The effects of need for autonomy and preference for seeking help from informal sources on emerging adults’ intentions to access mental health services for common mental disorders and suicidal thoughts

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Abstract
Emerging or early adulthood is the life stage spanning 18–25 years of age. In Australia, anxiety and affective disorders (often classified as ‘common mental disorders’) are prevalent in this age group and suicide is also a concern. Professional mental health care can reduce the long-term impact of these mental health problems and protect against the development of severe forms of these disorders. However, up to three-quarters of young people with mental health needs do not seek professional help for their condition. This study aimed to examine the extent to which belief in the need for autonomy and intentions to seek help from informal help-sources act as barriers or facilitators to seeking help from a mental health service for symptoms of a common mental disorder and suicidal thoughts, in a sample of 641 emerging adults aged 18–25 years. For common mental disorders and suicidal thoughts, results reveal that the family of origin has an important influence on mental health service access among emerging adults, but also, that the growing independence and autonomy of emerging adults needs to be accommodated if mental health treatment services are to be accessible to this important age group.

Keywords: help-seeking, intentions, beliefs, barriers, autonomy, youth

Emerging or early adulthood is the life stage spanning 18–25 years of age. It is a period of intense social and neurobiological change through which the brain continues to develop until reaching cognitive and emotional maturity at approximately 30 years of age (Arnett, 2000; Dumontheil, Hassan, Gilbert, & Blakemore, 2010; Peterson, 2004). Some researchers believe that the significant changes which occur during this developmental period provide a major reason to explain why young adults have high rates of mental health problems (Zivin, Eisenberg, Gollust, & Golberstein, 2009). In Australia, mental disorders are more prevalent in young people aged 16–24 years than in any other age group (Slade, Johnston, Oakley-Browne, Andrews, & Whiteford, 2009). Approximately one in four young Australians experiences a mental health problem (Australian Bureau of Statistics [ABS], 2008). Anxiety disorders and affective disorders are the most common mental disorders (CMD) in this age group and are often classified as ‘common mental disorders’ (ABS, 2008).

The impact of these disorders is not trivial – approximately one quarter of Australians with an anxiety disorder and half of those with an affective disorder are severely affected by their condition. The 2007 National Survey of Mental Health and Wellbeing (NSMHWB) found that those with an anxiety disorder reported having four days on average out of the last 30 when they were unable to pursue usual activities, and those with an affective disorder had six days out of role (Slade et al., 2009). Suicide is also a concern. Between 2004 and 2006, 20% of all Australian deaths in the 16–24 year age group ($N=266$) were by suicide, although this age-group comprises less than 14% of the population (ABS, 2008; Australian Institute of Health and Welfare [AIHW], 2007).

Treatment can reduce the long-term impact of many mental health problems and protect against the development of more severe forms of these disorders (Rickwood, Deane, & Wilson, 2007a). Receiving treatment for suicidal thoughts or behaviours can also reduce risk for suicide completion (Greenberg, Domitrovich, & Bumbarger,
have a particularly strong influence during early adulthood, might help explain why so many emerging adults think they do not need treatment for mental health problems.

Another reason that young people may think that treatment is not necessary, is that they may believe that seeking informal help from sources such as friends and family is sufficient. It is increasingly recognized that seeking help for psychological problems proceeds through stages and usually starts by accessing help from informal sources (Rickwood et al., 2007a). This process can be quite complex and lead to considerable delays from the start of the cognitive help-seeking process to when treatment is obtained, if treatment is obtained at all (Wills & Gibbons, 2009). Results from the 2007 NSMHWB show that while three-quarters of young people with a diagnosable CMD in the last year had not received treatment for their symptoms, approximately half had tried to self-manage their symptoms. Self-management strategies included: accessing alternative support services, such as internet chat-rooms to talk about their symptoms; increasing exercise and physical activity to suppress symptoms; and seeking support from friends and family (Olesen, Butterworth, & Leach, 2010). It is unclear, however, whether attempts at self-management act as a barrier to or facilitate the pathways to seeking help from professional sources.

