Depressive symptoms and help-seeking intentions in young people

Coralie Joy Wilson, Debra Rickwood, Frank Patrick Deane

Illawarra Institute for Mental Health, University of Wollongong, Wollongong, New South Wales
Graduate School of Medicine, University of Wollongong, Wollongong, New South Wales
School of Health Sciences, University of Canberra, Canberra, Australian Capital Territory, Australia
School of Psychology, University of Wollongong, Wollongong, New South Wales

Online Publication Date: 01 January 2007


To cite this article: Wilson, Coralie Joy, Rickwood, Debra and Deane, Frank Patrick
To link to this article: DOI: 10.1080/13284200701870954
URL: http://dx.doi.org/10.1080/13284200701870954

Full terms and conditions of use: http://www.informaworld.com/terms-and-conditions-of-access.pdf

This article maybe used for research, teaching and private study purposes. Any substantial or systematic reproduction, re-distribution, re-selling, loan or sub-licensing, systematic supply or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The accuracy of any instructions, formulae and drug doses should be independently verified with primary sources. The publisher shall not be liable for any loss, actions, claims, proceedings, demand or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.
Depressive symptoms and help-seeking intentions in young people

CORALIE JOY WILSON¹,², DEBRA RICKWOOD³, & FRANK PATRICK DEANE¹,⁴

¹Illawarra Institute for Mental Health, University of Wollongong, Wollongong, New South Wales, ²Graduate School of Medicine, University of Wollongong, Wollongong, New South Wales, ³School of Health Sciences, University of Canberra, Canberra, Australian Capital Territory, Australia and ⁴School of Psychology, University of Wollongong, Wollongong, New South Wales

Abstract

Whether the help-negation effect as demonstrated for suicidal thoughts was also evident for depressive symptoms was investigated in three studies of young people from diverse urban areas. The studies involved a large sample of younger high school students (years 7 – 10), a sample of older high school students (years 8 – 12), and first year university students. A self-report questionnaire that measured help-seeking intentions, prior help-seeking experiences, and depression was administered. It was found that the strongest inverse association between level of depressive symptoms was with intentions to seek help from parents across all three samples. There was a consistent trend for students to report being more likely to seek help from no one as depressive symptoms increased. Evidence of the help-negation effect being present for depressive symptoms is discussed in terms of ways to encourage appropriate and effective help-seeking in young people.

Keywords: adolescents, depression, help-negation, help-seeking, youth

It is widely recognised that adolescence is a developmental period with fluctuating levels of psychological distress, often in the form of depression and anxiety (e.g., Husler, Blakeney, & Werlen, 2005). Seeking appropriate help for these psychological problems, before they become severe, can reduce adolescents’ risk for developing other acute comorbid difficulties such as suicidal ideation (e.g., Gould et al., 2004; Kalafat, 1997). Consequently, encouraging appropriate and effective early help-seeking behaviour for mental health problems is essential for prevention and early intervention in adolescence and young adulthood (Rickwood, Deane, & Wilson, 2007).

Of considerable concern are reports that only around one third of young people with mental health problems receive professional mental health care (e.g., Sawyer et al., 2000; Zachrisson, Rödje, & Mykletun, 2006). A range of barriers to seeking treatment means that relatively few young people with mental health problems access professional psychological help when it is warranted. Saunders et al. (2006) recently categorised these barriers to treatment as either treatment related or person related. Treatment-related barriers include factors such as cost and lack of access, while person-related barriers include cognitive and emotional factors such as poor problem recognition and mental health literacy, embarrassment, and apathy.

Greater problem recognition is viewed as a facilitator of help-seeking behaviour, and increasing psychological distress has been shown to facilitate such recognition, although not to the extent that might be expected. Seeking help is not a simple process of experiencing psychologically distressing symptoms, recognising these, and acting to seek help (Rickwood, Deane, Wilson, & Ciarrochi, 2005). Psychological distress is, however, generally viewed as an “approach” factor for seeking help (e.g., Rickwood & Braithwaite, 1994), in that, as individuals experience more distress there is greater problem recognition and increased perceived need for help, which leads to higher help-seeking intentions and effort. But this may not be the case for all psychological symptoms, and some types of symptoms may contribute to person-related barriers to accessing appropriate help. For example, Deane and...
colleagues have found that as suicidal ideation increases, the help-seeking intentions of young people decrease, even at subclinical levels of ideation. The researchers found a significant inverse relationship between suicidal ideation and help-seeking intentions in samples of high school and university students (Carlton & Deane, 2000; Deane, Wilson, & Ciarrochi, 2001; Wilson, Deane, & Ciarrochi, 2005). Although psychological distress usually co-occurs with suicidality, symptoms of suicidal ideation seem to negate the help-seeking process.

