I'LL GET BY WITH A LITTLE HELP FROM MY FRIENDS:

YOUNG PEOPLE'S HELP-SEEKING FOR DEPRESSION

By

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Abstract

The present research involved two studies examining the impact of severity on the process of help-seeking for depression. The first study included a survey of 316 New Zealand Adolescents (14-18 years) help-seeking, their inclination to seek help from a friend, parent, medical person and mental health professional for each scenario, and barriers to seeking help from these sources. Young females were more likely to identify depressive symptoms as a problem, and reported higher help-seeking, as well as lower barriers to seeking help. Age and ethnicity impacted on the process of seeking help, and inclination to seek help from different sources, supporting a complex multi-stage process, which both individual and contextual variables impact on the different stages. Correspondence Analysis was conducted on participant barriers to seeking help, which revealed that the severity of symptoms and source of help were reflected in participants' selection of barriers. It was suggested that young people perceive formal sources of help as more appropriate for severe symptoms of depression than informal sources such as friends and family.

To examine this further, twenty-two semi-structured interviews were conducted with similar aged young people in the second study. Through thematic analysis, two overarching themes were identified. The expected response from a helper, and their relationship with a helper, were found to influence seeking help from different sources. The severity of depressive symptoms was found to overlap with these themes, to influence the perceived appropriateness of different helpers.

This research contributes to understanding the reasons young people prefer informal sources of help. That is, they are more trusted, the response is more predictable, and help is considered more relevant from informal sources, particularly friends. The importance of utilising and strengthening already established help-seeking pathways of friends and family is encouraged to improve help-seeking from professionals.

Acknowledgements

Table of Contents

List of Figures

List of Tables

Adolescence is a period of physical and cognitive maturation, but it is also characterised by important social development; it is when young people develop an independent sense of self, establish important peer relationships, and develop sexuality. Combined with the physical and hormonal changes, the numerous social changes during adolescence are thought to lead to an increase in stress experienced, as there are increasing demands put on young people by their family, teachers and peers. Developmentally, adolescents are exposed to new challenges and experiences, including learning to balance different roles, making decisions, and being responsible for the consequences of their decisions. Adaptive coping strategies, such as help-seeking, can enable young people to navigate adolescence more effectively, hindering the development of mental disorders such as depression. Therefore, adolescence is an important opportunity to educate young people about help-seeking, to aid adjustment and prevent the development of mental disorders, which can have a far-reaching impact on young people's well-being.

Adolescent Maladjustment

Early models of psychological disturbance (e.g. Freud, 1946) suggested that adolescence was a universal period of 'storm and stress', when the majority of young people experience disturbance. Although most adolescents exhibit significant emotional and behavioural changes during this period (e.g. increased conflict with parents), these are often normative and the majority of adolescents manage to traverse adolescence without significant disturbance (see Offer & Schonert-Reichl, 1992 for a review). However, despite not *all* adolescents experiencing psychological disturbance, it has been consistently found that there is an increase in behavioural and psychological problems during adolescence (Rickwood, 1995; Saunders, Resnick, Hoberman, & Blum, 1994), which is accompanied by an increase in diagnosis of mental disorders (Hankin et al., 1998; Kessler et al., 1994; Newman, Moffit, Caspi, Magdol, & Silva, 1996).

The Dunedin Multi-Disciplinary Health and Development Study (DMHDS) undertaken in New Zealand provided the first longitudinal tracking of mental disorders by age. Newman and colleagues (1996) reported that there was a steady increase in the one-year prevalence of mental disorders from late childhood to early adulthood (11 to 21 years), with rates of psychiatric disorder diagnoses in the population reaching a peak of 41 percent at age 18, double that age of 11. By age 21, 17 percent of the sample met criteria for a Major Depressive Episode (MDE), and 10 percent met criteria for alcohol and drug dependency (Newman, Moffit, Caspi, Magdol, & Silva, 1996). Of those participants with a mental health problem at age 21, the majority (73.8 percent) had a history of these problems prior to age 21 and were diagnosed between the age of 11 and 18 years (Newman, Moffit, Caspi, Magdol, & Silva, 1996).

These findings are consistent with those reported by Horwood and Fergusson (1998) from another longitudinal study in New Zealand, the Christchurch Health and Development Study (CHDS). The CHDS has cohort of 1025 participants, and a surprising 40 percent met diagnostic criteria for a psychiatric disorder between the ages of 16 and 18 years. Of those who had one disorder, 42 percent had a further disorder. The most common was substance misuse (24%), followed by mood disorder (22%), anxiety disorder (17%) and conduct disorder (5%). It was found that females were more likely to report internalising disorders, such as depression or dysthymia, whilst males were more likely to report externalising disorders, such as attention deficit disorder, conduct disorder, and substance abuse. Those who were of Maori cultural background were at greatest risk for all types of disorders (Horwood & Fergusson, 1998).

These findings reflect the high prevalence of mental health difficulties experienced by New Zealand youth, as well as showing that adolescence is a crucial period when the incidence of mental disorders increase. In the National Comorbidity Survey (NCS) in the United States, the prevalence of mental disorders was comparable to results found in New Zealand. Nearly 30 percent of the cross-sectional sample between 15 and 54 years were identified as having a

mental illness in the last 12 months The 15- to 24-year age group had the highest prevalence with approximately 37 percent diagnosed as having a psychiatric disorder, of which the most common disorder was depression (Kessler et al., 1994). In Australia's National Survey of Mental Health and Well-being (NSMW), 14 percent of participants aged between 4 and 17 years experienced problems that were clinically significant (as rated on the Child Behaviour Checklist). In addition, 3.7 percent of males and 2.1 percent of females aged 6-12 years, and 4.9 percent of females aged 13-17 years met diagnostic criteria for a depressive disorder (Sawyer et al., 2000). The incidence of mental disorder in the Australian sample is significantly less than those reported in previous studies. This is thought to be due to the NSMW using a cross-sectional design with point prevalence, instead of a longitudinal study. Overall, similar patterns emerged, with adolescents experiencing higher prevalence of depression than children, and the rate of depression in females more than doubled from childhood to adolescence.

Adolescent Depression

Findings suggest that approximately one in five adolescents will experience a mood disorder, primarily depression (Horwood & Fergusson, 1998; Newman, Moffit, Caspi, Magdol, & Silva, 1996). Despite high rates of depressive disorders, those young people who are disturbed by sub-clinical depressive symptoms are even higher. Young people who experience undiagnosed or sub-threshold depression demonstrate significant impairment and are at risk of similar outcomes to those diagnosed with depression. Gonzalez-Tejera and colleagues found that a large portion of adolescents who experienced symptoms of depression, and suffered severe impairment as a result, did not meet the diagnostic criteria for a MDD. Young people with sub-threshold depression had significant levels of impairment compared to those with few or no depressive symptoms. In addition, those with sub-threshold depression reported high levels of parent discord and poor parent-child attachment, similar to those with MDD. Those young people with sub-threshold depression also had similar outcomes in terms of

psychosocial variables and comorbidity, and reported higher service utilisation. No significant gender difference was found in sub-threshold depression; however, significantly more females were diagnosed as having a major depressive disorder.

Gender differences in adolescent depression are consistently reported in the literature, with female adolescents having a higher prevalence than same-age males (Ge, Lorenz, Conger, Elder, & Simmons, 1994; Hankin et al., 1998). In a 10-year longitudinal study, Hankin and colleagues (1998) found that the gender difference in depression emerged between 13 and 15 years, and by 15 to 18 years females were twice as likely to experience a depressive episode. Ge and colleagues' (1994) longitudinal study in the Midwest of the United States produced similar results, with age 13 found to be the crucial age when gender differences in depression emerged. Prior to age 13, males reported significantly higher rates of depression than females; however, females displayed a continual climb in depression from age 13, whilst the males had a relatively flat pattern, maintaining similar rates to those in childhood (Ge, Lorenz, Conger, Elder, & Simmons, 1994).

This increase in depression in females coincides with pubertal development, and pubertal changes (including increasing hormonal levels and the development of secondary sex characteristics) have been found to contribute to the development of depression. Pubertal stage has been found to predict the sex difference in prevalence of depression better than chronological age, with those females at Tanner Stage III (mid-puberty) or above having a consistently higher rate of depression than the same stage males (Angold, Costello, & Worthman, 1998). Further, in a review on the influence of hormones on psychosocial adjustment in young people it was concluded that although the direct hormonal effects on affect are small, they are found to be stable and to interact with psychological, physical and social factors, which influence the development of depression (Brooks-Gunn, Graber, & Paikoff, 1994). This suggests that the biological changes contribute to the onset of adolescent depression.

In addition to the biological changes that take place during adolescence, young people have to manage developmental stressors such as changing roles, developing sexuality, developing identity and managing educational and occupational achievement. Adolescence is a period of increased vulnerability and sensitivity to emotional and psychological problems (Dubow, Lovoko, & Kausch, 1990; Windle, 1992).Young people have been found to experience more negative events and report higher levels of daily distress than preadolescents (Larson & Ham, 1993). Early adolescence is considered the most stressful period for developing young people, due to multiple transitions (such as school and physical changes) that need to be mastered at the same time. In addition to normative or developmental stressors, critical life events may add to adolescent stress in a cumulative fashion. Stressful life events are thought to peak during adolescence, and those young people who encounter multiple, simultaneous life changes are more likely to experience emotional and behavioural disturbance (Simmons, Burgeson, Carton-Ford, & Blyth, 1987).

Concerns about school work, relationships (with teachers, parents, and peers) and development of health and career have been identified as important stressors for young people (Boldero & Fallon, 1995). In addition to the level of stress experienced, the way that stress is perceived and interpreted has been found to contribute to an increase in the prevalence of depression (Aldwin, 1994; Galaif, Sussman, Chou, & Wills, 2003; Jose & Ratcliffe, 2004). McFarlane, Bellissimo, Norman and Lange (1994) found that stress was causally linked to depression, but depression also increased vulnerability to stress. Being a female was a risk factor for depression, beyond the effects of stress (McFarlane, Bellissimo, Norman, & Lange, 1994). This is consistent with findings that females are more likely to meet criteria for a major depressive episode (Gonzalez-Tejera et al., 2005).

Females may be more vulnerable to stress, as they have been found to perceive events as more stressful (Jose & Ratcliffe, 2004) and are more likely to anticipate a negative outcome to problems, which is thought to increase the impact of events (Seiffge-Krenke, 1993). Jose and

Ratcliffe (2004) found that females and older adolescents reported a higher frequency and intensity of everyday stress, and females displayed higher levels of depression and psychosomatic complaints. This suggests that the gender difference in depression may be partly due to the appraisal of events experienced (Jose & Ratcliffe, 2004).

Impact of Adolescent Depression

Young people's well-being is significantly impaired when experiencing depressive symptoms, as these symptoms are consistently associated with poor educational achievement, sleep disturbance, and alcohol consumption (Coelho, Martins, & Barros, 2002). Depression has been found to be a leading risk factor for suicide in children and adolescents (Brent, Perper, Moritz, & Allman, 1993; Kisch, Leino, & Silverman, 2005), as well as a major source of distress and impairment (Weissman, Bruce, Leaf, Florio, & Holzer, 1991). In addition, depression has high co-morbidity with other adolescent problems, particularly substance and anxiety disorders (Kessler et al., 1994; Newman, Moffit, Caspi, Magdol, & Silva, 1996). The presence of psychopathology in adolescence is considered a risk factor for later adjustment, with those who have their first presentation of depression during adolescence at increased risk for further episodes of depression (Galaif, Sussman, Chou, & Wills, 2003).

Fergusson et al. (2000) found that by the age of 21, 29 percent of the CHDS cohort reported having thought about killing themselves, and 7.5 percent reported making an attempt. Those at greatest risk of suicidal behaviour were more likely to have experienced parental changes, child sexual abuse, poor attachment to parents, and parental alcohol abuse. Those with stressful childhood experience were more likely to experience mental health problems such as depression , which further contributed to the development of suicidal behaviour (Fergusson, Woodward, & Horwood, 2000). In New Zealand in 2004 suicide accounted for 24 percent of deaths in young people aged 15 to 24 years. Males had a higher suicide rate than females, with a ratio of three to one; however, females had more attempts, with twice as many

females than males hospitalised for attempted suicide and intentional self-harm. Maori young people had a higher rate of suicide than non-Maori. Although rates of suicide of young people in New Zealand have somewhat declined since 1995, it remains a significant problem, particularly due to the preventable nature of such deaths.

The literature reviewed on depression points out some important issues: first, the high level of distress and impairment amongst young people; second, the acceleration of diagnoses of mental disorders during the period of adolescence; third, the prevalence of depression amongst young people; fourth, the role of stress in the development of depression; and finally the far-reaching impact depression can have on young people (as well as the impact of sub-threshold depression), including being a significant factor in suicidal behaviour in young people.

