes towards professionals and the likelihood of seeking help when needed. Your responses will be converted to scores and used to explore which factors best predicts help-seeking behaviours. Such information can be useful for organisations who design services that meet the needs of young people. This research is a part of a doctoral thesis and will be submitted for publication in an academic psychology journal.

You have the right to withdraw your data from the study up to two weeks after completing the questionnaire. If you want to withdraw, please feel free to contact the researcher or his supervisor (contact details below). You will not be asked to give a reason if you do decide to withdraw.

If you need to seek help for anything at all, please approach your teacher, Director of Studies or speak with your parents or GP. Below are also some other useful contacts that could help you with any problems you may have.

If you have any questions or want to know more about the study please feel free to contact the researcher or his supervisor (contact details below), or staff at the college (for example your teacher or Director of Studies).

I would like to thank you for your time in completing the questionnaire. Volunteering your time has made this research possible.

Researcher's Contact Details:**Andrew Turner (Trainee Clinical Psychologist)**

Clinical Psychology Professional Doctorate

Faculty of Sciences

Staffordshire University

Stoke-on-Trent

ST4 2DE

t: 01782 294007

e: DClinPsy@staffs.ac.uk

Researcher Supervisor's Contact Details:**Prof. Helen Dent (Professor of clinical Psychology)**

Clinical Psychology Professional Doctorate

Faculty of Sciences

Staffordshire University

Stoke-on-Trent

ST4 2DE

t: 01782 294007

e: DClinPsy@staffs.ac.uk

Information on services Available to you**Services at xxx Sixth Form College****College Nurse and Doctor**

The college nurse and doctor run a drop-in clinic service (see their notice board for day and times). They offer free confidential medical assistance and advice on any health or mental health problem, including sexual health problems. If they can't help you directly they can refer you onto other services.

They are based in the xxx Centre.

The College Chaplain

xx, the Chaplain has an open-door policy to all students of any faith and those of none, to offer help and advice, support, to be a sounding board or just a 'friendly ear'. She is available in the Chaplaincy Room in the xx Centre for drop-in chats, or you can make an appointment by coming to the Chaplaincy Room.

The chaplaincy room is available for private reflection, prayer or relaxation throughout the day. xx also runs Christian fellowship meetings throughout the year. Details of these events are listed in the chaplaincy centre.

College Counsellor

Counselling and emotional support is available for all students. Talking things over, either as a 'one-off' or over a number of sessions, can help you find new ways of managing problems, without being judged or told what to do. You might want to talk about College, family life, relationships, feelings or worry, stress or anxiety, or about anything else that is causing difficulty in your life, however big or small. If you would like to see xx, the counsellor, you can 'drop-in' without an appointment during lunch break at the xx Centre. Alternatively, you can make an appointment by asking your tutor to book one or come down and reserve a time slot in the xx Centre.

Learning Support Centre

The xx Centre helps students with their learning difficulties, disabilities, health needs, study skills, literacy skills, assessments, writing coursework and offer confidential advice.

Students are referred to learning support by their teachers, Director of Studies or by parents. Students are also strongly encouraged to refer themselves by popping up to see the learning support staff on the top floor of the xx Building.

They arrange assessments and one-to-one support tailored to students' individual needs. They also provide workshops throughout the year to improve study skills (see college website or the xx Centre).

Bursary Fund

If students are struggling financially, the college's Bursary Fund can help out with travel costs, paying for essential college field trips, books and stationary to help with your learning. If you think you might qualify, please speak with your Director of Studies.

Student Services

The Student Services is dedicated to providing information, support and confidential advice exclusively for students. They support students with anything from bus passes to advice on complex problems with parents.

It is a drop-in service, so just go along, no appointment necessary. It is open all day during college opening times. The Student Services is situated next to the xx.

Director of Studies

The Director of Studies can be your first port of call for any issue or problem you may have, such as a problem at home or with a teacher, problems with your learning, feeling down, need of financial guidance and help, and advice on careers and A-level choices. They have information about different services available in xx. You can stop by and chat with them at any point, or book an appointment via the Director of Studies secretary. Their offices are based next to the xx in the xx building.

Services Based in xx**xx**

xx provides impartial career advice and information for young people in xx.

They have useful information on apprenticeships, local jobs, further education courses and help with university applications. They also have information on all the different services provided exclusively for young people in xx. You can drop-in and/or make an appointment to speak with one of their advisors.

a: xx

i: xx

t: xx

The xx Trust

xx provides free and confidential counselling services to young people and their families. You can make an appointment by calling them or visiting their website.

i: www.cldtrust.org.

t: xx

xx

This charity helps young people dealing with issues surrounding alcohol and drug taking. They can offer free, impartial and confidential advice and information. They also provide one-to-one counselling and interventions to help young people deal with their substance taking problems. You can drop-in for a chat with an advisor with or without an appointment.

a: xx

t: xx

xx Sexual Health Clinic

This clinic offers free confidential health screenings for sexually transmitted diseases. They provide individual information, advice and counselling on contraceptive, sexual identity issues and support for gay, lesbian, bisexual and transgendered young people. The clinic is open from 9 am to 6 pm Monday to Friday, with a drop-in service running from 9 to 11 am. The clinic runs a number coding system which avoids having to use people's names to maintain anonymity. Condoms are available for young people often free of charge.

a: xx

t: xx

i: xx

GP and Mental Health Services

xx has a variety of mental health services that can offer assessments, support and treatments for young people who may have emotional or mental health problems. To access these services you need to first visit your GP who can make a referral on your behalf. If you can't get to your own GP practice, the xx open-access GP surgery (next door to xx) will see people from any GP practice without appointment.

Other Support Available**Youth 2 Youth**

This charity offers young people help with problems, for instance helping those who are experiencing bullying and trouble at school. It is run by young people for young people. They have a confidential helpline, information available online, public and private web chats and email services available.

t: 020 88963675

i: www.youth2youth.org.uk

Childline

This charity offers emotional support for children and young people who are experiencing emotional distress and other problems. It is free and confidential. You can call them anytime day or night, or utilise their website for information and chat forums.

t: 08001111

i: www.childline.org.uk.