Depressive symptoms are one of the most common expressions of psychological distress experienced by young people, yet it is currently unclear whether they operate as “approach” or “avoidance” factors for help-seeking. Importantly, social withdrawal is commonly recognised as a symptom of major depressive disorder for children and adolescents, despite not formally being part of the DSM criteria in adults (Ryan et al., 1987). Young people who experience depressive symptoms are likely to withdraw from their usual social supports of family and friends and, at the same time, not approach professional services, which also require social interaction. Recent animal neuroscience research has confirmed that social withdrawal is associated with the brain changes related to depression (Berton et al., 2006). Consequently, it is possible that help-negation may operate for depression, partly through such social withdrawal.

In a study of 254 Australian high school students, Sheffield, Fiorenza, and Sofronoff (2004) aimed to identify promoting and preventing factors that influence adolescents’ intentions to seek professional psychological help. The results showed that adolescents with higher levels of comorbid depression, anxiety and stress were more likely to seek help from formal and informal help sources for a personal or emotional problem, but the effects were very weak, and the effect of depressive symptoms could not be separated in this research from the effects of anxiety and stress. In contrast, Gould et al. (2004) examined the coping and help-seeking strategies of a large sample of 2419 US high school students, and found that although most adolescents endorsed healthy coping attitudes about the management of depression, one quarter of the depressed adolescents who participated in the study indicated that they would keep their feelings to themselves. Similarly, when the relationship between depression and help-seeking behaviour of 9000 US high school students was examined, it was found that higher levels of depression were related to ‘not seeking help from anyone’ (Sen, 2004).

Whether depressive symptoms prompt seeking help, as would be expected, or negate help-seeking, as has been found for suicidal ideation, is currently unknown. Yet, understanding the impact of depressive symptoms on help-seeking in adolescence and young adulthood is essential given the high prevalence of such symptoms and the very disabling effects of depressive symptoms at this formative life stage. Furthermore, depression has high levels of comorbidity with other serious mental health problems such as suicidal ideation and harmful alcohol and other drug use (Fergusson & Woodward, 2002). Consequently, the aim of the current study was to explore the relationship between levels of depressive symptomatology and help-seeking intentions in adolescents and young adults, to determine whether depressive symptoms facilitate or inhibit help-seeking from both professional and informal sources of help. A secondary aim was to examine the relationship between prior professional help-seeking and future help-seeking intentions.

It was hypothesised that the relationship between depression and help-seeking intentions would be, in part, a function of the help source. As young people become more autonomous they often have a desire to be more independent and to separate from parents (i.e., individuate). In fact, it has been suggested that conflict associated with establishing autonomy from parents may contribute to adolescent depression: “Adolescent difficulties in the struggle to attain autonomy while maintaining positive relationships with parents create enormous developmental strains that may lead to depressive symptoms” (Allen et al., 2006, p. 55). To compensate, as adolescents become more independent from parents there is increasing reliance on their own coping resources as well as on peers and friendship networks for social support (Adams & Marshall, 1996). Thus, it was anticipated that while there would be an inverse relationship between levels of depression and help-seeking intentions from parents, there should be a positive relationship between depression and help-seeking intentions from friends. It was also anticipated that because of the increasing need for autonomy and the social withdrawal that is often associated with depression, there would be a consequent desire to attempt to resolve a problem oneself and that this would be evident in increasing intentions not to seek help, with higher levels of depression.

