Mental and substance use disorders are highly prevalent among young people. Worldwide, up to 20% of children and adolescents experience a significant mental health problem (Belfer, 2008). In Australia, approximately half of the burden of disease and injury among young people, aged 15–24 years, can be directly attributed to mental health problems (Australian Institute of Health and Welfare, 2007). Approximately one in four young Australians, aged 13–24 years, experiences a mental health problem (Sawyer et al., 2000). These are mostly anxiety disorders (15.4%), followed by substance use disorders (12.7%) and affective disorders (6.3%) (Australian Bureau of Statistics, 2008).

If left untreated, mental disorders that occur in adolescence can cause distress and disability that lasts for decades (McGorry, Purcell, Hickie, & Jorm, 2007). Approximately 50% of all adult mental disorders start by age 14 (Belfer, 2008) and three quarters start before age 24 (Kessler et al., 2005). A 21-year New Zealand study found that 13% of a birth cohort of 1,265 children developed a depressive disorder between the ages of 14–16 years. Even after confounding factors and disorders were controlled for, the study found that depression, with onset in ado-
lescence, significantly increased the risk for developing future major depression (OR, 3.5; 95% CI, 1.9-6.4) and anxiety (OR, 2.2; 95% CI, 1.4-3.5) (Fergusson & Woodward, 2002). These statistics highlight the need for mental health research to focus on factors that protect young people against the development of mental disorders.

**HELP-SEEKING**

Early treatment and prevention can successfully reduce the long-term impact of many mental health problems (Rickwood, Deane, & Wilson, 2007). However, epidemiological studies suggest that there might be a general tendency among young people to avoid help when experiencing symptoms of psychological distress. Australian and international studies indicate that up to one third of young people with symptoms of a mental health problem seek professional help (e.g., Sawyer et al., 2000; Zachrisson, Rodje, & Myklebust, 2006). A Norwegian study of 11,154 high school students found that at the highest levels of anxiety and depression symptoms, only a third of adolescents sought professional help for their symptoms – two-thirds did not (Zachrisson et al., 2006). Most concerning is evidence that many young people report a preference for no help from anyone for symptoms of psychological distress (e.g., Gould et al., 2004; Sen, 2004).

**HELP-AVOIDANCE AND SYMPTOMS OF GENERAL PSYCHOLOGICAL DISTRESS**

Across population-based studies, help-avoidance has often been measured as a correlation between levels of psychological distress symptoms and intentions to not seek help. Help-seeking intentions have been measured because they proximate help-seeking behaviour (Webb & Sheeran, 2006; Wilson, Deane, Ciarrochi, & Rickwood, 2005a). In two Australian studies, one with 269 high school students (Wilson, Deane, & Ciarrochi, 2005b) and one with 302 university students (Deane, Wilson, & Ciarrochi, 2001), those with higher levels of suicidal thinking had strong intentions to ‘not seek help from anyone’ than students with lower levels of suicidal thinking. An American study of 9,000 high school students (Sen, 2004) and an Australian study of 1,700 high school and university students (Wilson, Rickwood, & Deane, 2007) found that those with the highest and most likely clinically relevant levels of depressive symptoms also had the strongest intentions to ‘not seek help from anyone’. Similarly, an Australian study of 302 university students found that those with higher levels of anxiety symptoms were also those with stronger intentions to ‘not seek help from anyone’ (Wilson & Deane, 2010). Despite the benefits of seeking and receiving help, the results suggest that young people who are most at risk for developing a lifelong mental health problem or acting on their suicidal thoughts are often those who are likely to avoid seeking help and support from anyone.