Rethink

This charity offers information about mental health problem in adults and young people. You can download loads of free leaflets on different mental health problems and how to access different mental health services.

i: www.rethink.org

Talk to Frank

This nationwide organisation provides advice and information about alcohol and drugs. It has a wide selection of information pages with interesting facts and figures. It can provide confidential individual support and guidance for anyone who contacts them via telephone or web chat.

t: 0800 77 66 00

i: www.talktofrank.com

Samaritans

The Samaritans provides a 24 hour confidential support line and invites people to contact them at any point if something is troubling them, for instance if someone is thinking of hurting themselves or feeling suicidal.

t: 08457 90 90 90

i: www.samaritans.org

Appendix G: The General Help-Seeking Questionnaire measure (GHSQ; Wilson, Deane, Ciarrochi & Rickwood, 2005) as used in the current study

Below is a list of people who you might seek help or advice from if you were experiencing personal or emotional problems.

Please circle the number that shows **how likely is it** that you would seek help from each of these people for a personal or emotional problem during the **next 4 weeks?**

Extremely Unlikely		Extremely Likely						
1	Partner (e.g., significant boyfriend or girlfriend)	1	2	3	4	5	6	7
2	Friend (not related to you)	1	2	3	4	5	6	7
3	Parent	1	2	3	4	5	6	7
4	Other relative / family member	1	2	3	4	5	6	7
5	Mental health professional (e.g., college counsellor, psychologist, psychiatrist)	1	2	3	4	5	6	7
6	Phone help line (e.g., Samaritans, Childline)	1	2	3	4	5	6	7
7	Family doctor / GP	1	2	3	4	5	6	7
8	Teacher (director of studies, classroom teacher)	1	2	3	4	5	6	7
9	Pastor/Priest	1	2	3	4	5	6	7
10	Youth Worker	1	2	3	4	5	6	7
11	Someone else not listed above (please describe who this was) _____	1	2	3	4	5	6	7
12	I would not seek help from anyone	1	2	3	4	5	6	7

Appendix H: The Bem Sex Role Inventory Short Form (BSRI; Bem, 1974; Bem, 1981) as used in the current study

Read the words or phrases below. Circle the number that shows **how true** each word/phrase is of your personality

	1 = Never or almost never true	2 = Usually not true	3 = Sometimes but infrequently true	4 = Occasionally true	5 = Often true	6 = Usually true	7 = Always or almost always true
Defend my own beliefs	1	2	3	4	5	6	7
Affectionate	1	2	3	4	5	6	7
Conscientious	1	2	3	4	5	6	7
Independent	1	2	3	4	5	6	7
Sympathetic	1	2	3	4	5	6	7
Moody	1	2	3	4	5	6	7
Assertive	1	2	3	4	5	6	7
Sensitive to needs of others	1	2	3	4	5	6	7
Reliable	1	2	3	4	5	6	7
Strong personality	1	2	3	4	5	6	7
Understanding	1	2	3	4	5	6	7
Jealous	1	2	3	4	5	6	7
Forceful	1	2	3	4	5	6	7
Compassionate	1	2	3	4	5	6	7
Truthful	1	2	3	4	5	6	7
Have leadership abilities	1	2	3	4	5	6	7
Eager to soothe hurt feelings	1	2	3	4	5	6	7
Secretive	1	2	3	4	5	6	7
Willing to take risks	1	2	3	4	5	6	7
Warm	1	2	3	4	5	6	7
Adaptable	1	2	3	4	5	6	7
Dominant	1	2	3	4	5	6	7
Tender	1	2	3	4	5	6	7
Conceited	1	2	3	4	5	6	7
Willing to take a stand	1	2	3	4	5	6	7
Love children	1	2	3	4	5	6	7
Tactful	1	2	3	4	5	6	7
Aggressive	1	2	3	4	5	6	7
Gentle	1	2	3	4	5	6	7
Conventional	1	2	3	4	5	6	7

Appendix I: The Schutte Emotional Intelligence Scale (SEIS; Schutte, Malouff, Hall, Haggerty, Cooper, Golden & Dornheim, 1998)

Read the statements below. Circle the number that shows **how much you agree** with each statement.

	1 = Strongly disagree	2 = disagree	3 = Neither disagree or agree	4 = Agree	5 = Strongly agree
1. I know when to speak about my personal problems to others.	1	2	3	4	5
2. When I am faced with obstacles, I remember times I faced similar obstacles and overcame them.	1	2	3	4	5
3. I expect that I will do well on most things I try.	1	2	3	4	5
4. Other people find it easy to confide in me.	1	2	3	4	5
5. I find it hard to understand the nonverbal messages of other people.	1	2	3	4	5
6. Some of the major events of my life have led me to re-evaluate what is important and not important	1	2	3	4	5
7. When my mood changes, I see new possibilities.	1	2	3	4	5
8. Emotions are some of the things that make my life worth living.	1	2	3	4	5
9. I am aware of my emotions as I experience them.	1	2	3	4	5
10. I expect good things to happen.	1	2	3	4	5
11. I like to share my emotions with others.	1	2	3	4	5
12. When I experience a positive emotion, I know how to make it last.	1	2	3	4	5
13. I arrange events others enjoy.	1	2	3	4	5
14. I seek out activities that make me happy.	1	2	3	4	5
15. I am aware of the nonverbal messages I send to others.	1	2	3	4	5
16. I present myself in a way that makes a good impression on others.	1	2	3	4	5
17. When I am in a positive mood, solving problems is easy for me.	1	2	3	4	5
18. By looking at their facial expressions, I recognize the emotions people are experiencing.	1	2	3	4	5
19. I know why my emotions change.	1	2	3	4	5
20. When I am in a positive mood, I am able to come up with new ideas.	1	2	3	4	5
21. I have control over my emotions.	1	2	3	4	5
22. I easily recognize my emotions as I experience them.	1	2	3	4	5
23. I motivate myself by imagining a good outcome to tasks I take on.	1	2	3	4	5
24. I compliment others when they have done something well.	1	2	3	4	5