The most outstanding features of depression statistics are the age and sex findings; adolescents have significantly higher rates of depression than children, and females experience a higher level of depression than same-age males, a difference that emerges in early-to mid-adolescence (Hankin & Abramson, 2001; Hankin et al., 1998; Newman, Moffit, Caspi, Magdol, & Silva, 1996). Therefore, although the majority of young people traverse adolescence without significant mental health problems, a significant proportion develop mental health problems, including depression. Of those vulnerable to depression, first presentation is common during adolescence and young adulthood, and those who experience sub-threshold depression still suffer significant impairment and disturbance from their symptoms. However, it is important to point out that some adolescents who experience high levels of stress and multiple risk factors will not go on to develop depression, suggesting that it is a number of factors interacting, often in a cumulative fashion, which leads to the development of depression (Hankin & Abramson, 2001). Furthermore, individuals are likely to be protected from depression if there is the right combination of protective factors (Carr, 2006), including adaptive coping strategies (Aldwin, 1994; Lazarus, 1991).

Coping

While stress is an inevitable part of life, coping makes a difference in how stress leads to particular outcomes. 'Coping' has been defined as a cognitive and/or behavioural response to manage specific internal and external demands on an individual (Lazarus, 1991). Adolescent coping impacts on young people's well-being, with poor coping found to contribute to an increase in depression and other psychological problems (e.g. Garland & Zigler, 1994; Nolen-Hoeksema, Morrow, & Fredrickson, 1993). Further, the coping patterns developed in adolescence are likely to persist into adulthood, having a life-long impact (Hankin et al., 1998; Seiffge-Krenke, 1993).

In the literature a distinction is made between different types of coping. Lazarus (1991) distinguished between emotion-focused and problem-focused coping, with problem-focused coping (i.e. efforts to modify or change the cause of the problem) found to be more adaptive (Aldwin, 1994; Boldero & Fallon, 1995; Jose, Cafasso, & D'Anna, 1994; Lazarus, 1991). Social support can be an emotional- or problem-focused coping strategy, depending on the purpose of support (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986; Seiffge-Krenke, 1993). Although it can be difficult to distinguish between social support and help-seeking from informal sources of friends and family, help-seeking is thought to involve *actively* seeking support from social support networks to manage a particular problem (Schonert-Reichl & Muller, 1996). In the following section the literature on help-seeking will be reviewed, and findings on social support will be briefly reviewed.

Adolescent Help-Seeking

Help-seeking is an important subset of coping behaviour, which involves asking for assistance from others, to help resolve a problem (Boldero & Fallon, 1995; Rickwood, 1995). Although help-seeking is a term traditionally used to refer to formal support, such as youth centres, doctors or counsellors, it can also include informal support such as family, kinship

networks, friends and religious leaders (G. Barker, Olukoya, & Aggleton, 2005). Both informal or formal help-seeking have been found to be an adaptive coping strategy, resulting in better adjustment and less emotional and behavioural problems in young people (DuBois et al., 2002; Lazarus, 1991; Offer, Howard, Schonert, & Ostrov, 1991; Windle, 1992). Due to increased vulnerability to psychological problems such as depression during in adolescence, and the far reaching impact of developing a mental health problem at this age, it is important to research coping strategies, such as help-seeking, that contribute to adjustment.

Despite the benefits of help-seeking, and an increase in mental health problems during adolescence, a large percentage of young people do not access help they need (Carlton & Deane, 2000; Dubow, Lovoko, & Kausch, 1990; Flisher et al., 1997; Leaf et al., 1996; Offer & Schonert-Reichl, 1992; Potts, Gillies, & Wood, 2001; Saunders, Resnick, Hoberman, & Blum, 1994; Sawyer et al., 2000; Sheffield, Fiorenza, & Sofronoff, 2004). Only about a quarter of young people who experience clinical problems gain access to professional services (Boldero & Fallon, 1995; Gasquet, Chavance, Ledoux, & Choquet, 1997; Offer, Howard, Schonert, & Ostrov, 1991; Tishby et al., 2001).

Gap between young people who need and access professional help

The gap between young people with a mental disorder and those whom access mental health services has been identified as a service gap (e.g. Saunders, Resnick, Hoberman, & Blum, 1994), or an "unmet need" (e.g. Flisher et al., 1997). Research suggests even those young people who experience severe emotional and behavioural problems may not necessarily access the help they need. For example, of those Australian children and adolescents who were in the top 10 percent of the most severe emotional and behavioural problems, only 50 percent had accessed professional services in the last six months, and 17 percent over those who accessed professional services actually accessed mental health services (Sawyer et al., 2001).

Flisher et al. (1997) examined unmet need for mental health services in the Methods for

Epidemiology of Child and Adolescent Mental Disorders (MECA) Study. They found that 17.1

percent of the sample had unmet need (i.e. had a diagnosis of mental disorder with functional

impairment, but no contact with mental health services in the last six months), 3.6 percent had

met need, 76.5 percent had no need, and there was overprovision (i.e. the provision of services

for those without diagnosis or functional impairment) for 2.7 percent. Unmet need was

significantly associated with a number of indicators of social disadvantage, including being

African American, living on public assistance, not having health insurance for their child, the

presence of parent psychopathology, and poor school grades (Flisher et al., 1997).

Interestingly, those identified as having unmet need had the poorest reported mental health (as

reported by self and others). This unmet need was not related to beliefs or attitudes towards

seeking professional help, suggesting that there was a lack of mental health resources or

knowledge of these services, rather than those with high need unwilling to seek professional

support.

Demographic differences in help-seeking

As in the MECA study, several demographic variables impact on young people's access

to mental health services, as well as their willingness to seek help. Findings for gender, age and

ethnicity impacting on help-seeking and utilisation are examined below.

Gender. Females have been found to seek more help than males, for both formal and

informal sources of help. This has been consistently found across numerous studies, including

those of different cultures and ethnicities (e.g. Boldero & Fallon, 1995; Chandra & Minkovitz,

2006; Fallon & Bowles, 1999; Grinstein-Weiss, Fishman, & Eisikovits, 2005; Raviv, Sills,

Raviv, & Wilansky, 2000; Rickwood, Deane, Wilson, & Ciarrochi, 2005; Schonert-Reichl &

Muller, 1996). However, utilisation rates suggest that relationship between gender and mental

health utilisation changed overtime, with boys accessing more mental health services in early

adolescence, whilst there is more use amongst girls in later adolescence (Cuffe, Waller, Cuccaro, Pumariega, & Garrison, 1995).

Female adolescents report a greater willingness to seek help from their friends (Dubow, Lovoko, & Kausch, 1990; Hodgson, Feldman, Corber, & Quinn, 1986; Oliver, Reed, Katz, & Haugh, 1999; Rickwood, Deane, Wilson, & Ciarrochi, 2005). Mixed results have emerged for seeking help from parents: some studies suggest that females seek more help from parents (Raviv, Sills, Raviv, & Wilansky, 2000), whilst other found that males engage in higher help-seeking from their families, particularly older adolescent males (Chandra & Minkovitz, 2006; Rickwood, Deane, Wilson, & Ciarrochi, 2005). In a study conducted by Fallon and Bowles (1999), females were significantly more likely to seek help than males overall; but males were more likely to seek help from parents whereas females were more likely to seek help from friends. It was suggested that this was due to the different functions that friends fulfil for males compared to females (Fallon & Bowles, 1999).

Female adolescents report higher help-seeking from counsellors and mental health professionals than males (Boldero & Fallon, 1995; Rickwood, Deane, Wilson, & Ciarrochi, 2005). By contrast, there is some evidence that males seek more help from medical professionals, as they report greater ease at discussing personal issues with a physician than females (Hodgson, Feldman, Corber, & Quinn, 1986).

Some research suggests the relationship between gender and help-seeking is not direct, and that help-seeking may be mediated by other factors such as more positive attitudes toward seeking help (e.g. Sheffield, Fiorenza, & Sofronoff, 2004), better knowledge about mental health (e.g. Burns & Rapee, 2006), more positive expectancies of seeking help as well as having a more benevolent attitude to mental health problems, such as viewing it as a treatable illness (Leong & Zachar, 1999). Saunders and colleagues (1994) found that females were more likely to identify a need for help when experiencing a mental health problem; however, females and males were equally likely to obtain help once a need was identified. Therefore, females

may be better at identifying internal states, or males may be less willing to accept they have a problem, which impacts on their willingness to seek help for psychological problems (Saunders, Resnick, Hoberman, & Blum, 1994).

The gender difference in help-seeking may be due to the higher prevalence of distress in females, as females have been found to appraise events as more stressful and distressing (Jose & Ratcliffe, 2004) and have greater prevalence of depression (Ge, Lorenz, Conger, Elder, & Simmons, 1994; Hankin & Abramson, 2001). Dubow, Lovko and Kausch (1990) found that young females reported higher help-seeking and greater usefulness of their friends as helpers than males. However, females also reported greater distress from their problems, suggesting that higher help-seeking from friends may be due to higher distress.

Interestingly, in a study on Israeli youth, when satisfaction with school, friends and family as well as level of anxiety about problems were controlled for, gender differences in help-seeking were no longer significant (Grinstein-Weiss, Fishman, & Eisikovits, 2005). Conversely, Rickwood and Braithwaite (1994) controlled for the severity of emotional problems and found that gender still had a unique effect on the amount of help-seeking, although it is not known whether this result would be found for a depressed population. Due to the consistency of this finding, the gender difference in help-seeking appears to be robust. The most common explanation for the gender difference in help-seeking is socialisation theories, where independence, achievement and emotional suppression are thought to be encouraged in young Western males, whereas collaboration, dependence and emotional expression encouraged in young females (Raviv, Sills, Raviv, & Wilansky, 2000). Consistent with this explanation, children learn traditional sex-role stereotypes early in life, and the way parents interact with their children encourage behaviours and attitudes appropriate for each sex, including help-seeking behaviours (Barnett & Sinisi, 1990). Increasing autonomy and independence is development goal for adolescents in Western culture which may discourage help-seeking behaviour (Davies et al., 2000), particularly by young men who strongly

subscribe to the masculine stereotype (e.g. Timlin-Scalera, Ponerotto, Blumberg, & Jackson, 2003).

Age. Several studies have found that young people demonstrate increased willingness to seek help as they mature, with older adolescents seeking more professional help compared to early adolescents (Ciarrochi, Wilson, Deane, & Rickwood, 2003; Dubow, Lovoko, & Kausch, 1990; Gasquet, Chavance, Ledoux, & Choquet, 1997; Oliver, Reed, Katz, & Haugh, 1999; Sears, 2004; Wu et al., 1999). Conversely, some findings indicate that older adolescents are less likely to gain access mental health services than younger adolescents (P. Cohen & Hesselbart, 1993; Gasquet, Chavance, Ledoux, & Choquet, 1997; Schonert-Reichl, Offer, & Howard, 1995). Other studies have been inconclusive regarding age and rates of help-seeking (Boldero & Fallon, 1995; Fallon & Bowles, 2001; Yeh, 2002). Cohen and Hesselbart (1993) found that those under the age of 17 years accessed almost twice as many services than those aged 18 to 21 year olds but older youths indicated a higher desire to seek help than the younger participants to seek professional help, suggesting other factors such as availability of services may have influenced this result (P. Cohen & Hesselbart, 1993).

Wu et al. (1999) found that children 15 to 17 years were more likely to access mental health services than younger children (9-11 years old); however there was no age difference in use of school-based services. Dubow, Lovoko, and Kausch (1990) found that help-seeking from friends and the school guidance counsellor increased with age. In addition, older students reported their friends as significantly more helpful than younger adolescents, and were more aware of professional help-seeking sources available to them. Ciarrochi and colleagues (2003) found that with an increase in age, young people reported a shift away from seeking help from parents, and reported more help-seeking from friends for emotional problems and suicidal ideation. However, there was also greater likelihood of not seeking help at all as young people matured, and those whom sought help reported higher help-seeking from some formal sources (e.g. mental health professional).

A study on rural youth found that adolescents who sought professional help were more likely to be in senior high, and were less likely to seek help from their friends and parents (Sears, 2004). Garland and Zigler (1994) examined willingness to seek help for psychosocial problems as well as self-efficacy. Negative attitudes to help-seeking were associated with being male, adolescence, depressive symptoms, and lower self-efficacy. Self-efficacy had a positive relationship with help-seeking, suggesting that the ability to seek help is an indicator of a well-adjusted young person. Although adolescents have more negative attitudes to seeking help than children, help-seeking is not exclusive to independence and autonomy, and appropriate help-seeking appears to be essential for developing independent competence (Garland & Zigler, 1994).

Although younger adolescents and children may *access* more mental health services in some instances, this is thought to be due to parents seeking help on their behalf (Logan & King, 2001). Willingness to seek help appears to increase throughout adolescence, with attitudes towards seeking help, and awareness of mental health services improving with age (Ciarrochi, Wilson, Deane, & Rickwood, 2003; Dubow, Lovoko, & Kausch, 1990), which is reflected by higher help-seeking from friends and formal sources later in adolescence (Booth, Bernard, Quine, Kang, & Usherwood, 2004; Sears, 2004), and lead to an increase of use of professional services in some studies (e.g. Wu et al., 1999).