In terms of professional help-seeking, it was anticipated that consistent with adolescent individuation trends, (a) younger adolescents would be willing to consult a mental health professional who might be familiar and available to them (e.g., school counsellor); (b) older adolescents, whose core developmental focus is autonomy and identity formation, would demonstrate reluctance to seek professional psychological help and greater desire to solve their problems alone; and (c) university students with likely greater knowledge of the role of
mental health professionals and the importance of help-seeking as an autonomous problem solution strategy, would report greater intentions to seek professional help for solving personal or emotional problems. Additionally, in each age group it was expected that this would be affected by prior professional help-seeking experiences for those young people who had such previous experience.

Method

Participants

Participants were drawn from three independent studies from three different urban locations in Australia: Canberra, Brisbane and Wollongong. General sample characteristics for each Study are presented in Table I. Study 1 consisted of a younger high school sample (years 7–10, mean age 13.5 years) that was drawn from unstreamed classes in two large inner and two outer area public high schools in Canberra. Study 2 used an older high school sample (years 8–12, mean age 15 years) drawn also from unstreamed classes in one private

Christian (Lutheran) high school in Brisbane. Study 3 involved older students drawn from first year psychology classes in Wollongong (mean age approximately 19 years). An equivalent proportion of male and female students were reported in Study 1, whereas female subjects were overrepresented in Studies 2 and 3.

Procedure

All three studies involved completion of an anonymous, self-report questionnaire that consisted of measures of help-seeking intentions, quality of prior professional help, depression, and demographic information. Ethics approval was obtained from the appropriate institutional ethics and review committees. For the high school samples, both parental and student consent were required prior to participation: the research was described in an information sheet that was posted to parents, and students were provided with written and verbal information regarding the study in their classes during administration. The high school participants completed the anonymous self-report questionnaire in class groups

Table I. Sample characteristics (M, SD)

<table>
<thead>
<tr>
<th>Sample Characteristics</th>
<th>Total Sample</th>
<th>Minimal depression</th>
<th>Mild depression</th>
<th>Moderate – severe depression</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Study 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>nTotal</td>
<td>1184</td>
<td>716</td>
<td>342</td>
<td>124</td>
</tr>
<tr>
<td>nMale</td>
<td>595</td>
<td>402</td>
<td>154</td>
<td>39</td>
</tr>
<tr>
<td>nFemale</td>
<td>589</td>
<td>316</td>
<td>188</td>
<td>85</td>
</tr>
<tr>
<td>Age (years)</td>
<td>13.60 (1.20)</td>
<td>13.57 (1.20)</td>
<td>13.55 (1.24)</td>
<td>13.71 (1.12)</td>
</tr>
<tr>
<td>Age range (years)</td>
<td>11 – 17</td>
<td>11 – 17</td>
<td>11 – 17</td>
<td>11 – 17</td>
</tr>
<tr>
<td>Grade level</td>
<td>Years 7 – 10</td>
<td>Years 7 – 10</td>
<td>Years 7 – 10</td>
<td>Years 7 – 10</td>
</tr>
<tr>
<td>Depression</td>
<td>15.60 (10.85)</td>
<td>8.45 (3.96)</td>
<td>22.35 (4.64)</td>
<td>38.37 (5.80)</td>
</tr>
<tr>
<td>CES-D score (range)</td>
<td>0 – 56</td>
<td>0 – 15</td>
<td>16 – 31</td>
<td>32 – 56</td>
</tr>
<tr>
<td><strong>Study 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>nTotal</td>
<td>313</td>
<td>176</td>
<td>61</td>
<td>76</td>
</tr>
<tr>
<td>nMale</td>
<td>110</td>
<td>74</td>
<td>14</td>
<td>22</td>
</tr>
<tr>
<td>nFemale</td>
<td>203</td>
<td>102</td>
<td>47</td>
<td>54</td>
</tr>
<tr>
<td>Age (years)</td>
<td>15.50 (1.48)</td>
<td>15.48 (1.52)</td>
<td>15.46 (1.52)</td>
<td>15.59 (1.34)</td>
</tr>
<tr>
<td>Age range (years)</td>
<td>12 – 18</td>
<td>12 – 18</td>
<td>13 – 18</td>
<td>13 – 18</td>
</tr>
<tr>
<td>Grade level</td>
<td>Years 8 – 12</td>
<td>Years 8 – 12</td>
<td>Years 8 – 12</td>
<td>Years 8 – 12</td>
</tr>
<tr>
<td>Depression</td>
<td>14.07 (10.96)</td>
<td>6.49 (3.73)</td>
<td>16.67 (1.77)</td>
<td>29.57 (9.02)</td>
</tr>
<tr>
<td>BDI score (range)</td>
<td>0 – 63</td>
<td>0 – 13</td>
<td>14 – 19</td>
<td>20 – 63</td>
</tr>
<tr>
<td><strong>Study 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>nTotal</td>
<td>269</td>
<td>185</td>
<td>36</td>
<td>47</td>
</tr>
<tr>
<td>nMale</td>
<td>58</td>
<td>45</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>nFemale</td>
<td>211</td>
<td>140</td>
<td>29</td>
<td>41</td>
</tr>
<tr>
<td>Age (years)</td>
<td>19.16 (1.61)</td>
<td>19.09 (1.52)</td>
<td>19.17 (1.46)</td>
<td>19.47 (2.04)</td>
</tr>
<tr>
<td>Age range (years)</td>
<td>17 – 24</td>
<td>17 – 24</td>
<td>18 – 23</td>
<td>17 – 24</td>
</tr>
<tr>
<td>Undergraduate level</td>
<td>Yr 1, Psyc</td>
<td>Yr 1, Psyc</td>
<td>Yr 1, Psyc</td>
<td>Yr 1, Psyc</td>
</tr>
<tr>
<td>Depression</td>
<td>12.04 (8.94)</td>
<td>7.25 (3.48)</td>
<td>16.17 (1.91)</td>
<td>27.70 (7.51)</td>
</tr>
<tr>
<td>BDI score (range)</td>
<td>0 – 63</td>
<td>0 – 13</td>
<td>14 – 19</td>
<td>20 – 63</td>
</tr>
</tbody>
</table>

