BELIEFS AND ATTITUDES TOWARDS HELP SEEKING AND INTENTIONS TO SEEK PROFESSIONAL PSYCHOLOGICAL HELP AMONG ADOLESCENTS.

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DECLARATION

I declare that I am the sole author of this thesis and that the work contained herein is my own. This thesis, or any part of it, has not been submitted for any other degree or professional qualification.

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ABSTRACT

Introduction

The mental health needs of adolescents often go unmet, in part due to a high proportion of adolescents choosing not to seek help even when services are available. In order to ensure those in need receive services, there is a need for a better understanding of factors that influence an individual's decision to seek help. The present study aimed to identify the impact of beliefs and attitudes towards seeking and receiving help on professional psychological help seeking intentions in adolescents. A secondary aim was to begin to address the developmental trajectory of such attitudes and the role of one possible influence on their development, parental attitudes.

Method

517 adolescent high school pupils aged 13-18 years and their parents were administered three measures of attitudes and beliefs relating to help seeking: the Barriers to Adolescent Help Seeking-Revised (BASH-B), the Attitudes Towards Seeking Professional Psychological Help (ATSPPH-B), and the 5 Item Stigma Scale for Receiving Psychological Help (SSRPH) in addition to a measure of willingness to seek help for personal-emotional problems, the General Help Seeking Questionnaire (GHSQ).

Results

Regression techniques were used in order to determine the predictive value of the independent variables on willingness to seek help. Holding more positive attitudes towards seeking psychological help and receiving psychological help, holding fewer perceived barriers to help seeking, and having a history of help seeking were related to greater willingness to seek help from formal sources. Holding fewer perceived barriers to help seeking, having a history of help seeking and being female were related to greater willingness to seek help from informal sources.

Correlational techniques were employed to determine the relationship between age and the variables of interest. No relationship was found between age and beliefs and attitudes towards seeking and receiving help. An association was found between age and total help seeking intentions for all sources indicating that as age increased, intention to seek help decreased. Age and help seeking intentions for formal sources were negatively correlated, therefore as age increased, help seeing intentions for formal sources decreased. Age and help seeking intentions for informal sources were not associated. There was no association between adolescent children and their parents' attitudes towards seeking professional psychological help, receiving professional psychological help, or level of belief based barriers to help seeking held.

Discussion

Results were discussed with references to previous findings in the literature and theoretical implications were highlighted. Strengths and limitations of the study were discussed. Implications of the findings for attitudinal change programmes, and service design and development aimed at increasing help seeking were considered.

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CHAPTER 1: INTRODUCTION

The mental health needs of adolescents often go unmet. This is in part due to the high proportion of adolescents choosing not to seek help, even when services are available (Logan and King, 2002). In order to be able to ensure those in need receive services, it is recognised that there is a need to gain a better understanding of the factors that influence an individual's route into the mental health care system (Komiya *et al.*, 2000).

Adult service access has been comprehensively investigated and conceptualised, however it is recognised that because a number of factors differentiate adolescents from the adult population, there is a need for a specific research focusing on adolescent service access. Models of service access in adolescence, while in their early developmental stages, conceptualise the process as multi-faceted, whereby a number of predisposing factors influence whether the individual will enter the mental health service system. The direct role of parental and service related factors have been well documented in acting as facilitators or barriers in this process. As a result, services have been adapted to address these issues and to make services as accessible as possible to young people. In particular, services are increasingly being accessed in the absence of parental involvement and in less formal settings, such as schools.

However despite this, adolescents continue to choose not to make use of services. As such, a better understanding of the factors that influence an adolescent's decision to seek help is needed in order for services to further develop to accommodate their needs (Burns *et al.*, 1995).

The recognition of this has resulted in research which has focused upon investigating factors influencing the decision making process. In particular, knowledge, attitudinal and belief based factors relating to mental illness and help seeking, and their influence on both actual help seeking behaviour and intentions to seek help should future need develop have been investigated. Such research has begun to demonstrate the role of these cognitive factors in influencing adolescents' decision making processes. The impact of knowledge of mental illness and attitudes towards mental illness have now been relatively well documented and conceptualised. However, the impact of knowledge, attitudes and beliefs relating to actual help seeking are less well researched. Furthermore, influences on the development of such attitudes and the developmental trajectory that they take are not well understood. As such, there is a current need for research investigating these factors, how they relate to help seeking behaviour and intentions and what influences their development. Gaining a better understanding of these factors would then lead to a better understanding of the reasons why so many adolescents choose not to seek professional psychological help.

The current study, therefore, aims to investigate attitudes and beliefs relating to help seeking and their impact on help seeking intentions in adolescents, in addition to beginning to address their developmental trajectory and one possible influence on their development, parental attitudes. In order to introduce the study, mental health in adolescence will firstly be discussed, with particular reference to the manner in which the adolescent population differs from the adult population. Following this, mental health care provision and access routes, along with rates of service usage will be explored. A comprehensive review of the research investigating the gap between service need and provision will then be conducted, to place the current study in

context. Finally, research investigating cognitive influences on help seeking and the influences on the development of such cognitive factors will be briefly explored, before the aims and hypotheses of the study are outlined.

1.1 MENTAL HEALTH IN ADOLESCENCE

Within the context of investigating mental health service usage in adolescents, it is firstly of relevance to review adolescent mental health, with particular reference to the specific features that differentiate this population from other age groups.

1.1.1 Rates of Mental Health Problems in Adolescence

While reported prevalence rates vary, the Audit Commission's review of prevalence studies concluded that one in five adolescents in the United Kingdom experience some form of mental health difficulty (1999). Similar rates have been reported in other parts of the world, with the Australian Institute of Health and Welfare (AIHW) reporting 20% prevalence of mental health problems in adolescent Australians (Moon *et al.*, 1999) and similar rates reported by Irwin and colleagues in adolescents in the United States (Irwin *et al.*, 2002). Of those experiencing mental health problems, it is considered that roughly 10% are considered to have more serious problems that would meet diagnostic criteria for a psychiatric disorder (Target & Fonagy, 1996). Melzter and Gatward (2000) report that one in ten children in the United Kingdom suffer from some form of mental disorder meeting ICD-10 criteria and the US Public Health Service reports similar rates (9% - 13%) in American adolescents (US Public Health Service, 2000). Prevalence rates for specific disorders vary widely in the research

literature, with reported rates for depression ranging from 1% to 8% and for anxiety disorders ranging from 2% to 23% (Lynch *et al.*, 2006)

When considering prevalence rates, a number of factors must be taken into account. Firstly, given that psychopathology often goes unrecognised and under-reported in adolescents, prevalence data may underestimate the extent of the problem (Audit Commission, 1999). Secondly, co-morbidity is high in the adolescent population in relative terms between different psychiatric conditions (Harrington, 2003), and therefore it is likely that adolescents presenting with mental health problems are experiencing a wide range of difficulties. Thirdly, rates of particular mental health difficulties that young people present with vary according to a range of circumstances and familial situations. These include 'Child Risk Factors' such as low self-esteem, genetic influences, communication difficulties and learning disability; 'Family Risk Factors' such as overt parental conflict, parental psychiatric illness, death and loss, and abuse, and 'Environmental Risk Factors' such as socio-economic disadvantage, discrimination and other significant life events (Audit Commission, 1999). Nonetheless, prevalence estimates indicate that in a typical Scottish secondary school with a role of around 1000 children, it would be expected that 200 will currently be experiencing some form of mental health difficulty, with around 100 of these meeting diagnostic criteria, indicating that there are significant mental health needs in Scottish adolescents.

1.1.2 Developmental Issues in Adolescence

Prevalence studies indicate that adolescents tend to be more likely to experience mental health problems than children. To take depression for example, a recent

comprehensive meta-analytical review of epidemiological studies of rates of depression indicated a prevalence estimate of 2.8% in children under 13 years of age, compared with 5.6% in children aged 13-18 years (Costello *et al.*, 2006). This, along with similar findings have led to the suggestion that we are experiencing an 'epidemic' of adolescent depression (Kessler *et al.*, 2001), a concern that has been fuelled by the suggestion that rates of mental illness in adolescence are rising. This is evidenced by findings of a general trend of increased incidence of psychosocial disorders, and in particular, emotional disorders in the adolescent population over the past 50 years and more substantially in the past two decades (Collishaw *et al.*, 2004).

The Mental Health Foundation (2002) highlights a number of salient factors that would lead us to anticipate increased rates of mental health difficulties within this age group. Firstly, adolescence is considered to be a crucial stage for the development of mental illness (Reinhertz *et al.*, 1993), with epidemiological studies indicating that the risk for developing more severe and enduring mental health problems in particular rises in adolescence. It is estimated for example that 40% of males and 23% of females with schizophrenia experience onset before the age of 19 years (Schultz *et al.*, 1998) and that between 2% to 8% of adults with major depressive disorder (MDD) experienced their first episode of the illness by age 16 (Fergusson & Woodward, 2002).

Secondly, the nature of adolescence may result in the development of emotional difficulties. Adolescents are going through a transition stage of their lives in terms of social and sexual development, and increased autonomy and responsibility, and this can result in increased stress and vulnerability (Willis, 2005). Furthermore, a high

proportion of adolescents are exposed to additional sources of stress associated with this particular stage in their lives, including pressure to succeed, parental separation and bullying (Haavet *et al.*, 2005). Thus, the life experiences that adolescents face as part of growing up may place them at greater risk of developing mental health difficulties. In addition, given that adolescents are still developing their cognitive and emotional capabilities, they may lack the resources for psychologically readjusting and adapting to these experiences (Zwaanswijk *et al.* (2003), which places them at further risk of developing emotional difficulties and a subsequent need for services (Mental Health Foundation, 2002).

Thirdly, the types of behaviours that adolescents tend to engage in may act as both risk factors for developing mental health difficulties, and to exacerbate already existing problems. There are increased rates of engagement in risk taking behaviours within this age group, such as drug taking (Ouellette *et al.*, 1999), and alcohol use (Jones & Heaven, 1998). The fact that such rates appear to be increasing, along with the potential detrimental impact on mental wellbeing, is increasingly cause for concern (Gilvarry, 2000). Furthermore, there are increased rates of deliberate self harm and suicidality (Gould *et al.*, 2003). Of further concern is evidence of what is termed "suicidal clustering", that is, the tendency for increased rates of suicidal behaviour in adolescents who experience the suicide of an acquaintance, suggesting that adolescents are more affected by the occurrence of suicide than other age groups (Friedman, 2006). Indeed, Carlton & Deane (2000) highlight increased rates of suicidal ideation and suicidality as causing particular concern given low help seeking rates.

Evidently, a number of issues contribute to increased rates of mental health problems in adolescence. However, given that this is a transitional life stage, it is also important to consider the impact of mental health problems developing at this age on future development. The concern has been raised that experiencing mental health problems at this time may result in developmental trajectories which are irreversible (Willis, 2005). Indeed, it is well documented that adolescents who experience depressive tendencies for example, are at increased risk of depression in adulthood (e.g. Lewinsohn *et al.*, 1999). Furthermore, they are also at risk of a range of negative social and educational outcomes (Rueter *et al.*, 1999; Fergusson & Woodward, 2002), and a range of additional mental health problems including anxiety disorders, and drug and alcohol abuse and dependence (Bardone *et al.*, 1998; Fergusson & Wood, 2002). With schizophrenia, the importance of early detection and identification is a major focus currently due to recognition that adolescent onset has poorer prognosis than adult onset (Lay *et al.*, 2000). More specifically, the detrimental impact on developmental tasks such as separating from parents, forming close relationships and entering a career path cause particular concern (Pencer *et al.*, 2005). More generally, it has repeatedly been found that the presence of a psychiatric disorder in childhood or adolescence, particularly depressive disorder or anxiety disorder, is one of the strongest predictors of suicide among children and adolescents (Boden *et al.*, 2007; Gould *et al.*, 2003; Shaffer *et al.*, 1996).

1.2 MENTAL HEALTH CARE IN ADOLESCENCE

Clearly, there is a significant need for mental health care within the adolescent population. However, the recent SNAP Report (Furnivall *et al*, 2006) highlights that while adolescents are at particular risk of developing mental health difficulties due the

vulnerable life stage they are at, this risk is increased because services are not being provided in a manner that promotes service uptake and therefore a significant proportion of such adolescents do not receive the help they need. Before considering reasons for this service gap, it is firstly necessary to highlight the routes into mental health care that adolescents can take.

1.2.1 Structure of Services

Traditionally, mental health care provision for children and adolescents within the UK is conceptualised as comprising of a 4-tiered framework (Audit Commission, 1999). Some services offer separate child and adolescent services, while some offer joint child and adolescent care. At tier 1, promotion and prevention based work may be offered, in addition to provision of general advice and identification of problems early in their development. Such services are offered by non specialist staff including GPs, teachers and health visitors. At tier 2, assessment, treatment and consultation work is offered for less severe and enduring difficulties, by specialists such as educational psychologists, clinical psychologists, psychiatrists and nurse specialists. At tier 3, specialist services are offered for more severe, complex and persistent disorders, by staff including those working at Tier 2, but typically working in a more multi-disciplinary manner. Services offered include assessment and treatment, typically in dedicated outpatient services. At Tier 4, specialist services are offered for more severely ill children and young people, including day units and inpatient care, by highly specialist outpatient and inpatient teams. Movement between levels typically occurs at the recommendation of relevant health professionals working at each tier.

1.2.2 Entry Routes Into System

When considering how children and adolescents enter the mental health care system, Zwaanswijk *et al.* (2003) propose that the actual help seeking process, and as such, movement into the tier system and between tiers, requires movement through a number of 'filters' which determine whether the client receives mental health care. These filters include parental recognition of problem and decision to consult the GP, GP recognition of the problem, decision by GP to refer on for more specialist care, and decision by more specialist mental health staff to refer on to tier 4 based services for more severe and enduring problems. When considering the adolescent population in particular however, entry into the mental health service is now increasingly occurring independent of parental involvement, through self referral, as will be discussed below.

1.2.3 Recent Changes in Service Access Routes for Adolescents

A number of recent developments in mental health policy have set the ball rolling for making changes to the manner in which mental health services are delivered to adolescents in the UK. The Mental Health Framework for Children for example highlighted the importance of providing services for those at transitional life-stages, including adolescence, heralding a move towards focusing on providing services to those most in need (Scottish Executive, 2004). Additionally, it has increasingly been recognised that Child and Adolescent Mental Health Services (CAMHS) are not necessarily the most appropriate and furthermore, not always the best equipped setting to provide adolescent mental health care, with the recognition that schools may be in many cases a more appropriate setting (Mental Health Foundation, 1999). The most recent phase of the SNAP Child and Adolescent Mental Health Study (NHS Health

Scotland, 2006) identified that professionals involved in providing mental health care to adolescents viewed the manner in which services were delivered to be one of the most prominent barriers to adolescents entering the mental health care system. In particular, it was recognised that there was a need for adolescents to be able to access services independently of parents and teachers, in more accessible settings such as schools, and in a less formal manner, for example at 'drop-in' clinics. Such changes in how and where adolescent services are being delivered are evident in other parts of the world, including the United States and New Zealand (American Academy of Child and Adolescent Psychiatry, 2005; Carlton & Deane, 2000) highlighting the current prominence worldwide of adolescent mental health care on both research and policy agenda.

Clearly, in recognising low rates of service usage and from investigating professionals' views on this, policies are being devised and implemented to ensure services are as accessible as possible to adolescents. In addition, such changes in service delivery have also been informed by and resulted from the user involvement movement. User involvement research demonstrates that young people are indicating that they want to be accessing services independently of their parents (Curtis *et al.*, 2004). This has been supported by growing recognition that adolescence is a period of "increasing psychological separation from parents" (Ciarrochi *et al.*, 2003, p105), where young people increasingly spend time with their peers away from their parents and take more of an independent role in decision making in relation to their own affairs.

As a result, adolescents are increasingly able to access services entirely independently of their parents, or to have parents involved in the initial seeking out of services but then to access these services entirely independently (Mental Health Foundation, 2002). In addition to this, services are increasingly being provided in more easily accessible settings such as schools. Secondary schools provide an ideal setting in which to offer mental health services, in part because of the significant role that schooling plays in social and emotional development, but also because it provides a familiar and perhaps less threatening environment for young people to seek out help (Ford & Nikapota, 2000).

1.2.4 Rates of Service Usage

Services are therefore increasingly being developed and altered to make them as accessible as possible to young people deciding to seek help. However, it remains the case that only a small proportion (between 20-30%) of those experiencing significant psychological distress actually seek help for their difficulties, even when services can be accessed independently of parents or teachers. This has been well documented in the adolescent population in both the UK and other countries (e.g. Boldero & Fallon, 1995; Carlton & Deane, 2000; Deane *et al.*, 2001; Offer *et al.*, 1991). Of the estimated one in ten adolescents in the UK considered to suffer from some form of mental health difficulty, only 30% of these have been seen by their GP or tier 2-4 specialist mental health care services (Meltzer & Gatward, 2000; Potts *et al.*, 2001). In New Zealand, while 25% of those aged up to 16 in a substantive birth cohort study were viewed as meeting the criteria for diagnosis of at least one psychiatric condition, only 21% of those had contact with services to receive help (Fergusson *et al.*, 1993). Even when they are aware that they are experiencing difficulty and require help, up to

90% of adolescents experiencing distress choose to tell their peers rather than seek out professional help (Kalafat & Elias, 1995; Offer *et al.*, 1991). As such, low service usage continues to pose problems for service providers, because even when services are designed to be as accessible as possible, adolescents continue to choose not to seek them out or make use of them.

Furthermore, these low access rates cannot be explained by assuming that adolescents are not aware of access routes or services on offer. Even when the referral into independent access services is initially solicited by someone other than the adolescent themselves, there is still a high tendency to not engage in services. For example, in a recent study of adolescent service usage, Willis (2005) reported that while the proportion of young people in the 16-19 year old age range referred for services was equal to that in the adult population, they opted into services less frequently and less often attended the initial appointment even after opt in. This suggests that while research has prompted awareness in service providers that there *is* a significant need for easily accessible mental health care within the adolescent population, adolescents continue to avoid seeking out services and to reject services when offered (Willis, 2005).

It would be easy to assume that these findings indicate that adolescents don't seek help from any source for mental health difficulties. However, a limited amount of research has focused on whether they seek help from sources other than professional ones, and this indicates that while a significant proportion of adolescents experiencing difficulties seek help from no one, those who do choose to discuss their difficulties are more likely to discuss them with non professional sources than professional ones,

most commonly their peers, and less typically, family and teachers (e.g. Boldero & Fallon, 1995; Deane *et al.*, 2001; Offer *et al.*, 1991). This is particularly the case at the onset of difficulties, and more formal help tends not to be sought until problems reach crisis stage (Willis, 2005). These findings cause concern for a number of reasons. Firstly, adolescents with mental health problems tend to have deficits in social capabilities and relationship forming (e.g. Fergusson & Woodward, 2002), therefore they may lack adequate peer support networks from which to seek help. Secondly, studies investigating the benefits of seeking help from peers have indicated that on reflection, adolescents have tended to report this source of help as unhelpful (Deane *et al.*, 2001; Offer *et al.*, 1991). Thirdly, it is obviously of benefit to seek help from professional sources at times of emotional distress rather than to rely on the informal help of peers and family.