25. I am aware of the nonverbal messages other people send.	1	2	3	4	5
26. When another person tells me about an important event in his or her life, I almost feel as though I have experienced this event myself.	1	2	3	4	5
27. When I feel a change in emotions, I tend to come up with new ideas.	1	2	3	4	5
28. When I am faced with a challenge, I give up because I believe I will fail.	1	2	3	4	5
29. I know what other people are feeling just by looking at them.	1	2	3	4	5
30. I help other people feel better when they are down.	1	2	3	4	5
31. I use good moods to help myself keep trying in the face of obstacles.	1	2	3	4	5
32. I can tell how people are feeling by listening to the tone of their voice.	1	2	3	4	5
33. It is difficult for me to understand why people feel the way they do.	1	2	3	4	5

Appendix J: The Brief Version of the Barriers to Adolescents Seeking Help Scale (BASH-B; Wilson, Deane & Ciarrochi, 2005; Kuhl, Jarkon-Horlick & Morrissey, 1997)

Read the statements below about seeking help.
Circle the number that shows **how much you agree** with each statement.

	1 = Strongly disagree	2 = Disagree	3 = Slightly disagree	4 = Slightly agree	5 = Agree	6 = Strongly agree
1. If I had a problem, I would solve it myself	1	2	3	4	5	6
2. I think I should work out my own problems	1	2	3	4	5	6
3. Even if I had a problem, I would be too embarrassed to talk to a therapist about it	1	2	3	4	5	6
4. Adults really can't understand the problems adolescents' have	1	2	3	4	5	6
5. Even if I wanted to, I wouldn't have time to see a therapist	1	2	3	4	5	6
6. A therapist might make me do or say something I don't want to	1	2	3	4	5	6
7. I wouldn't want my family to know I was seeing a therapist	1	2	3	4	5	6
8. I could not afford to see a therapist even if I wanted to	1	2	3	4	5	6
9. No matter what I do, it will not change the problem I have	1	2	3	4	5	6
10. If I went to a therapist, I might find out I was crazy	1	2	3	4	5	6
11. If I had a problem and told a therapist, they would not keep it a secret	1	2	3	4	5	6

Appendix K: Reason for Living for Adolescence (RFL-A; Osman et al., 1998) as used in the current study

This section lists specific **reasons** people sometimes have **for not committing suicide** if the thought were to occur to them or if someone were to suggest it to them. Please read each statement carefully, and then choose a number that best describes how **important** each reason is to you for **not** committing suicide.

	1 = Not at all important	2 = Quite unimportant	3 = Somewhat important	4 = Somewhat important	5 = Quite important	6 = Extremely important
1. Whenever I have a problem, I can turn to my family for support or advice.	1	2	3	4	5	6
2. It would be painful and frightening to take my own life.	1	2	3	4	5	6
3. I accept myself for what I am.	1	2	3	4	5	6
4. I have a lot to look forward to as I grow older.	1	2	3	4	5	6
5. My friends stand by me whenever I have a problem.	1	2	3	4	5	6
6. I feel loved and accepted by my close friends.	1	2	3	4	5	6
7. I feel emotionally close to my family.	1	2	3	4	5	6
8. I am afraid to die, so I would not consider killing myself.	1	2	3	4	5	6
9. I like myself just the way I am.	1	2	3	4	5	6
10. My friends care a lot about me.	1	2	3	4	5	6
11. I would like to accomplish my plans or goals in the future.	1	2	3	4	5	6
12. My family takes the time to listen to my experiences at school, work, or home.	1	2	3	4	5	6
13. I expect many good things to happen to me in the future.	1	2	3	4	5	6
14. I am satisfied with myself.	1	2	3	4	5	6
15. I am hopeful about my plans or goals for the future.	1	2	3	4	5	6
16. I believe my friends appreciate me when I am with them.	1	2	3	4	5	6
17. I enjoy being with my family.	1	2	3	4	5	6
18. I feel that I am an OK person.	1	2	3	4	5	6
19. I expect to be successful in the future.	1	2	3	4	5	6
20. The thought of killing myself scares me.	1	2	3	4	5	6
21. I am afraid of using any method to kill myself.	1	2	3	4	5	6
22. I can count on my friends to help if I have a problem.	1	2	3	4	5	6
23. Most of the time, my family encourages and supports my plans or goals.	1	2	3	4	5	6

24. My family cares about the way I feel.	1	2	3	4	5	6
25. My future looks quite hopeful and promising.	1	2	3	4	5	6
26. I am afraid of killing myself.	1	2	3	4	5	6
27. My friends accept me for what I really am.	1	2	3	4	5	6
28. I have many plans I am looking forward to carrying out in the future.	1	2	3	4	5	6
29. I feel good about myself.	1	2	3	4	5	6
30. My family cares a lot about what happens to me.	1	2	3	4	5	6
31. I am happy with myself.	1	2	3	4	5	6
32. I would be frightened or afraid to make plans for killing	1	2	3	4	5	6

Appendix L: Mental Health Literacy Questionnaire (Jorm, Korten, Jacomb, Christensen, Rodgers & Pollitt, 1997)

Read the two following stories and answer the questions in the spaces provided:

Story 1:

John is a young person who has been feeling unusually sad and miserable for the last few weeks. He is tired all the time and has trouble sleeping at night. John does not feel like eating and has lost weight. He cannot keep his mind on his studies and his grades have dropped. He puts off making any decisions and even day-to-day tasks seem too much for him. His parents and teachers are very concerned about him.

Ques 1: What, if anything, do you think is wrong with John?

Ques 2: How do you think John could be best helped?

Story 2:

Mary is a young person who lives at home with her parents. She has had a few temporary jobs since finishing school but is now unemployed. Over the last 6 months she has stopped seeing her friends and has begun locking herself in her bedroom and refusing to eat with the family or to have a bath. Her parents also hear her walking about in her bedroom at night while they are in bed. Even though they know she is alone, they have heard her shouting and arguing as if someone else is there. When they try to encourage her to do more things, she whispers that she will not leave home because she is being spied upon by the neighbour. They realise she is not taking drugs because she never sees anyone or goes anywhere.