Suicide is not an impulsive act, but on a continuum from thinking about suicide to attempt and completion (Brown, Beck, Steer, & Grisham, 2000; Brown, Jeglic, Henriques & Beck, 2006). Suicidal thinking is rarely found without other psychological disturbance (Marttunen, Hillevi, Hendriksson, & Lonnqvist, 1991). Almost 50% of young people who complete suicide have a diagnosable mood disorder, such as major depression (Cheung & Dewa, 2007). Risk for major depression is increased by subsyndromal levels of depressive symptoms in adults (Judd, Akiskal, & Paulus, 1997; Judd et al., 1998), adolescents (Lewinsohn, Rohde, Klein, & Seeley, 1999; Pelkonen, Marttunen, & Aro, 2003; Pine, Cohen, Cohen, & Brook, 1999), and children (Kovacs et al., 1984). There is also increasing evidence that anxiety precedes the onset of mood disorders (Kovacs, Gatsonis, Paulauskas, & Richards, 1989; Cole et al., 1998; Avenevoli et al., 2001; Goodwin, 2002).

These results attest to the progressive nature of psychological distress and raise the question of whether a tendency to avoid help is peculiar to suicidal thinking and symptoms of common mental disorders (depression and anxiety). Help-avoidance might also be associated with
General psychological distress symptoms and help-avoidance in young Australians

symptoms of more general forms of psychological distress that can occur prior to, or alongside, the development of common mental disorders. Young people might have a predisposition toward help-avoidance that starts early in the development of a common mental disorder and prevents them from seeking help before their symptoms become severe. If evidence of help-avoidance can be related to symptoms of general psychological distress, it would suggest that prevention initiatives might be improved by targeting help-seeking for signs and symptoms of general distress, as well as common disorders.

Using the 21-item version of the Hopkins Symptom Checklist (HSCL-21; Green, Walkey, McCormick, & Taylor, 1988), a study of 590 Australian high school students found that higher levels of general distress symptoms were related significantly to lower intentions to seek help from a family doctor (GP) for suicidal and physical health problems (Wilson, Deane, Marshall, & Dalley, 2010). The HSCL-21 measures symptoms of general psychological distress, performance distress, and somatisation that are strongly associated with depression ($r = .72$, $p < .001$) and anxiety ($r = .75$, $p < .001$) (Harari, Waehler, & Rogers, 2005). These results suggest that increases in symptoms of general psychological distress, performance distress and somatisation can lead to help-avoidance from at least one type of health care professional. Whether these results provide evidence of a general tendency towards help-avoidance or reluctance to seek help from sources other than a GP is a question that is yet to be answered.

If evidence of help-avoidance can be associated with symptoms of general distress, it would highlight an opportunity for prevention initiatives to target factors that might be modified early in the development of psychological distress to reverse help-avoidance (Thompson, Hunt, & Issakidis, 2004). It would also highlight a need for easy access to mental health services that would allow young people to receive accurate advice when symptoms of general distress as well as common mental disorders first appear. Variables that inhibit the utilization and success of health care are commonly described as ‘barriers’. These are broadly categorized as ‘person-related’ (perceived or belief-related) and ‘treatment-related’ (e.g., service imposed cost) (Saunders, Zygowicz, & D’Angelo, 2006). The predominance of belief-based barriers over treatment-related barriers is highlighted in both quantitative and qualitative research. The National Youth Health and Wellbeing Survey found that the most common barrier given by young Australians to explain why they did not seek professional help, even though they met the criteria for mental health care, was a preference for managing problems alone (38%). This was followed by ‘thinking nothing could help’ (18%), ‘not knowing where to get help’ (17%), and ‘being afraid of what people think’ (14%) (Sawyer et al., 2000). In a focus group study, high school students emphasised the inhibiting influence of need for autonomy, along with help-seeking fears, anxiety, shame, and limited knowledge about the help that mental health sources provide (Wilson & Deane, 2001). If symptoms of general psychological distress promote help-avoidance, it seems likely that negative beliefs about seeking mental health treatment would have a role in explaining this relationship.