Notes: BDI = Beck Depression Inventory; CES-D = Centre for Epidemiologic Studies Depression Scale.

Study 1 = public high schools sample, suburban areas, Canberra, ACT; Study 2 = private Christian high school sample, suburban area, Brisbane, Qld; Study 3 = university sample, Wollongong, NSW.
Depressive symptoms and help-seeking

under the supervision of classroom teachers or the researchers, and questionnaires were returned in individual sealed envelopes to ensure confidentiality. University students were recruited through a Department of Psychology student research participation scheme, and completed the self-report questionnaire in small groups, also returning them in unmarked envelopes.

Measures

Help-seeking intentions and quality of prior professional help were measured using the General Help-Seeking Questionnaire (GHSQ) (Deane et al., 2001; Wilson, Deane, Ciarrochi, & Rickwood, 2005). Participants’ intentions are determined by asking them to rate the likelihood that they would seek help from a variety of specific help sources (e.g., friend, parent, mental health professional, doctor/general practitioner [GP]). The current studies used the following problem prompt: “If you were having a personal-emotional problem, how likely is it that you would seek help from the following people?” Participants rated their intentions to seek help from each specific help source, in addition to “I would not seek help from anyone”, on a 7-point scale (1 = extremely unlikely to 7 = extremely likely). Higher scores indicated higher help-seeking intentions from that source or no one.

Participants were also asked, “Have you ever seen a mental health professional (e.g., counsellor, psychologist, psychiatrist) to get help for personal problems? (Circle yes or no)”. If students reported “yes”, they were asked to rate “How helpful was/ were the visit/s to the mental health professional?” on a 5-point scale (1 = extremely unhelpful to 5 = extremely helpful). Higher scores indicated greater perceived helpfulness of prior help from a mental health professional.

Qualitative data, in addition to those collected in Studies 2 and 3, were obtained in Study 1 only. Participants in Study 1 were also asked an open-ended question about perceived barriers to seeking professional mental health help, and to rate their perceived ease, or efficacy, of seeking help from a mental health professional on a 6-point scale from very easy to very difficult.