Overall, it is clear that a significant proportion of adolescents tend not to seek out or accept mental health services, even when this help is sought on their behalf. Instead, they tend to look to their peers for help, but later view these experiences as unhelpful. It is particularly concerning that the adolescent age range tends not to seek professional help given the well documented detrimental impact on future outcomes when difficulties have onset in adolescence, particularly if these go untreated (Logan & King, 2002). In order to address low rates of service uptake, it is currently recognised that the process that adolescents go through, from onset of difficulties, through to receipt of care, needs to be better understood, in order to determine why there is a gap between service need and provision. In particular, there is a need for a focus on adolescents' perceptions of service routes, services provided and their view

on receiving help in order to increase initial and ongoing help seeking (Buston, 2002; Logan & King, 2002).

1.3 SERVICE ACCESS IN ADOLESCENCE

Many of the changes in mental health service set up and delivery have been informed by research aiming to conceptualise mental health service access. Indeed, there is a long history of research investigating mental health service access in the adult population, and as a result, a number of conceptual models of the service access process have been developed aiming to better understand factors influencing whether an individual will enter the mental health service system and to explain the gap between service need and provision. Less well documented and researched are the adolescent mental health access routes. Models on offer have in the past tended to group adolescents with children, or assume that adult models are applicable. However as has been demonstrated, this age range differs from both child and adult populations in terms of the types of difficulties they present with and the transitional life stage that they are in. Furthermore, as will be demonstrated, the current models on offer no longer fit for current service provision given recent changes in adolescent service provision discussed. In addition, they tend not to account for the adolescent's own role in the decision to seek help, irrespective of whether this help is sought with or without parental involvement. Nonetheless, consideration of such models is informative in that it demonstrates the type of research that provides the foundation for such models and gives an overview of what is known to date in relation to influences on service uptake in adolescents.

1.3.1 Why the Gap Between Service Need and Provision?

Format of Research

The gap between service need and provision is not just a feature of the adolescent population – a significant proportion of adults do not enter mental health services even when care is needed (Corrigan, 2004; Vogel *et al.*, 2005b). Research investigating this gap is largely derived from analyses of the relationships between particular factors and service uptake in clinical populations. Such research has demonstrated a number of variables associated with the individual and with services on offer which make service uptake more or less likely. A particular focus is on factors which influence the likelihood that the individual will seek out and take up services, and this is termed 'help seeking behaviour'. In clinical populations therefore, being in a service is viewed as an indication that help seeking behaviour has occurred. The value of such research lies in its ability to identify those at risk of lower levels of service usage, and this can then inform the design, implementation and analysis of intervention strategies aimed at improving both service uptake and service delivery (Rosenbaum *et al.*, 1988).

More recently however, there has been a move towards 'intention' based research, investigating the intentions of the individual to seek professional help, should the need develop in the future. Intention to seek help is viewed as a construct strongly predictive of actual help seeking behaviour, therefore it is considered to give an accurate measure of future help seeking behaviours in the non clinical population (Wilson *et al.*, 2005). A deficiency of help seeking behaviour research is that because it relies on clinical populations and is retrospective in nature, it excludes those who do not access services. Thus it cannot be determined whether aspects of the decision

making process or aspects of the service prevented the individual from receiving services (Kerkorian *et al.*, 2006). The value in measuring help seeking intentions in the non clinical population lies in the fact that it allows consideration of factors directly influencing the likelihood that an individual will seek help, such as attitudinal, knowledge related and belief based factors, and includes those who in the future would choose not to seek help. Thus in the current study, it allows consideration of factors likely to influence adolescents' decision making processes should future need for services develop. Furthermore, it allows identification of factors influencing help seeking separate from parental and service related barriers. A better understanding of such factors would go some way to explaining why, when adolescents do experience mental health difficulties, even in the absence of parental or service related barriers, they often choose not to seek out or take up services. Furthermore, such research would be more in keeping with current independent service access, and begin to provide the foundations for building a model of contemporary adolescent service access.

The most promising and well developed measure of help seeking intention is the General Help Seeking Questionnaire (GHSQ; Deane *et al.*, 2001), developed to formally assess help seeking intentions for personal and emotional problems. The measure has been demonstrated to relate to actual help-seeking behaviour in the previous month (Ciarrochi & Deane, 2001) and to predict future help-seeking behaviour in adolescents (Deane *et al.*, 2001), suggesting it to be a suitable measure of help seeking intention.

1.3.2 Conceptualising Adolescent Service Access

Both behavioural and intention based research in the adult population has highlighted the role of a number of 'actual' or 'perceived' barriers, which have acted to prevent people from seeking out, acquiring and making use of services, in addition to factors which may prevent people actually wanting mental health services (Kerkorian *et al.*, 2006). Increasingly research is looking to replicate such relationships in the adolescent population and to look more specifically at additional reasons why they, in particular, show such low levels of service access when compared with their adult counterparts.

Existing models of service access in adolescence conceptualise it as a multi-faceted process whereby a number of predisposing factors influence whether the individual will enter the mental health service system (e.g. Napoletano's 'Five Factor Model', Napoletano, (1981); the 'Children's Network-Episode Model (Costello *et al*, 1998) and Stiffman *et al.*'s 'Gateway Provider Model', (Stiffman *et al.*, 2004)). While the models on offer place slightly different emphasis on behavioural, social and cognitive elements, they have a common theme of viewing actual use of mental health services as a function of these predisposing factors. Such factors can loosely be grouped as the individual's predisposition towards using services, factors which facilitate actual service usage including parental and service related barriers, and the presence of need for mental health services (Judd *et al.*, 2006).

Most adolescent models have tended to be based upon qualitative research relating to patients' and parents' narratives of their experiences of receiving help. However, the 'Gateway Provider Model' (Stiffman *et al.*, 2004) is of particular relevance to the

current study as it is based upon factors identified as facilitators or barriers to entry into the mental health services system. In particular, the role of parents and teachers as 'gateway providers' (the individual who first identifies the problem and then makes the decision to seek help) is reviewed, along with consideration of barriers and facilitators to this. The benefits of this model are therefore twofold: firstly, it looks directly at factors which may prevent service access in both the clinical and non clinical population, and as such, provides a model that encompasses those who do not seek or receive help rather than just those who enter the mental health service system. Secondly, the model recognises the importance of a range of other sources in this process, including parents, teachers and tier 1 professionals, for example GPs. However, the model does not consider the role of adolescents as their own 'gateway providers', i.e. the model does not take into account adolescents choosing to enter the help system by themselves, and as such, potential barriers or facilitators to this.

As a result, available models to date have not appropriately conceptualised the role of the adolescent in the decision making process, and this is in part due to lack of research on adolescents' perceptions of service routes, services provided and their views on receiving help (such research in adults has been informative in the development of adult help seeking models), (Logan & King, 2002; Buston, 2002). Furthermore, Logan & King (2002) note that any such model would still need to incorporate both the direct role of parents when they are involved in facilitating service access, and the indirect role of parents, in terms of how their behaviours and attitudes indirectly influence their adolescent children's help seeking intentions and behaviours. As such, it is necessary therefore to investigate the developmental trajectory of such attitudes and how they correlate with parental attitudes. Finally,

criticism has been levelled at adolescent models for failing to adequately conceptualise school based routes into services (Florell & Swerdlik, 2000). Indeed, Stiffman & Pescosolido (2004) note that this aspect of their Gateway Provider Model is in the preliminary stages and further research is required to support it. An appropriate model of adolescents' independent service access has therefore not yet been developed, and this is no doubt in part due to the current fluidity of service provision, with a move towards providing more accessible and attractive services. It is therefore understandable and perhaps even necessary that models of the service uptake process are also in developmental stages. The available research that to date has informed such models however will now be reviewed.

1.3.3 Barriers in Parent-Facilitated Help Seeking

When parents are involved in the service access process, whether this be in initially seeking out services or in jointly accessing services with their adolescent children, research has identified a number of barriers that make service uptake less likely. Parent based barriers generally relate to factors influencing the parents' decision to seek help on behalf of their child. Much of the research in this area relates to younger children however, and it has been recognised that parents' role in seeking help for adolescents is under-researched and as such, not well understood (Logan & King, 2002). Existing research indicates that when parents are involved in the help seeking process in adolescents, their role lies in recognising a need for help and then facilitating the help seeking process on their child's behalf (Zwaanswijk *et al.*, 2003).

Research indicates that parents' ability to recognise a need for help is influenced by a number of factors. Firstly, this ability is more dependent on the levels of burden and

distress that it causes parents, rather than the level of severity of the problems that the child is experiencing (Logan & King, 2002; Wu *et al.*, 1999; Wu *et al.*, 2001). Secondly, if the parent is experiencing mental health problems, this increases their ability to recognise mental health problems in their children (Cornelius *et al.*, 2001; Flisher *et al.*, 1997). Thirdly, parents are less likely to perceive their child's behaviour as problematic if there are siblings present in the family (Verhulst *et al*, 1997), however this does not lead to decreased help seeking. Logan and King (2002) note that a number of developmental factors may make it more difficult for parents to recognise the presence of mental health difficulties in adolescents in particular, including the fact that older children presenting with internalizing disorders such as depression tend to withdraw from their parents (Martin and Cohen, 2000), and more generally the fact that adolescence itself is a time of increased autonomy and separation from parental involvement.

When a need for help is recognised, a number of additional factors influence whether parents will then seek professional help. One of the strongest predictors of parental help seeking is the level of perceived burden that parents report (Angold *et al.*, 1998). Thus, parents' ability to adjust to their child's difficulties predicts parental facilitated help seeking over and above the perceived level of severity of the child's problem (Morrissey-Kane & Prinz, 1999). Other factors associated with increased parental help seeking include the education level of the parents, (Saunders *et al.*, 1994; John *et al.*, 1995), increased family stress levels (Cunningham & Friedman, 1996, Gasquet *et al.*, 1997), parents themselves receiving psychological care (Cunningham & Friedman, 1996) and past positive experience with child and adolescent services (Kerkorian *et al.*, 2006). Finally, Morrissey-Kane & Prinz's (1999) comprehensive

review of research pertaining to parental involvement in adolescent mental health care help seeking highlights the important role of parental cognitions and attributions. In particular, they cite a number of studies indicating that parents' decision to seek help is influenced by their beliefs relating to the cause of their child's problems, their perception of their own ability to manage these problems and their expectations and attitudes relating to the utility of professional psychological help in addressing such problems. More recent experimental research has further confirmed the important role of parental attributions, in particular in relation to cause of problems and utility of services, on parents' decision to seek help (e.g. Draucker, 2005; Yeh *et al.*, 2005).

There is a general consensus in the literature that parent related barriers are now relatively well understood, however there remains a need for a focus on adolescent related factors. In particular, it is viewed that research should focus on determining more comprehensively, two main aspects of service usage behaviour and intention: the help seeking decision making process that adolescents go through along with the knowledge, belief and attitudinal based influences on this; and how this relates to adolescents' intentions to seek help from different sources, given their tendency to opt for informal rather than formal sources of help (Lopez, 1991; Sheffield *et al.*, 2004; Williams & Pow, 2007). Current research to this end will now be reviewed.

1.4 VARIABLES ASSOCIATED WITH ADOLESCENT HELP SEEKING

There is a long history of research looking to conceptualise and better understand help seeking decision making and behaviour, with most of this research focussing on factors influencing help seeking in the adult population. Such research has

consistently identified a number of socio-demographic, problem specific and experience related factors which influence help seeking. Early research by Kushner & Sher (1989) set a trend for identifying factors making help seeking more or less likely. They discussed a number of what they termed 'approach' or 'avoidance' factors in adult help seeking which they proposed were conflicting and influenced the decision whether or not to seek professional mental health help. These fall into the categories of socio-demographic variables, problem related variables and variables associated with past health care. How they relate to help seeking behaviour and intentions have subsequently been investigated in the adolescent population, and will be reviewed below. As noted however, the current focus in adolescent help seeking research relates to cognitive influences on service access, including knowledge, attitudes and beliefs relating to mental illness and the help seeking process, and particular focus will be given to research on this.

1.4.1 Sociodemographic Variables and Adolescent Help Seeking

Gender

It has repeatedly been shown that adolescent males are less likely to seek psychological help for emotional problems than females (e.g, Fischer & Turner, 1970; Rickwood & Braithwaite, 1994; Timlin-Scalera *et al.*, 2003). Furthermore, significantly fewer males in the non-clinical population report help seeking intentions than females should they develop emotional problems in the future (e.g. Shonert-Reich & Muller, 1996; Gasquet *et al.*, 1997; Carlton & Deane *et al.*, 2000; Wilson *et al.*, 2005). Even when adolescents are experiencing significant symptoms of depression, and are not receiving treatment, males continue to report lower intentions to seek help than their female counterparts (Aalto-Setälä *et al.*, 2002). Fischer &

Farina (1995) reported gender as the strongest demographic correlate of attitudes toward seeking professional psychological help. This strong gender-related difference in help seeking behaviours and intentions has largely been attributed to perceived stigma associated with males seeking help, in that males assume that others will view their help seeking as a sign of weakness (Timlin-Scalera *et al.*, 2003).

Age

Debate remains in the literature as to the relationship between age and professional psychological help seeking in adolescents. Zwaanswijk *et al.* (2003) provide perhaps the most comprehensive review of research on the relationship between age and help seeking in children and adolescents and note that some research indicates help seeking increases with age throughout adolescence, while some indicates a decrease. However, they conclude that this is a result of such studies not differentiating between adolescent solicited help seeking and parental solicited help seeking, and as such, an increase in rates in later adolescence may be related to parental service need, rather than actual service utilisation. Research looking only at adolescent solicited use of services is therefore more informative for the current study and indicates that adolescents tend to seek formal help less with increasing age throughout the adolescent years (Verhulst *et al.*, 1997). Ciarrocchi *et al* (2003) reported that with increasing age, adolescents expressed less intentions to seek help from parents for personal emotional problems, and the authors attributed this to the fact that with increasing age, children become increasingly separated from their parents. No significant relationship was found between age and help seeking from friends, or for formal sources for personal emotional problems. Finally, Ciarrocchi *et al* (2003) reported that adolescents reported increasing intentions to seek no help at all with

increasing age for suicidal ideation, however this was not the case for personal emotional problems. Clearly, the developmental trajectory for help seeking for personal emotional problems is not currently well understood.

Socio-Economic Status

The relationship between socio-economic status and mental health is well documented, demonstrating that low socio-economic status in all ages is strongly associated with mental health problems (Sheffield *et al*, 2004). The role between socio-economic status and service usage has therefore also been investigated. Findings suggest that when health care is readily available and free, there is no association between socio-economic status and actual help seeking, once the confounding effects of socio-economic status on rates of mental health problems are controlled for (e.g. Gasquet *et al.*, 1997; Verhulst *et al.*, 1997). Not surprisingly however, when mental health services have to be paid for (for example in the United States), low socio-economic status is associated with lower help seeking (Fischer *et al.*, 1997).

Ethnicity

Studies investigating ethnicity indicate that within ethnic minority groups, it is more common to seek help from informal sources rather than formal sources, and this is thought to largely relate to culturally specific beliefs about help seeking and mental illness (McMiller and Weisz, 1996; Rickwood & Braithwaite, 1994; Zwaanswijk *et al.*, 2003).

Rurality

Judd *et al.* (2006) report lower help seeking behaviour in adolescents living in rural areas. They propose that this may be in part due to rural individuals perhaps being more stoic and self reliant, and in part due to increased levels of perceived stigma in relation to receiving psychological help within a rural population. Indeed, they found higher levels of negative attitudes towards help seeking in those in rural non clinical samples.

Social Support

Finally, research has considered the role of social support networks. Burns and Rapee (2006) found that in the older adolescent age-group, the presence of close social support increased help seeking behaviour in those who had recently sought help, and while friends and family were seen as a good source of support, their tendency to encourage professional help seeking increased subsequent psychological help seeking behaviour. Rickwood & Braithwaite (1994) report similar findings. Intention based research indicates that adolescents report intentions to rely on friends and family for help for personal-emotional problems, but even when strong support networks are available, they would seek professional psychological help if they were to experience suicidal ideation (Wilson *et al.*, 2005). Overall, the finding that adolescents view family as an important source of help has highlighted the importance of educating parents on adolescent mental health problems.

1.4.2 Problem Related Variables and Adolescent Help Seeking

A number of factors related to type of psychological problem experienced have also been demonstrated to correlate with help seeking, including presence of co-morbid condition, level of impairment and type of psychological problem.

It has consistently been found that as level of psychological distress increases, so too does the probability of seeking help in adolescents (Offer *et al.*, 1991; Rickwood & Braithwaite, 1994). Adolescents also display increased help seeking as level of functional impairment increases (Leaf *et al.*, 1996; Rickwood & Braithwaite, 1994; Wu *et al.*, 1999; Wu *et al.*, 2001). Additionally, they report higher help seeking intentions for higher levels of psychological distress (Carlton & Deane, 2000). It would appear that in adolescents meeting diagnostic criteria for depressive disorder, the presence of a co-morbid condition made it more likely that they would seek professional help, and this was a stronger determinant of help seeking than degree of impairment due to primary condition. Furthermore, the presence of additional school and or medical problems is also associated with increased help seeking behaviour (Gasquet *et al.*, 1997).

Finally, research has repeatedly demonstrated that the type of psychological problem experienced is associated with service use with more severe and enduring problems being associated with increased help seeking behaviour (Deane *et al.*, 2001). Clearly, and perhaps understandably, as problem severity in terms of presence of additional problems or level of distress and impairment increases, so too does actual help seeking in clinical populations, and intentions to seek help for those hypothetically considering the situation. However, this relationship changes when the adolescent

population is experiencing suicidal ideation. This has also been found in non clinical older adolescents (Deane *et al.*, 2001). Presence of suicidal ideation is related to lower help seeking in adolescents currently experiencing psychological distress (Carlton and Deane, 2002; Cuffe *et al.*, 2001). Furthermore, intention based research indicates a significant negative relationship between levels of suicidal ideation and help seeking intentions (Deane *et al.*, 2001).

1.4.3 Past Experience of Psychological Help & Adolescent Help Seeking

Direct Experience

Similar to gender related differences in help seeking behaviour and intentions, a second consistently reported relationship is that between past experience of psychological help and help seeking. Past personal experience of help seeking in adults (Fischer and Turner, 1970), young adults (Deane and Todd, 1996), and adolescents (Carlton and Deane, 2000) results in increased help seeking behaviour in future, in that it is more likely that help will be sought again if it has been received in the past. Research has since focused on why this may be the case.

Masudo *et al.* (2005) found that older adolescents with past experience had more favourable attitudes towards seeking psychological help, but also greater recognition of need for help and greater confidence in the skills of the profession. In adolescents however, the quality of the experience reported by adolescents who have already received care appears more important in determining whether they seek help in the future (Buston, 2002). As such, Buston (2002) recommends that it is necessary to break down factors associated with having received help in the past, in particular to look at whether such experiences were viewed as positive. Indeed, in her small scale

qualitative study, Buston (2002) reported that those recalling negative experiences reported that they were less likely to attend in the future should they develop future need. Furthermore, the patients cited an understanding and supportive clinical relationship as the most important factors in past experience in influencing whether they would seek help in the future, over and above whether the experience itself was helpful in reducing symptoms. Overall, viewing past experience as positive is a positive motivator to seek formal help in the future should the need develop, as it resulted in more positive view toward help seeking (Fischer & Farina, 1998; Timlin-Scalera *et al.*, 2003).