STUDY AIMS

The aim of this study was to examine the extent to which belief in the need for autonomy (NA) and intentions to seek help from informal help-sources are related to intentions to seek help from a mental health service for symptoms of a CMD (stress, anxiety, depression) and for suicidal thoughts in emerging adults. It was expected that those high in NA would be less likely to intend to use a mental health service for both a CMD and suicidal thoughts. It was also anticipated that emerging adults with higher intentions to seek help from informal sources would have lower intentions to access and use a mental health service for symptoms of a CMD or suicidal thoughts, and that this association would not be accounted for by higher NA.
Youth mental health service use and access

METHOD
Participants
A total of 641 participants that ranged in age from 18–25 years ($M = 19.39, SD = 1.80$ years) were drawn from first year psychology classes of one regional Australian university. Of these, 562 participants ($87.7\%$ of the total sample) were aged 17–21 years and 79 participants ($12.3\%$) were aged 22–25 years. There were 164 who were male ($25.6\%$) and 477 ($74.4\%$) who were female. Approximately $92\%$ of the sample described their culture as ‘Australian’ or ‘New Zealand’. The remaining $8\%$ described their culture as ‘Other’.

Measures
Help-seeking intentions for a range of mental health problems were measured by an extended version of the General Help-Seeking Questionnaire (GHSQ; Wilson, Deane, Ciarrochi, & Rickwood, 2005b) – the GHSQ vignette version (GHSQ-V; Wilson, Bushnell, & Caputi, forthcoming). The GHSQ-V asks participants to rate the likelihood that they would seek help from a variety of specific help sources (e.g., intimate partner, friend, parent, family member who is not a parent, mental health professional such as a counsellor or psychiatrist, telephone counsellor, family doctor/GP) for different problem-types. In this study, the problems were: symptoms of a CMD (stress, anxiety, depression) and suicidal thoughts. Vignettes that describe DSM-IV-TR criteria are used alongside standard GHSQ stem-questions to measure help-seeking intentions for each symptom-type. The specific vignettes and stem-questions that were used in this study are reproduced in Table 1. Participants rated their intentions to seek help from each specific help source, in addition to ‘I would not seek help from anyone’, on a seven-point scale (1 = ‘Extremely unlikely’ to 7 = ‘Extremely likely’. Higher scores indicate stronger help-seeking intentions.

The results of principal axis factoring (PAF) with the GHSQ-V data for a CMD revealed that the help sources could be summarised through five subscales, which comprised: intimate partner, friend, family (parents and other family members), mental health services (including items for mental health professional, family doctor/GP, and telephone counsellor), and Would not seek help from anyone (Wilson et al., forthcoming). Similarly, for suicidal ideation, the same five subscales were evident.

Need for autonomy was measured by the NA subscale of the brief version of the Barriers to Adolescents Seeking Help scale (BASH-B; Wilson & Deane, 2010b), a measure previously derived from the longer scale developed by Kuhl et al. (1997). The NA consists of two statements that measure the extent to which belief in the NA acts as a barrier to seeking help: ‘If I had a problem, I would solve it myself’ and ‘I think I should work