Depression was measured in Study 1 using the Centre for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977). This is a 20-item scale that measures current levels of depressive symptoms with an emphasis on depressed mood. Designed for use in the general population, the CES-D has been shown to be valid and reliable for both adolescents and young adults (Garrison, Addy, Jackson, McKeown, & Waller, 1991; Radloff, 1991). A Cronbach alpha coefficient of .90 was obtained for the current sample. Generally, a score ≥16 indicates the presence of depressive symptomatology, and a cut-off score of ≥20 indicates clinically relevant depressive symptoms (Culp, Clyman, & Culp, 1995). In Study 1 those with scores of 0–15 were nominated as having a minimal level of depression, those with scores of 16–31 had mild depression, and those with scores ≥32 had moderate–severe depressive symptoms.

The Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996) was used in Studies 2 and 3 and is a widely used 21-item self-report measure that identifies the presence and degree of depressive symptoms in adults and adolescents. The CES-D and BDI have been shown to perform comparably as depression screening instruments (e.g., Zich, Attkisson, & Greenfield, 1990). The BDI was designed for use in general and clinical populations, the BDI-II has also been shown to be reliable and valid across age groups (Beck et al., 1996). Participants respond to each item on a 4-point scale that ranges from 0 to 3. A total BDI-II score is obtained by summing the ratings for the 21 items. A Cronbach alpha coefficient of .93 was obtained for Study 2 and .91 for Study 3. A total score of 0–13 was used to indicate a minimal level of depression, 14–19 indicated mild level, and a score of ≥20 indicated a moderate to severe level of depression (Beck et al., 1996, p.11).

Results

Depression and help-seeking intentions from different sources (all studies)

To examine differences between groups with different levels of depression, a series of one-way analyses of variance of the help-seeking intention measures (dependent variables) were undertaken. Tables II–IV provide mean intention ratings by help source for each depression group in each Study. In the younger high school students (Study 1, Table II), significant differences were found between groups with varying levels of depression for intentions to seek help from friends, parents, mental health professionals, and from no one. In the second high school sample (Study 2, Table III), significant differences were found for parents, other family, teachers, and for no one. In university students (Study 3, Table IV), differences between groups were found for help-seeking intentions from friends, parents, other family, and from no one.

Post hoc comparisons (with a Bonferroni adjustment) were conducted for all three studies. Only Study 1, of younger high school students (Table II), consistently supported predictions, in that intention to seek help from friends was significantly greater for
those with moderate–severe levels of depression compared to those with mild scores ($p = .024$) and those with minimal depression ($p = .001$). An opposite effect was evident for intention to seek help from parents, where those with moderate–severe levels of depression were less likely to seek parental help compared to those with minimal depression.
help than those with both mild and minimal depression levels \((p = .001)\). Those with mild depression were also less likely to seek parental help than those with minimal depression \((p = .012)\). Younger high school students with both moderate–severe \((p = .026)\) and mild \((p = .005)\) levels of depression were significantly more likely to intend to seek help from a mental health professional than those with minimal depression \((p = .024)\). But they were also more likely to intend to seek help from no one, with younger high school students with both moderate–severe \((p = .001)\) and mild \((p = .047)\) levels of depression significantly more likely to intend to seek help from no one compared with those with minimal depression.

In the older high school student sample in Study 2 (Table III), those with moderate–severe levels of depression were less likely to seek help from parents than those with mild \((p = .027)\) or minimal depression levels \((p = .000)\), less likely to seek help from a non-parent family member than those with mild \((p = .000)\) or minimal depression \((p = .016)\), and less likely to seek help from a teacher than those with mild \((p = .050)\) or minimal depression \((p = .007)\). Similar to the younger high school sample, the older high school students with moderate–severe \((p = .000)\) or mild depression levels \((p = .007)\) were significantly more likely to seek help from no one compared with those with minimal depression, and those with mild depression were more likely to seek help from no one than those with minimal depression \((p = .002)\).

In the university students in Study 3 (Table IV), those with moderate–severe levels of depression were also less likely to seek help from parents than those with mild \((p = .001)\), but not minimal depression levels \((p = .062)\), and those with moderate–severe levels of depression were less likely to seek non-parental family help than those with mild \((p = .003)\) or minimal depression levels \((p = .001)\). In contrast to the younger groups, the university students with moderate–severe depression levels were significantly less likely to seek help from a friend than those with minimal depression \((p = .029)\). But, consistent with both younger samples, the university students with depression levels that were moderate–severe were significantly more likely to seek help from no one compared with those with minimal depression \((p = .040)\).