Indirect Experience

Experience of others close to individuals having had mental health problems or having received psychological help can indirectly influence help seeking behaviours and intentions in adolescents. Stigma in relation to mental illness and psychological help seeking has been well documented as a barrier to help seeking, however familiarity with mental illness in someone close to the individual is associated with more positive attitudes towards mental illness and seeking psychological help (Watson *et al.*, 2005). Rickwood and Braithwaite (1994) reported that adolescents who knew someone who had actually received help before were more likely to have sought help for their own psychological problems in the past twelve weeks than those who had not. Indeed, having past experience of mental health problems acts as a motivator to encourage friends to seek help themselves should they require it (Wassef *et al.*, 1996). Clearly, past direct or indirect experience of mental health services, particularly if this experience is positive, increases help seeking intentions and behaviour.

1.5 COGNITIVE BARRIERS TO ADOLESCENT HELP SEEKING

As evidenced in models of help seeking discussed, the beliefs, knowledge and attitudes of adolescents also play a significant role in the help seeking process. These are often conceptualised as comprising 'Mental Health Literacy', a term first used by Jorm *et al.*, (1997) to refer to "knowledge and beliefs regarding mental disorders which aid their recognition, management or prevention" (p182). Within this, Jorm *et al.* (1997) include the ability to recognise the presence of mental health difficulties within oneself, knowledge of services available and how to access them, and attitudes that promote help seeking. Esters *et al.* (1998) note that these can broadly be defined as 'cognitive variables', citing a number of studies that demonstrate their role as precursors to the help seeking process in the adult population. More specific to adolescents, West *et al.* (1991) view that under-use of services in adolescents (in the absence of parental involvement) can predominantly be attributed to cognitive factors. Indeed, the view that cognitive factors are one of the most influential predisposing factors in service usage is strongly supported in the literature (Marcell *et al*, 2005) and yet is the area least well researched and understood, As a result, this is the main focus of the current study. Furthermore as noted, research needs to identify how such attitudes develop, in particular considering the indirect role of parents, in terms of how their attitudes indirectly influence their adolescent children's help seeking intentions and behaviours (Logan & King, 2002).

These cognitive factors can be grouped as adolescents' ability to understand their own mental health status and subsequent need for help, attitudes and beliefs relating to mental illness, and perceptions and beliefs relating to help seeking including views on the accessibility of services, the desirability of help seeking and the desirability of

actually accessing services. The first two will be reviewed briefly, before focus is given to attitudes and beliefs directly related to help seeking, their developmental trajectory and the potential influence of parental attitudes on such attitudes in adolescents.

1.5.1 Awareness of Mental Health Status

Within the adult literature, it has long been recognised that people differ in terms of their perceptions of their own mental health status, and that these perceptions are largely determined by the individual's own concept and definition of mental health and illness. Indeed, Lockwood (1984) proposed an early model of the development of such perceptions, highlighting their roots in individual, social and cultural factors, awareness of higher level needs, and perception of one's own mental health status. He proposed an association between such perceptions and help seeking behaviours. This model was later tested by Hourani & Khlat (1986) leading to confirmation that in particular, one's own definition of mental health and one's own self rating of mental health status were important predictors of later help seeking behaviour. More recently, Goldney *et al.* (2002) reviewed a wealth of literature supporting the relationship between awareness of need for mental health help and knowledge pertaining to mental illness and help seeking behaviour.

There is a growing body of research demonstrating a similar relationship in adolescents (Burns & Rapee, 2006). A number of school programmes aimed at increasing knowledge of signs of mental illness and help seeking processes have been audited and demonstrated to result in increased help seeking intentions, suggesting that a similar relationship between knowledge and help seeking as has been

demonstrated in adults would be found in children and young people (e.g. Esters *et al.*, 1998; Pinfold *et al.*, 2003). Burn and Rapee's (2006) research investigating knowledge and understanding of symptoms of depression and appropriate help seeking for vignette descriptions in 15-17 year olds, while highlighting some gaps in knowledge of symptomatology of depression and other conditions, reported that almost all of the participants thought that help should be sought for cases they identified as depressed. This suggests that adolescents have some recognition that when significant mental health problems are present, help should be sought. Conversely, lack of insight into presence of mental health problems has been demonstrated to act as a barrier to actual help seeking in adolescent males (Timlin-Scalera *et al.*, 2003).

Linked to this, intention based research has begun to focus on 'emotional competence', the ability of the individual to identify, describe, understand and manage emotions (Ciarrochi & Deane, 2001) and its impact on intention to seek help. Indeed, emotional competence is a construct closely related to the awareness of one's own mental health status. In non clinical research involving young adults, Ciarrochi and Deane (2001) found that those who reported being less skilled at managing their emotions were less willing to seek help should they develop a need in the future. Worryingly, this indicates that those with the lowest skill to understand and manage their emotions are least likely to seek help. Ciarrochi *et al.* (2003) extended this research to include the adolescent age range, and similarly found that adolescents with low emotional competence reported the lowest intentions to seek help from both formal and informal sources. Interestingly, they found that this relationship had a

developmental trajectory, in that it was less prominent in younger adolescents and increased with increasing age.

1.5.2 Attitudes Towards Mental Illness

There is a substantial body of research demonstrating the existence of mental illness stigma and its detrimental impact on help seeking in the adult population, and more recently there has been a surge in research demonstrating this in the adolescent population also (Watson *et al.*, 2005). This is reflected in the fact that in the United States, the Surgeon General's recent conference on child mental health identified reducing stigma of mental illness in children as its primary goal (US Public Health Department, 2002). Mental health is viewed as one of the most stigmatizing medical conditions in the United Kingdom today (Williams and Pow, 2007), and furthermore, evidence suggests that generally, public attitudes towards mental health are becoming increasingly negative, particularly among young people (Department of Health, 2003). Stigma research has investigated the impact of both 'self stigma' (holding stigmatising views towards oneself when experiencing mental health difficulties) and 'perceived' or 'public' stigma (viewing others as holding stigmatising views towards mental illness) on help seeking. Link *et al.*, (2004) conceptualise both forms of stigma towards mental illness as multi-faceted, encompassing components such as labelling, stereotyping, status loss, discrimination and emotional reactions. Watson *et al.*'s (2005) study of adolescent attitudes to mental illness confirmed similar components in this population.

In adolescents, boys typically report more stigmatising attitudes towards mental illness than girls, (Ng & Chan, 2000; Pinfold *et al.*, 2003; Watson *et al.*, 2004;

Williams & Pow, 2007). Developmental trends are less clear cut, with some research suggesting that negative attitudes increase with age throughout childhood and adolescence (Wahl, 1999), and others suggesting no age effect (Lopez, 1991; Watson *et al.*, 2004). Greater knowledge of symptoms of mental illness is associated with more positive attitudes (Esters *et al.*, 1998; Williams & Pow, 2007). Related to this, direct or indirect experience of mental illness and its relationship to mental illness stigma has been investigated, but results are contradictory, and not yet clear (Watson *et al.*, 2005; Williams & Pow, 2007). However, adolescents do report personal experience with someone with a mental illness as the most important source of their attitudes, suggesting that direct contact with someone experiencing mental health difficulties influences attitude development (Lopez, 1991).

The impact of both self and perceived stigma on help seeking have been investigated. In adults, holding stigmatizing views towards mental illness has been shown to have a significant detrimental impact on help seeking behaviours (e.g. Williams & Healy, 2001). Barney *et al.* (2006) found that adults who reported that they would view themselves in a negative manner (high 'self stigma') were they to suffer from mental illness, reported lower help seeking intentions, and this was particularly prevalent in young adults. Vogel *et al.* (2007) reported that perceived public stigma reduced willingness to seek help; however this relationship was mediated by self stigma levels.

In adolescents, research suggests that holding negative attitudes towards mental illness has also consistently been shown to influence subsequent help seeking behaviour and intentions. Churchill *et al.* (2000) found that adolescents' worries about

perceived public stigma towards mental illness made it less likely that they would consult their GPs for fear of others finding out. Seeker *et al.*, (1999) reported lower rates of adolescent service usage in rural areas and this was associated with high levels of both public and self stigma. They attributed this to individuals in rural areas being more susceptible to the effects of stigma because they tended to have higher regard for autonomy and preferred to deal with problems themselves. However, the most recent comprehensive review of factors impacting on adolescents' willingness to seek help conducted by Sheffield *et al.* (2004) suggests that negative attitudes towards mental illness as such don't influence help seeking intentions, but rather relate to other factors which influence help seeking, such as lower knowledge of mental illness, being male and lower levels of social support.

1.6 BELIEFS AND ATTITUDES TOWARDS HELP SEEKING

Evidently, other aspects of mental health literacy and their relationship with help seeking have been well documented in the adolescent population. Research focusing on adolescents' perceptions of service routes, services provided and their view on receiving help and how this influences help seeking is still in its early stages (Logan & King, 2002). A number of promising new measures to address these cognitive factors have been created and their findings will be reviewed here. However, there is a need for a more comprehensive study combining each of these components and making use of these measures to confirm already reported findings and to investigate how in conjunction these variables influence help seeking intentions in adolescence, and this is the predominant aim of the current study.

Research into this falls into three main areas: perception of services which act as barriers to help seeking; attitudes towards seeking professional help; and attitudes towards receiving professional help.

1.6.1 Perception of Services as Barriers to Help Seeking

In adults, a number of beliefs relating to particular aspects of services on offer have been demonstrated to influence help seeking behaviour, however, significantly less research exists on adolescents' perceived barriers to help seeking and the impact of this on subsequent help seeking intentions and behaviour (Sheffield *et al.*, 2004).

Confidentiality Concerns

Perhaps the most consistently researched perception based barrier in adolescents relates to concerns about confidentiality and about information being passed on to parents or teachers. This has repeatedly been demonstrated to inhibit help seeking behaviour in adolescents (e.g. Dubow *et al.*, 1991; Timlin-Scalera *et al.*, 2003; West *et al.*, 1991). Research has now begun to investigate how this relates to particular types of mental health problems. Lehrer *et al.* (2006) for example, report higher levels of several risk characteristics such as suicidal ideation and depressive symptomatology in those reporting such concerns about confidentiality, along with resultant lowered intentions to seek help, suggesting that those most in need are least likely to seek help.

Perceived Utility and Accessibility of Services

A number of factors have been identified in adolescents already having sought care as resulting in them viewing services as unhelpful, including holding negative

perceptions of the therapist (Offer *et al.*, 1991) and negative expectations about outcome (Simoni *et al.*, 1991). Churchill *et al.* (2000)'s retrospective study of adolescents' use of GP services highlighted a range of beliefs about accessibility of services and their impact on help seeking behaviour. They found that differences in GP consultation rates for mental health difficulties in adolescents seeking help in the absence of parental knowledge could be explained by perceived difficulty in getting an appointment, feeling able to confide in a GP and worry that adequate time would not be given in the session. This suggests that beliefs about the accessibility of services in adolescents impacts upon even the initial stages of help seeking.

Measuring Perceived Service Related Barriers to Help Seeking

Kuhl *et al.* (1997) identified and reviewed a wealth of studies demonstrating the impact of negative beliefs about usefulness of therapy and skills of the therapist on subsequent help seeking behaviour, including concerns about the helpfulness of therapy, time availability, affordability, confidentiality concerns, and perceptions of the therapist. On the basis of this, they developed the Barriers to Adolescent Help Seeking measure ('BASH'), a measure intended to measure the relative strength of such barriers. This was done in order to provide a means of identifying adolescents least likely to uptake services, in order to then adapt services appropriately. This measure has since been used in its entirety to provide a measure of perceived barriers to help seeking (Sheffield *et al.*, 2004), and in part ('BASH-B') to provide a measure of belief based barriers to seeking professional help (Wilson *et al.*, 2005a, Wilson *et al.*, 2005b), in all cases demonstrating that adolescents perceiving fewer barriers to help seeking are more willing to seek professional help. A search of the literature

suggests this to be the only validated and consistently used measure of perceived barriers to help seeking in adolescent literature.

1.6.2 Attitudes Towards Seeking Professional Help

Actual attitudes towards seeking professional psychological help and their relationship towards help seeking behaviour and intentions is also receiving focus in the research.

Measuring Attitudes Towards Seeking Help

Much of the research in attitudes and orientations towards help seeking originates from Fischer & Turner's (1970) seminal study of help seeking and subsequent development of the 'Orientations to Seeking Professional Help' measure. The initial measure was created on the basis of orientation towards help seeking as being conceptualised as comprising a number of dimensions. The long history of studies making use of this measure in the decades that followed its creation demonstrate the view in the literature that this is an important facet of the help seeking decision making process, and also demonstrates the utility of the measure. The most consistent findings making use of this measure are that women express more positive attitudes towards help seeking than men (Fischer & Tuner, 1970; Rickwood & Braithwaite, 1994; Yeh *et al.*, 2002; Masudo *et al.*, 2005), and that past experience of mental health care is also associated with more positive attitudes towards help seeking (Al-Darkami, 2003; Masudo *et al.*, 2005, Sheikh & Furnham, 2000).

Relationship with Help Seeking Behaviour and Intentions

This measure has also been used to investigate the relationship between attitudes towards help seeking and actual help seeking behaviour and intentions. Tijhuis *et al.*

(1990) reported that in adults, favourable attitudes towards seeking professional help facilitated actual help seeking. Furthermore, they reported such favourable attitudes were greater in those who were younger, had higher levels of education, higher family income, were more open generally with regards to discussing mental health, and were less likely to view mental health problems as resultant from 'chance'. Rickwood & Braithwaite's (1994) study followed a similar format with an adolescent population. This demonstrated that some of the factors associated with more favourable attitudes towards help seeking in adolescents differed from those demonstrated in adults, suggesting that this needed to be further investigated in adolescents. They did however report that help seeking orientation and actual help seeking were closely linked.

Advances in Research Methods

As noted, a great deal of research over the past three decades has made use of the scale first developed by Fischer and Turner in 1970, however the scale was revised by Fischer and Farina in 1995, to address internal consistency concerns raised by contradictory findings in the published literature. The previously multi-dimensional structure was changed to provide a uni-dimensional measure of help seeking orientation. Fischer & Farina (1995) explain this change as resulting from the recognition that the attitude construct of most relevance and utility was best defined by a single unitary measure of attitudes towards seeking professional psychological help. Since the re-development of the scale (now termed the 'Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH-B), it has been consistently used in the current help seeking behaviour and intention literature, confirming the position of attitudes towards seeking psychological help as a significant facet of the

help seeking decision making process. Furthermore, the repeated use of both the original and re-developed version of the measure demonstrates the confidence in the quality of the measure. Using the ATSPPH, it has again been demonstrated in the young adult population that having more positive attitudes towards seeking help is associated with increased help seeking intentions (Kelly & Achter, 1995; Deane & Todd, 1996; Vogel *et al.*, 2005a). In adolescents, Carlton & Deane (2000) reported attitudes towards help seeking as one of the most significant predictors of help seeking intentions for personal emotional problems and suicidal thoughts. With the old form, Wilson *et al.* (2005b) reported that in those experiencing suicidal ideation, attitudes towards help seeking as measured by the ATSPPH and the presence of belief based barriers to help seeking as measured by the BASH-B alone could account for low help seeking intentions.

1.6.3 Attitudes Towards Receiving Professional Help

Stigma and Receiving Help

The final important component of attitudes and beliefs directly related to help seeking is that of stigma in relation to receiving professional psychological help. There is a strong body of literature in adults indicating that receiving psychological help is perceived as stigmatising by both consumers of health services and by the general population (e.g. Wahl, 1999).

Stigma of Receiving Help and Help Seeking Behaviour and Intentions

It is already widely reported that stigma in relation to having a mental illness is associated with decreased help seeking behaviour and intentions as discussed, in both adults and adolescents. Barney *et al.* (2006) note however that the other important

form of stigma in the context of help seeking is that of 'perceived stigma' (often termed 'social stigma'); the belief that others hold stigmatising views of the individual's need for help. Indeed, the impact of high levels of perceived stigma in help seeking on lowering help seeking intentions has been demonstrated in adults (e.g. Barney *et al.*, 2006; Deane & Chamberlain *et al.*, 1994). Komiya *et al.* (2000) cite a range of research demonstrating that stigma surrounding receiving psychological help is associated with reluctance to receive help in adults, however they recognise that only a limited amount of research has investigated this in the adolescent population, but recognise the considerable need for it.

A search of the literature heralded two qualitative studies investigating perceived stigma surrounding receiving help and help seeking in adolescents. Lindsey *et al.*'s (2006) small scale qualitative study of help seeking behaviour in adolescent boys consistently reported the theme of stigma as a barrier associated with mental health service usage. In particular, participants reported that shame, embarrassment about others finding out, and fear of exclusion as a result of this made them reluctant to seek out services. Timlin-Scalera *et al.*'s (2003) investigation of perceived stigma in adolescent males took a grounded theory approach and identified that concerns that help seeking would be seen as sign of male weakness and participants consistently reported that this would act as a barrier to help seeking should they develop a need for help.

In addition to qualitative studies, there are a limited number of quantitative studies using adolescent populations, although this research is in early stages. Kuhl *et al.* (1997) recognised the importance of perceived stigma in the help seeking process as a

barrier to help seeking and therefore included this variable as one of the barriers in their measure (the BASH). However, their study did not differentiate between seeking help from formal and informal sources, and as such, choosing to seek help from informal sources such as friends or family, or dealing with problems oneself were more significant barriers to help seeking intentions that perceived stigma (Kuhl *et al.*, 1997). However, when help seeking was broken down to include only help seeking from formal sources, Sheffield *et al.* (2004) reported that lower perceived stigma, along with higher adaptive functioning and greater psychological distress were significant predictors of greater willingness to seek psychological help from formal sources.

Measuring Stigma of Receiving Help

To further investigate perceptions of stigma surrounding receiving professional help, Komiya *et al.* (2000) developed the 'Stigma Scale for Receiving Psychological Help' (SSRPH), a measure designed to assess individuals' perceptions of how stigmatising they think it would be to receive professional mental health care. In their study, they reported that greater perceptions of stigma were associated with gender (males reported higher rates that females) as is the case of much of the help seeking research. Of particular interest, they reported that scores on the SSRPH were negatively correlated with favourable attitudes towards psychological help seeking (using the ATSPPH), suggesting that those who thought that receiving professional help would be seen by others in a negative light, showed lower orientation towards seeking help (Komiya *et al.*, 2000). This measure has since been used by Vogel *et al.* (2005a) to investigate the role of outcome expectations and attitudes in young adult help seeking,

and demonstrated that perceived social stigma in receiving help significantly predicted intentions to seek professional help in the future.

A search of the literature suggests this to be a promising measure of perceived stigma in help seeking, and furthermore that there is a role for its use in furthering understanding of help seeking in the adolescent population. Vogel *et al.* (2005a) for example note the need for the measure to be administered in a range of age groups including adolescents to determine how such attitudes alter with increasing age, and Komiya *et al.* (2000) report a need for the measure to be administered in conjunction with measures of other aspects of attitudes and beliefs relating to help seeking to determine how such variables interact.