**STUDY AIMS**

The first aim of this study was to examine whether higher levels of general psychological distress symptoms relate to stronger intentions to avoid help in a subclinical sample of 15–25 year-olds. It was hypothesised that higher levels of general distress symptoms would be associated significantly with stronger intentions to not seek help from anyone for mental health problems.

The second study aim was to explore whether a general tendency towards help-avoidance for symptoms of general psychological distress could be related to different types of help. It was
hypothesized that a significant inverse relationship would be found between young people’s levels of general distress symptoms and their intentions to seek help from informal sources (including family and friends) and from formal help sources (including doctors and counselors) for mental health problems.

The third aim of the current study was to examine the influence of belief-based barriers to seeking mental health care on help-avoidance. It was hypothesised that stronger barriers would be associated significantly with stronger intentions to not seek help from anyone and weaker intentions to seek help from formal sources.

**METHOD**

**Participants**

A total of 109 students, 95 from Wollongong (65.1% of the total sample) and 38 from Nowra (34.9% of the total sample) completed the study measures. Ten students were recruited from book keeping and accounting classes, 18 from architecture classes, 44 from automotive and carpentry classes, and 19 from child studies and welfare classes. Eighteen students were completing Higher School Certificate. Seventy-three participants (67%) were male and 36 participants (33%) were female. The mean age was 18.47 years (SD = 2.21 years), ranging from 15–25 years. Eighty-seven percent of the sample described themselves as ‘Australian’, 3% as ‘Aboriginal’ and 10% as ‘Other’.

**Procedure**

The study received approval from the University of Wollongong Human Ethics Committee. Two trade (TAFE) colleges were included in the study: one located in a regional area and the other located in a rural area of New South Wales, Australia (Wollongong and Nowra, respectively). TAFE approval was provided from the Principal and Head of Student Welfare.

The study was described in an information sheet that was presented to all students across the range of skills-based classes by the Head Teacher of Student Welfare in both locations. Students who volunteered to participate provided active consent prior to survey completion. Each participant completed the anonymous research survey individually under the supervision of the welfare teacher, and placed completed surveys in unmarked envelopes that were sealed before collection. A debrief sheet outlining available help sources was supplied to students after all envelopes were collected.

**Measures**

**Intentions:** The General Help-Seeking Questionnaire (GHSQ; Wilson et al., 2005a) assesses participants’ prospective help-seeking intentions by asking them to rate the likelihood that they would seek help for different problem-types from different help sources (informal and formal). There were 2 problem-types measured in the current study: suicidal thoughts and personal-emotional problems. Informal sources were: intimate partner, friend, parent, non-parent family (4 items). Formal sources were: mental health care professional such as a psychologist or counsellor, telephone counselling, doctor/GP (3 items). The item ‘I would not seek help from anyone’ was also measured. The following problem prompt was used: ‘If you were having [problem-type], how likely is it that you would seek help from the following people?’ Participants rated their intentions to seek help from each of the eight help-source items, for both problem-types (16 items in total), on a 7-point scale (1 = ‘Extremely unlikely’ to 7 = ‘Extremely likely’). Higher scores indicate stronger help-seeking intentions. Intentions are related to prospective help-seeking behaviour and inverse associations with negative beliefs about seeking professional psychological help (Wilson et al., 2005a).

**Distress symptoms:** Symptoms of general psychological distress were measured by the 21-item Hopkins Symptom Check-List (HSCL-21; Green et al., 1988). The measure has satisfactory concurrent and construct validity in clinical and non-clinical samples (Deane, Lethem, & Spicer, 1992). The HSCL-21 has been related to prior help-seek-
ing experience, gender, treatment fearfulness, and higher levels of suicidal thinking in non-patient adolescents (Carlton & Deane, 2000). It has also been related to higher levels of depression and anxiety in non-patient university students (Harari et al., 2005). The 21 items examine the degree to which general psychological symptoms (e.g., self-blame, feeling blue), performance distress (e.g., difficulty speaking, remembering things), and somatisation (e.g., back pain, hot/cold spells) have affected individuals in ‘the past seven days, including today’. The items are self-rated on a 4-point scale (1 = ‘Not at all’ to 4 = ‘Extremely’) that can be summed to obtain a general psychological distress symptom score ranging from 21–84. Higher scores indicate greater degrees of general psychological distress. A Cronbach alpha coefficient of .92 was obtained for the current sample.