Ques 3: What, if anything, do you think is wrong with Mary?

Ques 4: How do you think Mary could be best helped?

Appendix M: Demographic and prior help seeking questions used in the current study**Demographic Questions**

1. What is your age? _____
2. What is your gender? **Male / Female**

Prior Help-Seeking Questions

3. Have you ever sought help for an emotional or personal problem?
Yes / No
4. If yes, who did you receive help from (e.g. friend, family, GP doctor, Psychologist)

Appendix N: General Help-Seeking Questionnaire inter-item correlations**And descriptive statistics**

	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12
M	4.23	4.64	4.65	3.42	2.42	1.55	2.50	2.38	1.34	1.39	1.30	2.90
SD	2.13	1.75	1.67	1.65	1.54	.99	1.43	1.43	.77	.81	1.02	1.91
Q1	1.00											
Q2	.32***	1.00										
Q3	.03	.30***	1.00									
Q4	.01	.26***	.60***	1.00								
Q5	.20***	.17**	.26***	.24***	1.00							
Q6	.18**	.20***	.17**	.16**	.60***	1.00						
Q7	.19**	.20***	.40***	.31***	.52***	.45***	1.00					
Q8	.11	.29***	.36***	.39***	.35***	.31***	.38***	1.00				
Q9	.03	.09	.09	.15	.26***	.35***	.22***	.30***	1.00			
Q10	.16*	.18**	.11	.20**	.44***	.57***	.34***	.38***	.52***	1.00		
Q11	-.14	-.11	.12	.16	.19*	.20*	.17	.07	.34***	.06	1.00	.
Q12	-.23***	-.41***	-.42***	-.35***	-.21***	-.09	-.23***	-.25***	-.01	-.10	.12	1.00

* $p < .05$, ** $p < .01$, *** $p < .001$

Note: SD = Standard Deviation, M = Mean, Q1 = Partner (e.g. boyfriend or girlfriend), Q2 = Friend, Q3 = Parent, Q4 = Other relative, Q5 = Mental Health professional, Q6 = Phone help line, Q7 = Family Doctor/GP, Q8 = Teacher, Q9 = Pastor/Priest, Q10 = Youth Worker, Q11 = Someone else not listed above, Q12 = I would not seek from anyone

Appendix O: Results from standard multiple regression using all variables

Table 1:

Summary of the standard multiple regression model with Formal General Help-Seeking as the criterion variable and Biological Gender, Prior Formal and Informal Help, Emotional Intelligence, Belief Barriers, Mental Health Literacy, Reasons for Living, Femininity and Masculinity Sex Role Identity as predictors: Unstandardised, standardised coefficients and 95% confidence intervals (in parentheses) and probability values based on 1 000 Bootstrap samples

	<i>B</i>	<i>SE B</i>	β	<i>p</i>
Constant	1.31 (-.26, 2.72)	0.76		.091
Biological Gender	.01 (-.14, .35)	0.12	0.05	.400
Prior Formal Help	-.08 (-.30, .14)	0.12	-0.04	.442
Prior Informal Help	.15 (-.06, .36)	0.10	0.08	.134
SEIS	.01 (-.01,.02)	0.01	0.06	.384
BASH-B	-.02 (-.01, .02)	0.01	-0.18	.003
MHL	-.05 (-.15, .30)	0.04	-0.07	.203
RFL-A	.13 (-.01, .26)	0.07	0.10	.057
BSRI Feminine	.09 (-.40, .23)	0.07	0.08	.177
BSRI Masculine	-.03 (-.14, .10)	0.06	-0.03	.637

Note: $R^2 = .11$; Adjusted $R^2 = .08$

Table 2:

Summary of the standard multiple regression model using Informal General Help-Seeking as the criterion variable and Biological Gender, Prior Formal and Informal Help, Emotional Intelligence, Belief Barriers, Mental Health Literacy, Reasons for Living, Feminine and Masculine Sex Role Identities as predictors: Unstandardised, standardised coefficients and probability values

	<i>B</i>	<i>SE B</i>	β	<i>p</i>
Constant	1.17	0.92		.210
Biological Gender	-.32	0.13	-0.13	.012
Prior Formal Help	-.40	0.13	-0.15	.002
Prior Informal Help	.33	0.12	0.14	.005
SEIS	.02	0.01	0.12	.037
BASH-B	-.03	0.01	-0.19	<.001
MHL	-.05	0.05	-0.05	.307
RFL-A	.41	0.09	0.26	<.001
BSRI Feminine	.18	0.07	0.13	.020
BSRI Masculine	.05	0.07	0.04	.440

Note: $R^2 = .34$; Adjusted $R^2 = .32$

Table 3:

Summary of the standard multiple regression model with No Help-Seeking as the criterion variable and Biological Gender, Prior Formal and Informal Help, Emotional Intelligence, Belief Barriers, Mental Health Literacy, Reasons for Living, Femininity and Masculinity Sex Role Identity as predictors: Unstandardised, standardised coefficients and 95% confidence intervals (in parentheses) and probability values based on 1 000 Bootstrap samples

	<i>B</i>	<i>SE B</i>	β	<i>p</i>
Constant	4.03 (1.01, 6.65)	1.44		.007
Biological Gender	.15 (-.27, .56)	0.21	0.04	.482
Prior Formal Help	.22 (-.19, .64)	0.21	0.06	.269
Prior Informal Help	-.40 (-.76, -.07)	0.18	-0.11	.024
SEIS	-.01 (-.02, .02)	0.01	-0.02	.482
BASH-B	.06 (.04, .08)	0.01	0.29	.001
MHL	.18 (.05, .32)	0.07	0.13	.014
RFL-A	-.50 (-.81, -.17)	0.16	-0.21	.002
BSRI Feminine	-.36 (-.60, -.12)	0.12	0.17	.003
BSRI Masculine	.13 (-.09, .35)	0.11	0.06	.279