TABLE 1: VIGNETTES AND STEM QUESTIONS MEASURING INTENTIONS IN THE CURRENT STUDY

<table>
<thead>
<tr>
<th>Stress symptoms</th>
<th>Anxiety symptoms</th>
<th>Depression symptoms</th>
<th>Suicidal thinking</th>
</tr>
</thead>
</table>
| Jake is 18 years old. In the last couple of weeks he has found it hard to wind down or relax. He’s also been feeling pretty overwhelmed, ‘twitchy’, and intolerant. He’s been over-reacting to things that are going on. **If you were feeling like Jake, how likely is it that you would seek help from the following people?**
| Jane is 19 years old. In the last few weeks she has noticed that she has felt worried or scared without any particular reason, and her hands have trembled a lot even though she doesn’t drink coffee or caffeine drinks. On a few occasions she has felt close to panic, and at the same time became aware that her mouth has got really dry and that she has difficulty breathing. **If you were feeling like Jane, how likely is it that you would seek help from the following people?**
| John is 21 years old and has been feeling unusually sad and down-hearted for most of the day for nearly two weeks. He doesn’t feel like eating and has lost weight. He can’t keep his mind on his studies and his marks have dropped. He has put off making decisions and feels that even day-to-day tasks are too much for him. To him, life feels meaningless and he doesn’t feel he is worth much as a person. **If you were feeling like John, how likely is it that you would seek help from the following people?**
| Jess is 17 years old. In the last four weeks she has found herself thinking about how easy it would be to end it all, and she knows that at least once a week during this time she has thought about how and when she could kill herself. **If you were having thoughts like Jess, how likely is it that you would seek help from the following people?**
out my own problems’. Each item is rated on a six-point scale (1 = ‘Strongly disagree’ to 6 = ‘Strongly agree’). Scores are averaged and a higher score indicates greater perceived NA. The NA has shown good validity and reliability in a non-clinical sample of adolescents and emerging adults (Wilson & Deane, 2010b). In the current study, the NA had a Cronbach’s alpha of 0.78, and a mean of 3.60 (SD = 1.13), suggesting that in this sample of emerging adults, the NA was a reliable measure of a moderately important barrier to help-seeking.

Procedure
Approval was obtained from the University’s Human Research Ethics Committee. Participants were recruited through a university research participation scheme and completed an anonymous online self-report survey. Information about the study was provided online to ensure informed consent before participants commenced the questionnaire. The measures took approximately 10 minutes to complete. At the conclusion of the questions, active links to mental health websites and online counseling were provided. Participants were also given email access to trained project staff for referral to local face-to-face counseling services should this be required, however, no participant took up this option.

Frequencies of participants’ help-seeking intentions for each help source and symptom type were calculated. Chi-square analyses examined the differences between frequencies by symptom-type. The associations between NA and intentions for each symptom type were calculated using bivariate correlations. On the basis of these correlations, two multiple regression (MR) analyses were conducted. The purpose of the MRs was to test whether emerging adults with higher intentions to seek help from informal sources have lower help-seeking intentions for a mental health service and greater NA. The MRs used NA, the three intentions variables for informal sources (intimate partner, friend, family), and Would not seek help from anyone to predict help-seeking intentions from a mental health service. Sex was included as a covariate because females were overrepresented in the sample. Significance was set at $p < .01$ to minimise the possibility of Type I error from the number of analyses that were conducted.

RESULTS
Differences between help-seeking intentions by symptom type
Mean help-seeking intentions for CMD and suicidal thoughts for each source of help are presented in Table 2. Differences in help-seeking intentions between the symptom types were examined using a repeated measures analysis of variance (ANOVA). There were significant multivariate main effects for symptom type (Wilks Lambda, $F_{(2,637)} = 78.63, p < .001, \eta^2 = .11$) and help source ($F_{(4,2548)} = 379.08, p < .001, \eta^2 = .37$). These effects were qualified by a significant interaction effect ($F_{(4,2548)} = 144.84, p < .001, \eta^2 = .19$), indicating that the effect of symptom type varied across the help sources. Follow-up pairwise comparisons revealed that participants were significantly more likely to intend to seek help from all sources for a CMD than for suicidal thoughts, but that there was no difference between the two symptom types for intentions to not seek help. Follow-up one-way ANOVAs conducted separately for each symptom type revealed significant differences in intentions across help source for both types of symptoms. For symptoms of a CMD and suicidal thoughts, intentions to seek help from an intimate partner were significantly higher than intentions to seek help from a friend, family member and mental health service; help-seeking intentions for a friend