**Barriers**: The brief version of the Barriers to Adolescents Seeking Help scale (BASH-B; Wilson et al., 2005b) was derived from the longer scale developed by Kulh, Jarkon-Horlick, and Morrissey (1997). The BASH-B comprises 11 of the original 37 self-report items that specifically target perceived or belief-based barriers to seeking professional mental health care (original items: 3, 5, 6, 10, 17, 18, 23, 26, 29, 33, 36). Each item is rated on a 6-point scale (1 = ‘Strongly disagree’ to 6 = ‘Strongly agree’). Higher scores indicate stronger barriers to seeking professional mental health care. In adolescent samples, the BASH-B has shown good validity and reliability with Cronbach’s alphas of .84 (Wilson et al., 2005a) and .83 (Wilson et al., 2005b). In the current study, the BASH-B had a Cronbach’s alpha of .88.

**RESULTS**

**Preliminary analyses**

Based on the results of confirmatory principal component analyses, intentions variables for formal and informal help-source categories were created by averaging group items across the 2 problem-types. The new help-source variables were labeled: informal help for mental health problems (8 items: girlfriend/boyfriend, friend, parent, and non-parent relative × 2 problem types; $M = 3.91, SD = 1.52, \alpha = .85$) and formal help for mental health problems (6 items: mental health professional, telephone counsellor, and doctor/GP × 2 problem-types; $M = 2.22, SD = 1.24, \alpha = .85$). Intentions for both help source categories were significantly related ($r = .39, p < .001$). However, the mean difference between the new variables found that intentions to seek help from informal sources was significantly stronger than for sources of formal help ($t = 11.46, df = 108, p < .001$). The new intentions variables were used in the main analysis, along with a new 2-item variable measuring intentions to not seek help from anyone for mental health problems (2 items: ‘would not seek help from anyone’ × 2 problem-types; $M = 2.65, SD = 1.86, \alpha = .73$).

The means and standard deviations revealed that the current sample had moderate levels of general psychological distress symptoms ($M = 39.72, SD = 13.11$) and moderately strong belief-based barriers to seeking formal help for mental health problems ($M = 3.54, SD = 1.08$). Mean differences by location found that Wollongong students had significantly stronger intentions to seek informal help ($M = 4.12, SD = 1.54$) than students from Nowra ($M = 3.52, SD = 1.24; t = 2.02, df = 107, p = .046$). Mean differences by gender found that males had significantly stronger belief-based barriers to seeking formal help ($M = 2.62, SD = 1.04$) than females ($M = 2.12, SD = 1.07; t = -.234, df = 107, p = .021$). Correlations found that the type of skills class attended by participants was not associated significantly with other study variables (all $p$-values $>.05$).

Most participants reported that their intentions to not seek help, as well as their intentions to seek formal help for a mental health problem were at the unlikely end of the response spectrum (scores of 1–3). Prior to the main analysis, log-linear transformation was applied to both intentions variables to correct for skew. All other variables were normally distributed.
Main analyses
Evidence for help-avoidance is provided by significant positive correlations between symptoms of general psychological distress and intentions to not seek help. Evidence is also provided by significant negative correlations between symptom levels and intentions to seek help from specific sources. In the current study, higher levels of general distress symptoms were correlated significantly with stronger intentions to not seek help from anyone ($r = .34, p < .001$) and weaker intentions to seek help from informal sources ($r = -.20, p = .037$) for mental health problems. As levels of general distress symptoms increased, participants reported that they were more likely to not seek help and less likely to seek help from informal sources for a mental health problem. In contrast, the correlation between general distress symptoms and intentions to seek formal help was not significant ($r = .03, p = .754$). As symptoms of general psychological distress increased, participants remained unlikely to seek formal help for mental health problems.