Ethnicity. Although some ethnic differences emerge (e.g. Grinstein-Weiss, Fishman, & Eisikovits, 2005), it is difficult to differentiate ethnic differences from other contextual factors, such as socioeconomic status. Individuals from some minority cultures have been found to access less mental health services in the United States, however this was primarily due to having lower socioeconomic status (e.g. Power, Eiraldi, Clarke, Mazzuca, & Krain, 2005). This is consistent with other studies which found that when controlling for socioeconomic status, the association between help-seeking and ethnicity disappeared (Gasquet, Chavance, Ledoux, & Choquet, 1997; Saunders, Resnick, Hoberman, & Blum, 1994). The literature

suggests that those of ethnic minority cultures seek less help from professional sources, despite

higher need for such services (L. A. Barker & Adelman, 1994; Wu et al., 1999). This is thought

to be due to a number of factors, including lack of trust in institutions of dominant culture, fear

of psychological help (and potential hospitalisation), higher tolerance of malfunctioning, and

greater reliance on informal support (Morgan, Ness, & Robinson, 2003; Saunders, Resnick,

Hoberman, & Blum, 1994).

In New Zealand, despite those of some ethnic minority cultures have a higher prevalence

of mental disorders compared to the general population, use of mental health services is often

not in proportion to their need. For example, New Zealand Maori are at higher risk of mental

health problems, however the percentage of Maori seeking and accessing formal mental health

services is a smaller proportion than those New Zealand Europeans' who experience mental

disorders (Bir et al., 2007).

Grinstein-Weiss, Fishman and Eisikovits (2005) found that young people who had high

levels of emotional distress were most likely to seek help from friends, followed by family,

then use formal sources a last resort, regardless of ethnicity. However, those from ethnic

minority cultures are more likely to seek formal sources if provided within their own

community. This suggests that it is integral to involve the community when developing and

delivering mental health services, which is likely to increase utilisation of these services by

these communities.

Cauce and colleagues (Cauce et al., 2002) reviewed the help-seeking literature and

incorporated contextual factors, such as culture, into their adolescent pathway to help-seeking.

Cultural variables are thought to impact all identified stages of help-seeking: problem

recognition, the decision to seek help, and service selection. Further, parents play an important

role in young people accessing professional help, as they are thought to identify mental health

problems in their children, as well access mental health services on their behalf (Logan &

King, 2001). Parents are more likely to seek help if they experience high anxiety about their

child's problems; however, anxiety about a child's problems has been found to be less likely in parents who are under stress, which is more common for those in poor and minority families (McLoyd, 1995). Mental health services have been found to be used more, and be more effective, if they stem from the ethnic community for which they are trying to provide (Yeh, Eastman, & Cheung, 1994).

Informal sources that are in the position to encourage young people to seek help, or access help on their behalf are called gatekeepers in the help-seeking literature (e.g. Srebnik, Cauce, & Baydar, 1996). The role of gatekeepers in ethnic minority communities is under-researched. However, it is expected that in these communities the family, extended family, and those with traditional and spiritual roles play an important role for young ethnic minorities seeking and accessing mental health services. Thus, help-seeking arises out of a dynamic interaction between individual and family choice, cultural values and beliefs around mental health and help-seeking, as well as systemic factors which influence availability (Cauce et al., 2002).

From the literature reviewed above it is certain that gender, age and cultural variables such as socioeconomic status impact on help-seeking and accessing mental health services. However, several of these findings are mediated by other factors such as attitudes to seeking help, the developmental goals of adolescence, and the role of contextual factors, such as gatekeepers. Further, several of these factors interact, for example developmental goals may differ for different ethnicities, and children and younger adolescents who are an ethnic minority may have stronger connections to their family and community than those older adolescents and young adults, who may be more assimilated due to increased exposure to the dominant culture. Willingness to seek help is dependent on the availability of a chosen helper, with young people having different helper preferences depending on their gender, age and ethnicity.

Selecting a helper

Young people prefer to seek help from informal sources, such as friends and family, than professional sources of help, regardless of gender, age and ethnicity, and severity of the problem (Boldero & Fallon, 1995; DuBois et al., 2002; Fallon & Bowles, 1999; Offer, Howard, Schonert, & Ostrov, 1991; Oliver, Reed, Katz, & Haugh, 1999; Raviv, Sills, Raviv, & Wilansky, 2000; Rickwood, Deane, Wilson, & Ciarrochi, 2005; Saunders, Resnick, Hoberman, & Blum, 1994; Schonert-Reichl & Muller, 1996; Schonert-Reichl, Offer, & Howard, 1995).

Young people have been found to increasingly seeking help from friends instead of parents as they mature (e.g. Ciarrochi, Wilson, Deane, & Rickwood, 2003). This is thought to be due to the developmental goals of independence and autonomy for western adolescents, and increased importance of peer relationships, which leads to changes in parent-child relationships (Boldero & Fallon, 1995; Noller & Callan, 1991). Papini and colleagues (1990) examined emotional self-disclosure in adolescents (12-15 years) and found that self-disclosure to friends was greatest amongst older adolescents. This increase in disclosure to friends with age was thought to be due to seeking support from friends going through developmentally similar experiences (Papini, Farmer, Clark, Micka, & Barnett, 1990).

Despite increased help-seeking from peers, parents continue to be an important source of help during adolescence, which is associated with better adjustment in young people (DuBois et al., 2002; Offer, Howard, Schonert, & Ostrov, 1991). DuBois and colleagues found that social support was associated with better adjustment in young people, however, if young people relied more on their peers than their parents for support, they were more likely to experience maladjustment (DuBois et al., 2002). Offer and colleagues also found that disturbed adolescents more frequently reported seeking help primarily from their friends instead of parents, which suggests parents play an important role in providing help and support in adolescence, which contributes to adjustment (Offer, Howard, Schonert, & Ostrov, 1991).

Sullivan, Marshall, and Schonert-Reichl (2002) found that young people sought help from their parents for the expertise they could provide, whilst friends were selected for their nurturing response. Young people sought more help from friends for interpersonal problems, whereas mothers were selected more often for school problems and health issues (Sullivan, Marshall, & Schonert-Reichl, 2002). Sullivan and colleagues suggested that help-seeking may have more than one function, obtaining support but also means to establish relationships. Conversely, young people may select helpers based on their perceived appropriateness as a helper, due to the nature of the problem and the expected response from the helper.

A longitudinal study conducted by Rickwood (1995) found that help-seeking (from friends, family and professionals) was found to be ineffective for dealing with psychological problems when controlling for life events, previous symptoms, and help-seeking behaviour. In fact, females who sought help from friends in the first wave actually had significantly more symptoms three months later. Peer support is believed to be reciprocal, and sharing distress with close friends could possibly reinforce each other's distress, due to focusing on their problems (Rickwood, 1995).

Reviewing the literature on social support can further understanding of informal help-seeking, as the nature of the support and whom help is sought from are comparable. A review of social support by Kessler, Price, and Wortman (1985) found some evidence that social support ameliorates life stress, although these early results were difficult to interpret due to methodological problems. In another study, social support was found to buffer those experiencing high stress from depression (S. Cohen & Wills, 1985). More recently, Hogan, Linden, and Najarian (2002) completed a review on social support interventions. Due to the large variety of formal and informal interventions, and the inconsistent measurement of social support, there is not enough evidence to conclude which types of social support interventions work best for which problems. However, it was reported that 83 percent of the studies reported benefits of support interventions, relative to either no-treatment or controls (Hogan, Linden, &

Najarian, 2002). In addition, emotional support, or the perception of having support available, has been found to diminish the impact of major life events on mental distress (Bal, Crombez, Van Oost, & Debourdeaudhuij, 2003), and social support has been found to play at least a partial role in the prevention of development of depression (Kendler, Myers, & Prescott, 2005). These findings suggest that social support is protective, particularly compared to having no support at all.

Despite concerns about the quality of help that friends and families can provide for young people suffering from severe distress (Offer, Howard, Schonert, & Ostrov, 1991; Rickwood, 1995), willingness to seek support from family and friends is associated with greater willingness to seek help in general and more positive attitudes towards help-seeking (Rickwood, Deane, Wilson, & Ciarrochi, 2005; Schonert-Reichl & Muller, 1996; Sheffield, Fiorenza, & Sofronoff, 2004). Young people have been found to seek help from their friends first, followed by family, then professional sources (Grinstein-Weiss, Fishman, & Eisikovits, 2005; Oliver, Reed, Katz, & Haugh, 1999). Therefore, friends and family play an important role providing help and support but also helping the position to assist young people accessing professional help, such as recommending further help, and/or access support on the young person's behalf (Logan & King, 2001; Srebnik, Cauce, & Baydar, 1996). The role of friends and family acting as gatekeepers is examined in more detail below.

Gatekeepers to professional help

Young people have been found to have low self-referral to formal services (Fallon & Bowles, 1999; Sawyer et al., 2001), where as significant others often seek help on behalf of the young person, and/or provide advice about whether they should seek help (Srebnik, Cauce, & Baydar, 1996; Stiffman, Pescosolido, & Cabassa, 2004). Friends and family are trusted, which is an important reason they are preferred to formal sources of help (G. Barker, Olukoya, & Aggleton, 2005; Rickwood, Deane, Wilson, & Ciarrochi, 2005; Tatar, 2001). Gatekeepers who

have knowledge about mental illness and mental health services available are more likely to identify youth with problems and refer them to these services (Stiffman, Pescosolido, & Cabassa, 2004). Gatekeepers can also impede help-seeking by young people through their lack of knowledge of and mental illness and availability of services, as well as negative attitudes to mental health services (Srebnik, Cauce, & Baydar, 1996). Important gatekeepers for young people are examined below.

Parents. Although developing an independent sense of self and becoming responsible for oneself is an important developmental goal of adolescence, young people have been found to require adult input when it comes to gaining access to medical and mental health services (Logan & King, 2001; Wintre & Crowley, 1993). Logan and King conducted a review on adolescent mental health utilisation, and proposed a parent facilitation help-seeking model, suggesting that parents were integral to all stages of the help-seeking process, from identifying adolescent distress in the contemplation stage of help-seeking to obtaining access to mental health services on their behalf. Consistent with this, young people who maintain good relationships with their parents, and who seek help from them, have been found to be less disturbed (Schonert-Reichl & Muller, 1996; Schonert-Reichl, Offer, & Howard, 1995). This role appears to be particularly salient during early adolescence, with younger adolescents reporting higher help-seeking from parents, where as older adolescents seek more help from friends (Fallon & Bowles, 1999; Logan & King, 2001).

It is important to address adult attitudes and beliefs around access and utilising mental health services, as these are thought to influence their children's beliefs about mental health and help-seeking. Sawyer et al. (2000) found that only half of children and adolescents who had a mental disorder *and* had clinically significant symptoms *and* their parents reported they needed professional help, had actually utilised a mental health service in the past six months. The reasons parents provided for not seeking help were grouped into 11 categories, with the majority of barriers related to practical issues around help-seeking, for example, not knowing

where to go to seek help, the cost, waiting times, and physical accessibility to service. Other barriers included the belief that they could handle the problem on their own, the child or adolescent would not want to attend, and that treatment would not help. These latter beliefs could have reciprocal influences between child and parent, in that the parent's beliefs and attitudes could influence the child beliefs willingness to seek help, and vice versa (Rickwood, Deane, Wilson, & Ciarrochi, 2005).

School. School-based services have been found to be one of the most frequently used sources of help for children and adolescents with mental health problems (Sawyer et al., 2000). Of those aged 13 to 17 years, 16 percent of those who had clinically significant symptoms accessed counselling in school, though access to counselling was more common for those with externalising than internalising problems. As with parents, teachers' beliefs and attitudes about help-seeking are thought to influence their willingness to recommend young people to seek professional help. In a study on teachers' attitudes to help-seeking, Wilson and Deane (2001) found that teachers were more likely to seek help from friends or family than seek professional help; however, for suicidal thoughts teachers indicated a higher inclination to seek professional help than for their students. Teachers had a number of concerns around seeking professional help, including the competency of clinicians, the effectiveness of treatment, worry about stigma, and anxiety around the process of help-seeking (Wilson & Deane, 2001b). As their attitudes impact on their willingness to refer young people to seek help, it is important to educate teachers about mental illness. As teachers are in a position to encourage help-seeking, but also are in a position of seeing young people functioning in several domains everyday, and are in a unique position to identify changes in behaviour and mood, and identify mental health problems.

Family doctors. When young people decide to seek professional help, family doctors are often the first point of contact (Sawyer et al., 2000). In a stocktake of adolescent mental health services in New Zealand, 74 percent of GPs reported working with young people who had

mental health issues. Due to the high prevalence of depression and suicide in New Zealand, there is concern that family doctors may overlook the seriousness of mental health problems in young people, and may prevent access to further professional help (Bir et al., 2007).