1.7 INFLUENCES ON HELP SEEKING ATTITUDES AND BELIEFS

As noted, gaining a better understanding of beliefs and attitudes towards help seeking and how they influence help seeking would facilitate understanding of why adolescents choose not to seek out services and reject services even when sought on their behalf. However, identification of such attitudes would potentially also allow for them to be targeted with the ultimate aim of increasing positive attitudes toward seeking and receiving help and ultimately increasing help seeking intentions. Indeed, Rosenbaum *et al.* (1988) note that, when aiming to alter negative attitudes in adolescents, the value in gaining a better understanding of the correlates of such attitudes is threefold: it allows for identification at both the individual and epidemiological level of those who are more likely to require increased levels of help in improving their attitudes; the identification of such factors can inform the design, implementation and analysis of intervention programmes aimed at improving

attitudes; and finally, knowledge of such factors can facilitate the development and testing of a model of the development of such attitudes, allowing consideration of the relative importance of contributing factors. For example, in relation to the second point raised, Jones (2001) noted that identifying belief based differences between different groups of potential services users could allow for differing marketing strategies to be used in each group in order to increase appropriate help seeking.

1.7.1 Attitude Change

Clearly, these goals are beyond the scope of the current study. However, gaining a better understanding of attitudinal and belief based correlates of help seeking intentions, the main aim of the current study, would be a promising first step. Carlton & Deane (2000) note that focusing on attitudes in particular is useful because attitudes have the potential to be changed, with the ultimate goal of changing help seeking intention and behaviour. Indeed, research suggests that with educational programmes, negative attitudes towards mental illness can be altered in children and adolescents (e.g. Pinfold *et al.*, 2003, Watson *et al.*, 2004). Specific to help seeking, Battaglia *et al.* (1990) reported the success of a mental illness awareness programme in increasing favourable attitudes towards help-seeking in adolescents and this was more recently demonstrated in a similar school based intervention study by Esters *et al.* (1998). In order for this to be achieved however, better understanding of the developmental trajectory and influences on such attitudes in terms of how they develop with age, and what influences their development would be required. In particular, this would then inform both when and how to deliver educational programmes aimed at increasing help seeking intentions.

1.7.2 Influences on Attitudinal Development

Attitudes are typically conceptualised as being learned and acquired through social and contextual learning, rather than being innate (Lopez, 1991). In adolescence, parents and peers are considered to be the most prominent and influential 'socialising agents' in relation to adolescents' opinions, beliefs and attitudes (Santrock, 1990). Studies investigating the influence of parental and peer attitudes on adolescents' attitudes are typically correlational in nature and tend to report positive, but not always significant relationships (Lopez, 1991). Additionally, adolescents themselves perceive parental attitudes as the main source of their attitudes in relation to mental health (Lopez, 1991). Specific to attitudes towards mental illness and mental health care, the potential role of additional socialisation sources such as teachers and the media have also been recognised (Fischer & Farina, 1995; Ford & Nikapota, 2000). However, a search of the literature indicates that specific to help seeking, no research has to date considered the relationship between parental, peer or teacher attitudes and help seeking and those of adolescents. Having a better understanding of the influence of parental attitudes in particular, would be beneficial not only in identifying adolescents more likely to hold lower help seeking intentions, but also in facilitating programmes aimed at changing such attitudes. If parents views are found to correlate with those of their children, it would be prudent to consider including parents in attitudinal change programmes.

1.7.3 Developmental Trajectory of Attitudes

In addition to identifying the relationship between parental and adolescent attitudes, it would be of benefit to gain a better understanding of the developmental trajectory of such attitudes in terms of when they emerge and whether they alter with increasing

age. Indeed, Carlton & Deane (2000)'s finding that the influence of attitudes towards help seeking on help seeking intentions were evident by adolescence led them to conclude that the relationship between such variables likely forms during childhood. Furthermore, Hinshaw, (2005) report that from an early age, children show persistently negative attributions towards labels and behaviours signifying mental illness.

Having a clearer understanding of the relationship between cognitive variables investigated herein and age would again inform design and implementation of programmes aimed at increasing help seeking intentions. Additionally, as noted the developmental trajectory of help seeking intentions has not been clearly and consistently demonstrated in the adolescent literature. As such, an investigation of the attitudes and beliefs relating to help seeking and receiving included in this study to determine whether they show a developmental trajectory would then inform consideration of the manner in which help seeking intentions are associated with increasing age, if such cognitive variables are found to be associated with help seeking intentions.

A secondary aim of the current study therefore is to consider the relationship between parental attitudes and those of their adolescent children, along with the manner in which help seeking attitudes and beliefs alter with increasing age throughout adolescence.

1.8 SUMMARY

Rates of mental health service usage in adolescents are low, with a significant proportion choosing not to seek out or accept services at times of need (Logan and

King, 2002). This is concerning given the relatively high rates of mental illness in this age range (Target & Fonagy, 1996) and the contention that experiencing mental health problems during adolescence may result in developmental trajectories which are irreversible (Willis, 2005).

Research has identified a number of parental, service related and socio-demographic factors associated with lower levels of help seeking. Service provision has altered to attempt to address such barriers. However, adolescents continue to avoid seeking out services and to negate help even when it is sought on their behalf, often opting instead to seek help from informal sources such as parents or friends (Deane *et al.*, 2001). This suggests that the influences on help seeking may differ for different sources of help.

Research is now focusing on cognitive factors that may influence the help seeking decision making process in adolescents including beliefs, attitudes and knowledge. Cognitive factors have the potential to be changed, with the ultimate goal of increasing help seeking intentions and behaviour (Carlton & Deane, 2000), therefore a full understanding of how they relate to help seeking intentions and how they develop is required. It has been suggested that attitudes and beliefs relating to seeking and receiving help may be of particular relevance, however there is a need for a more comprehensive investigation of these factors in the adolescent population.

1.9 AIMS

The main aim of the current study is to provide a more comprehensive understanding of how attitudes towards seeking and receiving help, and belief based barriers to help

seeking influence help seeking intentions in adolescence, for both formal and informal sources. A secondary aim is to investigate the developmental trajectory of such attitudes and beliefs and to consider whether they relate to parental attitudes.

1.10 HYPOTHESES

STUDY 1

1. All of the following factors will be related to greater willingness to seek help for personal-emotional problems from formal sources: holding more positive attitudes towards seeking psychological help and receiving psychological help; holding fewer perceived barriers to help seeking; having a history of help seeking and being female.
2. All of the following factors will be related to greater willingness to seek help for personal-emotional problems from informal sources: holding more positive attitudes towards seeking psychological help and receiving psychological help; holding fewer perceived barriers to help seeking; having a history of help seeking and being female.
3. Beliefs and attitudes towards help seeking and receiving will intercorrelate with each other. Attitudes towards seeking help will be positively correlated with belief based barriers to help seeking, in that more positive attitudes towards seeking help will be correlated with holding fewer belief based barriers. Attitudes towards seeking help will be negatively correlated with attitudes towards receiving professional help, in that more positive attitudes towards seeking help will be associated with more positive attitudes towards receiving help (note this hypothesised correlation is negative as the Stigma Scale for Receiving Psychological Help (SSRPH, Komiya *et al.*, 2000) used to

measure attitudes towards receiving help is negatively scored, therefore unlike the other cognitive measures, lower rather than higher scores on the SSRPH indicate more positive attitudes). Finally, belief based barriers will be negatively correlated with attitudes towards receiving professional help, in that holding lower levels of belief based barriers to help seeking will be associated with more positive attitudes towards receiving help (again this correlation is predicted to be negative given the negative scoring of the SSRPH).

4. Beliefs and attitudes towards help seeking and receiving will correlate with help seeking intentions for formal and informal sources. Attitudes towards help seeking will be positively correlated with help seeking intentions (more positive attitudes will be associated with greater intentions to seek help), attitudes towards receiving help will be negatively correlated with help seeking intentions (in that more positive attitudes will be associated with greater intentions to seek help); (again this correlation is predicted to be negative given the negative scoring of the SSRPH), and belief based barriers will be positively correlated with help seeking intentions (in that holding fewer barriers will be associated with greater help seeking intentions).

STUDY 2

5. Age will correlate with beliefs and attitudes towards seeking and receiving help. Given that the developmental trajectory of such attitudes and beliefs has not yet been clearly investigated, and as such is not yet adequately understood, this hypothesis is non-directional.

6. Age will be negatively correlated with total willingness to seek help, as has been demonstrated in past help seeking intention research (Ciarrocchi *et al.*, 2003; Verhulst *et al*, 1997).
7. Age will correlate with help seeking intentions from formal and informal sources. Given that the manner in which help seeking for different sources alters with increasing age has not yet been fully investigated, this hypothesis is non-directional.
8. Child beliefs and attitudes towards seeking and receiving help will be positively correlated with parental beliefs and attitudes towards seeking and receiving help. This hypothesis was directional given that attitudes are typically conceptualised as being acquired through social and contextual learning (Lopez, 1991), with parents being viewed as key 'socialising agents' in this process in adolescence (Santrock, 1990). As such, it was proposed that adolescent and parent beliefs would be related.

CHAPTER 2: METHOD

2.1 STUDY DESIGN

2.1.1 Study 1

Repeated measures design was employed to investigate the relationship between adolescents' attitudes and beliefs relating to help seeking, and intentions to seek help (herein termed 'cognitive factors' for ease of expression). Two multiple regression analyses were conducted to investigate the relationship between 5 predictor variables (attitudes towards seeking help, attitudes towards receiving help, belief based barriers to help seeking, gender and previous counselling experience) and a measure of help seeking intentions for formal sources and help seeking intentions for informal sources.

2.1.2 Study 2

Correlational techniques were employed to investigate the relationship between attitudes and beliefs with increasing age. Correlational techniques were also employed to investigate the relationship between child and parental responses to measures of attitudes and beliefs relating to help seeking.

2.2 PARTICIPANTS

2.2.1 Adolescent participants

Adolescent participants were recruited from two Scottish secondary schools from S2 to S6. Questionnaire sets were provided to 517 participants and a total of 500 sets were completed either in part or in full, giving a response rate of 96.7%. Of those who took part, two hundred and forty-two participants (48%) were male and two hundred and fifty-eight participants (52%) were female. The mean age was 14.6 years (SD = 1.2); age ranged from 13-17 years.

2.2.2 Parent Participants

Of the 517 parental questionnaire double sets (a total of 1034 individual sets) sent home with child participants for parents to complete, 102 were returned, giving a response rate of 9.9%. 29 sets were returned by both parents (a total of 58 individual sets). 44 were returned by one parent of the child only, 9 by fathers (or male guardians) and 35 by mothers (or female guardians). The parental sample therefore comprised 38 males and 64 females. Three children did not return or fully complete their questionnaires, therefore 3 of the 35 lone female respondents' questionnaires had to be removed from analyses. As a result, the final parent sample comprised 38 males and 61 females.

2.3 RECRUITMENT

Initially, the regional Director of Education was contacted by letter to request permission to conduct the research within secondary schools in that locality. A summary of the study was provided along with copies of the measures used (Appendix 2.3.1). Written permission was received from the Director of Education (Appendix 2.3.1b). Initially, the head teacher of one local secondary school was contacted by letter and permission was granted to conduct the study within that secondary school. Following a low response rate from parental participants, a second secondary school was contacted and the study was subsequently repeated in this second school. Information letters were sent to parents of all children to be included in the study by the school (Appendix 2.3.2). In line with school protocol, unless parents specifically opted out of the study, questionnaire packs were provided to children in social education classes. Children were asked to complete a consent form (Appendix 2.3.3) if they wished to take part in the study. Children were advised of their right not

to take part in the study and of the anonymity of the study. They were then given the questionnaire packs to complete in class and were given two sets to take home to parents. Parental sets included a consent form (Appendix 2.3.4).

2.4 ETHICAL APPROVAL

Formal ethical approval was not required because the study was conducted in a non clinical population (this was confirmed by the University Research Ethics Tutor).

The ethical implications of the study were considered and taken into account when designing the study. Help seeking intentions are often measured in relation to experiencing suicidal thoughts, as well as for personal-emotional problems (e.g. Ciarrochi *et al.*, 2003, Wilson *et al.*, 2005a). However it was decided in the current study to focus only on help seeking intentions for personal emotional problems. This was largely due to the view that the school setting was likely an inappropriate setting to ask about issues relating to suicidal ideation. In particular, it was deemed likely that adolescents' would perhaps experience concern that peers may see their answers, or that information would be shared with parents or teachers. Additionally, such concern would perhaps result in less accurate and honest responses being given to questions relating to suicidal ideation. It was expected that asking about help seeking intentions in relation to personal emotional problems was unlikely to result in such concerns.

A meeting took place with each of the head teachers and with guidance staff in each school in order for any questions relating to the questionnaires to be discussed. Staff did not raise any ethical concerns in relation to the measures or methodology of the study, or request any changes be made. Questionnaires were administered during

social education classes and in the presence of guidance staff, so that if respondents for any reason were to have any concerns in relation to the issues discussed in the questionnaires, these could be shared with their guidance teacher either during class or at another time.

Because the questionnaires asked about personal information which young people may not have wanted their peers or others to be aware of (in particular, whether prior help had been sought), it was important to ensure that the questionnaires were anonymous and did not contain identifying information, and also to advise participants that information was anonymous and would be treated confidentiality, in addition to advising them that they did not need to take part or answer all questions if they did not want to. Indeed, only 9 of the 500 adolescents who opted into the study (1.8%) chose not to respond to questions relating to prior help. This was similarly the case for parental responses and addressed envelopes were provided so that parental responses could be returned in sealed envelopes and therefore not be seen by the children returning them or by office staff.

2.5 MEASURES

2.5.1 Demographics

Each questionnaire pack had a cover sheet asking for demographic information. Child packs asked for the age, year group and gender of the participant (see Appendix 2.5.1). Parent packs asked for the gender of the participant (see Appendix 2.5.2).

2.5.2 Attitudes Towards Receiving Help

The attitudes towards receiving professional psychological help were measured by the Stigma Scale for Receiving Psychological Help (SSRPH, Komiya *et al.*, 2000), which was devised to assess individual's perceptions of levels of public stigma towards seeking professional psychological help (Appendix 2.5.3). The measure comprised 5 questions relating to perceived levels of stigma, for example 'people tend to like less those who are receiving professional psychological help'. Responses were given on a 4 point Likert scale ranging from "strongly disagree" to "strongly agree". Komiya *et al.* (2000) reported strong internal consistency (.73) and Vogel *et al.* (2005a) reported similar findings (.78).

Komiya *et al.*, (2000) recommend scoring from 0 to 3, however more recent research has scored the measure from 1 to 4, presumably to remove the score of zero from subsequent calculations (Vogel *et al.*, 2005a, Vogel *et al.*, 2006). In order to allow for comparison with past research, however, the original scoring procedures were followed. Item response scores were summed and as such, higher scores represented higher levels of perceived public stigma.

2.5.3 Attitudes Towards Seeking Professional Help

Attitudes towards seeking professional help were measured by means of the Attitudes Towards Seeking Professional Psychological Help Scale, ('ATSPPHS-B', Fischer & Farina, (1995), Appendix 2.5.4). As noted, this measure is a shortened form of the original 29 item measure (Fischer & Turner, 1970).

Fischer & Farina (1995) reported that the ATSPPH-B had sufficient overlap with the original 29 item ATSPPH, and as such advised that the ATSPPH-B could therefore be

used as an alternative shorter and more easily administered form. Additionally, they reported the scale to have the same psychometric properties as the original measure. The original measure was standardized on a non clinical population of 212 young adults, 78 of whom were still in secondary school. It was demonstrated to have good internal consistency (Fischer & Turner, 1970) and as discussed in the introduction, has been widely used to assess attitudes towards help seeking.

The measure consists of 10 questions covering attitudes towards seeking help. For example, "a person should work out his or her own problems; getting psychological counselling would be a last resort". Again, a Likert scale is used ranging from 0 (disagree) to 3 (agree). Half of the items have reversed scoring, so that higher scores represent more positive attitudes towards seeking professional help. Similar to their reported use of the SSRPH, Vogel *et al.*, (2005a; 2006) scored the measure ranging from 1 to 4 to remove the score of zero, however to allow for comparison with prior adolescent research, the original scoring procedure was used.

Fischer & Farina (1995) advise that a total score is calculated by adding up all coded responses and this was initially done with the data to provide descriptive statistics to allow comparison with their reported findings. More recent research investigating the relationship between the ATSPPHS-B and help seeking intentions, however, has opted to convert the ATSPPHS-B to an averaged score to form a single score representing core attitude towards seeking help (Carlton & Deane, 2000; Wilson *et al.*, 2005b). As a result, in the current study, scores were converted in a similar manner for formal analyses, to allow for comparison with other help seeking intention

studies. This was achieved by dividing the total score for each participant by the number of items (10).

2.5.4 Belief Based Barriers to Seeking Help

The initial Barriers to Adolescents Seeking Help Scale (BASH, Kuhl *et al.*, 1997) comprised 37 items measuring resistance to help seeking in adolescents and aiming to identify relevant barriers (Kuhl *et al.*, 1997). The authors standardised the measure on a non clinical sample of 280 adolescents demonstrating good test-retest and internal reliability, and adequate validity in the test population (Kuhl *et al.*, 1997). The brief version used in the current study, the BASH-B, was created from 11 items taken from the original measure that specifically related to belief based barriers to seeking help and was demonstrated to have similar psychometric properties as the original measure (Wilson *et al.*, 2005a). Questions included "if I had a problem and told a therapist, they would not keep it a secret". Participants rated each statement on a 6 point Likert scale, ranging from 1 ("strongly agree") to 6 ("strongly disagree"), meaning that lower scores indicated greater levels of belief-based barriers to help seeking. Scores for each participant are totalled and then divided by the number of items to give a single belief score.

One of the questions in the BASH-B which related to the cost of therapy ("I could not afford to see a therapist even if I wanted to") was excluded from the current study given that mental health care is available free of charge in the United Kingdom and, therefore, this would not be an applicable barrier (see Appendix 2.5.5). Wilson *et al.* (2005a) noted the flexibility of the scale in that it allows for particular aspects of help seeking barriers to be targeted separately and furthermore, they noted that utilising

fewer items reduced item overlap. Given that the 10 BASH-B items in the current study were averaged to form a single scale representing participants' perceived belief based barriers to help seeking, scores were considered to be comparable with those reported in studies making use of the 11 item BASH-B (e.g. Wilson *et al.*, 2005a, Wilson *et al.*, 2005b). However, such comparisons were interpreted with caution as a result of the removal of the cost related question.

2.5.5 Help Seeking Intentions

Help seeking intentions were measured using the General Help Seeking Questionnaire (GHSQ, Wilson *et al.*, 2005a, see Appendix 2.5.6). This measure was created to measure help seeking intentions and asked participants to rate the likelihood that they would seek help for personal-emotional problems from a range of specific sources of help. The questionnaire was designed to be flexible so that could be used to assess help seeking from a wide range of sources previously identified to be accessible to the target population. In the adolescent population, this included familial, formal, religious and school based sources. In the current study, options offered in the originally developed measure were included. Participants were asked "If you were experiencing a personal-emotional problem, how likely is it that you would seek help from the following people?" Participants responded on a 7 point Likert scale ranging from 1 (extremely unlikely) to 7 (extremely likely). In all scoring scenarios, higher scores indicate higher intentions to seek help.