Note: $R^2 = .29$; Adjusted $R^2 = .26$

**Appendix P: Letter of Approval from Staffordshire University's Faculty of Science
Ethics Panel**



Faculty of Health Sciences

ETHICAL APPROVAL FEEDBACK

Student name:	Andrew Turner
Title of Study:	Exploring factors that predict help-seeking intention in young people
Award Pathway:	DClinPsy
Status of approval:	Approved

Action now needed:

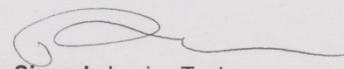
Your project proposal has now been approved by the Faculty's Ethics Panel and you may now commence the implementation phase of your study. You do not need to approach the Local Research Ethics Committee. You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

Comments for your consideration:

Thank you for forwarding the amendments requested by the Panel

PP


Signed: Louise Taylor
Acting Chair of the Faculty of Health Sciences
Ethics Panel

Date: 18th April 2013

Appendix Q: Letter of approval from the sixth form college

[REDACTED]
[REDACTED]

25th October 2012

Ref: oct12001at.doc

Mr A Turner
35 Bryngwyn Close
HEREFORD
HR1 1EW

Dear Andrew,

I am delighted to confirm that [REDACTED] Sixth Form College is giving you permission to conduct a questionnaire survey with students in [REDACTED]
[REDACTED]

I would like to wish you great success with the research you are undertaking and look forward to reading your eventual thesis.

With best wishes,

Yours sincerely
[REDACTED]

[REDACTED]
Deputy Principal (Staff and Students)

Appendix R: Evidence of permission to use measures in the current study (General Help-Seeking Questionnaire, Bem Sex Role Inventory, Schutte Emotional Intelligence Scale, Barriers to Adolescents Seeking Help, Mental Health Literacy Questionnaire and Reasons for Living for Adolescents)

Copy of electronic sales receipt for purchase of license to use the Bem Sex Role Inventory Short Form

Sales Receipt

Order #30190

Date: 03/01/2014 10:19:16 EST

Thank you for your order. A copy of this sales receipt will be e-mailed to you for your records. Please login to access your electronic products (login directions are at the bottom of this page). If you ordered a report as part of an academic course, your product requires additional set up and is not immediately available.

Please do not reload this page or click the back button or your credit card may be charged twice.

Ship To:		Bill To:	
Name:	Andrew Turner	Name:	Andrew Turner
Email Address:	nowandy@hotmail.com	Email Address:	nowandy@hotmail.com
Phone Number:	+44 7796004475	Phone Number:	+44 7796004475
Fax Number:		Fax Number:	
Company:		Company:	
Address:	35 Bryngwyn Close Hereford, Herefordshire HR1 1EW GB	Address:	35 Bryngwyn Close Hereford, Herefordshire HR1 1EW GB

Product	Code	Quantity	Price/Each	Total
BEM Reproduction License Licenses: 350 Format: downloadable PDF file	BEM-License	1	\$252.00	\$252.00
<i>Shipping: Online Product Delivery:</i>				\$0.00
<i>Sales Tax:</i>				\$0.00
				Total: \$252.00



Email confirming permission to use Reason for Living Adolescent**RE: Permission to use the RFL-A**

Augustine Osman [augustine.osman@utsa.edu]

Sent: 19 June 2013 16:20

To: TURNER Andrew

Attachments:

- [RFL-A Instrument.pdf \(19 KB\)\[Open as Web Page\];](#)
-  [RFL-A Brief Manual.pdf \(90 KB\)\[Open as Web Page\];](#)
-  [BRFL-A Items Osman et al. ~1.pdf \(160 KB\)\[Open as Web Page\]](#)

Andrew, I am indeed sorry for the delay in making a response to your previous query. I'm glad that you did do a follow-up. I do occasionally take time away from the office; thus the likelihood for me not to attend carefully to some of my email queries. I have attached copies of the RFL-A and BRFL-A. Please note that the BRFL-A is actually an extension of the adult version of the original RFL, and may not be content specific for adolescents. The RFL-A was specifically designed to address the content -specificity issue. Currently, there is no short-form of the RFL-A.

Good luck with your project!

Regards,

Augustine

=====

Augustine Osman, Ph.D., ABAP
 Professor & Associate Dean--- COLFA
 The University of Texas at San Antonio
 San Antonio, TX 78249-0641
 Ph: (210) 458-6854
 Fax: (210) 458-4347

.....

"The challenge [in life] is not to forecast the future, but to work hard to shape it " --- Kazdin

From: TURNER Andrew [mailto:t038941a@student.staffs.ac.uk]
Sent: Wednesday, June 19, 2013 9:43 AM
To: Augustine Osman
Subject: Permission to use the RFL-A

Dear Prof. Osman,

My name is Andrew Turner, I am a Clinical Psychology Doctoral student from Keele University in the UK. I emailed you a couple

of weeks ago about permission to use a measure you and your colleagues devised. I am sorry to take up your time by writing again. I know you must be very busy. I just wondered if you had time to consider my email request?

Ideally, with your permission, I would like to use the Adolescent Reasons for Living (RFL) measure (hopefully the brief version; BRFL-A) in my up-coming doctoral research. I am investigating how reasons for living, gender, gender role identification, emotional competence and mental health literacy best predict help-seeking intention for emotional and personal problems in young people aged from 16 to 18 years old.

I have been given a unique opportunity to access a local college here in England to carry out the research and I am hoping to start research within the year. My research has received ethical approval from my university.

Many thanks you for your time.