The trends evident from the analyses of variance were confirmed by the correlations between the continuous depression scores and help-seeking intentions. In Study 1 (Table II), as predicted, there were weak but positive and significant correlations between depressive symptoms and intentions to seek help from friends and mental health professionals. In Study 2 (Table III) these associations were not significant, and in Study 3 (Table IV) there was a negative association between depressive symptoms and help-seeking intentions from friends and a non-significant association with intentions to seek help from a mental health professional.

A consistent finding over the three studies was a significant negative correlation between depression scores and help-seeking from parents. The inverse relationship between depression and help-seeking from parents was consistent across all three studies, and was the strongest association evident. In addition, all three studies found significant differences in help-seeking intentions from parents between depression groups, such that those groups with higher levels of depression had significantly lower intentions to seek help from parents.

The other consistent finding was the significant positive correlation between depression scores and intending to seek help from no one. Both the correlational analyses and analyses of variance showed that for all the samples, as depressive symptoms increased participants reported greater intentions to seek help from no one.

Prior mental health experience, depression and help-seeking intentions (all studies)

Twenty-three per cent of high school students in both Study 1 and 2 indicated that they had previously seen a mental health professional for a personal or emotional problem (Table V). The rate of prior help-seeking from mental health professionals in the university student sample was more than twice that of the high school samples at 51%. For students in groups with higher levels of depression, there was a strong trend of greater likelihood of having had prior contact with a mental health professional.

In Study 1 23% of high school students found prior visits to a mental health professional helpful or very helpful, whereas 42% found it unhelpful or very unhelpful. Overall, perceived helpfulness of prior mental health experiences was weakly correlated with greater intentions to see a mental health professional \((r = .16)\). But this relationship was non-significant at minimal and moderate–severe levels of depression, and most evident at mild levels \((r = .33)\). The relationship between perceived helpfulness and help-seeking intentions was considerably stronger in Studies 2 and 3 \((r = .46\) and \(.49\), respectively).

Perceived barriers to seeking help from a mental health professional (Study 1 only)

In Study 1 all students were asked how easy it would be for them to see a mental health professional (e.g., counsellor, psychologist, psychiatrist) if they had a personal or emotional problem they wanted to talk
about. There were 40% who thought it would be easy and 60% who thought it would be difficult. Higher perceived ease was weakly associated with greater intentions to see a mental health professional ($r = .25, p = .001$).

Participants were also asked an open ended-question, “What sorts of things would make it hard for you to see a mental health professional if you wanted to?” Approximately 30% ($n = 359$) of the sample gave answers, which were coded into 11 reason categories. Of those who gave reasons, overwhelmingly, the most common reason given was that the young person would be embarrassed (30.5%), with a further 4.7% specifically stating that they would be “afraid”. The next most common reason given was that they did not want to talk to someone who was a stranger (19.8%), and this was often related to being embarrassed or afraid (i.e., “I’d feel stupid and embarrassed and wouldn’t be able to tell a stranger”). Almost 10% simply said they would not want to. There were 6.7% who would prefer to talk to a friend or family member – someone well known to them. Next were concerns that the mental health professional would breach confidentiality or could not be trusted (6.1%), and an equal number who thought that they could not effectively help. That one should rely on oneself rather than seek help was reported by 5.3%, and a small proportion said that they would be too busy and have no time to seek help (3.3%), or that their problems did not warrant professional intervention (2.8%).

**Discussion**

The most consistent finding was that as depression increases, intentions to seek help from parents decrease and intentions to seek help from no one increase. These associations appear to be robust and occurred across all three samples. Importantly, those young people with the highest, and most likely clinically relevant, levels of depressive symptoms were significantly less likely to intend to seek help from parents compared to those with lower levels of depression. Overall, the trend across all sources of help in each of the studies confirmed the help-negating effect of depressive symptoms, with intentions to seek help decreasing for most sources of help as the level of depressive symptoms increased. Only in the younger high school sample did help-seeking intentions significantly increase with higher levels of depression, and this was only for friends, and was a weak effect. In contrast, the help-negating effect of depression was significant for intentions to seek help from friends in the older university student sample.