The measure was designed to be scored in a variety of means to suit research purposes. For example, each individual source can be analysed separately, to investigate help seeking for each source, or totalled to investigate total help seeking

intentions for all sources included (Wilson *et al.*, 2005a). Additionally, given the well documented difference in help seeking intentions in adolescents for formal and informal sources, the measure has been used in the past to compare help seeking for formal and informal sources by combining scores for related sources (Wilson *et al.*, 2005b). In Study 1 therefore, a total score for help seeking intentions for formal sources was calculated by combining scores for sources of 'mental health professional' and 'GP' and a total score for help seeking intentions for informal sources was calculated by combining scores for sources of 'friend' and 'parent,' in keeping with past protocol (Carlton and Deane, 2000) and to represent sources of interest in the current study. In study 2, total help seeking scores were calculated by adding all sources, in order to assess the developmental trajectory of help seeking.

2.5.6 Prior Help

A prior help seeking measure devised by Wilson *et al.* (2005a) was used to assess whether participants had received professional help in the past, by asking "have you ever seen a mental health professional (e.g. counsellor, psychologist or psychiatrist) to get help for personal problems" and respondents could respond yes or no (see Appendix 2.5.7). This was used in other similar research (e.g. Carlton and Deane, 2000; Sheffield *et al.*, 2004; Wilson *et al.*, 2005b). Additional questions asked how many times the participant had seen the health professional and what type of health professional they had seen. Finally, participants were asked to give a rating of how helpful this contact had been on a 5 point likert rating scale from 1 ("extremely unhelpful" to 5 ("extremely helpful"), (Wilson *et al.*, 2005a).

2.6 PROCEDURE

Questionnaire packs were provided to secondary school pupils during their social education class for them to complete in class, taking on average ten to fifteen minutes to complete. Two sets of parental questionnaires were provided to be taken home to parents. While the data collection was anonymous, each child questionnaire was coded and a corresponding code was placed on parental questionnaires. This ensured that returned parental questionnaires could be matched with child questionnaires. A deadline of two weeks was given for the return of parental questionnaires and children were advised to return them to the school office in an envelope provided.

2.7 POWER ANALYSIS

In study 1, it was anticipated that there would be a medium effect size in both regression analyses ($R^2 = 0.13$ based, Clark-Carter, 2004) based on previous research investigating the relationship between attitudes and beliefs and help seeking. Miles & Shelvin (2001) advise that for 5 predictors for an anticipated medium effect size and to achieve 0.8 power level (considered high, (Cohen, 1988)), would require a minimum of 90 participants. Similarly, Green (1991) recommends the following formula for the minimum number of cases required: $n \geq 50 + 8k$ (where k is the number of predictor variables) when testing the overall fit of the model, and $n \geq 104 + k$ when drawing inferences on individual predictors. This indicates a minimum of 109 participants were required in order to draw inferences on individual predictors (104 + 5). For study 2 where Correlational techniques were employed, power analysis indicated that for an anticipated medium effect size of .30 (based on prior research by Ciarrocchi *et al.*, 2003), to achieve a high level of power (.80), 90 participants would be required (Field, 2005). It was anticipated that the response rate for parents would

be between 20% to 25% (based on discussion with the schools used in relation to their past experience). In order to ensure that a big enough parental sample size was achieved, it was decided to aim for an initial child sample of a minimum of 500 child participants.

CHAPTER 3: RESULTS

3.1: STUDY 1

Study 1 aimed to provide a more comprehensive understanding of how in conjunction attitudes towards seeking and receiving help, and belief based barriers to help seeking influence help seeking intentions in adolescence, for both formal & informal sources.

3.1.1 Preliminary Considerations

Prior to analysis, scores for the ATSPPHS-B, the BASH-B, the SSRPH and the GHSQ were examined in order to check for missing values, outliers and to ensure that the assumptions of planned analyses were not violated. There was significant kurtosis and positive skew in the SSRPH scores (indicating that most cases reported low levels of perceived stigma in receiving professional help), and in GHSQ intentions to seek help from formal sources (indicating that most cases reported low intentions to seek help from formal sources), and to a lesser extent, significant negative skew in GHSQ intentions to seek help from informal sources (indicating that more cases reported high intentions to see help from informal sources).

Transformations were conducted, but made little difference to the distributions of GHSQ formal and informal scores and SSRPH scores. When sample size is over 200 however, Field (2005) recommends considering the shape of the distribution visually rather than the significance of skewness and kurtosis statistics when determining whether the distribution of scores are normal. The SSRPH scores and GHSQ informal scores did visually appear to be normally distributed, however the positive skew in the GHSQ formal sources scores was particularly evident. It was deemed appropriate, however, for the main analyses reported to use untransformed data. This decision was

based in part on the fact that the statistics associated with multiple regression (the main analyses used in the current study) are legitimate measures independent of any distribution assumptions (Howell, 1997), and in part following protocol of past research utilising the GHSQ reporting similarly skewed scores on predictor and outcome variables and not transforming data (e.g. Wilson *et al.*, 2005b). Furthermore, correlational and regression techniques do require homogeneity of variance, in that the variance of one variable stays the same at all levels of the other variables, and these assumptions were met. For statistical comparisons making assumptions of normality where the GHSQ formal help seeking intentions was one of the variables, non-parametric analyses were used.

3.1.2 Descriptive Statistics

Attitudes towards seeking help

Descriptive statistics for the first independent variable, the ATSPPHS-B were as follows: $M = 15.21$, $SD = 5.32$, $n = 491$. Following protocol of research investigating the relationship between the ATSPPHS-B and help seeking intentions, ATTSPPHS-B scores were then converted into an average score by dividing the total by the number of questions to give a mean attitudinal response, for purposes of comparison with prior intentional research. This indicated that mean attitude towards seeking help was 1.52, ($SD = 0.53$), based on response scale ranging from 0 to 3, with higher scores indicating more positive attitudes. Subsequent analyses in the current study are based on averaged scores. Comparison by gender indicated that girls ($M = 1.60$, $SD = 0.51$) reported more positive attitudes than boys ($M = 1.43$, $SD = 0.54$), $t(489) = 3.38$; $p = 0.001$ (two-tailed).

Belief Based Barriers in Seeking Help

Following the manner in which the BASH-B was scored in previous literature (Wilson *et al.*, 2005a; Wilson *et al.*, 2005b), the BASH-B scores were averaged to form a single score/scale representing perceived barriers to seeking counseling as follows: $M = 3.33$, $SD = .86$, $n = 481$. Comparison by gender indicated that girls ($M = 3.45$, $SD = 0.83$) reported fewer perceived barriers to help seeking than boys ($M = 3.19$, $SD = 0.87$), $t(479) = 3.34$; $p = 0.001$ (two-tailed).

Attitudes towards receiving professional help

Descriptive statistics for the SSRPH were as follows: $M = 6.64$, $SD = 2.73$, $n = 483$. Nonparametric comparison by means of a Mann-Whitney U Test indicated that girls ($M = 6.26$, $SD = 2.63$) reported significantly more positive attitudes towards receiving help than boys ($M = 7.04$, $SD = 2.79$), $U = 24492.50$; $p<0.01$ (two-tailed).

Prior Help

Of the 500 completed questionnaire sets, 9 children did not answer the 'prior help' question. Of the 491 who did, 54 (9.1%) reported that they had received prior help. A Chi-square test of association indicated that gender and prior help were not associated. The types of reported help received were as follows:

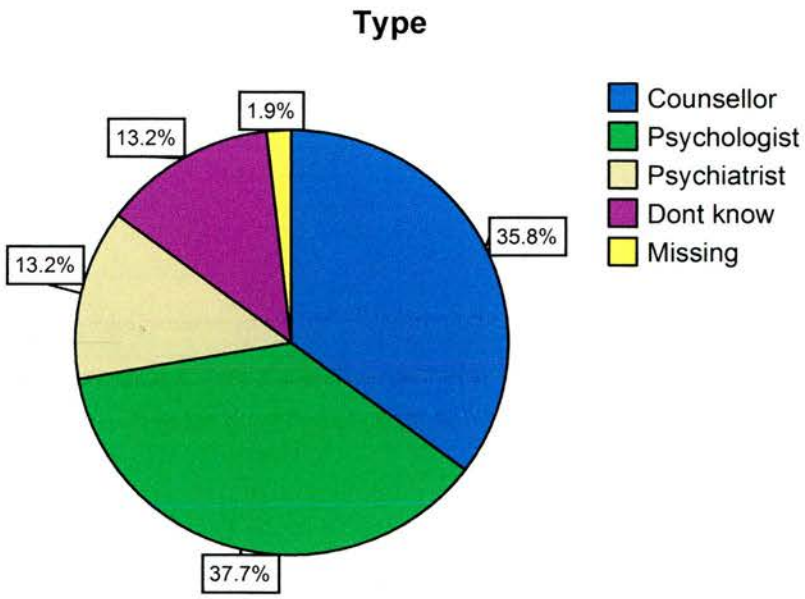

Figure 3.1.1: Pie chart of sources of help for those having received prior help (n=54)

Of the total sample, 5.4% had previously been seen by a psychologist or a psychiatrist (6.8% if include 'don't know'). Number of visits ranged from 1 to 30, $M = 7.20$, $SD = 7.342$, $n = 54$. Ratings of helpfulness ranged from 1 to 6 (with greater scores indicating higher perceived helpfulness), $M = 3.94$, $SD = 1.64$, $n = 54$.

Intention to Seek Help

For the purposes of study 1, intentions to seek help from formal sources (GP or Mental Health Professional) and informal sources (Parent or Friend) were calculated as follows; formal sources $M = 5.12$, $SD = 3.01$, $n = 481$; and for informal sources, $M = 9.23$, $SD = 2.82$, $n = 481$ (see figure 3.1.2).

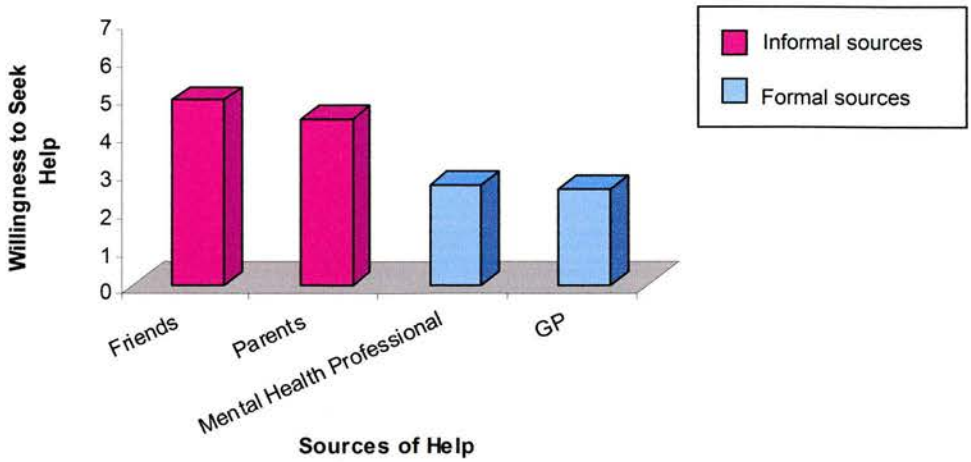

Figure 3.1.2: Bar chart of mean willingness to seek help from formal and informal sources (1 = *extremely unlikely*, 7 = *extremely likely*).

A Wilcoxon matched-pairs, signed ranks test showed that the difference between intentions to seek help from informal sources were significantly higher (M = 9.22) than intentions to seek help from formal sources (M = 5.12), T = 5743.5, p<.001, r = 0.53. Consequently, because there was a significant difference between willingness to seek help from formal sources and willingness to seek help from informal sources, two separate regressions were conducted in keeping with past help seeking research (Sheffield *et al.*, 2004).

3.1.3 Main Analysis 1: Help Seeking Intentions for Formal Sources

To determine whether the cognitive variables of interest could explain low help seeking intentions for personal emotional problems from formal sources, a multiple regression analysis was conducted. As listwise deletion was used in the multiple regression, missing data resulted in a reduction in sample size (n = 460).

Intercorrelations Between Variables

The intercorrelations between each of the variables are presented in Table 3.1.1 below.

Variable	1	2	3	4	5	6
1. Intentions – formal sources	-	**.13****	.07	**.38*****	**.27*****	.07
2. Prior help		-	.13	**.09***	.06	.01
3. Gender			-	**.16*****	**.15*****	**-.15****
4. Attitudes towards help seeking				-	**.44*****	**-.29*****
5. Belief based barriers to help seeking					-	**-.48*****
6. Attitudes towards receiving help						-

*p<0.05, **p<0.01, ***p<0.001.

Table 3.1.1: Intercorrelations between variables in the regression (n = 460)

Firstly, the three attitudinal and belief based measures will be discussed. All three measures correlated with each other. Attitudes towards seeking help were related to both other measures; r = .44 (belief based barriers, medium effect), and r = -.29 (attitudes towards receiving help, medium effect) and belief based barriers were related to attitudes towards receiving help; r = -.48, (medium effect), all p<0.001. Thus, adolescents with more positive attitudes towards seeking help reported lower belief based barriers to help seeking, and lower levels of perceived public stigma surrounding receiving professional help, and those reporting higher levels of belief based barriers to help seeking also reported higher levels of perceived stigma of receiving help. Finally, holding more positive attitudes towards receiving help was related to greater intentions to seek help from formal sources (r = .38, medium effect) as was holding fewer belief based barriers to help seeking (r = .27, medium effect), both p<0.001. Higher levels of perceived stigma of receiving help was not significantly related to intentions to seek help from formal sources.

Having received prior help was related to having more positive attitudes towards help seeking, r = .09, p<0.5, however the effect size was less than Cohen's (1988) cut-off of 0.1 indicating a small effect. Furthermore, having received prior help was not related to any of the other independent variables, or to intentions to seek help from

formal sources. Gender was related to all three attitudinal and belief based variables; $r = .16$ (attitudes towards help seeking, small effect), $r = .15$ (belief based barriers to help seeking, small effect), both $p<0.001$; and $r = -.15$ (attitudes towards receiving help, small effect), $p<0.01$. Being female was therefore related to having more positive attitudes towards seeking help, holding fewer belief based barriers and having lower levels of perceived stigma of receiving help. Gender was not related to help seeking intentions for formal sources.

Regression Model 1: Help Seeking For Formal Sources

Variables were entered into the regression model using a standard ('forced entry') approach. This method was deemed more appropriate than hierarchical or stepwise entry in part due to the fact that the relative order of importance of each variable had not previously been demonstrated in the research literature, and in part because the independent variables were correlated. Prior to consideration of findings, it was necessary to determine that the assumptions of the model were met. Variance inflation factors ('VIF') and tolerance statistics were calculated and this determined that multicollinearity did not exist between variables in the regression model. Consideration of casewise diagnostics confirmed that there were no outlier cases influencing the regression model. Consideration of the Durbin-Watson statistic indicated that the errors in the regression were independent, and consideration of histograms and normal probability plots of the residuals indicated normality of residuals.

The regression model for intention to seek help from formal sources was significantly different from zero ($F(5, 454)=19.54$, $p<0.001$, therefore was a significant fit of the

data overall. Altogether, 18% (adjusted 17%) of the variability to seek help for a personal-emotional problem from formal sources was accounted for by the five variables in the equation (f^2 = 0.20 indicating a medium effect size (Cohen, 1988)). Table 3.1.2 provides the regression coefficients. Prior help, attitudes towards receiving help, belief based barriers to help seeking and attitudes towards seeking help were unique predictors of intentions to seek help from formal sources. Gender did not make a significant unique contribution to the model. The beta coefficients suggested that attitudes towards help seeking made larger contribution than did belief based barriers, attitudes towards receiving help and having received help in the past.

	B	S.E.M.	Beta
Constant	-0.65	0.84	
Prior Help	0.83	0.41	.09*
Gender	0.01	0.26	<.01
Attitudes towards help seeking	1.87	0.27	.333***
Belief based barriers to help seeking	0.60	0.18	.17**
Attitudes towards receiving help	0.12	0.05	.11*

R^2 = .18, p<0.001.
*p<0.05, **p<0.01, ***p<0.001

Table 3.1.2: summary of standard multiple regression for variables predicting intentions to seek help from formal sources (n = 460)

3.1.4 Main Analysis 2: Help Seeking Intentions for Informal Sources

Again, as listwise deletion was used in the multiple regression, missing data resulted in a reduction in sample size (n = 458). Variance inflation factors ('VIF') and tolerance statistics were calculated and this determined that multicollinearity did not exist between variables in the regression model. Consideration of casewise diagnostics confirmed that there were no outlier cases influencing the regression model. Consideration of the Durbin-Watson statistic indicated that the errors in the

regression were independent, and consideration of histograms and normal probability plots of the residuals indicated normality of residuals.

Intercorrelations Between Variables

The intercorrelations between each of the variables are presented in Table 3.1.3.

Variable	1	2	3	4	5	6
1. Intentions – informal sources	-	**-.10***	**.30*****	**.18*****	**.26*****	**-.21*****
2. Prior help		-	<.01	**.09***	.06	-.01
3. Gender			-	**.16*****	**.16*****	**-.14****
4. Attitudes towards help seeking				-	**.44*****	**-.30*****
5. Belief based barriers to help seeking					-	**-.48*****
6. Attitudes towards receiving help						-

*p<0.05, **p<0.01, ***p<0.001.

Table 3.1.3 Intercorrelations between variables in the regression (n = 458)

Two participants were dropped from the regression model for help seeking from informal sources compared with the regression model for formal sources (due to missing data), however understandably given the large sample size, correlations between the three attitude and belief based independent variables correlated with each other at a similar level to those reported in the formal model. As a result, they will not be re-reported. Of particular interest however, were the intercorrelations between the independent variables and help seeking intentions from informal sources. All variables were related to informal help seeking intentions; r = .18, (attitudes towards seeking help, small effect); r = -.26 (belief based barriers to help seeking, medium effect); and r= .21 (attitudes towards receiving help, medium effect), all p<0.001. Thus, holding more positive attitudes towards receiving help was related to greater intentions to seek help from informal sources as was holding fewer belief based barriers to help seeking and having lower levels of perceived stigma of receiving help.

Having received prior help was related to lower intentions to seek informal help (r=.10; p<0.05, small effect). Being female was related to higher intentions to seek help from informal sources (r = .30; p<0.001, large effect).

Regression Model 2: Help Seeking For Informal Sources

The regression model for intention to seek help from informal sources was significantly different from zero, indicating it to be a significant fit of the data overall ($F(5, 452 = 17.16, p<0.001$). Altogether, 16% (adjusted 15%) of the variability to seek help for a personal-emotional problem from informal sources was accounted for by the five variables accounted for in the equation, a large effect size (Field, 2005). Table 3.1.4 provides the regression coefficients. Prior help, gender and belief based barriers to help seeking were unique predictors of intentions to seek help from informal sources. Attitudes towards seeking help and attitudes towards receiving help did not make significant contributions to the model. The beta coefficients suggested that gender made a larger contribution to intentions than did prior help or belief based barrier variables.

	B	S.E.M.	Beta
Constant	6.94	0.80	
Prior Help	-1.05	0.39	-.12**
Gender	1.43	0.25	.25***
Attitudes towards help seeking	0.27	0.26	.05
Belief based barriers to help seeking	0.55	0.17	.17**
Attitudes towards receiving help	-0.09	0.05	-.08

R^2 = .16, p<0.001.
*p<0.05, **p<0.01, ***p<0.001

Table 3.1.4: summary of standard multiple regression for variables predicting intentions to seek help from informal sources (n = 458)

3.2: STUDY 2a: DEVELOPMENTAL TRAJECTORY

Study 2 aimed to investigate the developmental trajectory of attitudes and beliefs towards seeking and receiving help and of intentions to seek help, and to consider whether child beliefs and attitudes were associated with parental attitudes.