Kind regards,

Andrew Turner

Email conforming permission to use Mental Health Literacy Questionnaire






RE: Permission to use Mental Health Literacy Interview

Anthony Francis Jorm [ajorm@unimelb.edu.au]

Sent: 03 June 2013 06:26

To: TURNER Andrew

Attachments:

- [PR0739b Youth Boost Surve~1.docx \(76 KB\)\[Open as Web Page\];](#)
-  [PR0739m Main Survey \(15+\)~1.docx \(77 KB\)\[Open as Web Page\];](#)
-  [recognition-mental-disorde~1.pdf \(121 KB\)\[Open as Web Page\];](#)
-  [stigmatizing-attitudes-tow~1.pdf \(93 KB\)\[Open as Web Page\];](#)
-  [young-peoples-recognition--~1.pdf \(132 KB\)\[Open as Web Page\];](#)
-  [young-peoples-stigmatizing~1.pdf \(103 KB\)\[Open as Web Page\]](#)

Hello Andrew

Attached are the interviews we used for recent national surveys in Australia. The first interview was for a largely adult sample aged 15+ and the other for a youth sample aged 15-25. I think the latter would be better for your purposes. I have also attached a few relevant publications (thereare many more if you are

interested).
Let me know if you need anything else.
Regards
Tony Jorm

Anthony Jorm PhD, DSc
Professorial Fellow and NHMRC Australia Fellow
Population Mental Health Group
Melbourne School of Population and Global Health
University of Melbourne
207 Bouverie Street, Carlton
Victoria 3010
Australia
Ph +61 3 90357799

From: TURNER Andrew [mailto:t038941a@student.staffs.ac.uk]
Sent: Monday, 3 June 2013 10:13 AM
To: Anthony Francis Jorm
Subject: Permission to use Mental Health Literacy Interview

Dear Prof. Anthony Jorm,

My name is Andrew Turner and I am a clinical psychology doctoral student from the D.Clin.Psy course run jointly by Staffordshire and Keele Universities in the UK. I am writing regarding possible permission to use an interview survey you and your colleagues have previously developed.

I am planning on carrying out my doctoral thesis research on help-seeking intention among young people. I will be sampling 16 to 18 year-old from a local college here in the UK. I will hopefully be assessing their mental health literacy, sex role identification, reasons for living and belief-based barriers. I aim to explore how these factors relate to the young people's help-seeking intention.

Consequently, I wondered if I could have your permission to use the mental health literacy interview that was published in your paper 'Mental health literacy: a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment'?

My research has received ethical approval from my universities and I would ideally like to start the data collection in July this year.

Many thanks for your help.

Kind regards,

Andrew Turner

Email confirming the permission to use Barriers to Adolescence Seeking Help scale**Re: Permission to use the BASH questionnaire**

Josephine Kuhl, MD [jkuhl@BLYTHEDALE.ORG]

Sent: 04 June 2013 02:07**To:** TURNER Andrew

Absolutely no problem and good luck. Would love to see the results

Sent from my iPhone

On Jun 3, 2013, at 6:41 PM, "TURNER Andrew"
<t038941a@student.staffs.ac.uk<mailto:t038941a@student.staffs.ac.uk>>
wrote:

Dear Dr. Josephine Kuhl,

My name is Andrew Turner and I am a clinical psychology doctoral student from a D.Clin.Psy course run jointly by Staffordshire and Keele Universities in the UK. I am writing regarding possible permission to use a questionnaire you and your colleagues have previously developed.

I am planning on carrying out my doctoral thesis research on help-seeking intention among young people. I will be sampling 16 to 18 year-old from a local college here in England. I will hopefully be assessing their belief-based barriers, mental health literacy, sex role identification and reasons for living. I aim to explore how these factors predict young people's help-seeking intention. Consequently, I wondered if I could have your permission to use the Barriers to Adolescents Seeking-Help Questionnaire (Kuhl, Jarkon-Horlick & Morrissey, 1997) within my research.

My research has received ethical approval from my universities and I would ideally like to start the data collection in July this year.

Many thanks for your help.

Kind regards,

Andrew Turner

Email confirming the permission to use the General Help-Seeking Questionnaire**RE: Permission to use GHSQ**

Coralie Wilson [cwilson@uow.edu.au]

Sent: 05 May 2014 01:32**To:** TURNER Andrew

Dear Andrew,

Thanks you for your request. You are welcome to use the measure. If you go to my staff webpage (address at the bottom of my signature) you can download different versions of the GHSQ.

Best wishes for a successful (and fun) thesis. Let me know if there is anything else I can help you with.

Warm regards,

Coralie

Dr Coralie Wilson | Academic Leader Personal and Professional Development
Graduate School of Medicine | University of Wollongong | NSW | 2522
T + 61 2 4221 5135 | F + 61 4221 4341 | E Coralie_Wilson@uow.edu.au
W <http://smah.uow.edu.au/medicine/contacts/UOW028294.html>

From: TURNER Andrew [t038941a@student.staffs.ac.uk]

Sent: Monday, 5 May 2014 10:26 AM

To: Coralie Wilson

Subject: FW: Permission to use GHSQ

Dear Dr. Wilson,

My name is Andrew Turner and I am a clinical psychology doctoral from Keele University in the UK. I am writing regarding permission to use the GHSQ.

I am planning on carrying out my doctoral thesis research on help-seeking intention among young people. I will be sampling 16 to 18 year-old from a local college here in the UK. I will be assessing their mental health literacy, sex role identification, reasons for living and belief-based barriers. I aim to explore how these factors relate to young people's help-seeking intention. My research has received ethical approval from the university.