All three studies followed the well-established pattern of greatest help-seeking intentions for friends, followed by parents and other family members (Rickwood et al., 2005). Intentions then decreased for other help sources and tended to remain in the unlikely end of the response spectrum. On average, young people indicated that it was unlikely that they would seek help from professional sources.

While help-negation was not clearly evident for seeking professional mental health care, this may be due to the very low level of intentions to seek such help altogether. Ways to encourage young people to be more likely to seek professional mental health care are necessary. Not surprisingly, students who had previously received professional mental health care and viewed it as helpful were more likely than those who viewed it as unhelpful to intend to seek professional psychological help in the future. Clearly, positive professional help-seeking experiences are essential to encouraging future service use.

Wisdom, Clarke, and Green (2006) suggest that depression causes young people to question their normalcy, autonomy and importantly, their connection with others; thus, “when [adolescent] disclosure is met with compassion, connection, information,
and choices from providers, teens are more likely to view the visit as positive” (p. 141). Young people want a therapeutic relationship that gives them a voice and emphasises respect, time sharing and openness between themselves and the clinician (Martin, Romas, Medford, Leffert, & Hatcher, 2006). And service dropout might be avoided by developing a therapeutic relationship that has a strong sense of safety and interpersonal connectedness, where young people have the opportunity to identify and discuss ways that treatment is relevant to them, and the chance to discuss strategies to overcome practical issues such as transport and office hours (Mensinger, Diamond, Kaminer, & Wintersteen, 2006).

The current results have particularly important implications for the role of parents in the help-seeking process, which is especially pertinent for younger adolescents. Parental perception of problems is argued to be the starting point for referral to professionals, and younger adolescents and children do not tend to self-refer (Logan & King, 2001; Sayal, 2006). The capacity for self-referral develops over adolescence alongside independence from parents, but parents continue to play a key role (Vogel, Wade, Wester, Larson, & Hackler, 2007; Wilson & Deane, 2001), particularly for young male subjects (Rickwood et al., 2005), and up until young people are financially independent.

Consequently, there is a need to address parental barriers to supporting their young person in seeking help, and in particular, their limited knowledge about where to get help and their young person’s reluctance to attend available services (Sawyer et al., 2000). This highlights a need for parents to influence and guide young people to reach professional help (Sawyer et al.). There is also a need to help parents appropriately recognise depressive symptoms in their adolescent children and to support parents to respond in ways that guide effective help-seeking. A valuable first line of support may be internet sites, which enable young people to be autonomous in finding out more about their mental health (Berger, Wagner, & Baker, 2005). Sites to suggest include Reachout (www.reachout.com.au), BluePages (www.bluepages.anu.edu.au), and the online cognitive–behavioural prevention program Moodgym (www.moodgym.anu.edu.au) (Christensen, Griffiths, & Jorm, 2004; Griffiths & Christensen, 2006).

For more serious concerns, encouraging a visit to the family doctor may be advised (see the Mind-Matters Plus GP Resource Kit, www.adgp.com.au). There is emerging evidence that adolescents’ intentions to consult a GP for physical and psychological problems can be improved, along with their rates of actual consultation, by a cognitive–behavioural program that specifically addresses belief- and knowledge-based barriers to adolescents engaging in treatment (Wilson, Deane, Marshall, & Dalley, 2007). But much more needs to be learned about the most effective strategies that parents can use to influence their adolescent children to seek mental health help.

The apparent help-negating effect of depressive symptoms, as evidenced by this research, suggests that there may be specific factors associated with depressive syndromes that impede help-seeking. It has been suggested that a likely factor is the social withdrawal that is commonly associated with depression, especially for adolescents, but this is yet to be empirically tested. It may be that other features of psychological distress states, such as hopelessness, might explain refusal to accept available help. But, to date, help-negation studies that have controlled for hopelessness find that it does not fully explain the effect (e.g., Deane et al., 2001; Wilson, Deane, & Ciarrrochi, 2005). Other aspects of depression that might be of interest include the loss of motivation or apathy that is part of the depressive symptom spectrum. As levels of depression increase, young people may experience increased levels of apathy and indifference towards help-seeking that subsequently reduce their motivation to seek help for their personal or emotional problems. Further research needs to examine these possibilities, because these factors may provide useful intervention points to both inhibit the help-negation process and facilitate more effective health care-seeking behaviour.