<table>
<thead>
<tr>
<th>Help source</th>
<th>Symptom type</th>
<th>CMD</th>
<th>Suicide-thts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$M$ ($SD$)</td>
<td>$M$ ($SD$)</td>
</tr>
<tr>
<td>Intimate partner</td>
<td></td>
<td>5.37 (0.81)</td>
<td>4.72***</td>
</tr>
<tr>
<td>Friend</td>
<td></td>
<td>4.93 (0.79)</td>
<td>4.53***</td>
</tr>
<tr>
<td>Family</td>
<td></td>
<td>4.11 (0.88)</td>
<td>3.52***</td>
</tr>
<tr>
<td>Mental health service</td>
<td></td>
<td>3.43 (0.87)</td>
<td>3.98***</td>
</tr>
</tbody>
</table>
| Would not seek help  |                      | 2.63 (0.82) | 2.64     | 1.80

*** Significant difference at $p < .001$ between symptom types
* Significant difference at $p < .001$ between all sources of help for CMD
$^b$ Significant difference at $p < .05$ between Intimate partner and Friend, and at $p < .001$ between all other sources of help for suicide-thts.
were significantly higher than those for family and mental health services; and help-seeking intentions for family were significantly higher than intentions to seek help from a mental health service.

Table 3 further reveals the differences in help-seeking intentions for the different symptom types by showing the percentage of participants who were likely or unlikely to seek help from each help source. For symptoms of a CMD, the highest percentage of participants reported that they were likely to seek help from an intimate partner or from a friend. Just over half were likely to seek help from an intimate partner and just under half, from a friend. The highest percentage of participants also reported that they were unlikely to seek help from family members and mental health services. Two-fifths were unlikely to seek help from family and approximately three-quarters were unlikely to seek help from a mental health service for their condition. Nevertheless, almost 87% were unlikely to not seek help at all.

For suicidal thoughts, the highest percentage of participants reported they were unlikely to seek support from any informal help source, and this was particularly pronounced for family where over two-thirds were unlikely to seek help. Over half were unlikely to seek help from a mental health service. About one-third were likely to seek help from an intimate partner or from a friend. As for intentions related to CMD, again the majority reported it was unlikely that they would not seek help at all.

### Relationships between intentions and need for autonomy

The strength of the interrelationships between help-seeking intentions and NA are shown through the Pearson correlation coefficients presented in Table 4. These reveal significant, but weak, negative relationships between NA and help-seeking intentions from both informal sources and mental health services for CMD, but only with intentions to seek help from a mental health service for suicidal thoughts (the correlation with intentions to seek help with family, while significant, is less than \( r = .10 \)). For both symptom types, each of the other variables was significantly related to intentions to seek help from a mental health service. Greater intentions to seek help from a mental health service for CMD were moderately associated with higher intentions to seek help from family, weakly associated with higher intentions to seek help from friends and intimate partner, and weakly associated with lower NA. For seeking help from a mental health service for suicidal thoughts, greater intentions were also weakly associated with higher intentions to seek help from each of the informal sources of help and weakly associated with lower NA.

To determine the relative strength of the relationships within a multivariate model, MR analyses were undertaken and the results predicting intentions to seek help from a mental health service for CMD and for suicidal thoughts are presented in Table 5. For CMD, 13% of the variance in intentions was explained, with intentions to seek help from family, weakly associated with higher intentions to seek help from friends and intimate partner, and weakly associated with lower NA. For seeking help from a mental health service for suicidal thoughts, greater intentions were also weakly associated with higher intentions to seek help from each of the informal sources of help and weakly associated with lower NA.