3.2.1 Preliminary Analyses and Descriptive Statistics

Listwise deletion was used for correlational analyses, which reduced the sample size to 466 participants. Given that preliminary analyses of the data set in study 1 indicated that the assumptions of parametric correlational techniques had not been met, non-parametric techniques were used (Spearman's Correlation). Furthermore, given that repeated correlational analyses were conducted, alpha was set at the conservative level of 0.01 for correlational tests, in order to reduce the likelihood of Type 1 error.

Age

Mean age of participants included was 14.6 years, (SD = 1.17, n = 466), and ranged from 13-17 years. A histogram of the distribution of age in the sample (figure 3.2.1) indicated that there were not equal numbers of participants at each age. A Kolmogorov-Smirnov test of normality indicated that the distribution of age, $D(466)$ 0.21, $p<0.001$, was significantly non-normal.

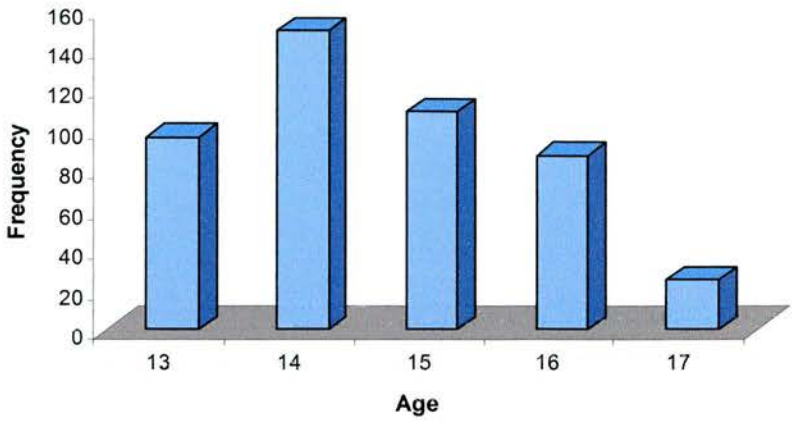

Figure 3.2.1: Histogram of Distribution of Age in Child Sample (n = 466)

Attitudes Towards Seeking Professional Psychological Help

Mean scores on the ATSPPH-B for those included in study 2 was as follows: M = 1.53, SD = 0.53, n = 466.

Attitudes Towards Receiving Professional Psychological Help

Mean scores on the SSRPH for those included in study 2 was as follows: M = 6.64, SD = 2.67, n = 466.

Belief Based Barriers to Help Seeking

Mean scores on the BASH-B for those included in study 2 was as follows: M = 3.34, SD = 0.85, n = 466.

Help Seeking Intentions – All Sources

Total help seeking intentions for all sources was calculated by summing help seeking ratings for all sources (excluding 'intimate partner' and 'other' as these were optional questions and as such, response rate was low). Mean total help seeking intentions for

all sources was 25.7, (SD = 8.35, n = 466) and scores ranged from 9 to 57. The possible range of scores was from a minimum of 7 (indicating the participant had rated likelihood of seeking help from all of the sources as "extremely unlikely") to a maximum of 63 (indicating the participant rated likelihood of seeking help from all of the sources as "extremely likely"). A histogram of the distribution of mean help seeking intentions for all sources suggested that participants tended to report lower total help seeking intentions (figure 3.2.2). This also indicated that scores may be positively skewed, and a Kolmogorov-Smirnov test of normality indicated that total help seeking intentions, $D(466) = 0.76$, $p<0.001$, was significantly non-normal.

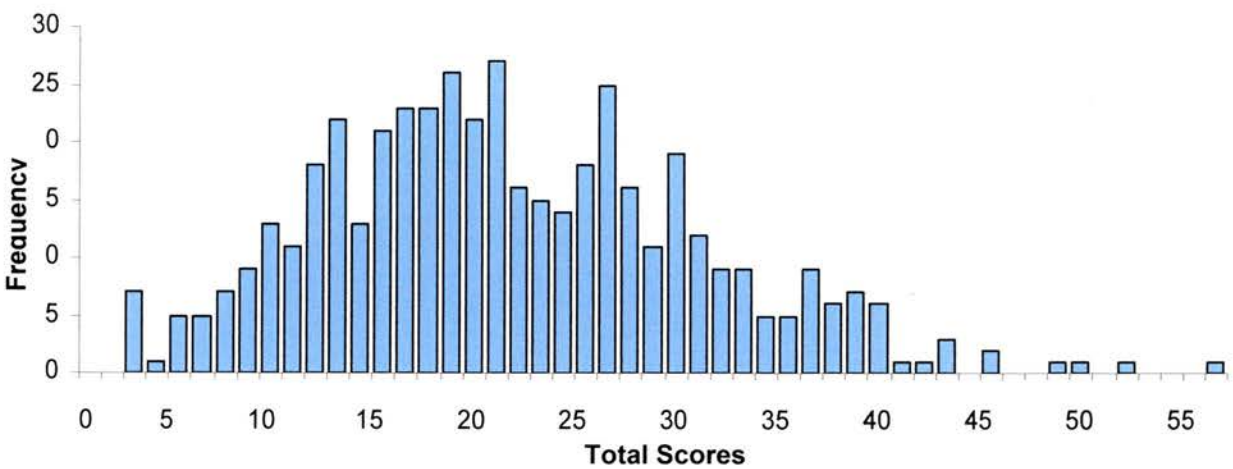

Figure 3.2.2: Histogram of Distribution of Total Intention to Seek Help Scores in Child Sample (n = 466)

Help Seeking Intentions – Formal Sources

Descriptive statistics for total help seeking intentions for formal sources for cases included in study 2 were as follows; M = 5.10; SD = 3.02, n = 466. Total scores ranged from 2 to 14, from a possible range of 2 to 14.

Help Seeking Intentions – Informal Sources

Descriptive statistics for total help seeking intentions for informal sources for cases included in study 2 were as follows; M = 9.20; SD = 2.82, n = 466. Total scores ranged from 2 to 14, from a possible range of 2 to 14.

3.2.2 Main Analyses

Age and Attitudes Towards Seeking Professional Psychological Help

A correlational analysis indicated that age was not associated with attitudes towards seeking professional psychological help (r = 0.04, n = 466, *NS* (two-tailed)).

Age and Attitudes Towards Receiving Professional Psychological Help

A correlational analysis indicated that age was not associated with attitudes towards receiving professional psychological help (r = -.12, n = 466, *NS* (two-tailed)).

Age and Belief Based Barriers to Help Seeking

A correlational analysis indicated that age was not associated with belief based barriers to help seeking (r = .07, n = 466, *NS* (two-tailed)).

Age and Total Help Seeking Intentions

A correlational analysis was conducted and an association was found between age and total help seeking intentions for all sources, indicating that as age increased, intention to seek help decreased (r = -.19, n = 466, p<0.01(two-tailed), a small effect). This is illustrated in figure 3.2.3.

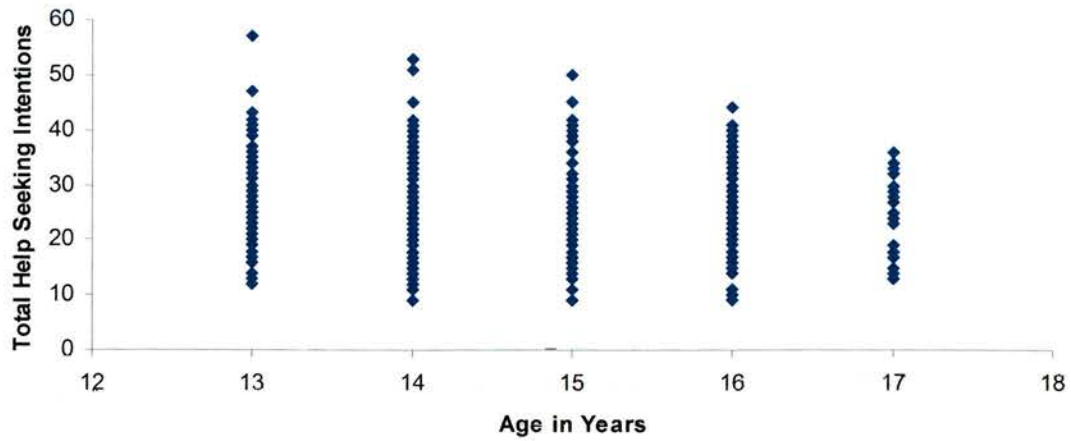

Figure 3.2.3: Scatter Plot of Total Help Seeking Intentions Scores and Age (n = 466)

Age and Help Seeking for Formal Sources

Age and help seeking intentions for formal sources were negatively correlated (r = -.17, n = 466, p<0.01(two-tailed), small effect size), therefore, as age increased, help seeing intentions for formal sources decreased (Figure 3.2.4).

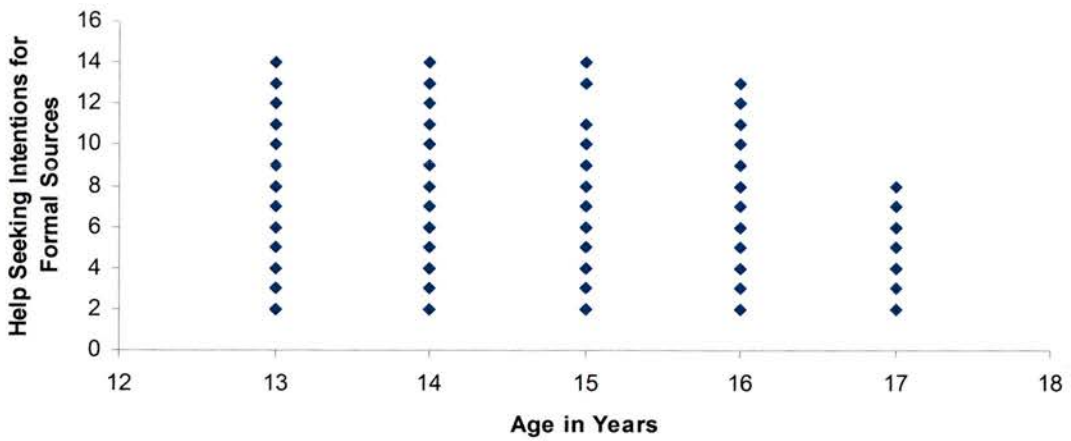

Figure 3.2.4: Scatter Plot of Help Seeking Intentions for Formal Sources Scores and Age (n = 466)

Age and Help Seeking for Informal Sources

Age and help seeking intentions for informal sources were not associated, (r = -.07, n = 466, *NS*).

3.3: STUDY 2b: PARENT AND CHILD ATTITUDES AND BELIEFS

3.3.1 Preliminary Analyses

Parent Respondents

As noted in Chapter 2, the 102 parental responses comprised 44 responses from one parent only and 29 sets of couple responses (both parents responding). Nonparametric t-tests were conducted to determine whether male and female responses to the cognitive measures differed for the couple responses. Parental scores on the ATSPPH-B, the BASH-B and the SSRPH did not differ significantly. As a result, mean parental score for each couple was calculated to provide a single score of mean parental response and these were included in Correlational analyses with child responses. This resulted in 73 sets of parent-child responses being included in comparisons. However, due to missing data, the sample size was reduced to 66 in each group.

In relation to prior help, Of the 102 completed questionnaire sets, 1 adult male did not answer the 'prior help' questions. Of the 101 who did, 21 (20.8%) reported that they had received prior help, 64 females and 37 males. A Chi-square test of association for gender and prior help showed significance at the 0.001 level:

$\chi^2(1) = 10.71$, exact $p = 0.001$.

Of the total sample, 16.7% had previously been seen by a psychologist or a psychiatrist (19.6% if include those responding 'don't know' to type of professional

seen). Number of visits ranged from 1 to 24, $M = 8.7$, $SD = 7.3$, $n = 21$. Ratings of helpfulness ranged from 2 to 6 (with greater scores indicating higher perceived helpfulness), $M = 4.05$, $SD = 1.19$, $n = 21$.

3.3.2 Main Analyses

Attitudes Towards Seeking Help

In the parental sample, descriptive statistics for the first independent variable, the ATSPPHS-B were as follows: $M = 1.91$, $SD = .057$, $n = 66$. In the child sample, as follows: $M = 1.54$, $SD = .059$, $n = 66$. Spearman's correlation indicated that there was no association between parental and child attitudes towards seeking professional psychological help ($r = -.14$, $n = 66$, *NS*).

Attitudes Towards Receiving Help

In the parental sample, descriptive statistics for the second independent variable, the SSRPPH, were as follows: $M = 6.08$, $SD = 2.45$, $n = 66$. In the child sample, as follows: $M = 6.48$, $SD = 2.93$, $n = 66$.

Spearman's correlation indicated that there was no association between parental and child attitudes towards receiving professional psychological help ($r = -.21$, $n = 66$, *NS*).

Belief Based Barriers to Help Seeking

In the parental sample, descriptive statistics for the third independent variable, the BASH-B were as follows: $M = 4.1$, $SD = 0.74$, $n = 66$. In the child sample, as follows: $M = 3.2$, $SD = 0.95$, $n = 66$.

Spearman's correlation indicated that there was no association between parental and child levels of belief based barriers to help seeking (r = -.15, n = 66, *NS*).

CHAPTER 4: DISCUSSION

The present study examined help seeking attitudinal and belief based factors influencing adolescents' willingness to seek help for personal-emotional problems, from both formal and informal sources. A secondary aim was to investigate the developmental trajectory of such attitudes and their relationship with one potential source in their development, parental attitudes. Main findings will be summarised (numbered as the hypotheses were), then each hypothesis will be discussed in turn in relation to theoretical implications. The clinical and ethical implications of the findings will be considered, followed by discussion of limitations and strengths of the study and indications for further research.

4.1 SUMMARY OF FINDINGS

1. Multiple regression was used to examine the relationship between attitudes towards seeking psychological help, attitudes towards receiving psychological help, belief based barriers to help seeking, gender and having prior experience of professional help and help seeking intentions for formal sources. The regression equation accounted for 17% (adjusted) of the variability to seek help for personal-emotional problems from formal sources, indicating that the combined influence of the cognitive variables, gender and prior help experience was a significant predictor of formal help seeking intentions. Findings suggested that attitudes towards seeking help made the largest contribution, followed by belief based barriers, attitudes towards receiving help and having received help in the past. Gender did not make a significant contribution to the model. Thus, holding more positive attitudes towards seeking psychological help and receiving psychological help, holding fewer perceived barriers to help seeking, and having a history of

help seeking were related to greater willingness to seek help for personal-emotional problems from formal sources.

2. The above regression model was repeated for help seeking intentions for informal sources. The regression equation accounted for 15% (adjusted) of the variability to seek help for personal-emotional problems from informal sources, indicating that the combined influence of the cognitive variables, gender and prior help experience was a significant predictor of formal help seeking intentions. Findings suggested that gender made a larger contribution to intentions than did prior help or belief based barrier variables. Attitudes towards seeking psychological help and receiving psychological help did not make significant contributions to the model. Thus, holding fewer perceived barriers to help seeking, having a history of help seeking and being female were related to greater willingness to seek help for personal-emotional problems from informal sources.

3. Beliefs and attitudes towards seeking and receiving help intercorrelated. Adolescents with more positive attitudes towards seeking help reported lower belief based barriers to help seeking, and lower levels of perceived public stigma surrounding receiving professional help, and those reporting higher levels of belief based barriers to help seeking also reported more negative attitudes towards receiving help.

4. Holding more positive attitudes towards receiving help was associated with greater intentions to seek help from formal sources, as was holding fewer belief

based barriers to help seeking. Higher levels of perceived stigma of receiving help was not significantly related to intentions to seek help from formal sources. Holding more positive attitudes towards receiving help, fewer belief based barriers to help seeking and having lower levels of perceived stigma of receiving help were all associated with greater intentions to seek help from informal sources.

5. There was no association found between age and attitudes towards seeking professional psychological help, receiving professional psychological help or level of belief based barriers to help seeking held.

6. An association was found between age and total help seeking intentions for all sources indicating that as age increased, intention to seek help decreased.

7. Age and help seeking intentions for formal sources were negatively correlated, therefore as age increased, help seeing intentions for formal sources decreased. Age and help seeking intentions for informal sources were not associated.

8. There was no association between adolescent children and their parents' attitudes towards seeking professional psychological help, receiving professional psychological help, or level of belief based barriers to help seeking held.

4.2 DISCUSSION OF HYPOTHESES & THEORETICAL IMPLICATIONS

4.2.1 Attitudes & Belief Towards Help Seeking, and Help Seeking Intentions

Hypothesis 1: All of the following factors will be related to greater willingness to seek help for personal-emotional problems from formal sources: holding more positive attitudes towards seeking psychological help and receiving psychological help; holding fewer perceived barriers to help seeking; having a history of help seeking and being female.

The results of the current thesis supported the central hypothesis that attitudes and beliefs towards help seeking would be associated with intentions to seek help from formal sources. This was demonstrated by the fact that all of the cognitive variables showed significant multivariate relationships with intentions to seek help from formal sources, all making significant contributions to the predictor model.

Attitudes towards seeking help (as measured by the ATSPPH-B) had the strongest correlational relationship with formal help seeking intentions of all variables included, and made the largest contribution to the predictor model suggesting that this was the strongest predictor of formal help seeking intentions, (followed by belief based barriers and then attitudes towards receiving help). Indeed, attitudes towards seeking formal help have consistently been found to be a strong predictor variable, typically over and above other variables, in the help seeking literature. For example, Wilson *et al.* (2005b) reported responses on the ATSPPH-B to be a particularly strong predictor of help seeking intentions for suicidal ideation. Using the 29 item ATSPPH (Fischer & Turner, 1970), Carlton & Deane (2000) found attitudes towards seeking help to be

the strongest predictor of help seeking intentions for suicidal ideation, over and above treatment fearfulness, psychological distress and suicidal ideation in adolescents. This relationship has similarly been demonstrated in adults (Deane & Todd, 1996). The current research suggests that attitudes towards seeking help have a significant influence on willingness to seek formal help for personal emotional problems too.

Clearly, attitudes towards seeking help is well established as an important influential variable in help seeking intentions. This begs the question why such a relationship is so consistently and strongly found? In the past, prior to the development of help seeking intentional measures, the ATSPPH was often used as a measure of willingness to seek help, rather than in its intended use as a measure of orientation towards help seeking (e.g. Kuhl *et al*, 1997). However its use in this manner in the past, along with the strong correlations demonstrated, has to raise the question of whether the ATSPPH scale and the GHSQ both measure similar constructs. Validation of the GHSQ and associated psychometric properties (Wilson *et al.*, 2005a), along with studies demonstrating a differential relationship between the two for different types of problems (Carlton & Deane, 2000) suggests this not to be the case. Instead, it is likely that they measure separate but strongly linked constructs, attitudes towards seeking help, and orientation towards seeking out such help. Thus for example, someone who holds negative attitudes towards seeking help is unlikely to show orientation towards seeking out formal services, however may show orientation to seek help if need arises, despite continuing to hold negative attitudes towards seeking such help.