Australian family doctors' referral practices of young people to mental health professionals were examined by Rickwood and colleagues. It was found that good practice guidelines were generally followed, however, there was room for improvement, particularly with regard to discussing confidentiality with young people, clarifying costs, and explaining what a young person could expect when referred to a mental health service. Interestingly, those doctors who had lower beliefs about the efficacy of mental health services were less likely to follow ideal referral practices (Rickwood, Deane, Wilson, & Ciarrochi, 2005).

Peers. Peers can also be gatekeepers to young people accessing formal help. Young people prefer to seek help from friends, particularly as they get older, and teachers and school counsellors report that students (particularly female) often identify or seek help of behalf of their friends or fellow students (Rickwood, Deane, Wilson, & Ciarrochi, 2005). One perceived advantage of help-seeking from peers is that they are thought to normalise the problem through finding out that they are not alone, and others have similar experiences (Wilson & Deane, 2001a). Although young people may have a positive attitude to help-seeking, they have been found to be more likely to seek for others than themselves (Raviv, Sills, Raviv, & Wilansky, 2000). When making the decision to seek help, young people are thought to weigh up the problem severity, versus the threat to self by seeking help, before making a decision to help-seek. When seeking help on behalf of other people, young people focus on the benefits and not the costs of help-seeking. It was suggested that help-seeking for someone else is less threatening, due to the absence of conflict with the developmental goals of individuation and self-reliance when seeking help for someone else (Raviv, Sills, Raviv, & Wilansky, 2000).

From the literature reviewed above, it is clear there are several factors that influence help-seeking, many which interact, which makes help-seeking extremely complex. Of young

people who enter the help-seeking process, several leave without accessing the help they need, or potentially access less than ideal support from an informal source. Several studies which examined utilisation of mental health services only included samples of those who had *accessed* professional help. This does not help researchers understand the reason for the gap between those young people who need help, and those who access it. These studies assume help-seeking is a single-step process, and it is not known whether young people identified a need for help, or perhaps made the decision to seek help and did not succeed, therefore missing out important stages of the process. The literature reviewed above suggests that help-seeking is a dynamic process, influenced by demographic variables, and involving multiple stages, and needs to include the role of gatekeepers found to impact on different stages of the process of help-seeking.

The Process of Help-Seeking

Saunders and colleagues (1994) found that there was a minimum of two stages, with young people identifying a need for help prior making the decision to seek help, and selecting a helper. In recent years, adolescent help-seeking has been conceptualised as a pathway with multiple stages (Adams & Bromley, 1998; Logan & King, 2001; Rickwood, Deane, Wilson, & Ciarrochi, 2005; Srebnik, Cauce, & Baydar, 1996; Stiffman, Pescosolido, & Cabassa, 2004). Theories of adolescent help-seeking have proposed between three and six stages to help-seeking. Several of these models tend to be descriptive rather than explanatory, and some have primarily focused on social or economic factors that affect access to services (e.g. Pescosolido & Boyer, 1999), whereas other models have focused on a particular aspect of help-seeking (e.g. parent facilitation of help seeking, Logan & King, 2001).

Ana Mari Cauce and colleagues developed a pathway to adolescent help-seeking (Srebnik, Cauce, & Baydar, 1996), which was able to account for the important findings in the literature (e.g. the service gap, gender and age differences and the role of gatekeepers).

Srebnik, Cauce and colleagues have developed their pathway of adolescent help-seeking over the last 10 years to include contextual variables (including social and economic factors), and currently this model is the most detailed in the literature (Cauce et al., 2002). Cauce and colleagues pathway model proposes three important stages to adolescent help-seeking. The first stage they called problem recognition, which can include a need identified by a young person (or significant other), or an epidemiologically defined need, such as diagnosis of a mental disorder with clinically significant impairment in social or occupational functioning. Another stage is the decision to seek help, which is dependent on whether a problem or need has been identified, as well as a decision about whether they would like to seek help for this problem. Numerous factors can act as a barrier or facilitate help-seeking at this stage. Once a young person has made a decision to seek help, a source of help is selected, whether formal, informal or a combination of both. The process of help-seeking may not follow a sequential series of steps, rather it can be multi-directional, and stages may interact and overlap at different stages.

A pathway model to accessing help incorporates individual predisposing factors (e.g. age, gender, attitudes to help-seeking), as well as contextual factors (e.g. ethnicity, availability of help), as well as the nature of the mental health problem, and the severity of symptoms, which impact on a young person's seeking and accessing help. Further, this model includes the role of gatekeepers, which is integral to adolescent help-seeking, as a high percentage of young people primarily access mental health services through others, such as parents, school, friends, and doctors (Logan & King, 2001; Stiffman, Pescosolido, & Cabassa, 2004).

Rickwood and colleagues (Rickwood, Deane, Wilson, & Ciarrochi, 2005) also conceptualised help-seeking as a process, however suggested four stages. Rickwood and colleagues model (2005) focused on individual and psychological factors that facilitate or inhibit the help-seeking process, and placed less emphasis on the role of contextual factors such as help-seeking. The four stages included young people developing an awareness and

appraisal of problems, followed by expressing symptoms and need for support, identifying available sources of help, and finally being willing to seek out help and disclose to a chosen helper. This model also stressed the importance of barriers and facilitators to the process of help-seeking, however the process was suggested to be sequential, with the ability of young people to drop out of the help-seeking process at any stage: "Help-seeking is not simply a process of identifying need, deciding to seek help and carrying out that decision. At each of these decision points, factors intervene to prevent the progression of the help-seeking process: need may not be identified; if identified, need may not be translated into intention; and intention does not always lead to behaviour" (Rickwood, Deane, Wilson, & Ciarrochi, 2005, p. 13).

Both of these models sustain that adolescent help-seeking is a process, which can account for the gap between those young people who have mental health needs and those whom access professional services. Similarities across these models include young person identifying a need for help, thought to be influenced by the perceived severity of depressive symptoms (Sears, 2004; Sheffield, Fiorenza, & Sofronoff, 2004), the young person or significant other aware of the importance of seeking help for the mental health problem (including knowledge and attitudes of mental health and help-seeking), followed by their willingness or inclination to follow through with seeking help. This process will be examined in relation to help-seeking for depression below, including examining important barriers to help-seeking.

Severity of and type of symptoms

Despite there being a service gap or unmet need between those who would benefit from professional help and those who access it, young people who experience a high level of impairment and distress are generally more likely to access mental health services (Leaf et al., 1996; Potts, Gillies, & Wood, 2001; Sawyer et al., 2001). Both subjective need and diagnosis of mental disorder increases access mental health services, and those young people with both

perceived need and mental disorder are most likely to access services. For example, Sheffield, Fiorenza and Sofronoff (2004) found that those who experienced higher distress were more likely to seek help, and those diagnosed with a mental disorder were more likely to access professional help than those who experienced emotional or behavioural problems without a diagnosis (Carlton & Deane, 2000; Sheffield, Fiorenza, & Sofronoff, 2004). The MECA study collected data on diagnosis of mental disorder, impairment, and the utilisation of mental health and substance abuse services for 1285 parent/youth pairs. Those children who were most functionally impaired (regardless of presence of a psychiatric disorder), were the most likely to access services; although it was not known whether they accessed the correct type of services, and whether they went on to be treated (Leaf et al., 1996).

Although there is a relationship between severity of symptoms and access to professional services, there are concerns that young people might not access the correct type of services. Adelman, Barker, and Nelson (1993) found that users of a school based clinic in a predominantly Latino area in Los Angeles had higher reported rates of psychological distress and psychosocial problems than those who did not use the clinic. However, despite using the clinic, only 28 percent went on to access mental health services. Consistent with this, Gasquet and colleagues (1997) found there were significant differences for age, sex and the family make up for whether they accessed help for depression. That is, females, older adolescents and those young people whose parents did not live together were more likely to access services for depression. However, despite seeking help from medical professionals, only 8 percent went on to receive specialist mental health services (Gasquet, Chavance, Ledoux, & Choquet, 1997). Wu and colleagues (1999) found that adolescents with internalising disorders (major depression and dysthymia) were less likely to access adequate mental health support compared to those with disruptive disorders (attention-deficit hyperactivity disorder, oppositional defiant disorder, and conduct disorder). Although there was a strong relationship between psychiatric diagnosis and mental health service use, this relationship was indirect, mediated by the

perceived needs of the young person (that is, the reported perception of need for services for emotional, behavioural or drug problems as reported by the child, parent and teacher). Those youth with comorbid depressive and disruptive disorders had the highest level of impairment overall. Children and adolescents in the depressed group had the highest perceived need for services, but were the least likely to receive mental health services. Those with disruptive disorders had the highest perceived need by others (parents and teachers), and accessed the greatest number of services. The increased access of services for those with disruptive disorders is thought to be due to externalising problems having more of an impact on other people, attract attention, and consequently access services (Wu et al., 1999). Those with mental health needs with a high level of distress are more likely to access mental health services; however, there is still a large amount of unmet need from those who have a disorder, or those who experience impairment. Those with depression may be at increased risk of not accessing appropriate mental health services.

Importance of seeking help

The severity of problems and the importance of seeking help as a coping strategy has been found to determine the likelihood an individual will seek help (Adams & Bromley, 1998). Knowledge about mental illness and mental health services has been found to increase the importance young people place on help-seeking, and influence their willingness to use mental health services (Burns & Rapee, 2006; Chandra & Minkovitz, 2006). Conversely, not knowing where to seek help, as well as not knowing what to expect from a professional help-seeking encounter, are significant reasons adolescents and their parents do not seek help for mental health problems (Rickwood, Deane, Wilson, & Ciarrochi, 2005; Sawyer et al., 2001).

Burns and Rapee (2006) presented young Australians with five vignettes of young people experiencing emotional problems. In two of the vignettes the case studies were experiencing symptoms consistent with a depressive disorder. Participants rated their concern, as well as the

perceived importance of seeking help higher for those vignettes with depression. Female participants expressed higher concern and importance of those who were depressed seeking help and were better able to identify the cluster of symptoms as depression. Although the ability to identify case studies as depressed was variable, young people were more likely to recommend those vignettes experiencing depression to seek help. Interestingly, young people were more likely to recommend a counsellor than a mental health specialist, suggesting they may not be familiar with the role of mental health professionals in treating depression (Burns & Rapee, 2006).

Young people with positive attitudes to help-seeking are more likely to view help-seeking as important. It has been consistently found that female adolescents have more positive attitudes to help-seeking and report higher willingness to seek help for mental health problems. Leong and Zachar (1999) found that females reported more positive attitudes towards professional help-seeking than males, and these attitudes accounted for a significant percentage of help-seeking, beyond the effect of gender. That is, being more benevolent (having a friendly, nurturing view of mental illness), and less authoritarian (having prejudicial attitudes against those with mental illness, viewing them as inferior), as well as viewing mental illness as treatable illness, increases willingness to seek professional help more than sex (Leong & Zachar, 1999).

Sheffield and Colleagues (2004) found that being female, having a greater knowledge about mental illness, as well as previous experience seeking help predicted less negative attitudes toward mental illness. Those young people who had higher adaptive functioning, as well as greater psychological distress reported a greater willingness to seek help from formal sources. Therefore, although attitudes to mental illness did not mediate the willingness to seek help, attitudes about mental illness were found to influence a number of the predictor variables, for example, prior help-seeking, which was related to less negative attitudes (Sheffield, Fiorenza, & Sofronoff, 2004).

Wilson and Deane (2001) found that high school students obtained the majority of their knowledge about help-seeking from discussion with peers about their help-seeking, as well as successful prior help-seeking. Students had increased likelihood of future help-seeking if previous help-seeking was viewed as successful (Wilson & Deane, 2001a). Consistent with this, young people who had a history of help-seeking reported fewer barriers to help-seeking (Kuhl, Jarkon-Horlick, & Morrissey, 1997). Consistent with this, Cramer (1999) found that having a positive attitude to counselling and viewing help-seeking as an important coping strategy, increased the likelihood of seeking professional help, but only when social support networks are impaired. That is, those with strong support networks were less likely to seek formal help, and this is thought to be due to obtaining support and advice from their informal network (particularly for females).

Barriers to Help-Seeking

Barriers to professional help-seeking can be divided into practical barriers to accessing professional sources of help, and personal barriers, or reasons that prevent young people from seeking help. Cohen and Hesslebart (1993) examined practical barriers to accessing mental health services in the United States and found that those living in rural or semi-rural communities were less likely to access mental health services compared to those in cities and suburbs due to availability of mental health services. Financial barriers also emerged for those of middle income, with those from lower income families gained provision through the state, whilst higher income families were able to afford to pay for specialist mental health services.

Flisher and colleagues (1997) identified five main barriers to accessing mental health services by young people: including concerns about what others (including friends and family) would think; being unsure about where to go and who to ask for treatment; worry about paying for treatment; thinking the problem would go away or be solved without help; and feeling that

it is too difficult to get help (e.g. being on a waiting list, not being seen without parent's consent, or transportation problems).