### Table 3: Percentage reporting different intentions for each source of help by symptom type

<table>
<thead>
<tr>
<th>Intentions</th>
<th>Unlikely</th>
<th>Not sure</th>
<th>Likely</th>
<th>( \chi^2 )</th>
<th>( p )</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intimate partner</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMD</td>
<td>15.8</td>
<td>24.3</td>
<td><strong>59.9</strong></td>
<td>192.99</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Suicide-thts</td>
<td><strong>43.2</strong></td>
<td>17.9</td>
<td>38.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Friend</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>CMD</td>
<td>27.5</td>
<td>25.9</td>
<td><strong>46.6</strong></td>
<td>104.90</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Suicide-thts</td>
<td><strong>45.5</strong></td>
<td>20.4</td>
<td>34.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMD</td>
<td>40.4</td>
<td>31.5</td>
<td>28.1</td>
<td>115.01</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Suicide-thts</td>
<td><strong>68.6</strong></td>
<td>13.3</td>
<td>18.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental health service</strong></td>
<td></td>
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<tr>
<td>CMD</td>
<td><strong>71.6</strong></td>
<td>20.7</td>
<td>7.6</td>
<td>596.00</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Suicide-thts</td>
<td>53.8</td>
<td>23.2</td>
<td>22.9</td>
<td></td>
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</tr>
<tr>
<td>Would not seek help</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMD</td>
<td><strong>86.9</strong></td>
<td>8.7</td>
<td>4.4</td>
<td>15.39</td>
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<tr>
<td>Suicide-thts</td>
<td>81.7</td>
<td>10.1</td>
<td>8.1</td>
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</table>

\( N = 641 \), ‘Unlikely’ (scores of 1, 2, or 3), ‘Not sure’ (scores of 4), and ‘Likely’ (scores of 5, 6, or 7). Friedman \( \chi^2 \) reported. Bold type highlights the highest intention frequencies for each help source.
DISCUSSION
The current study sought to determine the effects of NA and informal help-seeking intentions on intentions to seek help for CMD and suicidal thoughts from a mental health service. For both CMD and suicidal thoughts, intentions to seek professional help were associated with greater intentions to seek informal help from family, and more weakly with lower NA. Not surprisingly, intentions to not seek help from anyone were negatively associated with intentions to seek professional help. The results support the hypothesis that greater NA would be associated with lower help-seeking intentions for mental health professionals among emerging adults, and that this relationship would be direct and not mediated by intentions to seek help from informal sources. Contrary to expectations, however, the hypothesis that stronger help-seeking intentions for informal sources would be associated with lower help-seeking intentions for mental health sources was not supported; the direction of the observed relationships was reversed. In particular, higher intention to seek help from family was positively associated with stronger intention to seek help from a professional mental health service.

The results reveal a significant, albeit weak, effect of NA on help-seeking intentions. This is congruent with a recent survey of 1,032 young Australians aged 14–25 years, which found that regardless of age, sex, and prior experience with a mental health professional, belief in

**Table 4: Intercorrelations between measures**

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td>CMD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need for autonomy</td>
<td>-.10**</td>
<td>-.11**</td>
<td>-.18***</td>
<td>-.21***</td>
<td>.24***</td>
</tr>
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<td></td>
</tr>
<tr>
<td>1. Intimate partner</td>
<td>.42***</td>
<td>.32***</td>
<td>.14***</td>
<td>-.33***</td>
<td></td>
</tr>
<tr>
<td>2. Friend</td>
<td>.31***</td>
<td></td>
<td>.13***</td>
<td>-.27***</td>
<td></td>
</tr>
<tr>
<td>3. Family</td>
<td>.32***</td>
<td></td>
<td></td>
<td>-.38***</td>
<td>-.25***</td>
</tr>
<tr>
<td>4. Mental health service</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>5. Would not seek help from anyone</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Suicidal thoughts</td>
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<td>.02</td>
<td>-.08*</td>
<td>-.13***</td>
<td>.07</td>
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<td>Help-seeking intentions</td>
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<td>1. Intimate partner</td>
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<td>.30***</td>
<td>-.33***</td>
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</tr>
<tr>
<td>2. Friend</td>
<td>.52***</td>
<td></td>
<td>.33***</td>
<td>-.23***</td>
<td></td>
</tr>
<tr>
<td>3. Family</td>
<td>.48***</td>
<td></td>
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<td>-.29***</td>
<td>-.28***</td>
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<td>4. Mental health service</td>
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</table>