Bivariate correlations and regression analyses were used to test the hypothesis that participants with higher levels of general distress symptoms would have stronger intentions to not seek help because they also have stronger belief-based barriers to seeking formal mental health care. Correlations found that stronger barriers were associated significantly with stronger intentions to not seek help ($r = .28, p = .003$) and weaker intentions to seek formal help ($r = -.28, p = .010$). Two regression equations, one for intentions to not seek help and one for intentions to seek formal help were run with barriers and general distress symptoms used as covariates. The results are presented in Table 1. Stronger barriers and higher symptom levels both predicted stronger intentions to not seek help from anyone, with symptoms being the largest unique predictor of these intentions ($F_{(2,107)} = 4.80, p = .001, \text{Adj. } R^2 = .16$). In contrast, stronger barriers also predicted weaker intentions to seek help from formal sources for a mental health problem, but the relationship between general distress symptoms and intentions to seek help from formal sources was not significant ($F_{(2,107)} = 3.67, p = .020, \text{Adj. } R^2 = .05$).

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<tr>
<td>General distress symptoms</td>
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<tr>
<td>Barriers</td>
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<td>Intentions to seek formal help</td>
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<td>Barriers</td>
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***$p < .001$; **$p < .01$

Discussion
The most important finding from the current results was that higher levels of general psychological distress symptoms were associated with stronger intentions to not seek help from anyone for a mental health problem. The study also found that higher levels of general distress symptoms were associated with weaker intentions to seek help from informal sources, such as friends and family. Importantly, the results suggest that, in the current study, those young people with the highest levels general psychological distress symptoms were also those most likely to not seek help from anyone and least likely to seek help from family and friends for a mental health problem. The results support the hypothesis that help-avoidance can occur in relation to increased levels of general psychological distress symptoms in young people aged 15–25 years.

This study found no evidence that increased levels of general psychological distress symptoms were related to these young people's intentions to seek help from formal sources for mental health problems, despite the availability of cost-free on-campus and confidential counselling services. The influence of identity formation in young people might help explain this apparent help-avoidance
when symptoms of general distress are experienced. Wisdom, Clarke and Green (2006) suggest that ‘contrasted with adults, the threat of an illness identity is likely to be much more salient to young people already struggling with defining their identity’ (p. 142). It is possible that the perceived threat of being viewed as mentally unwell means that young people avoid seeking and engaging in help, even when professional mental health care is free of charge and widely accessible – as it is for TAFE students.

Another possibility is that the young people in the current study might not have perceived a need for formal help for their symptoms. There might be a critical level that symptoms of general distress need to reach before a young person will seek formal help for their mental health problem. At low to normal levels, general psychological distress symptoms might not relate to help-seeking intentions for formal sources because these symptoms are not perceived as severe enough to warrant formal help. However, higher symptom levels might act as ‘approach’ factors to seeking treatment. A study of 233 clients at an Australian specialist anxiety clinic found that increased symptom severity was the primary prompt for clients’ actual help-seeking (Thompson et al., 2004). The same might be true for young people with clinically relevant symptoms of general psychological distress. As general distress symptoms become more severe, young people might also become more likely to perceive a need for formal help then seek it. Further research needs to examine this possibility.