Early research by Amato and Bradshaw (1985) concluded that there were five motives to avoid of delay seeking help for mental health problems in adult community sample. Desire to maintain independence, fear about the consequences of seeking help, denial of the problem, concern around suitability of the source of help, and external or practical barriers (Amato & Bradshaw, 1985). Thus, practical barriers are only one aspect of reasons people may not seek help for mental health problems, with several other personal concerns which prevent help-seeking.

A more detailed examination of barriers to help-seeking was conducted by Kuhl, Jarkon-Horlick and Morrissey (1997). From reviewing the literature, Kuhl and colleagues identified 13 categories of potential barriers to adolescent help-seeking, which included not requiring help (as family are sufficient to help, peers are sufficient to help, or self-sufficiency), practical barriers (such as time, availability, knowledge of resources, and affordability) and barriers to therapy (including alienation, beliefs about usefulness of therapy, self-awareness/self-perception, perception of therapist, locus of control, stigma, and confidentiality). Consistent with gender differences in help-seeking, females reported fewer barriers to help-seeking.

The reliance on self, family, and friends were found to be the most prevalent barriers to seeking help (Kuhl, Jarkon-Horlick, & Morrissey, 1997). This is consistent with findings that young people were less likely to access help from a school clinic if they experienced availability and satisfaction of support from their friends and family (Adelman, Barker, & Perry, 1993). This suggests that the provision of informal support can act as a barrier to professional help-seeking, however, it may be that good informal support means less professional help-seeking is required. This is consistent with previous literature reviewed, that help from friends and family is preferred by young people, making these sources important gatekeepers to professional sources of help.

Sheffield and colleagues (2004) also found that young people's preference to manage on their own was the most frequently endorsed barrier to seeking help for a mental illness for Australia secondary school students. This was followed by not thinking seeking help would actually be helpful, and concerns that the help was not confidential. Conversely, greater willingness to seek help was predicted by fewer barriers to seeking help, higher adaptive functioning, and greater psychological distress (Sheffield, Fiorenza, & Sofronoff, 2004). Jorm and colleagues (2006) found that 13 percent of adults and adolescents believed that it was helpful to deal with depression alone. This belief was significantly associated with being male, having less favourable views of the mental health profession, more likely to use substances to manage depressive symptoms and were more likely to expect a positive outcome by not seeking help (Jorm et al., 2006). Managing on their own was also identified as a barrier to seeking help for a distressing problem, as well as feeling that no person or helping service could help, that the problem was too personal, and concerns about friends or family finding out (Dubow, Lovoko, & Kausch, 1990).

Young people wanting to manage on their own instead of seeking help for mental health problems is consistent with developmental theories of adolescence. Similarly, young people often feel that other people cannot understand, and often report feeling uncomfortable about disclosing personal or sensitive information to people they do not know (G. Barker, Olukoya, & Aggleton, 2005). Consistent with concerns about disclosure, concerns about confidentiality consistently emerge as an important barrier to help-seeking for mental health problems (Adelman, Barker, & Perry, 1993; Chandra & Minkovitz, 2006; Dubow, Lovoko, & Kausch, 1990; Kuhl, Jarkon-Horlick, & Morrissey, 1997). Trust is one of the most important reasons that young people prefer to seek help from friends and family (Wilson & Deane, 2001a). Young people are more likely to seek help if they have developed a good relationship with the helper, as part of this it was suggested raising issues gently and slowly was important to build trust and confidence in help-givers (Wilson & Deane, 2001a). Tatar (2001) examined

considerations for self-referral to a counsellor. The primary consideration for both counsellors and young people was the importance of trust, including the counsellor maintaining confidentiality, followed by the expertise of the counsellor, both related to young people's ability to trust a counsellor with their problems.

Research conducted by Chandra and Minkovitz (2006) found that female youths (mean age 13 years) had greater experience of mental health than same age males. Other gender differences were that adolescent males reported greater stigma relating to mental health, and a reduced willingness to seek help from mental health services. Once the role of stigma was included in the statistical model, the gender difference in adolescent help-seeking became non-significant. This result suggests the role of stigma in preventing help-seeking from a professional is particularly salient for adolescent males. Stigma of having a mental health or addiction problem has been found to reduce motivation to access mental health services, and act as an important barrier to young people seeking help professional help (Ballon, Kirst, & Smith, 2004).

Timlin-Scalera and colleagues (2003) conducted a grounded theory study on help-seeking behaviours among white male high school students. They found that the pressures of wealth, success and high expectations created stress for the participants to be successful and "fit in", which contributed to a gender-linked stigma about help-seeking behaviour. The barriers identified were young males lack of awareness of available resources, lack of insight into problems, concerns about confidentiality, unfamiliarity of mental health professionals, not wanting to burden others, and stigma about weakness and what it means for a male to seek help (Timlin-Scalera, Ponerotto, Blumberg, & Jackson, 2003).

Finally, suicidal ideation is an important barrier to seeking help. Suicidal ideation is related to lower help-seeking from all sources, and higher likelihood of seeking from no one (Carlton & Deane, 2000; Wilson, Deane, & Ciarrochi, 2005). A decrease in seeking help when a need for help is apparent has been labelled 'help-negation' (Wilson, Deane, & Ciarrochi,

2005), and it is strongest for informal sources. Although there is decreased willingness to seek help in general for suicidal thoughts, young people report being more likely to seek help from a professional or a phone counsellor rather than someone they know. In particular, young people are least likely to seek help from family when experiencing suicidal ideation, particularly for young females. Feelings of hopelessness, beliefs about barriers to help-seeking, and negative attitudes were found to account for some of the help-negation, but did not fully explain the help-negation effect (Wilson, Deane, & Ciarrochi, 2005). Those who are low in emotional competence have been found to have the lowest intention to seek help, and this emotional competence has been found to change with age (Ciarrochi, Wilson, Deane, & Rickwood, 2003).

Adaptive coping is important in the developmental pathway to psychological well-being for adolescents, and help-seeking is a helpful coping behaviour. Several studies that examine help-seeking conceptualise it as a single step process (e.g. Offer, Howard, Schonert, & Ostrov, 1991). However, from the literature reviewed above, help-seeking is best perceived as a multi-stage process (Rickwood, Deane, Wilson, & Ciarrochi, 2005; Saunders, Resnick, Hoberman, & Blum, 1994; Srebnik, Cauce, & Baydar, 1996), which is influenced by individual factors (such as age, gender, emotional competence, knowledge of mental health), and contextual factors (such as, culture, ethnicity, and parents who are willing to seek help on their behalf). These factors can directly and indirectly impact on young people's identification of depression as a problem, the perceived importance of seeking, and their willingness to seek help for depressive symptoms, as well as choosing who to seek help from, including access to mental health services. In addition to those mentioned above, certain factors can facilitate help-seeking (e.g. knowledge of mental illness and professional services available) and others act as a barrier to seeking help (e.g. beliefs about coping alone).

Adolescents with a mental health diagnosis are more likely to access mental health services (Leaf et al., 1996; Sawyer et al., 2001), however, the relationship between need and

service utilisation is not direct (Flisher et al., 1997) and subjective need is an important

predictor of willingness to seek help (Sheffield, Fiorenza, & Sofronoff, 2004). Thus, how

young people perceive depressive symptoms is an important part of the process of help-seeking

(Offer, Howard, Schonert, & Ostrov, 1991). Despite recognition of this possibility, there is

little research examining how severity of depressive symptoms impacts on the process of help-

seeking.

This Study

The aim of this study was to examine how severity of depressive symptoms impacts on

the *process* of help-seeking: including how distressing and serious the scenario is perceived;

the importance young people place on seeking help with regard to the severity of depressive

symptoms; and the reported likelihood of seeking help for mild to severe symptoms of

depression. Young people prefer seeking help from informal sources, such as their parents and

friends (e.g. Boldero & Fallon, 1995), over professionals. The age and gender of young people

impact their willingness to seek help (e.g. Rickwood, Deane, Wilson, & Ciarrochi, 2005), and

young people are less likely to seek help from formal sources if they are satisfied with the

support they receive from friends and family (Adelman, Barker, & Perry, 1993; Kuhl, Jarkon-

Horlick, & Morrissey, 1997). Although some findings suggest that severe depressive

symptoms, such as when one experiences suicidal thoughts, young people may be less willing

to seek help from informal sources, particularly their parents (Carlton & Deane, 2000).

Young people experience a number of barriers to seeking help, particularly for formal

sources of help; including practical barriers to accessing help, such as cost and location, as well

as personal barriers, such as preferring to manage problems on own (Amato & Bradshaw,

1985; Kuhl, Jarkon-Horlick, & Morrissey, 1997). Although a significant body of research

exists on how suicidal ideation impacts on help-seeking (e.g. Carlton & Deane, 2000), there is

little research on other barriers impact on help-seeking for depression, including whether the

severity of depressive symptoms impacts on these barriers. This study seeks to address the gap in the research regarding how adolescents perceive different barriers to different sources of help. The first study examined *how* the severity of depressive symptoms impacts on young peoples' reported willingness to seek help from the different sources of parent, friend, medical person, and mental health professional, and examined the impact of age gender, and ethnicity on the process of seeking help. Young peoples' selection of important barriers to seeking help were also examined. The hypotheses of study one are detailed below, followed by the method, results and discussion of results for this study.

Hypotheses

The Effect of Severity on the Process of Help-Seeking for Depression

The first hypothesis was that with an increase in the severity of depressive symptoms, participants would judge the scenario as more distressing and serious (Offer, Howard, Schonert, & Ostrov, 1991; Saunders, Resnick, Hoberman, & Blum, 1994; Sheffield, Fiorenza, & Sofronoff, 2004), and young people would report an increase in the importance of help-seeking (Adams & Bromley, 1998; Chandra & Minkovitz, 2006) and found to be more likely to seek help (Rickwood & Braithwaite, 1994; Sawyer et al., 2001).

For the second hypothesis, it was expected that the variables capturing the process of help-seeking would be positively correlated, as help-seeking has been found to be a multi-stage process, and the process variables in this study were expected to tap aspects of this process (Rickwood, Deane, Wilson, & Ciarrochi, 2005; Srebnik, Cauce, & Baydar, 1996). In addition, the positive relationship between these variables were expected to increase, as the severity of depressive symptoms was expected to impact on all of these process variables, and cumulatively lead to an increase in adolescent help-seeking for mental health difficulties (Leaf et al., 1996; Sawyer et al., 2001).

The third hypothesis was that the rated distress and seriousness of the scenarios were expected to be most highly correlated, as these variables were expected to tap the first stage of the process help-seeking, which is identification of depressive symptoms as a problem (Gasquet, Chavance, Ledoux, & Choquet, 1997; Offer, Howard, Schonert, & Ostrov, 1991). Identification of need, does not necessarily lead to a decision to seek help (Saunders, Resnick, Hoberman, & Blum, 1994), whereas the rated importance of seeking help has been found to impact the likelihood young people will help-seek for depression (Raviv, Sills, Raviv, & Wilansky, 2000; Sawyer et al., 2001). Therefore, the fourth hypothesis was that the importance of seeking help would be most highly correlated to the likelihood of seeking help.

Gender

The fifth hypothesis was that female adolescents would judge symptoms of depression as more distressing and serious (Jose & Ratcliffe, 2004; Saunders, Resnick, Hoberman, & Blum, 1994) and report higher importance and likelihood of seeking help for symptoms of depression than their male counterparts (Sheffield, Fiorenza, & Sofronoff, 2004). As the sex findings of help-seeking are robust (Boldero & Fallon, 1995), these gender differences were expected to emerge for both correlations and multivariate analyses. Although there is an abundance of research on age and ethnicity on the *utilisation* of mental health services, there is limited literature on how age and ethnicity impact on the process of help-seeking, which will be explored in this study.

The Effect of Severity on Inclination to Seek Help for Depression

The sixth hypothesis was that as the severity of depressive symptoms increased, the inclination to seek help from formal sources, such as a medical doctor or mental health professional would increase (Wilson, Deane, & Ciarrochi, 2005). Informal help-seeking is preferred by young people, particularly for female adolescents (G. Barker, Olukoya, & Aggleton, 2005; Sheffield, Fiorenza, & Sofronoff, 2004). However, severe symptoms of

depression including suicidal thoughts have been related to a decrease in adolescent help-seeking from informal sources of friends and family, particularly for young females (Carlton & Deane, 2000; Wilson, Deane, & Ciarrochi, 2005). Thus, for the seventh hypothesis, it is expected that help-seeking will be high for informal sources of help but it is expected to decrease for severe symptoms of depression.

Gender differences in adolescent help-seeking is one of the most prominent findings in the literature, with females found to be more likely to seek more help (Boldero & Fallon, 1995; Dubow, Lovoko, & Kausch, 1990; Rickwood & Braithwaite, 1994; Schonert-Reichl & Muller, 1996; Sheffield, Fiorenza, & Sofronoff, 2004). The eighth hypothesis was that female adolescents would report a higher inclination to seek help for all sources, particularly from friends.