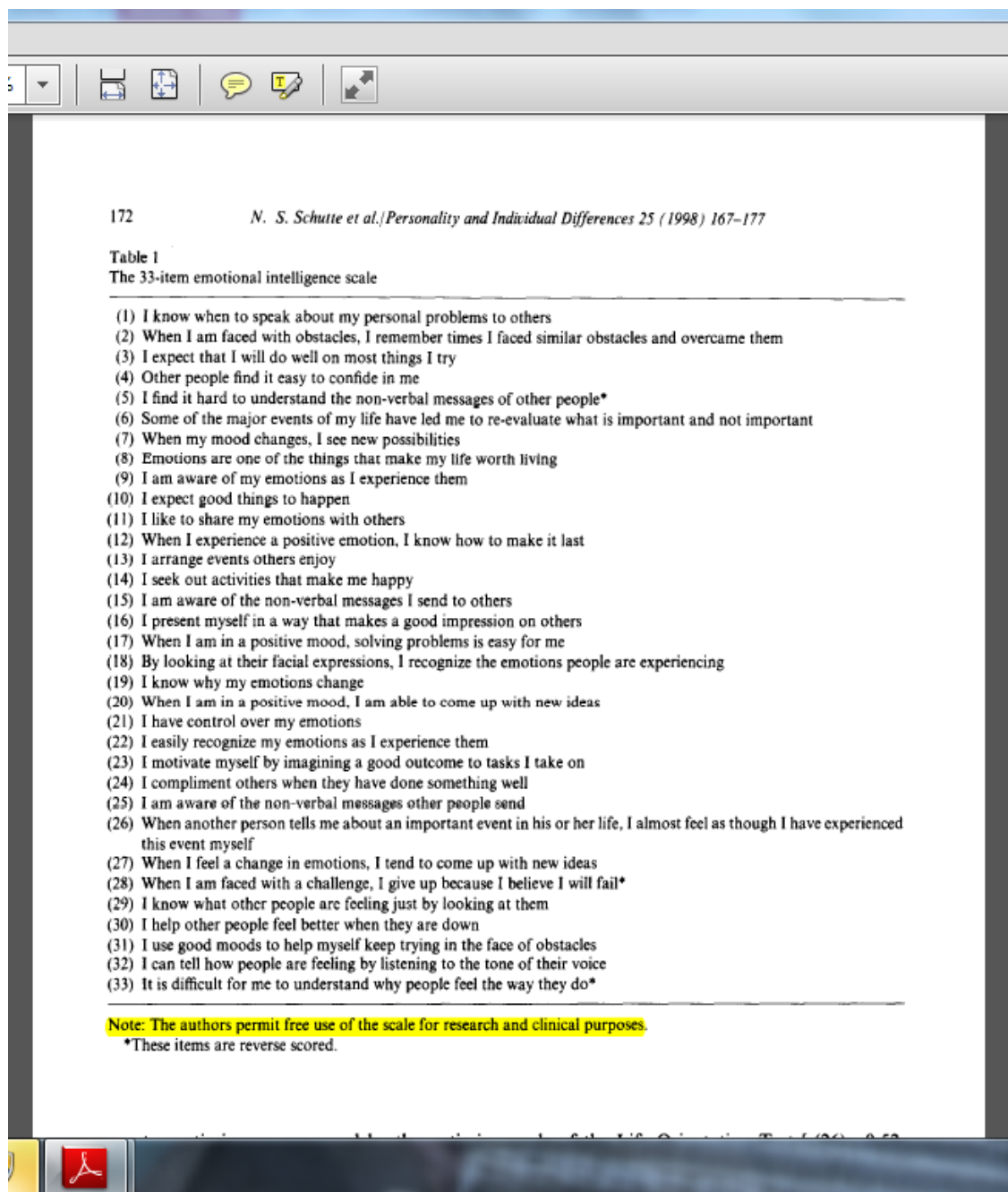
Consequently, I wondered if I could have your permission to use the GHSQ?

Many thanks for your help.

Kind regards,

Andrew Turner

Excerpt from Schutte, Malouff, Hull, Haggerty, Cooper, Golden and Dornheim (1998) showing the permission to freely use the Schutte Emotional Intelligence Scale



Note: Taken from Schutte et al. (1998), p. 172

Appendix S: Excerpts from Journal of Educational and Psychological Consultation's aims, scope and author's Instructions

Aims and Scope

The *Journal of Educational and Psychological Consultation (JEPC)* provides a forum for improving the scientific understanding of consultation and for describing practical strategies to increase the effectiveness and efficiency of consultation services. Consultation is broadly defined as a process that facilitates problem solving for individuals, groups, and organizations.

JEPC publishes articles and special thematic issues that describe formal research, evaluate practice, examine the program implementation process, review relevant literature, investigate systems change, discuss salient issues, and carefully document the translation of theory into practice.

Examples of topics of interest include individual, group, and organizational consultation; collaboration; community-school-family partnerships; consultation training; educational reform; ethics and professional issues; health promotion; personnel preparation; preferral interventions; prevention; program planning, implementation, and evaluation; school to work transitions; services coordination; systems change; and teaming.

Of interest are manuscripts that address consultation issues relevant to clients of all age groups, from infancy to adulthood. Manuscripts that investigate and examine how culture, language, gender, race, ethnicity, religion, and exceptionality influence the process, content, and outcome of consultation are encouraged.

Author's Instructions

Submission of Manuscripts. Manuscripts should be prepared according to the *Publication Manual of the American Psychological Association* (APA; 6th edition, 2009). All components of the manuscript should be double-spaced, including the title page, abstract, text quotes, acknowledgments, references, appendices, tables, figure captions, and footnotes. The abstract should be 100–150 words in length. To enable authors to address their topics comprehensively, manuscripts of up to 35 pages of text (excluding references, tables, and figures) will be considered.

All manuscripts must address implications for the practice of consultation by a broad, interdisciplinary audience. The content should be original and should not have

been published (in whole or in part) in any other journal or source. The journal will publish one or two guest-edited special issues each year.

Each manuscript must be accompanied by a statement that it has not been published elsewhere and that it has not been submitted simultaneously for publication elsewhere. Authors are responsible for obtaining permission to reproduce copyrighted material from other sources and are required to sign an agreement for the transfer of copyright to the publisher. As an author, you are required to secure permission if you want to reproduce any figure, table, or extract from the text of another source. This applies to direct reproduction as well as “derivative reproduction” (where you have created a new figure or table which derives substantially from a copyrighted source). All accepted manuscripts, artwork, and photographs become the property of the publisher.

Tables and Figures. Tables and figures should not be embedded in the text, but should be included either as separate sheets or files or at the end of the manuscript. A short descriptive title should appear above each table with a clear legend and any footnotes suitably identified below. All units must be included. Figures should be completely labelled, taking into account necessary size reduction. Captions should be typed, double-spaced, on a separate sheet.