Additional results suggest that for formal help, these young people’s intentions were influenced more by their negative beliefs about seeking professional mental health care than their levels of general distress symptoms per se. In the current study, young people with stronger belief-based barriers to seeking therapy had stronger intentions to not seek help from anyone and weaker intentions to seek formal help for a mental health problem. The barrier measure captures a generally negative disposition toward mental health treatment that also provides a list of specific beliefs that should be targeted in prevention initiatives. Interventions should aim to adjust inaccurate beliefs by providing information about the role of different mental health professionals. Special effort is needed to promote the value of seeking professional mental health care to young people alongside the consequences of not seeking help. These consequences must be explained in ways that do not conflict with normal processes of adaptive development (e.g., individuation) or promote fear that exacerbates help-avoidance. Ongoing education to promote mental health literacy and raise awareness of the most appropriate type of help sources for different types of mental health problems is also warranted. Interventions need to continue to teach young people to identify early signs and symptoms of different forms of psychological distress and to encourage young people to seek appropriate help for symptoms of general distress – even when symptoms levels are low. An example of how this might be done is provided by the Australian national ‘headspace PASS!’ – Promoting Access and Support Seeking – program, which uses classroom presentations to promote the value of help-seeking from a range of available sources. ‘headspace PASS!’ also implements a range of rehearsal activities to teach young people how to seek help and what they can do when they find the response of others, to their initial help-seeking advances, to be unhelpful.

The current results suggest that there may be specific factors associated with each of the three constructs that are captured by the distress measure – general psychological symptoms, performance distress, and/or somatisation – which promote help-avoidance for mental health problems. It might be that symptoms, such as self-blame or difficulty speaking to others, have a stronger role in promoting help-avoidance than other symptom-types. Young people have explained that they would avoid seeking professional mental health care because they fear not being able to adequately express themselves (Wilson & Deane, 2001). Lack of emotional compe-
tence and not having the language or skills to recognise, interpret and share emotional experiences inhibits help-seeking in young people (Rickwood, Deane, Wilson, & Ciarrochi, 2005). It is possible that as levels of general psychological distress symptoms increase, even at subclinical levels, young people find it increasingly difficult to articulate their thoughts and feelings, which subsequently leads to help-avoidance. It has also been suggested that a possible factor in help-avoidance is the general social withdrawal that is associated with the neurobiology of different forms of psychological distress (Wilson et al., 2007). Further research needs to examine these possibilities. These factors might provide useful intervention points to both inhibit help-avoidance and facilitate more effective mental health care seeking behaviour.

**Limitations**

There are several limitations to the current study that should be noted. Firstly, the sample was small so whether these results generalise to the wider TAFE student population, as well as the broader community, is unclear. The current sample was drawn from different locations (regional vs. rural) and classes with different skills preferences (e.g., welfare versus automotive). However, the only difference that was associated with sample characteristics indicated that students who attended the regional TAFE had stronger intentions to seek help from informal sources than students attending the rural TAFE. Further research might examine help-seeking intentions in a larger sample that includes a broader range of demographic variables. Recruiting larger representative samples might be achieved by using a combination of cross-sectional and targeted sampling. Secondly, the results were based solely on self-report measures and biases in reporting may be present. Further research might include observational or interview ratings of young people’s distress symptoms, together with a measurement of their longitudinal help-seeking behaviour. Further research might also include an examination of how actual help-seeking behaviour changes as levels of different types of symptoms rise and fall.

**Conclusions**

The current study suggests that, even at low levels, increases in levels of general psychological distress symptoms and negative beliefs about seeking mental health treatment can lead to help-avoidance for mental health problems. The fact that help-avoidance was indicated for informal help sources in a sample with very low overall help-seeking intentions highlights the robust nature of the tendency. Special effort is needed to reach out to young people to determine whether they need help and when they do, to support them to seek and receive appropriate help in a timely manner. Promotion, prevention and early intervention programs that are related to mental health should be encouraged to incorporate education about young people’s general tendency to avoid help for low levels of general psychological distress symptoms and common mental disorders. It is possible that making young people aware of the possibility that they might avoid their usual help sources when they become distressed, even when their symptom levels are low, will help them overcome help-avoidance when faced with mental health problems.

**Acknowledgement**

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