The ninth hypothesis was that younger adolescents would be more inclined to seek help from a parent or guardian than older adolescents, whereas older adolescents would demonstrate a higher inclination to seek help from friends (e.g. Fallon & Bowles, 1999). For formal help-seeking the tenth hypothesis was that older adolescents would report a higher inclination to seek help from professionals than younger adolescents (Booth, Bernard, Quine, Kang, & Usherwood, 2004; Fallon & Bowles, 2001; Schonert-Reichl & Muller, 1996).

Barriers to Help-Seeking

Many reasons have been identified for why young people choose not to seek help, particularly from formal sources of help (e.g. Kuhl, Jarkon-Horlick, & Morrissey, 1997; Sawyer et al., 2001), however, there is little research on how severity of symptoms impacts young people's perceived barriers to seeking help, as well as barriers specific to different sources of help. In this study, the following barriers to help-seeking for depression were examined: not serious enough, not emotionally available, not physically available, wrong

person, felt embarrassed, did not want to worry the person, the cost is too much, and worried about a bad response.

Young people are thought to weigh up the importance of seeking help for their difficulties, versus the cost of seeking help, such as impacting on the developmental goal of independence (Raviv, Sills, Raviv, & Wilansky, 2000). Young people are more likely to seek help when symptoms are more severe (Adams & Bromley, 1998; Saunders, Resnick, Hoberman, & Blum, 1994; Schonert-Reichl, Offer, & Howard, 1995), therefore for the eleventh hypothesis, it was expected that severity would impact on the barriers to seeking help. More specifically, as severity of depressive symptoms increased, young people were expected to report fewer barriers to seeking help for all sources. Consistent with this, the twelfth hypothesis was that endorsement of the barrier 'not serious enough' would significantly decrease with the scenarios of depression, as young people consider the depressive symptoms more serious.

As females have been found to seek help more than males and have fewer barriers to seeking help (Boldero & Fallon, 1995; Rickwood & Braithwaite, 1994; Schonert-Reichl & Muller, 1996; Sheffield, Fiorenza, & Sofronoff, 2004; Srebnik, Cauce, & Baydar, 1996), the thirteenth hypothesis was that males would report more barriers to seeking help for the different sources of help, regardless of the severity of depressive symptoms (Kuhl, Jarkon-Horlick, & Morrissey, 1997).

Correspondence Analysis (CA) was used to examine barrier data because it provided an opportunity to explore the relationships between the barriers and sources of help simultaneously, by examining the relationships between sources of help and barriers pictorially. Consistent with the eleventh hypothesis, it was expected that severity would impact on the barriers to help-seeking. As practical issues such as cost and location have been found to be a barrier to seeking help from formal sources, the fourteenth hypothesis was that barriers would differ dependent on the formality of the source of help. For example, practical barriers

such as cost would be closely related to formal sources of help, whilst barriers related to the

personal relationship, such as concern about worrying a person was expected to be related to

informal or personal sources of help.

STUDY ONE

Method

Participants

The sample consisted of 316 young people from five secondary schools in the Wellington

and Kapiti regions of the lower North Island, New Zealand. There were 157 male and 159

female participants. The participants were from year 10 to year 13 (aged 13-to 18-years), with

the sample average age $M = 15.32$, $SD = 1.21$. The number of male and female participants in

each age group is represented in Table 1.

Table 1. *Number of Participants by Gender and Age for Study One*

Age (years)	Males	Females	Total	Female (%)
13	7	9	16	56.3
14	48	33	81	40.7
15	33	33	66	50.0
16	45	51	96	53.1
17	23	29	52	55.8
18	1	4	5	80.0
Total	157	159	316	50.3

Most participants (74%) identified themselves as New Zealand European/Pakeha. Of the

remaining participants, 4% identified themselves as Maori, 5% identified themselves as both

Maori and New Zealand Pakeha, 3% identified themselves as Polynesian, 6% as Asian, and the

remaining 8% identified themselves as other or more than one ethnicity. Information about

parental occupation was used to determine the adolescent's socio-economic status (SES). The

SES is a continuous scale based on the New Zealand Socio-Economic Index of Occupational

Status (NZSEI). It uses New Zealand norms and combines ratings of educational level,

employment, and income factors to produce a two digit code for socio-economic status (Davis,

McLeod, Ransom, & Ongley, 1997). The NZSEI ranges from 10 = "beneficiary" to 90 = "chief

executive". In this sample, the maternal NZSEI was $M = 40.48$, $SD = 14.68$ and paternal NZSEI

was $M = 45.85$, $SD = 14.95$. Thus, the sample was predominantly middle class. Occupations

that cluster around the mean include professions such as nursing (45), teaching (43), and real

estate agent (48).

Most participants (69%) lived with both biological parents. Twenty three percent lived in

single parent families; in these cases the biological parent had been separated (11%), divorced

(10%), or widowed (2%). Another 6% lived with a biological parent and a step-parent.

Participants living in other arrangements made up 2%.

Materials

All participants completed a 39-page questionnaire that was part of the Help-Seeking in

New Zealand Youth Study (Kramer, 2006). The questionnaire contained several parts. Firstly,

it collected demographic details (i.e., age, gender, year at school, school, ethnicity, family

structure and occupations of mother and father). Secondly, there were a number of self-report

measures, including measures on everyday and major life stress, coping strategies scale, an

anxiety scale, a measure of self-esteem and depression. Thirdly, participants were asked to

disclose whether they experienced 'depression', the severity and duration of their 'depression',

and help-seeking for depression in the last 12-months. The last part of the questionnaire

collected attitudes towards a hypothetical scenario of depression and inclination to seek help

from friend, parent/caregiver, Medical Doctor (GP)/Nurse and

Counsellor/Psychologist/Psychiatrist for depression through four fictitious audiotape role-plays

(please refer appendix A). The fictitious scenarios increased in severity from symptoms of mild

depression (scenario one) to severe depression (scenario four).

Of the data collected in the Help-Seeking in New Zealand Youth Study, Kramar (2006)

used 107 of the school sample data matched by age, gender and ethnicity to a Youth Health

Centre sample. Kramer undertook a comparison across groups of previous depression and

inclination to seek help. Data collected on self-reported depression and help-seeking in the last 12-months were used in my Honours dissertation. For the purpose of this study, the data from the hypothetical scenarios of depression and help-seeking from friend, parent, medical person and mental health professional will be analysed.

Scenarios of Depression

The participants were asked to listen to four hypothetical scenarios that were specifically designed and recorded for this study, which were an interaction between a young male or female, and a same sex counsellor. In the audiotape the counsellor screens the adolescent's functioning across different life domains; including problems at school, their relationships with others, how they are feeling and thinking, and their physical symptoms of depression. Each scenario is approximately five minutes long, is unique, and has a different set and number of depressive statements. The scenarios increase in severity from mild symptoms of depression (scenario one) to severe symptoms of depression (scenario four). Scenarios were presented to participants in order of increasing severity, from scenario one to scenario four.

The audiotape scenarios were devised by Jason Spendlow for his dissertation work. Spendlow (2004) administered the Beck Depression Inventory – 2nd Edition (BDI-II; Beck, Steer, & Brown, 1996) to first year university students at Victoria University Wellington and descriptive statistics ($M = 4$, $SD = 8$) were used in creation of the scenarios (Spendlow, 2004). The first year university sample had a mean score on the BDI-II of four, which represents a low severity of depression, 16 (1.5 standard deviations greater than mean) represents a moderately-low severity of depression, 28 (3 standard deviations greater than mean) represents a moderately-high severity of depression, and 36 (4 standard deviations greater than mean) and represents a high severity of depression (Beck, Steer, & Brown, 1996). The 12 most commonly endorsed statements from the BDI-II were identified for participants who obtained a score of four, and were used to create the hypothetical audiotape scenario of low severity

depression (scenario one), the 16 most commonly endorsed statements of those who scored 16 were used for moderately-low depression (scenario two), the 18 most commonly endorsed statements for those who scored 28 were used to for moderately-high depression (scenario three), and the 20 most commonly endorsed statements were used for those who scored 36 or more for the high severity depression (scenario four). The statements used in the audiotape scenarios are presented in Table 2.

The Process of Help-Seeking. After participants listened to each scenario they were asked four questions regarding their perceived impact of the hypothetical of depression, in response to the audiotape role play. Participants were required to select a number between one and seven on a seven-point likert-type scale for the following four questions: (1)*"How distressed or upset would you feel if you were the person on the tape?"* with participants selecting a response from *"Not at all distressed"* (rated one) to *"Extremely distressed"* (rated seven), (2)*"How serious a problem would you judge these feelings?"* with responses ranging from one *"Not at all serious"* to *"Extremely serious"*, (3) *"How important would it be for you to seek help?"* with responses ranging from *"Not at all important"* to *"Extremely important"*, and (4) *"How likely would it be that you would actually seek help?"* with responses ranging from *"Not at all likely"* to *"Extremely likely"*. Participants were then asked whether they would seek help from five different sources (friend, parent/caregiver, Medical Doctor/Nurse, Counsellor/Psychologist/Psychiatrist and/or other.

Table 2. *Statements used in the Hypothetical Scenarios of Depression*

Scenario	School Problems	Relationships with Others	Emotional/Cognitive Symptoms	Physical Symptoms
Scenario 1 *Low Severity*	Marks a bit lower than normal Teachers picking on him/her lately	A few problems with girl/boyfriend Not really getting on with friends	Feeling a bit sad Hard to get going sometimes Feeling guilty about self Something is not really right at the moment Not enjoying stuff as much as he/she use to	Couple more headaches Few stomach aches Not quite as much energy as normal
Scenario 2 *Moderately- low severity*	Work in Class is getting hard Class is boring Hanging out by him/herself Does not like being around others at the moment	Not getting on with boss Thinking that people are avoiding him/her Thinking that people are talking about him/her behind his/her back	Feeling really sad Feeling pretty depressed Cannot wake up happy Feeling like a failure Cannot concentrate well Does not enjoy stuff he/she normally likes doing Has not felt this unhappy before	Getting a really dry mouth Getting the shakes
Scenario 3 *Moderately- high severity*	Most classes are boring and he/she does not see the point One teacher always picks on him/her saying he/she is not does not do as much work as he/she use to School is going bad	Real problems getting on with a couple of friends Sister pisses him/her off	Cannot focus or concentrate Cannot even watch TV anymore Finding it really hard to keep thoughts on one thing Feeling completely stupid about self Feeling like a disappointment Does not see future for self Feeling really bad about self Does not enjoy doing anything Feeling really sad Wondering what it would be like to hurt self Does not see way out	Really tired a lot Has no energy
Scenario 4 *High Severity*	Teachers suck and he/she feels hassled Classes suck Sits by him/herself in class and at lunchtime Skips classes	Broke up with boy/girlfriend Boss is dickhead, wants to stuff job Wishes parents were dead as they are on his/her back all the time Cousins are a real pain in the butt Does not even get on with team mates in touch rugby	Hates self Feels like a failure Hates the way he/she looks, feels ugly Does not have anything to look forward to in life Feels like a psycho	Had a cold for weeks Body aches all the time Cannot sleep at all Has had stomach aches everyday Constant headache Feels sick when thinking of eating

If a participant selected *"Yes"* to seeking help from a particular source they were consequently asked (1) *"What do you think their reaction would be?"* with the response options being *"Negative", "Neutral"* or *"Positive"* and (2) *"How helpful would you predict this person to be?"* with the response options being *"Not helpful", "Somewhat helpful"* or *"Very helpful"*. If a participant selected *"No"* the participant were asked *"Why not?"* and asked to tick *"all that apply"* of a list of eight barriers to help seeking (e.g. *"Not serious enough"*). Please refer appendix A for an example of the survey.

Procedure

Schools in the Wellington and Kapiti region were initially contacted by letter to the principal (please refer to Appendix B), which was followed up by a telephone call by post-graduate researcher from Victoria University Wellington. A monetary incentive of $2 per participant was offered to the schools. Five schools agreed to participate in the study. The researchers coordinated data collection with a primary contact (usually the Guidance Counsellor at the school). A letter providing information about the study and a parental permission form (please refer to Appendix C) were provided by Victoria University of Wellington, and sent out by the school, and then collected by teachers prior to data collection, or in some cases given to the researcher prior to commencement of data collection. Permission from parents' was required for all participants under the age of 16-years; those without a completed parental permission were not permitted to take part in the study. In addition, all individuals were provided with an information sheet and were required to complete a personal permission form (Appendix D) at the beginning of the data collection session, and participants were advised that they could cease participation at any time without penalty.

Data collection took place in the secondary schools, most often in a regular classroom setting; however, the library and the Marae (Maori meeting house) were also used. Data for boys and girls were collected separately due to the audiotape role plays being gender-specific.

Data collection took approximately one hour (the class period). The questionnaire was introduced by the researcher and the students were given verbal instruction to complete the questionnaire in silence, and to respect each other's privacy by not looking at others, or their sharing responses.