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

**Table 5: Summary of regression analyses predicting intentions to seek help from a mental health service**

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>SE</th>
<th>β</th>
<th>Partial r</th>
<th>Adj R²</th>
<th>F</th>
<th>p</th>
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<tbody>
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<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Family</td>
<td>.20***</td>
<td>.04</td>
<td>.24</td>
<td>.22</td>
<td>.13</td>
<td>16.73</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Need for autonomy</td>
<td>-.13***</td>
<td>.04</td>
<td>-.14</td>
<td>-.14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Would not seek help</td>
<td>-.10**</td>
<td>.03</td>
<td>-.12</td>
<td>-.12</td>
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<td></td>
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<tr>
<td>Friend</td>
<td>.07</td>
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<td>.01</td>
<td>.01</td>
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<tr>
<td>Family</td>
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<td>.04</td>
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<td>.33</td>
<td>.36</td>
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<td>-.14</td>
<td>-.16</td>
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<tr>
<td>Need for autonomy</td>
<td>-.14**</td>
<td>.05</td>
<td>-.10</td>
<td>-.11</td>
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<td></td>
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<tr>
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<td>.08</td>
<td>.10</td>
<td>.09</td>
<td>.19</td>
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<td>.08</td>
<td>-.01</td>
<td>-.01</td>
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<td></td>
<td></td>
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</tbody>
</table>

**p < .01, ***p < .001.**
need for autonomy was a stronger barrier to seeking mental health treatment for a personal-emotional problem than current help-seeking fears (Wilson & Deane, 2010b). Need for autonomy and greater independence are important developmental issues for emerging adults, and need to be taken into account in relation to help-seeking for mental health problems. While the effects shown here are relatively weak, they do suggest that mental health services need to be mindful of the importance of autonomy and independence on deciding to seek help and selecting a help source among emerging adults, and ensure that services acknowledge and support this growing independence.

In contrast, the results of the current study reveal a stronger impact of the effect of family, and other informal supports, on help-seeking from professional mental health sources. Intentions to seek help from family were associated with significantly higher intentions to seek mental health care. It should be noted, however, that the highest help-seeking intentions were for intimate partner, followed by friend and then family member. This pattern was evident for both CMD and suicidal thoughts. While there were moderately strong correlations between help-seeking intentions across the different informal sources, intentions were strongest for intimate partner. This reveals the emergence of the role of the intimate partner in the help-seeking process for young adults. Developmentally, the early adult years are strongly focused on the development of intimate relationships, and this is one factor that distinguishes emerging adults from adolescents. It also shows a major transition to adulthood, as evidence shows that for adults intimate partners are particularly relevant in the help-seeking process (Rickwood et al., 2005; Tudiver & Talbot, 1999), and more so than family of origin.

Nevertheless, for these emerging adults, it was still the family, and not intimate partners, who had the greatest influence on intentions to seek help from mental health sources. Family, especially mothers, have a vital role in helping young people recognise their symptoms and need for professional mental health care (e.g., Cusack, Deane, Wilson, & Ciarrochi, 2004; Rickwood et al., 2007a; Wilson & Deane, 2001). One difficulty for parents and other family members, however, is that the symptoms of mental health problems can act as important help-seeking barriers. The help-negation process refers to the help withdrawal or avoidance that has been repeatedly found in samples of young people with clinical and subclinical levels of suicidal ideation, depression, anxiety, and general psychological distress (Wilson, Bushnell, & Caputi, 2011). Studies of emerging adults in both Australia and the US have established that young people with higher symptom levels are most often those with the lowest intentions to seek help from family and friends, and particularly from parents (see Wilson et al., 2011, for a review).