The fact that a strong univariate and multivatiate relationship between these two variables has consistently been found in the adolescent population may relate in some

manner to aspects of adolescence. As noted in the introduction, adolescence is a time of increasing separation from parents and a desire for autonomy (Willis, 2005). It may be the case that adolescents view seeking formal help as directly opposed to this strive towards autonomy, independence and managing ones own problems. In this sense, the negative attitudes that adolescents hold towards seeking formal help may be an internal representation of this strive, and therefore, actively choosing not to seek out help would perhaps in their eyes be viewed as the external representation of such a strive. Thus, more negative attitudes towards help seeking and low help seeking intentions would be associated with this aspect of adolescence. In order to fully address this however, the relationship between these variables and age would need to be considered. This will be addressed in hypothesis 5.

The BASH-B, which measured level of belief based barriers to help seeking held, was also a unique predictor in the model, consistent with past research demonstrating a similar associated with help seeking for non specific sources (Kuhl *et al.*, 1997 (using the original BASH), Wilson *et al.*, 2005a). This suggests that during the help seeking decision making process, if adolescents hold significant belief barriers to seeking help, (for example thinking that they will be too embarrassed to talk about their problems), they will be less likely to go through the process of seeking help or accepting it.

Similarly, attitudes towards receiving help (as measured by the SSRPH) was a unique predictor of help seeking intentions for formal sources, which again has already been demonstrated in the literature in adults (Vogel *et al.*, 2005a), therefore the current study confirmed that this relationship exists in adolescents. This suggests that when

engaging in the decision making process in relation to seeking help, the implications of actually receiving help are taken into account. As a result, those who anticipate that receiving help will be a negative experience, may well then factor this into their decision making process, making them less willing to put themselves in a positive that they perceive as stigmatising.

Prior help was included in the regression model because it was consistently demonstrated in the literature to be related to formal help seeking behaviour (e.g. Carlton & Deane, 2000) and intentions (Fischer & Farina, 1995; Timlin-Scalera *et al.*, 2003). In the current study, prior help positively correlated with intentions to seek help from formal sources, thus having received prior help related to greater willingness to seek help. Furthermore, it was a unique predictor in the model, however it made less of a contribution than the cognitive variables.

Gender was included in the model again because it was one of the most consistently demonstrated correlates of help seeking behaviour (Rickwood & Braithwaite, 1994) and intentions (Carlton & Deane, 2000; Schonert-Reichl & Muller 1996; Wilson *et al.*, 2005b). In the current study however, no univariate or multivariate relationship was found between gender and formal help seeking intentions. Sheffield *et al.* (2004) in one of the most comprehensive studies of factors influencing help seeking intentions also reported that gender didn't have a significant univariate or multivariate relationship with formal help seeking intentions, however it did correlate with other attitude and belief based barriers in their study. Similar findings are reported in the current study, whereby gender significantly correlated with each of the cognitive variables. Such findings may give credence to West *et al.*'s (1991) proposal that the

under-use of services by adolescents in the absence of parental involvement can largely be attributed to cognitive factors, rather than demographic or service related factors. Findings presented here therefore may indicate that gender is indirectly associated with help seeking intentions by being associated with cognitive variables that in turn, have strong uni- and multivariate relationships with help seeking intentions for formal sources.

Hypothesis 2: All of the following factors will be related to greater willingness to seek help for personal-emotional problems from informal sources: holding more positive attitudes towards seeking psychological help and receiving psychological help; holding fewer perceived barriers to help seeking; having a history of help seeking and being female.

Preliminary analyses revealed that intentions to seek help from informal sources were significantly higher than those for formal sources. Furthermore, past research suggested that the influences on help seeking for formal and informal sources differ (e.g. Ciarocchi & Deane, 2001; Sheffield *et al.*, 2004). As a result, a different regression model for help seeking for informal sources was calculated. While not directly hypothesised, it was anticipated that the model would therefore differ from that for formal help seeking intentions.

A regression model indicated that holding fewer perceived barriers to help seeking, having a history of help seeking and being female were related to greater willingness to seek help for personal-emotional problems from informal sources. Attitudes towards seeking psychological help and receiving psychological help did not make

significant contributions to the model. Gender made the most significant contribution to the model, followed by prior help.

Evidently, only one of the cognitive variables, belief based barriers to help seeking, was a unique predictor of help seeking intentions in the regression model. All three variables had significant univariate relationships with help seeking intentions for informal sources. This finding is perhaps not surprising given that the cognitive variables largely measure attitudes and beliefs relating to help seeking from formal sources. Thus, perceiving receiving formal help as stigmatising for example (as measured by the SSRPH) would not act as a barrier to seek help from a parent or a friend.

The fact that gender is a significant, unique predictor in the regression model for formal sources but not for informal sources is of interest however. Within help seeking intention research, gender has been demonstrated to correlate with levels of social support available, (Ciarrocchi & Deane, 2001; Sheffield *et al.*, 2004) and with emotional competence (Ciarrocchi & Deane, 2001) with females having higher levels of social support and greater emotional competence. Both level of social support and emotional competence have also been demonstrated to be associated with help seeking intentions for informal sources, (Ciarrocchi & Deane, 2001, Ciarrocchi *et al*, 2003). In the current study gender may have been the strongest predictor due to its correlation with other explanatory variables also associated with help seeking such as these, which were not included in the regression model.

Hypothesis 3: Beliefs and attitudes towards help seeking and receiving will inter-correlate with each other. Attitudes towards seeking help will be positively correlated with belief based barriers to help seeking, in that more positive attitudes towards seeking help will be correlated with holding fewer belief based barriers. Attitudes towards seeking help will be negatively correlated with attitudes towards receiving professional help, in that more positive attitudes towards seeking help will be associated with more positive attitudes towards receiving help. Finally, belief based barriers will be negatively correlated with attitudes towards receiving professional help, in that holding lower levels of belief based barriers to help seeking will be associated with more positive attitudes towards receiving help.

All of the cognitive measures correlated with each other. Adolescents with more positive attitudes towards seeking help reported lower belief based barriers to help seeking, and lower levels of perceived public stigma surrounding receiving professional help, and those reporting higher levels of belief based barriers to help seeking also reported higher levels of perceived stigma of receiving help.

These findings were consistent with a number of previous studies that investigated correlations between each of these measures separately. For example Komiya *et al.*, (2000) found that attitudes towards receiving help (SSRPH) were negatively correlated with attitudes towards seeking help in their adult sample. Wilson *et al.*, (2005b) using the original 29 item ATSPPH also found that attitudes towards seeking help and belief based barriers were negatively correlated (Wilson *et al.*, 2005b,). Research using a similar measure of attitudes towards help seeking found a similar

relationship (Sheffield *et al.*, 2004). The relationship between attitudes towards receiving help and belief based barriers to help seeking do not appear to have been investigated in the past, and this is the first demonstration of a relationship between the SSRPH and the BASH-B (indicating that more positive attitudes towards receiving help were associated with holding fewer belief based barriers to help seeking).

Taken together, it is not surprising that these variables correlate, as they measure distinct, yet related concepts. While causality cannot be assumed, it would be expected for example that someone who views receiving help as a potentially stigmatising experience (as measured by the SSRPH), and who hold beliefs that one cannot change their problems no matter what they do (a BASH-B item) would also demonstrate lower orientation towards seek help (as measured by the ATSPPH-B). A search of the literature has suggested that this is the first time that all three aspects of beliefs and attitudes towards seeking and receiving help have been considered together, and findings presented here suggest that when conceptualising influences on the help seeking decision making process, they need to be viewed as related facets, and as such, to be considered in conjunction with each other and not in isolation.

Hypothesis 4: Beliefs and attitudes towards help seeking and receiving will correlate with help seeking intentions for formal and informal sources. Attitudes towards help seeking will be positively correlated with help seeking intentions (more positive attitudes will be associated with greater intentions to seek help), attitudes towards receiving help will be negatively correlated with help seeking intentions (in that more positive attitudes will be associated with greater

intentions to seek help) and belief based barriers will be positively correlated with help seeking intentions (in that holding fewer barriers will be associated with greater help seeking intentions).

Two of the cognitive variables were associated with help seeking intentions for formal sources. Holding more positive attitudes towards seeking help was associated with greater intentions to seek help from formal sources, as was holding fewer belief based barriers to help seeking. Higher levels of perceived stigma of receiving help was not significantly related to intentions to seek help from formal sources. All three of the cognitive variables were associated with help seeking intentions for informal sources. Thus, holding more positive attitudes towards receiving help, fewer belief based barriers to help seeking and having lower levels of perceived stigma of receiving help were all associated with greater intentions to seek help from informal sources. Given that these findings have already been discussed in relation to univariate and multivariate relationships, they will not be discussed further here.

4.2.2 Development of Attitudes and Beliefs

Hypothesis 5: Age will correlate with beliefs and attitudes towards seeking and receiving help. This hypothesis is non-directional.

Hypothesis 5 was non-directional given that the relationship between the cognitive variables and age did not appear to have been investigated to date. The association between age and cognitive variables was investigated for two reasons: primarily, to determine whether such variables displayed a developmental trajectory. If this were found to be the case and additionally, these variables were found to predict help

seeking intentions, then investigating their developmental trajectory would be of benefit clinically when devising means of altering such cognitive factors. A secondary benefit of investigating possible association with age is that this would in turn inform understanding of the developmental trajectory of help seeking should cognitive variables be found to be predictive of help seeking. As noted, the developmental trajectory of help seeking intentions is not yet well understood and findings are inconsistent.

No significant associations were found between cognitive variables and age. Thus, there was no evidence to support the hypothesis that such variables would show a developmental trajectory with increasing age. It may be the case however, that these attitudes and beliefs develop prior to age thirteen, the lowest age included in the study. Indeed, Carlton & Deane (2000) in their study of 14-18 year olds suggest that attitudes towards seeking help, and indeed, their subsequent influence on help seeking intentions, may be formed at a relatively early developmental stage, prior to adolescence.

In hypothesis 1, the possibility that attitudes and beliefs relating to help seeking intentions related in some manner to developmental aspects of adolescence such as increased autonomy and separation from parents, was raised and it was noted that it would be of benefit to consider the developmental trajectory of these variables. While no relationship with age has been demonstrated here, perhaps these attitudes and beliefs alter and become more positive once autonomy has been achieved in adulthood. To investigate this, it would be of interest to include young adults in the study, or perhaps to take a measure of perceived autonomy and individuation to

determine whether this plays a mediating role between age and attitudes and beliefs measured here.

Hypothesis 6: Age will be negatively correlated with total willingness to seek help.

As noted, the developmental trajectory of help seeking has to date not been clearly conceptualised in the literature and findings have been contradictory (Zwanswiijk *et al.*, 2003). Verhulst *et al.* (1997) report that help seeking behaviours in absence of parental involvement decrease with increasing age, therefore it was hypothesised that help seeking intentions would also decrease with age. This hypothesis was supported as an association was found between age and total help seeking intentions for all sources indicating that as age increased, intention to seek help decreased. As already discussed, this may reflect adolescents' attempts to move towards a more autonomous role whereby they manage their own affairs and no longer rely on the support of external, formal sources. However, adolescence is also associated with increased closeness with and reliance on peers and the development of supportive social networks and this would suggest that help seeking for informal sources would not decrease as a by-product of the strive for autonomy. The analyses of the relationship between age and help seeking for formal and informal sources separately discussed below was therefore helpful in considering this further.

Hypothesis 7: Age will correlate with help seeking intentions from formal and informal sources. This hypothesis is non-directional.

Because published findings relating to the developmental trajectory of help seeking for different sources are inconsistent, this hypothesis was non-directional. For formal sources, the hypothesis was supported as age and help seeking intentions for formal sources were negatively correlated, therefore as age increased, help seeing intentions for formal sources decreased. As noted however, research in this area is inconsistent, demonstrated by the fact that Ciarrocchi *et al.* (2003) previously reported no significant relationship between age and formal help seeking both for personal emotional problems and for suicidal ideation. Results presented here therefore must be interpreted with caution. However, they do lend support to the contention that a desire for and indeed move towards autonomy is evident in help seeking intentions and behaviour.

Age and help seeking intentions for informal sources were not associated. In the current study, parents and friends were combined to give a measure of 'informal' help seeking, in keeping with past research (Ciarrocchi & Deane, 2001). However, given that parents in many ways may be more like formal sources, this combination of sources may have acted to mask any age related changes. Indeed, Ciarrocchi *et al* (2003) found that intention to seek help from parents lowered as age increased, however increased for intimate partners. It may be the case that intention to seek help from friends also increases with age, in that help seeking shifts from parents to friends, but this relationship has been masked by the manner in which data were combined and analysed in the current study. As a result, it cannot be concluded that there is no association between age and help seeking for parents and friends.

Hypothesis 8: Child beliefs and attitudes towards seeking and receiving help will be positively correlated with parental beliefs and attitudes towards seeking and receiving help.

It was proposed that child and parent attitudes would correlate based on the view that attitudes and beliefs are learned rather than innate (Lopez, 1991), and therefore develop in childhood, and also on the proposition that parents are significant 'socialising agents' in this process (Santrock, 1990). A search of the literature suggested that the relationship between parent and child help seeking beliefs and attitudes had not been investigated. Inferences were drawn from the limited research available looking at sources of attitudes relating to mental health and mental illness, which have identified parents as having potential influence in the developmental process (Lopez, 1991; Ford & Nikopolta, 2000).

In the current study, there was no association found between adolescent children and their parents' attitudes towards seeking professional psychological help, receiving professional psychological help, or level of belief based barriers to help seeking held. However, this lack of significant finding may be attributable to methodological weaknesses in this part of the study. The decision to combine maternal and paternal responses to cognitive measures may have resulted in associations between groups being masked. Limited research has investigated the relative influence of parental gender on attitudes. In relation to attitudes towards people with a physical disability, Rosenbaum *et al.* (1988) reported a stronger correlation between mother and daughter attitudes than father and daughter attitudes, however this paternal gender difference was not evident for son attitudes. Rosenbaum and colleagues (1988) concluded that

the determinants of attitude in boys may be both qualitatively and quantitatively different from determinants of attitudes in girls. If this were to be the case for attitudes towards help seeking in the current study, then having combined male and female parental responses may have been an inappropriate approach. As such, in order to fully investigate the role that parents may play in the development of such cognitive variables, it would be beneficial to investigate gender specific association, in a far larger sample.

It therefore cannot be decisively concluded on the basis of these findings that child and parent attitudes and beliefs towards help seeking are not associated. Alternatively, it may rather be the case that additional socialisation sources play a role, for example, teachers, peers or the media (Fischer & Farina, 1995; Ford & Nikopolta, 2000), or that differences were masked by the lack of gender specific comparisons.

4.3 CLINICAL & ETHICAL IMPLICATIONS

4.3.1 Formal Help Seeking

The predominant aim of the current study was to investigate whether attitudes and beliefs towards seeking and receiving help were related to help seeking intentions for formal sources, and this was found to be the case, supporting the contention that lack of service uptake in adolescents is predominantly attributable to cognitive variables, due to their demonstrated influence on the decision making process.

As discussed in the introduction, Rosenbaum *et al.* (1988) advised that the value in gaining a better understanding of the correlates of attitudes that one aims to chance

(such as willingness to seek help, as measured by the GHSQ) is threefold: it allows for identification at both the individual and epidemiological level of those who are more likely to require increased levels of help in improving their attitudes; the identification of such factors can inform the design, implementation and analysis of intervention programmes aimed at improving attitudes; and finally, knowledge of such factors can facilitate the development and testing of a model of the development of such attitudes, allowing consideration of the relative importance of contributing factors.

As noted, these achievements were well beyond the scope of the current study. However, findings are of relevance in relation to considering how to ensure that adolescents do choose to seek help when needed. These findings identify that adolescents who hold negative beliefs and attitudes towards help seeking and receiving will be less likely to seek help should the need develop, and as such indicate that educational programmes aimed at ultimately increasing help seeking intentions and behaviours may want to target these cognitive variables. Indeed, success has been found in school based programmes aimed at reducing stigma associated with mental illness and increasing knowledge of mental illness (e.g. Pinfold *et al*, 2003, Watson *et al*, 2005).

Additionally however, it may be the case that identifying belief based differences between different groups of potential services users could allow for differing marketing strategies to be used in each group in order to increase appropriate help seeking (Jones, 2001).

Finally, age was found to correlate with help seeking intentions for formal sources, again suggesting that strategies may be best introduced prior to or at onset of adolescence to address help seeking intentions.

Finally, findings presented here have implications for help seeking models. Stiffman and Pescosolido's (2004) 'Gateway Provider Model' faced criticism for failing to incorporate the fact that services now allow for adolescents to be their own 'gateway providers' by seeking out services autonomously. The identification of a number of cognitive variables as 'facilitators' or 'barriers' to adolescent help seeking decision making processes suggests that models do need to incorporate such factors given the fact that services now allow for young people to opt in or out of services in the absence of traditional 'gateway providers' such as parents and professional staff.

4.3.2 Informal Help Seeking

As expected, cognitive factors contributed less to the model of help seeking for informal sources than for formal sources. This likely is resultant from the fact that the cognitive measures relate to beliefs and attitudes towards seeking and receiving professional help. The finding of greater willingness to seek help from informal sources also has implications for interventions aimed at increasing help seeking. Wilson *et al* (2005b) note that an alternative to looking to alter attitudes and beliefs that have a detrimental impact on help seeking would be to identify sources for which the help negation effect is weakest, and then aim to make that source more accessible and useful. As noted, prior research has demonstrated that adolescents may choose to seek help from friends more with increasing age rather than from formal sources. This was not found here, however as noted it may have been masked by combining

parent and peer sources. If adolescents do tend to seek help from peers more as they get older, these findings cause concern for a number of reasons. Firstly, adolescents with mental health problems tend to have deficits in social capabilities and relationship forming (e.g. Fergusson *et al.*, 2002), therefore they may lack adequate peer support networks from which to seek help. Secondly, studies investigating the benefits of seeking help from peers have indicated that on reflection, adolescents have tended to report this source of help as unhelpful (Offer *et al.*, 1991; Deane *et al.*, 2001). Furthermore, more formal help tends not to be sought until problems reach crisis stage (Willis, 2005).

It may be the case that Wilson *et al.*'s (2005b) suggestion that instead of working to increase help seeking from formal sources, we aim to improve the helpfulness and utility of the sources that adolescents show greatest willingness to seek help from is worthy of consideration, even if these sources are same aged peers. Perhaps there would be a role for providing educative programmes in schools aimed at helping young people recognise symptoms of personal and emotional problems in their friends, and providing them with means of offering support and encouraging help seeking on their behalf. In this sense, peers would be viewed as 'Gateway Providers'.

4.4 METHODOLOGICAL CONSIDERATIONS

Consideration of the methodology employed in the study highlighted some strengths and weaknesses in the study, which will now be discussed.

4.4.1 Measures

Firstly, the BASH-B was developed to measure belief based barriers to help seeking in the adolescent population, however in the current study it was also administered to parents. This was done so in order to measure whether there were similar attitudes in parents as in children, however given their different developmental life-stage, the measure may not have been appropriate. However, the original BASH (Kuhl *et al.*, 1997), was derived from research indicating barriers to help seeking in both the adult and the adolescent population, therefore the barriers included had been demonstrated to be significant in adult help seeking as well as in adolescent help seeking.