All questionnaires were kept confidential unless an individual demonstrated a significant risk by selecting high responses on item seven and/or nine on the depression inventory (CDI: Kovacs, 1985). When this situation arose the researcher made contact with the school guidance counsellor to see if they were aware of an individual's high risk. It was left to the discretion of the school whether they would act on this information. Participants were advised of this process, and that their responses to the questionnaire would remain confidential, except under the circumstance that there was significant risk of harming themselves. It was emphasised that under no circumstances would school staff would not have access to their questionnaires, to encourage honest responding. A debriefing was provided at the end of data collection, in which the participants were encouraged to ask questions about the study. Once the questionnaire was completed by all participants, they were provided with a debriefing handout (Appendix E), which included the name of their school guidance counsellor, and a telephone number for an external and confidential help-seeking service. Participants were rewarded with a pen for their participation.

Coding

Please note that when the data were coded, female participants were coded as zero and male participants were coded as one. Due to the small sample size, age was split into two groups, with those aged between 14 and 16 years were grouped into the "younger adolescent" age group and coded as zero, and those aged 16 years and over grouped into the "older adolescent" age group, and coded as one. In addition, participants who identified as New

Zealand European/Pakeha were coded as one, whilst all other nationalities (again due to small sample size), were grouped as "other" and coded as zero.

Inclination to Seek Help

After being asked to rate the severity of each depression scenario, participants were asked questions about hypothetical help-seeking from four different sources of help, including what they thought the helpers reaction would be, and how helpful they predicted the helper to be. These variables were used to calculate an 'inclination to seek help' variable from a friend, parent, medical person, and mental health professional. The mean inclination to seek help from different sources ranged from 0 to 3, with 0 equal to not seeking help from that source, and a rating of 1 to 3 depending on the expected reaction, and helpfulness of the source.

Results

Severity of Depressive Symptoms on the Process of Help-Seeking

After playing the audiotape of each scenario of depression, participants were asked a number of questions regarding the process of help-seeking for the severity of depressive symptoms. This included how distressed or upset they would feel if they were the person on the tape (distress), how serious a problem they judged these feelings (serious), how important they felt it was for the person to seek help (seek) and how likely it was that they would seek help (likely) if they were the person on the audio tape.
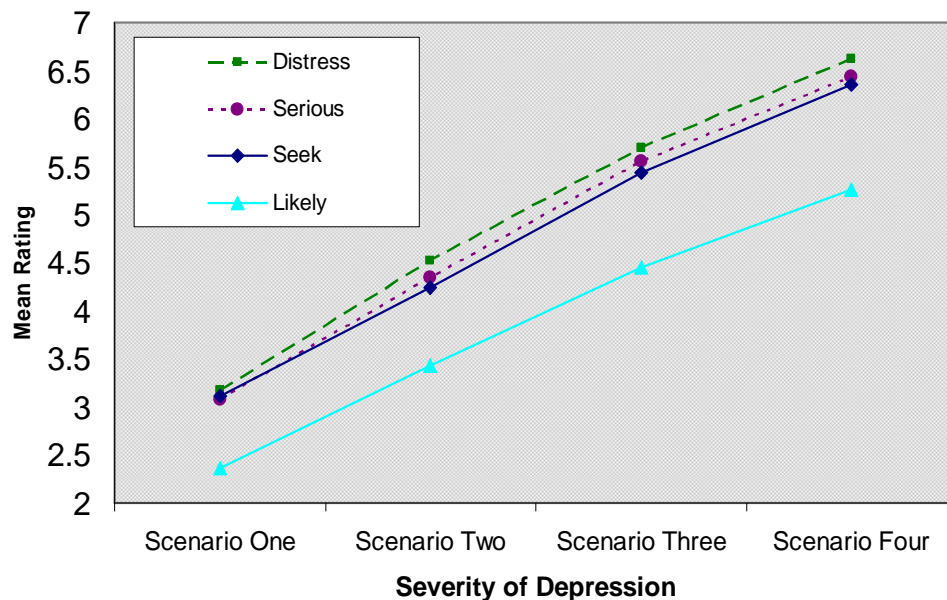
Figure 1. *Mean Participant Ratings of the Four Process Variables*

As the four scenarios were a manipulation of the severity of the depression symptoms, the first hypothesis was that as the symptoms of depression increased over the scenarios, the scenarios would be viewed as more distressing, participants would view it as a more serious problem, that it was more important to seek help, and that they would report being more likely to seek help. Figure 1 shows the mean participant ratings of the four severity variables, which supports this prediction.

Table 3 to 6 shows the Pearson's correlations among gender, age group, ethnicity, and the help-seeking process variables for the four scenarios of depression. The second hypothesis was that these process variables would be positively correlated. This prediction was supported by correlations, with relationships between the variables (distress, serious, seek and likely) being increasingly positively correlated as the scenarios increased in severity (please see Tables 3 to 6).

The third hypothesis was that participants' rated distress of each scenario would be most highly correlated to how serious they judged the feelings in the scenario, as both these variables indicate recognition of depressive symptoms as a problem. Correlations presented in Tables 3 to 6 support these predictions with distress and serious being most highly correlated for each scenario, and the relationship strengthening over the scenarios (scenario one, $r = .644$, $p < .01$; scenario two, $r = .730$, $p < .01$; scenario three, $r = .828$, $p < .01$; scenario four, $r = .832$, $p < .01$).

Table 3. *Correlations for Scenario One*

Variable	Distress	Serious	Seek	Likely
Gender	.027	.012	-.002	-.009
Age Group	-.001	-.055	-.078	-.043
Ethnicity	-.039	.013	-.102	-.114*
Distress	-	.644**	.430**	.325**
Serious		-	.568**	.395**
Seek			-	.633**

Note: **$p < .01$, *$p < .05$; Gender: Male = 1, Female = 0;
Age Group: 16 years and older = 1, Younger than 16 years = 0;
Ethnicity: New Zealand European = 1, Other = 0

The fourth hypothesis was that the importance of seeking help (seek) would be most highly correlated with the likelihood of seeking help (likely). This prediction was supported with seek being *most* highly correlated to likely for each scenario (scenario one, $r = .633$, $p <$

.01, scenario two, $r = .610$, p < .01, scenario three, $r = .634$, p < .01, scenario four, $r = .552$, p <

.01).

Table 4. *Correlations for Scenario Two*

Variable	Distress	Serious	Seek	Likely
Gender	-.032	.008	-.055	-.041
Age Group	-.005	-.037	.025	-.017
Ethnicity	.106	.018	.011	-.106
Distress	-	.730**	.521**	.374**
Serious		-	.666**	.496**
Seek			-	.610**

Note: **p < .01, *p < .05; Gender: Male = 1, Female = 0;
Age Group: 16 years and older = 1, Younger than 16 years = 0
Ethnicity: New Zealand European = 1, Other = 0

Table 5. *Correlations for Scenario Three*

Variable	Distress	Serious	Seek	Likely
Gender	-.163**	-.140*	-.155*	-.173**
Age Group	.066	.105	.114*	.027
Ethnicity	.031	.066	-.002	-.078
Distress	-	.828**	.720**	.460**
Serious		-	.803**	.519**
Seek			-	.634**

Note: **p < .01, *p < .05; Gender: Male = 1, Female = 0;
Age Group: 16 years and older = 1, Younger than 16 years = 0
Ethnicity: New Zealand European = 1, Other = 0

Gender. The fifth hypothesis was that female adolescents would judge the scenarios as

more distressing and serious, as well as report higher importance of seeking help, and report

greater likelihood of seeking help than their male counterparts. This prediction was supported

for scenario three and four only, with significant correlations between gender and distress ($r = -$

.163, p < .01), serious ($r = -.140$, p < .05), seek ($r = -.155$, p < .01) and likely ($r = -.173$, p <

.01) in scenario three; and significant correlations between gender and distress ($r = -.2.15$, p <

.01), serious (r = -.195, p < .01), seek (r = -.172, p < .01) and likely (r = -.160, p < .01) in

scenario four. Therefore, significant gender differences only emerged once depressive

symptoms were moderately to highly severe.

Table 6. *Correlations for Scenario Four*

Variable	Distress	Serious	Seek	Likely
Gender	-.215**	-.195**	-.172**	-.160**
Age Group	.026	.020	.052	-.011
Ethnicity	.232**	.157**	.159**	-.035
Distress	-	.832**	.743**	.398**
Serious		-	.765**	.468**
Seek			-	.552**

Note: **p < .01, *p < .05; Gender: Male = 1, Female = 0;
Age Group: 16 years and older = 1, Younger than 16 years = 0
Ethnicity: New Zealand European = 1, Other = 0

Age Group. Analyses between age and process variables were exploratory due to mixed

findings of adolescent help-seeking varying by age. However, there were no significant

correlations between age group and how participants perceived the scenarios, except for a

significant relationship between age group and the importance of seeking help (seek, r = .114,

p < .05), with older adolescents reporting significantly higher importance of seeking help for

the symptoms of depression in scenario three.

Ethnicity. The correlations between ethnicity and process variables were also exploratory,

as there is limited research on ethnicity and the process of help-seeking. Ethnicity was

significantly negatively correlated to 'likely' in the first scenario, indicating that those who

were not New Zealand European reported a stronger likelihood of seeking help for these

problems. In scenario four, ethnicity was significantly correlated with 'distress', 'serious' and

'seek', indicating those who were New Zealand European reported this scenario as more

distressing, more serious and rated the importance of seeking help higher than those of not of New Zealand European ethnicity, please refer to Table 6.

Mean Group Differences and the Process of Help-Seeking

A significant multivariate effect for age group was found: $F(4, 259) = 2.456$, $p < .05$, Wilks' $\lambda = .963$, partial $\eta^2 = .037$. However, there were no significant univariate findings. There was no significant multivariate effect for gender or ethnicity. A significant interaction was found for age group by ethnicity: $F(4, 259) = 2.858$, $p < .05$, Wilks' $\lambda = .958$, partial $\eta^2 = .042$. Univariate analysis revealed this interaction had an effect which approached significance on the reported likelihood of seeking help (likely): $F(1, 262) = 3.505$, $p = .062$, partial $\eta^2 = .13$. Figure 2 illustrates this interaction, which resulted chiefly from younger adolescents of non-New Zealand European ethnicity reporting higher likelihood of seeking help than older non-New Zealand European, whereas New Zealand European reported similar likelihood of help-seeking regardless of age.
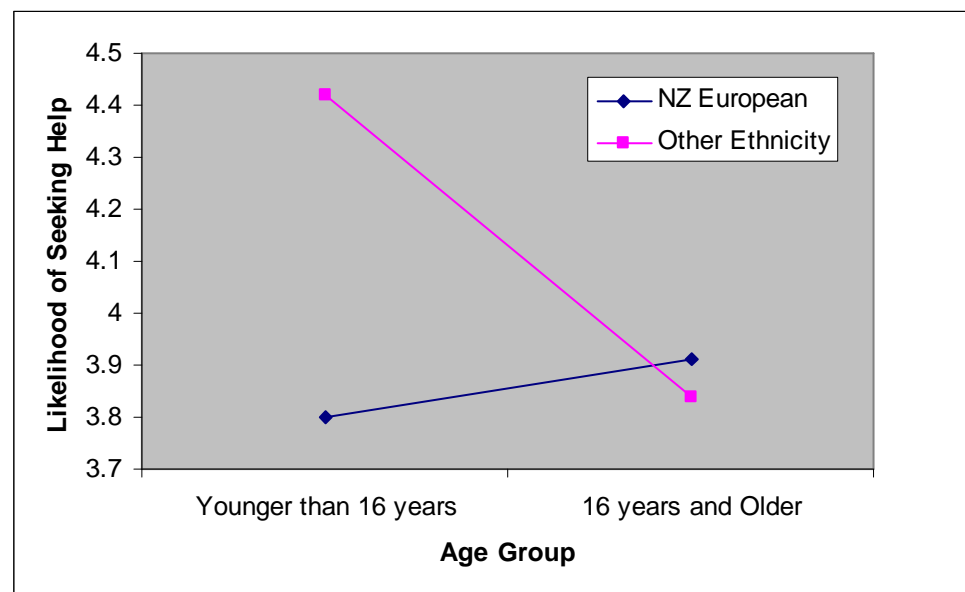
Figure 2. *Interaction of Age Group by Ethnicity for Participants' Likelihood of Seeking Help*