The vital influence of identity formation at the adolescent and youth life-stage might also help explain the reluctance to disclose mental health issues, when depression is evident. Wisdom et al. (2006) suggest that “contrasted with adults, the threat of an illness identity is likely to be much more salient to adolescents already struggling with defining their identity” (p. 142). It is possible that perceived threat of an illness identity or stigma associated with mental health problems or help-seeking means that adolescents are more likely than older young people to avoid behaviour such as seeking and engaging in help, which they might believe has the potential to deliver a damaging diagnostic label or an intervention that might damage their identity (Raviv, Sills, Raviv, & Wilansky, 2000).

Promotion, prevention and early intervention programs related to mental health should be encouraged to incorporate education about the help-negation effect. It is possible that by making young people aware that they may subtly withdraw from help sources when depressed, we may be able to “inoculate” them against such help-seeking avoidance. The Meichenbaum (1985; 1996) three-phase stress-inoculation program provides a useful model.
for such preventative interventions that could potentially be delivered in schools. In the conceptualisation phase, a collaborative relationship between the adolescents and trainer is established and the goal is to educate about problem appraisal processes, desire for independence and how individuals may inadvertently avoid or refuse help when it is needed as a result of these processes. The skill acquisition and rehearsal phases might involve behavioural rehearsal, such as, practice in locating appropriate help sources, role plays in how to ask for help, or cognitive reappraisal of threats to self-esteem (e.g., distortions in thinking around the meaning of seeking help). The final application and follow-through phases usually allow participants to implement these coping skills under increasing levels of stress. But in the current context it may be that they also support other students who are experiencing distress to implement appropriate help-seeking behaviours. Thus, by making adolescents aware of help-negation processes, it might be possible to reduce the negative help-seeking beliefs and behaviours that result in reluctance to seek necessary help, or worse, proactive help avoidance.

Limitations and conclusion

There were several limitations to the current studies that should be noted. First, the present high school samples differed in school climate in that the younger sample was sourced from a public high school while the older sample was sourced from a Christian high school. It could be expected that in a Christian high school, on average, students would have stronger religious beliefs than comparative public high school samples and such beliefs might influence the acceptability of help-seeking and/or the interpretation of depressive symptoms. But the help-negation effect was found in both samples, further highlighting the robust nature of the effect. Further research might examine help-seeking intentions in samples of differing age but with matching religious beliefs. Second, in all three of the present samples, students with minimal levels of depression were overrepresented because these were non-clinical samples. Thus, the results may not generalise to groups of young people with mild and moderate–severe levels of depression who are identified in other ways (e.g., at-risk groups such as unemployed or high school dropouts). Further research is needed to replicate the results of the current study in larger samples of moderately to severely depressed young people as well as to examine variables with potential to moderate the help-negation effect. Recruiting larger representative samples might be achieved by using a combination of cross-sectional and targeted sampling. Third, 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 levels of depression along with a measurement of their longitudinal help-seeking behaviour. Finally, the rate of prior professional help-seeking (around 51%) in the university sample seemed high and may be peculiar to psychology participant pools or reflect a selection bias or interest in those volunteering for the study. There is a need to test these findings in broader tertiary samples both within university and other settings such as Colleges of Technical and Further Education (TAFE).

In conclusion, the present study provides preliminary support for the help-negating effect of depressive symptoms. The cognitive and behavioural mechanisms by which this might occur require further investigation, but nonetheless the results indicate that families and professionals in contact with young people need to be vigilant regarding changes in social behaviour, motivation, and other signs of depression that might be acting as barriers to asking for help. Special effort is needed to reach out to such young people to determine whether they need help and, when they do, support them to seek and receive appropriate help in a timely manner.

References