Help-negation for family and especially parents means that young people who are most at-risk for developing severe mental disorders or completing suicide may not receive the support they need to facilitate early access to specialist mental health treatment (Wilson et al., 2011). The quality of family relationships is important in this regard, as the help-negation process is partly a function of the perceived quality of support that a young person expects to receive from parents and other family members. A study in the US of 321 university students found that perceptions of social support mediated the help-negating effect of suicidal ideation for informal sources (Yakunina, Rogers, Waehler, & Werth, 2010). Family members need to ensure that they maintain strong links with emerging adults as they leave home, develop strong intimate attachments, and enter the adult world of work and further education. Despite growing independence, family members continue to have an important role in helping young people to recognise their symptoms and need for professional help.

Family members, and parents in particular, need to have a clear understanding of the behaviours, thoughts and emotions that are normal for young adults, as well as the behaviours (including social disengagement and withdrawal), thoughts and emotions that might indicate mental health problems are developing (Wilson et al., 2011). For many emerging adults, family of origin remains the primary source of help – most likely to notice unusual behavior and comprising trusted relationships that enable discussion about issues related to
mental health care. Consequently, family members need to be clear about the point at which their support becomes insufficient for managing symptoms of psychological distress, and how to best support their son, daughter, or sibling to access and use professional mental health care. Family members also need to know about the help-negation process and what to do to intervene when their loved ones are demonstrating signs and symptoms of psychological distress (Wilson et al., 2011). Strategies that focus on increasing the perceived and actual quality of relationships that exist within the young person’s social network might also help to manage, to some extent, the problem of diminished opportunity that the parents of emerging adults have to observe distress symptoms when young people move away from home.

These results highlight several other implications for research and early intervention. For research, the consistency between the help-seeking intentions that are reported in this study and nationally reported rates of help-seeking behaviour suggests that future research needs to pay far greater attention to understanding the role of help-seeking intentions and the cognitive processes that influence these intentions, which drive help-seeking behaviour. The 2007 NSMHWB revealed that among emerging adults with a 12-month diagnosis of a CMD, three-quarters did not access mental health services for their symptoms (Burgess et al., 2009). In congruence, our results show that approximately three-quarters of emerging adults reported it unlikely that they would access mental health services for symptoms of a CMD. Similarly, the 2007 NSMHWB found that approximately two-fifths of Australians with serious thoughts of suicide in the last 12 months did not seek help for their condition (Johnston et al., 2009). Our results show that approximately half these emerging adults think it is unlikely that they would access a mental health service if they were suicidal. Help-seeking intentions are the action component of making a decision to seek help and the cognitive function that is proximal to help-seeking behaviour (Webb & Sheeran, 2006; Wilson & Deane, 2010a; Wilson et al., 2005a). The general consistency between our results and those of the 2007 NSMHWB suggest that large numbers of emerging adults might not access or use mental health services for symptoms of a CMD or suicidal thoughts because they have a pervasive orientation to not seek mental health care prior to the development of symptoms.

There are several limitations to the current study that should be considered when reviewing these results. Primarily, our study did not measure behaviours so a causal relationship between help-seeking intentions and behaviours cannot be established. Similarly, the use of cross-sectional data, collected at one time-point, does not allow for causal inferences. The extent to which the results were influenced by shared sources of method variance in the self-report data is not known. It is also unclear how responses to a vignette would translate to actual help-seeking behaviours, and the use of university students as the only source of data means that the extent to which these results generalize to young adults at the community or population-level is not known.

The mental health system needs to be especially responsive to the needs of emerging adults, as symptoms of psychological distress should not be discounted and tolerated as an expected part of the journey through adolescence to adulthood (Rickwood, White, & Eckersley, 2007b). Emerging adults have unique needs due to their developmental life-stage. This research reveals that the family of origin still has an important influence on service access, but also, that the growing independence and autonomy of emerging adults needs to be accommodated if mental health treatment services are to be accessible to this important age group.

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