Please follow current conventions for data graphs. Some specific guidelines follow:

- (a) If more than one set of data appears on a graph, each should be represented by a different symbol. A legend or labels should be used to describe the sets used.
- (b) No more than 3 data paths should be plotted in a single line graph when possible. A bar graph might be a better alternative.
- (c) To indicate phases or conditions, use dashed vertical lines between the last session in one condition and the first session in another. Data points should NOT be connected across conditions.
- (d) Each condition needs a brief, descriptive condition label placed above the data path, centred between dashed lines.

References. Manuscripts must conform to the *Publication Manual of the American Psychological Association* (APA; 6th edition, 2009). APA style should be followed for both the Reference pages and in-text and parenthetical citations.

Appendix T: Excerpts from Journal of Adolescence's aims, scope and authors Instructions

Aims and Scope

The *Journal of Adolescence* is an international, broad based, cross-disciplinary journal that addresses issues of professional and academic importance concerning development between puberty and the attainment of adult status within society. It provides a forum for all who are concerned with the nature of adolescence, whether involved in teaching, research, guidance, counseling, treatment, or other services. The aim of the journal is to encourage research and foster good practice through publishing both empirical and clinical studies as well as integrative reviews and theoretical advances. The *Journal of Adolescence* is essential reading for psychiatrists, psychologists, social workers, and youth workers in practice, and for university and college faculty in the fields of psychology, sociology, education, criminal justice, and social work. Research Areas Encompassed:

- Adolescent development with particular emphasis on personality, social, and emotional functioning
- Effective coping techniques for the demands of adolescence
- Disturbances and disorders of adolescence
- Treatment approaches and other interventions

Author's instructions

Full research articles. The majority of the articles carried in the Journal are full research articles of up to 5000 words long. The word count relates to the body of the article. The abstract, references, tables, figures and appendices are not included in the count. These can report the results of research (including evaluations of interventions), or be critical reviews, meta-analyses, etc. Authors are encouraged to consult back issues of the Journal to get a sense of coverage and style, but should not necessarily feel confined by this. Articles should clearly make a new contribution to the existing literature and advance our understanding of adolescent development.

Language (usage and editing services). Please write your text in good English (American or British usage is accepted, but not a mixture of these). Authors who feel their English language manuscript may require editing to eliminate possible grammatical

or spelling errors and to conform to correct scientific English may wish to use the English Language Editing service available from Elsevier's Web Shop (<http://webshop.elsevier.com/languageediting/>) or visit our customer support site (<http://support.elsevier.com>) for more information.

General style. The Journal follows the current American Psychological Association style guide. Papers that are not submitted in APA style are likely to be returned to authors. You are referred to their Publication Manual, Sixth Edition, copies of which may be ordered from <http://www.apa.org/pubs/books/4200066.aspx>, or APA order Dept, POB 2710, Hyattsville, MD20784, USA, or APA, 3 Henrietta Street, London, WC3E 8LU, UK. There are also abbreviated guides freely available on the web. Text should be written in English (American or British usage is accepted, but not a mixture of these). Italics are not to be used for expressions of Latin origin, for example, *in vivo*, *et al.*, *per se*. Use decimal points (not commas); use a space for thousands (10 000 and above). If (and only if) abbreviations are essential, define those that are not standard in this field at their first occurrence in the article: in the abstract but also in the main text after it. Ensure consistency of abbreviations throughout the article. Manuscripts must be typewritten using double spacing and wide (3 cm) margins. (Avoid dull justification, i.e., do not use a constant right-hand margin). Ensure that each new paragraph is clearly indicated. Present tables and figure legends on separate pages in separate electronic files. If possible, consult a recent issue of the Journal to become familiar with layout and conventions. Number all pages consecutively.

Use of word processing software. It is important that the file be saved in the native format of the word processor used. The text should be in single-column format. Keep the layout of the text as simple as possible. Most formatting codes will be removed and replaced on processing the article. In particular, do not use the word processor's options to justify text or to hyphenate words. However, do use bold face, italics, subscripts, super scripts etc. When preparing tables, if you are using a table grid, use only one grid for each individual table and not a grid for each row. If no grid is used, use tabs, not spaces, to align columns. The electronic text should be prepared in a way very similar to that of conventional manuscripts (see also the Guide to Publishing with Elsevier: <http://www.elsevier.com/guidepublication>). Note that source files of figures, tables and text graphics will be required whether or not you embed your figures

in the text. See also the section on Electronic artwork. To avoid unnecessary errors you are strongly advised to use the 'spell-check' and 'grammar-check' functions of your word processor.

Article structure.

Subdivision - unnumbered sections. Divide your article into clearly defined sections. Each subsection is given a brief heading. Each heading should appear on its own separate line. Subsections should be used as much as possible when cross referencing text: refer to the subsection by heading as opposed to simply 'the text'.

Appendices. If there is more than one appendix, they should be identified as A, B, etc. Formulae and equations in appendices should be given separate numbering: E.g. (A.1), Eq. (A.2), etc.; in a subsequent appendix, E.g. (B.1) and so on. Similarly for tables and figures: Table A.1; Fig. A.1, etc.

Essential title page information.

Title. Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible.

Author names and affiliations. Where the family name may be ambiguous (e.g., a double name), please indicate this clearly. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name and, if available, the e-mail address of each author.

Corresponding author. Clearly indicate who will handle correspondence at all stages of refereeing and publication, also post-publication. Ensure that phone numbers (with country and area code) are provided in addition to the e-mail address and the complete postal address. Contact details must be kept up to date by the corresponding author.

Present/permanent address. If an author has moved since the work described in the article was done, or was visiting at the time, a 'Present address' (or 'Permanent address') may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.

Abstract. A concise and factual abstract is required (maximum length 150 words). The abstract should state briefly the purpose of the research, the principle

results and major conclusions. An abstract is often presented separate from the article, so it must be able to stand alone. References should therefore be avoided, but if essential, they must be cited in full, without reference to the reference list.

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