A second limitation in relation to the use of the BASH-B was the fact that one item was removed as it related to cost and was not relevant in the UK where health care is free. This was deemed an acceptable alteration in part given the utility of the measure and lack of specific alternatives, and in part due to the fact that scoring procedures required mean response rather than total response to be calculated. However, findings relating to the BASH-B should be interpreted with caution, particularly when being compared with published findings relating to the full BASH-B.

Thirdly, while help seeking intentions were intended to give an approximation of likely future help seeking behaviour, Barney *et al.* (2006) note that interpretation of findings require caution, given that help seeking intention measures are not perfect predictors of help seeking behaviour. Thus, while the regression models presented herein demonstrate the role of cognitive variables in predicting help seeking intentions in the sample, their role in the actual decision making process in relation to seeking professional help can only be suggested and not confirmed.

4.4.2 Sample Issues

Comparisons Between Attitude and Belief Measure Scores and Published Research

A potential limitation of the current study is that the participants were drawn from a predominantly rural population, and therefore the results may not generalise to other adolescents in other areas. An examination of the mean scores on the various measures used in the study was carried out to address this potential issue and will be discussed in turn.

Descriptive statistics for the ATSPPHS-B demonstrated that when combined as a total score ($M = 15.21$, $SD = 5.32$, $n = 491$) findings were similar to those reported by Fischer & Farina (1995) in their original validation of the measure in the young adult population ($M = 17.45$; $SD = 5.97$, $n = 389$) and by Komiya *et al.* (2000) also in the young adult population ($M = 14.66$, $SD = 6.05$, $n = 311$). When these were converted to provide the mean response score, (1.52, ($SD = 0.53$), these were again comparable with findings reported by Wilson *et al.* (2005) in their study of help seeking in a New Zealand adolescent population, as follows: $M = 1.52$, $SD = 0.55$, $n = 269$. The finding that females reported significantly more positive attitudes than males was also consistent with past literature (e.g. Fischer & Farina, 1995).

Mean scores on the BASH-B, the measure of belief based barriers to help seeking ($M = 3.33$, $SD = .86$, $n = 481$) were consistent with previously reported findings in the adolescent population by Wilson *et al.* (2005b) using the 11 item scale as follows: $M = 3.37$, $SD = .91$, $n = 269$. The finding that females reported fewer belief based barriers than males was again consistent with previous adolescent literature (Kuhl *et al.*, 1997; Wilson *et al.*, 2005b).

Mean score on the SSRPPH, a measure of attitudes towards receiving professional psychological help ($M = 6.64$, $SD = 2.73$, $n = 483$) was within half a standard deviation of previously reported data by Komiya *et al.* (2000) in their initial validation of the measure in an American adolescent population ($M = 5.79$, $SD = 3.06$, $n = 311$).

Taken together, these findings suggest that the sample included in the current study displayed similar attitudes and beliefs in relation to seeking and receiving professional psychological help to adolescents in the general population, suggesting them to be a representative sample of the adolescent population.

4.4.3 Data Analysis

A number of limitations are evident in the data analysis. Firstly, some of the data that were gathered were not used in subsequent analyses. Information relating to usefulness of prior help received was gathered, however this was not included in formal analyses. The information was gathered as part of the standard 'prior help' measure used in published help seeking literature in order to ensure similar methods were used, however only the question relating to whether prior help had been received was used in formal analyses, as consideration of the literature relating to the other information gathered suggested that had not been demonstrated to show an association with help seeking intentions and as such would not be a valuable addition to formal analyses of help seeking intentions.

Secondly, given that prior help and age had consistently been demonstrated in the literature to be significant predictors of help seeking intentions, it may have been advisable to take a stepwise regression approach and enter them in the model first.

Furthermore, conducting stepwise rather than standard 'forced entry' regression may have allowed for the individual contributions of each cognitive variable to have been considered in turn. However, given that the study was exploratory in nature and measuring variables that had not been consistently shown to be predictive of help seeking intentions, it was deemed more appropriate to use a standard 'forced entry'.

4.4.4 Strengths of the Study

While the adult sample was small, a large child sample was included as a by-product of trying to ensure adequate adult sample size was achieved, therefore in the primary comparisons in the current study, sample size was considerably higher than the minimum required indicated by the power analyses. Secondly, most of the effect sizes reported were medium in magnitude, and as a-priori power analyses for Study 1 were based on medium effect sizes and minimum sample sizes were considerably exceeded, the Type 2 error rate in Study 1 can be considered to be at an acceptably low level.

As demonstrated, scores on the key independent variables were deemed to be representative of the general population and as such, this increased generalisability of findings. Additionally, measures used were largely well researched and standardised, and because of their consistent use in the help seeking literature, allowed comparisons to be drawn with published literature.

4.5 FURTHER RESEARCH

The current study was proposed and conducted as an exploratory investigation of the relationship between a number of variables which had not been consistently investigated together before. It demonstrated that the variables of interest when

combined were predictive of help seeking intentions from formal sources. However, such findings are proposed to be tentative in nature and requiring further validation and investigation. In particular, it would be of interest to determine the contribution that such factors would make to a regression model incorporating other cognitive, demographic and psychological variables that have consistently been demonstrated in the literature to be predictive of help seeking intentions such as emotional competence or level of psychological distress. Furthermore, making use of stepwise multiple regression techniques would allow for the relative importance of the cognitive variable included in this study to be considered.

The current study only investigated help seeking intentions for personal-emotional problems, however a wealth of research has also aimed to conceptualise factors influencing help seeking intentions for suicidal ideation (e.g. Carlton & Deane, 2000, Ciarrocci *et al*, 2003). Given the issues surrounding suicidality in adolescence discussed in the introduction, it would be beneficial to repeat the current analyses in relation to help seeking intentions for suicidal ideation.

A secondary aim of the current study was to consider the developmental trajectory of such cognitive variables, and extending the study to include a younger age group would allow for this to be more comprehensively considered. It may also be of benefit to include older participants to consider more formally whether increased autonomy is of relevance in adolescent help seeking. As noted, it would be of interest to investigate the association between child attitudes and other significant individuals in their lives, such as teachers and peers, and to investigate gender related correlations between child and parent responses in a much larger sample. As a result, it may be

that in adolescents, a more comprehensive study including a range of socialisation agents is required. Finally, as noted, parental responses were combined and this prevented consideration of potential differences in maternal and paternal attitude and whether these correlate differently with child attitudes to be considered. Thus, conducting the study with a far larger parent sample size and analysing responses based on gender would be of interest.

4.6 CONCLUSIONS

The current study demonstrated that in adolescents, holding more positive attitudes towards seeking psychological help and receiving psychological help, holding fewer perceived barriers to help seeking, and having a history of help seeking were related to greater willingness to seek help from formal sources. Holding fewer perceived barriers to help seeking, having a history of help seeking and being female were related to greater willingness to seek help from informal sources.

No relationship was found between age and beliefs and attitudes towards seeking and receiving help. An association was found between age and total help seeking intentions for all sources indicating that as age increased, intention to seek help decreased. Age and help seeking intentions for formal sources were negatively correlated, therefore as age increased, help seeking intentions for formal sources decreased. Age and help seeking intentions for informal sources were not associated. There was no association between adolescent children and their parents' attitudes towards seeking professional psychological help, receiving professional psychological help, or level of belief based barriers to help seeking held.

Results were discussed with references to previous findings in the literature and theoretical implications were highlighted. Strengths and limitations of the study were discussed. Implications of the findings for attitudinal change programmes, and service design and development aimed at increasing help seeking were considered.

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APPENDIX 2.3.1

Letter to Director of Education requesting permission to conduct study

Date: 19th January 2007

Enquiries to:
Direct Line:
Mobile:
Email:

Dear Mr ,

Re: Request to conduct research in secondary schools

I am in my final year of a doctorate in Clinical Psychology at the University of Edinburgh, and as part of my course, I am required to complete a research thesis. My research investigates factors that influence the likelihood that adolescents will seek psychological help should they develop emotional and / or personal difficulties in the future. In particular, I am interested in adolescents' and their parents' attitudes and beliefs about receiving psychological help. It is estimated that 20% of adolescents show signs of emotional or behavioural disturbance, but the majority do not receive help, and those who do rarely receive help from mental health professionals. It is therefore hoped that this research will identify barriers to service uptake in the adolescent population. A more detailed description of the rationale for the study is attached.

My research involves asking pupils in 2nd to 6th year to complete some brief questionnaires (attached), which investigate their attitudes and beliefs about seeking psychological help. I am therefore writing to ask your permission to contact one to two secondary schools within the to ask if they will participate in my research. My research is being supervised by Dr , a Chartered Child Clinical Psychologist based in the and I have family links with the , hence my preference to conduct research here. With you agreement, I would then contact schools to determine whether they would be willing to allow me to conduct the research. I would then contact parents and provide them with an information pack. I would anticipate asking children to complete the questionnaires during their social education class. Parental questionnaires would be sent home with children and stamped addressed envelopes would be provided in order for them to be mailed back. I would hope to carry this out over the first two weeks of March 2007.

Should you require any further information, I can be contacted on any of the numbers above, or by e mail, and would be very happy to meet with you in person. I very much appreciate you taking the time to read this and I look forward to hearing from you in response to my request. If you are in agreement with me going ahead with my research proposal within a 's secondary school, I would be very grateful if you could let me know to that effect in writing; this is in fact a requirement of my course.

Yours sincerely,

Trainee Clinical Psychologist

Chartered Clinical Psychologist (Supervisor)

APPENDIX 2.3.1b

Letter from Director of Education granting permission to conduct research

Education and Lifelong Learnin

Please ask for:

Our Ref:

Your Ref:

E-Mail:

Date:

Dear

REQUEST FOR ACCESS TO SCHOOLS FOR RESEARCH PURPOSES

Thank you for your letter of 19 January 2007 requesting access to schools for the research purposes.

I am happy to approve your request on the understanding that you will arrange the necessary Disclosure Checks in advance of your visits, should contact with pupils be required.

For your information, I attach the names, addresses and telephone numbers of our High Schools - although the Head Teachers are also available by email using the following format and email address.

I would be most interested in a copy of your final analysis if this is permissible. Please accept my very best wishes for a successful outcome!

Yours sincerely

ACTING HEAD OF SECONDARY AND ASN

APPENDIX 2.3.2

Parental Information Letter

Date: 5th February 2007

Dear parent / guardian,

I am in my final year of Clinical Psychology training at the University of Edinburgh, and as part of my course, I am required to complete a research thesis. My research looks at teenagers' and their parents' thoughts and beliefs about seeing a psychologist. It is thought that as many as 20% of teenagers shows signs of emotional or behavioural difficulties at some point during their teenage years, however most of these young people won't seek help for this. My research investigates how attitudes about seeing a psychologist might influence young people's views on seeing a psychologist should they need to in the future. A more detailed outline of the study is attached for your information.

I am hoping to carry out this research in The High School during February and March 2007. It will involve asking pupils in 2nd to 6th year to complete some brief questionnaires during their Social Education class. It will take at most, 15 minutes to complete these. I will then ask pupils to take two sets of these questionnaires home for their parents/guardians to fill in and an envelope will be provided so that these questionnaires can be returned to the school.

The questionnaires look at attitudes towards and beliefs about seeing a psychologist, and whether the individual has seen a psychologist, counsellor or psychiatrist in the past. The research will be conducted anonymously and all of the information will be treated confidentially. There will be no identifying information on the questionnaires (such as name, address or date of birth). It is hoped that this will encourage children and their parents to be as honest as possible in their answers.

In due course, more information will be provided about the study, along with the opportunity to ask any questions that you may have. Please note that at any stage of the data collection, yourself or your child will be able to withdraw from the study if you decide that you no longer wish to take part.

Yours sincerely,

Trainee Clinical Psychologist

Chartered Clinical Psychologist (Supervisor)

APPENDIX 2.3.3

Child Consent Form

'Beliefs About Seeking Psychological Help' Study

Dear pupil,

My research looks at teenagers' and their parents' beliefs about seeing a psychologist. I am interested in how these beliefs may influence young people's views on seeing a psychologist should they need to in the future.

To take part in this research, you need to fill in the attached questionnaires today. The questionnaires are anonymous - they do not have your name or your date of birth on them. Your answers will not be shown to your parents or your teachers.

If you would like to take part in this research, please fill in the consent form below, and then complete the attached questionnaire pack.

I agree to take part in this study.

Name: _____ Class: _____

Signed: _____

APPENDIX 2.3.4

Parent Consent Form

'Beliefs About Seeking Psychological Help' Study

Dear parent,

You received a letter recently explaining my research, which looks at teenagers' and their parents' beliefs about seeing a psychologist. I am interested in how these beliefs may influence young people's views on seeing a psychologist should they need to in the future.

If you would like to take part in this research, I would very much appreciate if you could complete this consent form and the enclosed questionnaires, put them back into the envelope, seal it and ask your child to return it to the school.

There are two sets of questionnaires enclosed. Each parent / carer living at home should complete a set of questionnaires. If there is only one parent / carer living at home, then only one set of questionnaires needs to be completed. Please note, if you have more than one child at the school, then you may receive more than one set of questionnaires. Please complete both sets and return them.

I agree to take part in this study.

Signed: _____

APPENDIX 2.5.1

Child demographic information sheet

Study in Adolescent Help Seeking

Thank you for agreeing to take part in this study. Please fill in the information below, then answer the attached questionnaires. The questionnaires are anonymous and the information that you provide will not be shared with your teachers or with your parents / guardians. Please let me know if you have any questions.

INSTRUCTIONS: Please circle the answer to each question below

---

1) Which year are you in: 3rd year 4th year 5th year 6th year

---

2) How old are you: 13 yrs 14 yrs 15yrs 16yrs 17yrs 18 yrs

---

3) Gender: Male Female

Please now complete all of the attached questionnaires and put them into the attached envelope when you have finished.

Code: _____

Date: _____

APPENDIX 2.5.2

Parent demographic information sheet

Study in Adolescent Help Seeking

Thank you for agreeing to take part in this study. Please fill in the information below, then answer the attached questionnaires. The questionnaires are anonymous.

INSTRUCTIONS:

Please circle the answer to the question below:

Gender: Male Female

Please now complete all of the attached questionnaires, put them into the attached envelope when you have finished and give them to your child to return to school.

Code: _____

Date: _____

APPENDIX 2.5.3

Stigma Scale for Receiving Psychological Help (SSRPH)

SSRPH

Code: _____

Date: _____

DIRECTIONS

Read each statement carefully.

Circle the answer which most closely answers each question to show the extent to which you agree or disagree with each statement.

Seeing a psychologist for emotional or interpersonal problems carries social stigma.	Strongly Agree	Agree	Disagree	Strongly Disagree
It is a sign of personal weakness or inadequacy to see a psychologist for emotional or interpersonal problems.	Strongly Agree	Agree	Disagree	Strongly Disagree
People will see a person in a less favourable way if they come to know that he/she has seen a psychologist.	Strongly Agree	Agree	Disagree	Strongly Disagree
It is advisable for a person to hide from people that he/she has seen a psychologist.	Strongly Agree	Agree	Disagree	Strongly Disagree
People tend to like less those who are receiving professional psychological help.	Strongly Agree	Agree	Disagree	Strongly Disagree

APPENDIX 2.5.4

Attitudes Towards Seeking Professional Psychological Help Scale (ATSPPH-B)

ATSPPHS

DIRECTIONS

Read each statement carefully.

Circle the answer which most closely answers each question to show the extent to which you agree or disagree with each statement.

If I believed I was having a mental breakdown, my first inclination would be to get professional attention.	Agree	Partly agree	Partly disagree	Disagree
The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.	Agree	Partly agree	Partly disagree	Disagree
If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.	Agree	Partly agree	Partly disagree	Disagree
There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears *without* resorting to professional help.	Agree	Partly agree	Partly disagree	Disagree
I would want to get psychological help if I were worried or upset for a long period of time.	Agree	Partly agree	Partly disagree	Disagree
I might want to have psychological counselling in the future.	Agree	Partly agree	Partly disagree	Disagree
A person with an emotional problem is not likely to solve it alone; he or she *is* likely to solve it with professional help.	Agree	Partly agree	Partly disagree	Disagree
Considering the time involved in psychotherapy, it would have doubtful value for a person like me.	Agree	Partly agree	Partly disagree	Disagree
A person should work out his or her own problems; getting psychological counselling would be a last resort.	Agree	Partly agree	Partly disagree	Disagree
Personal and emotional troubles, like many things, tend to work out by themselves.	Agree	Partly agree	Partly disagree	Disagree

APPENDIX 2.5.5

Barriers to Adolescent Help Seeking Scale (BASH-B)

BASH

DIRECTIONS

Read each statement carefully.

Circle the number which most closely answers each question to show the extent to which you agree or disagree with each statement.

	Strongly Agree					Strongly Disagree
If I had a problem, I'd solve it by myself	1	2	3	4	5	6
Even if I wanted to, I wouldn't have time to see a psychologist	1	2	3	4	5	6
If I had a problem and told a psychologist, he would not keep it secret	1	2	3	4	5	6
A psychologist might make me do or say something that I don't want to do	1	2	3	4	5	6
I'd never want my family to know I was seeing a psychologist	1	2	3	4	5	6
Adults really can't understand the problems that children have	1	2	3	4	5	6
Even if I had a problem, I'd be too embarrassed to talk to a psychologist about it	1	2	3	4	5	6
No matter what I do, it will not change the problems I have	1	2	3	4	5	6
If I went to see a psychologist, I might find out I was crazy	1	2	3	4	5	6
I think I should work out my own problems	1	2	3	4	5	6

APPENDIX 2.5.6

General Help Seeking Questionnaire (GHSQ)

GHSQ

DIRECTIONS

Circle the number which most closely answers each question to show the extent to which you agree or disagree with the following statement.

1) If you were having a personal-emotional problem, how likely is it that you would seek help from the following people?

	Extremely Unlikely						Extremely Likely
Intimate partner (e.g. significant boyfriend or girlfriend, husband, wife). NOTE if you do not have an intimate partner, please skip this question. Please answer all the remaining questions.	1	2	3	4	5	6	7
Friend (not related to you)	1	2	3	4	5	6	7
Parent	1	2	3	4	5	6	7
Other relative / family member	1	2	3	4	5	6	7
Mental Health Professional (e.g. counsellor, psychologist, psychiatrist)	1	2	3	4	5	6	7
Phone help-line	1	2	3	4	5	6	7
Doctor / GP	1	2	3	4	5	6	7
Teacher (guidance, classroom teacher, Social Education teacher)	1	2	3	4	5	6	7
Minister / Priest	1	2	3	4	5	6	7
Youth Worker / Youth Group Leader	1	2	3	4	5	6	7
I would not seek help from anyone	1	2	3	4	5	6	7
Other not listed above Please list: _____ If no other, leave blank.	1	2	3	4	5	6	7

APPENDIX 2.5.7

Measure of Prior Help

2a) Have you ever seen a mental health professional (e.g. counsellor, psychologist, psychiatrist) to get help for personal problems? (Circle one)

Yes No

If you circled "no" in question 2a, you are finished this section. If you circled "yes" please complete 2b, 2c and 2d below.

2b) How many visits did you have with the health professional(s)? _____

2c) Do you know what type of health professional(s) you've seen (e.g. counsellor, psychologist, psychiatrist)? _____

_____

2d) How helpful was the visit to the mental health professional? (please circle)

Extremely Unhelpful **Extremely Helpful**

1 2 3 4 5 6