For the within-subjects factor, a significant multivariate effect of scenario was found; $F(12, 251) = 12.166$, p < .01, Wilks' $\lambda = .632$, partial $\eta^2 = .368$. A univariate effect was found for all four dependent variables (distress, serious, seek, and likely), demonstrating an increase in participant ratings of these variables as the manipulated symptoms of depression increased over the four scenarios: distress, $F(3, 786) = 46.878$, p < .01, partial $\eta^2 = .152$; serious, $F(3,786) = 55.558$, p < .01, partial $\eta^2 = .175$; seek, $F(3,786) = 37.65$, p < .01, partial $\eta^2 = .126$; and likely, $F(13,786) = 23.965$, p < .01, partial $\eta^2 = .084$. These results support the first hypothesis that adolescents judged the later scenarios as more severe. This pattern is illustrated in the descriptive graph of Figure 1.
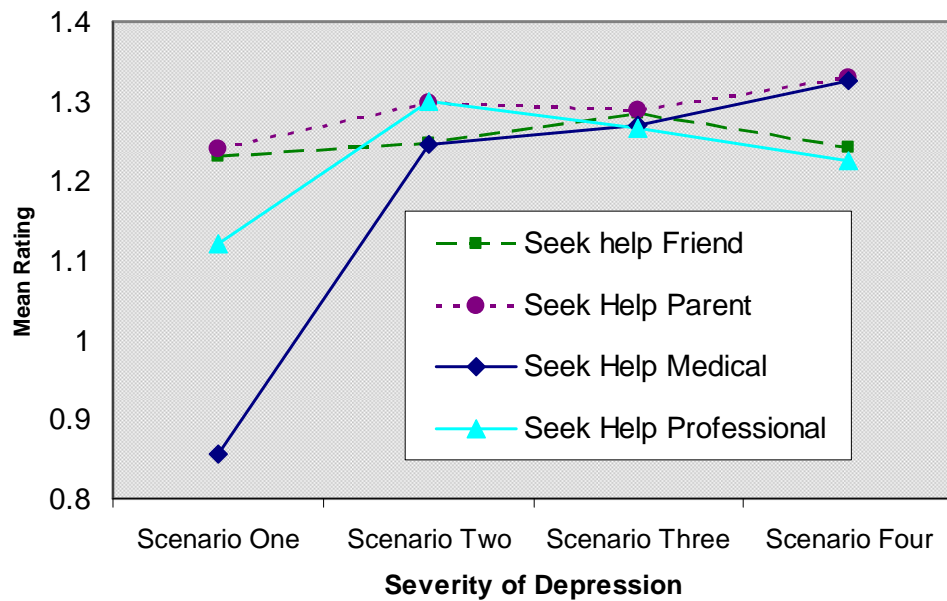
Figure 3. *Mean Participant Inclination to Seek Help from Different Sources*

Severity of Depressive Symptoms and Inclination to Seek Help

After being asked about the process of help-seeking for each scenario, participants were asked about hypothetical help-seeking from four different sources of help. These variables were used to calculate a scale of 'inclination to seek help' variable from four important sources of help.

The mean inclinations to seek help from different sources ranged from naught to three, and are presented in Figure 3. The sixth hypothesis was that as depressive symptoms increased in severity, so would the inclination to seek help from formal sources. This was partially supported by descriptive statistics, with an increase in inclination to seek help from a medical person. The seventh hypothesis was that there would be a decrease in help-seeking for severe symptoms of depression. This is not supported by descriptive statistics but will be examined further in the multivariate analyses.

Correlations of Participants Inclination to Help-Seek

Table 7 shows the Pearson's correlations between gender, age group, ethnicity and the inclination to seek help from four different sources; friend, parent, medical person and mental health professional, for the four scenarios of depression.

Gender. The eighth hypothesis was that female adolescents would be inclined to seek more help from friends than their male counterparts, which was partially supported by the correlation results. Gender was significantly (negatively) correlated with inclination to seek help from a friend in scenario one and two only (scenario one, $r = -.198$, p < .05; scenario two, $r = -.157$, p < .01), indicating females had a higher inclination to seek help from friends than males for scenario one and two.

Age group. The ninth hypothesis was that younger adolescents would be more inclined to seek help from parents than older adolescents. This was not supported by correlations, however will be examined further in multivariate analyses. The tenth hypothesis was that older adolescents would be more inclined to seek help from formal sources such as a medical or mental health professional. There was a significant correlation with age group and an inclination to seek help from a health professional in scenario four ($r = .123$, p < .01), indicating that those participants who were 16 years and older were more likely to report an inclination to seek help from a medical person for this scenario than those younger than 16.

Table 7. *Correlations between Inclination to Seek Help from Different Sources and Gender, Age Group and Ethnicity*

Scenario	Source	Gender	Age Group	Ethnicity
Scenario One	Friend	-.198**	.017	-.013
	Parent	.014	-.010	-.085
	Medical	.047	.012	-.090
	Professional	.008	-.092	-.097
Scenario Two	Friend	-.157**	-.095	-.038
	Parent	-.035	.005	-.033
	Medical	.090	.06	-.117*
	Professional	.002	.016	-.033
Scenario Three	Friend	-.098	-.009	-.070
	Parent	-.030	.018	-.015
	Medical	.007	.043	-021
	Professional	-.103	.006	.004
Scenario Four	Friend	-.025	.042	-.136*
	Parent	.081	.035	-.065
	Medical	-.011	.123*	-.044
	Professional	-.50	-.032	.008

Note: **$p<.01$, *$p<.05$; Gender: Male = 1, Female = 0;
Age Group: 16 years and older = 1, Younger than 16 years = 0;
Ethnicity: New Zealand European = 1, Other ethnicity = 0

Ethnicity. Ethnicity was significantly correlated with an inclination to seek help from a medical professional in scenario two ($r = -.117$, $p < .05$), and a friend in scenario four ($r = -.136$, $p < .05$), indicating those who were not of New Zealand European ethnicity reported significantly greater inclination to seek help from these sources.

Mean Group Differences in Participants' Inclination to Seek Help

A repeated measure MANOVA was conducted on the inclination to seek help from the four different sources (friend, parent, medical person and mental health professional), for the four scenarios of depression (from mild depression in scenario one to severe depression in scenario four). A between-subjects multivariate effect (when the findings are averaged across

the four scenarios) approached significance for gender, $F(4, 271) = 2.144$, p = .076, Wilks' λ =

.969, partial $\eta^2 = .031$. Univariate analysis revealed that inclination to seek help from a friend

approached significance, $F(1, 274) = 2.824$, p = .094, partial $\eta^2 = .010$, indicating females

reported higher inclination to seek help from a friend, supporting the eighth hypothesis. A

significant interaction was found for gender by age group, $F(1, 271) = 3.117$, p < .05, Wilks' λ

= .956, partial $\eta^2 = .044$. By examining univariate tests, it was revealed that this was driven by

a significant interaction of age group by inclination to seek help from a friend $F(1, 274) = 6.64$,

p < .01, partial $\eta^2 = .024$. An illustration of this interaction is presented in Figure 4.
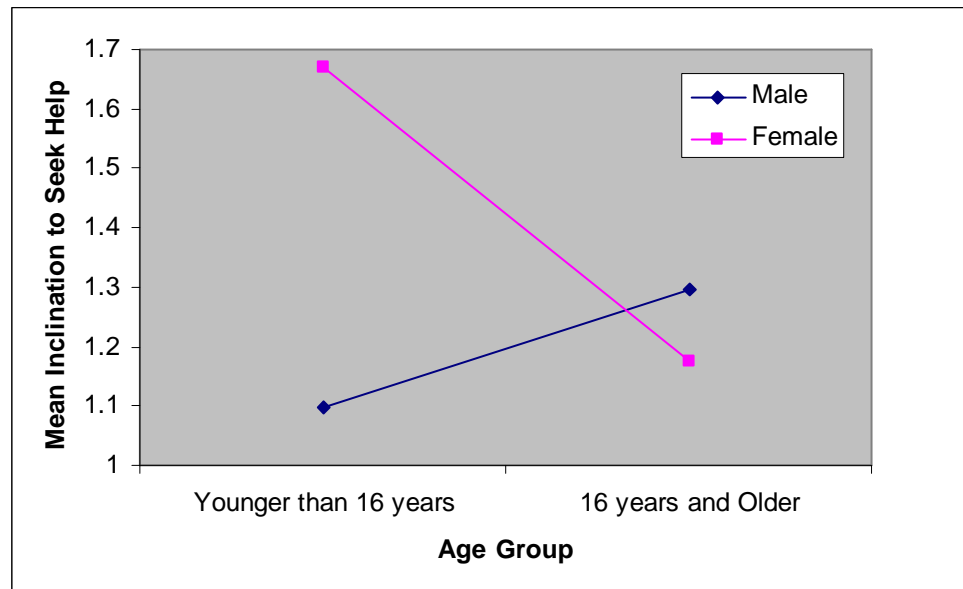
Figure 4. *Age Group by Gender for Participant's Inclination to Seek Help from a Friend*

For within-subjects comparisons (that is examining results across the four scenarios), a

significant multivariate main effect for scenario was found, $F(12, 263) = 1.865$, p < .05, Wilks'

$\lambda = .922$, partial $\eta^2 = .078$. Examining univariate within-subjects analyses, it was found that

there was a significant effect for inclination to seek help from a mental health professional,

$F(3, 822) = 4.011$, p < .01, partial $\eta^2 = .014$, and an effect for inclination to seek help from a

friend which approached significance, $F(3, 822) = 2.156$, p = .092, partial $\eta^2 = .008$. The

different patterns of inclination to seek help from a friend and mental health professional are

illustrated in figure 5, with inclination to seek help from a friend relatively stable across the

four scenarios, whereas help-seeking from a mental health professional gradually increased

with the severity of depressive symptoms, supporting the sixth hypothesis.
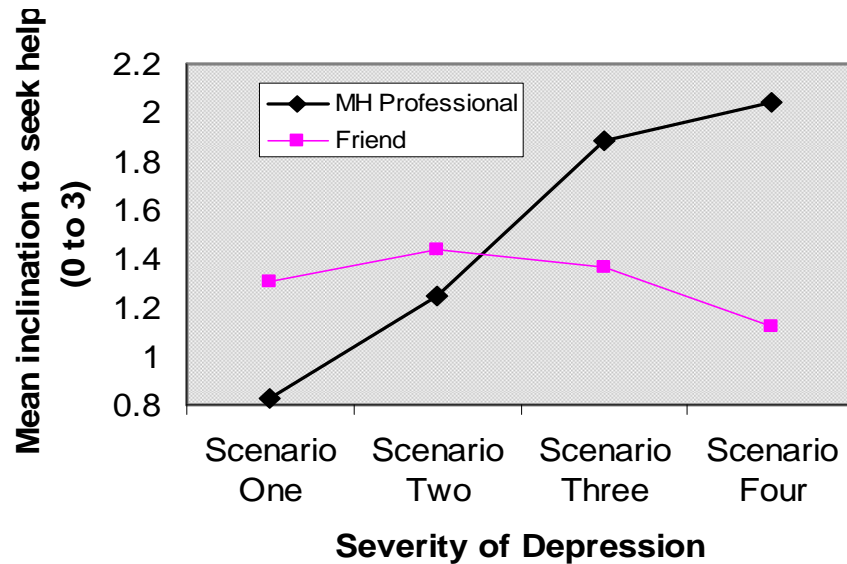
Figure 5. *Participants' Inclination to Seek Help from a Friend and Mental Health Professional over the Four Scenarios*

There was a significant interaction for scenario by gender, $F(12, 263) = 3.261$, p < .01,

Wilks' $\lambda = .870$, partial $\eta^2 = .130$. Through examining univariate findings, it was found that

this interaction was significant for inclination to seek help from a friend, $F(3, 822) = 4.391$, p <

.01, partial $\eta^2 = .016$, and parent, $F(3, 822) = 4.793$, p < .01, partial $\eta^2 = .017$, illustrated in

figures 6 and 7.
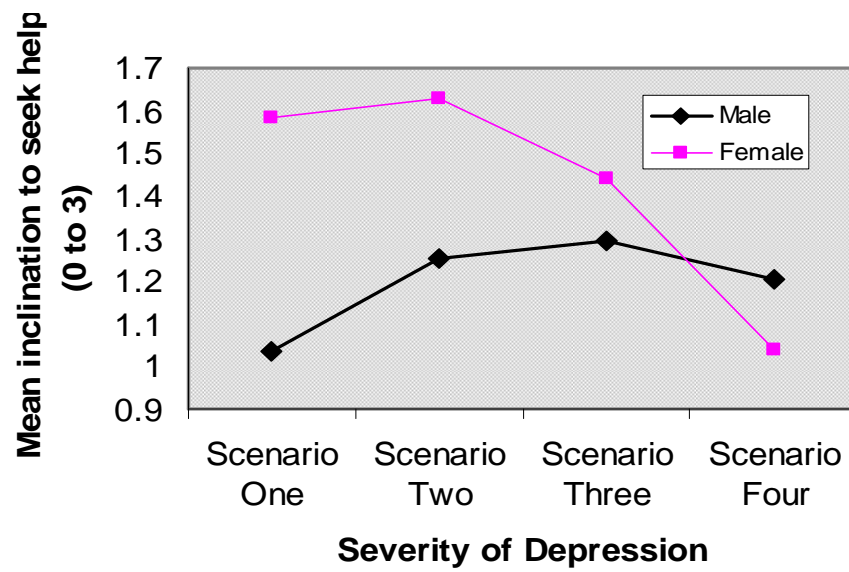
Figure 6. *Scenario by Gender Interaction for Participants' Inclination to Seek Help from a Friend*
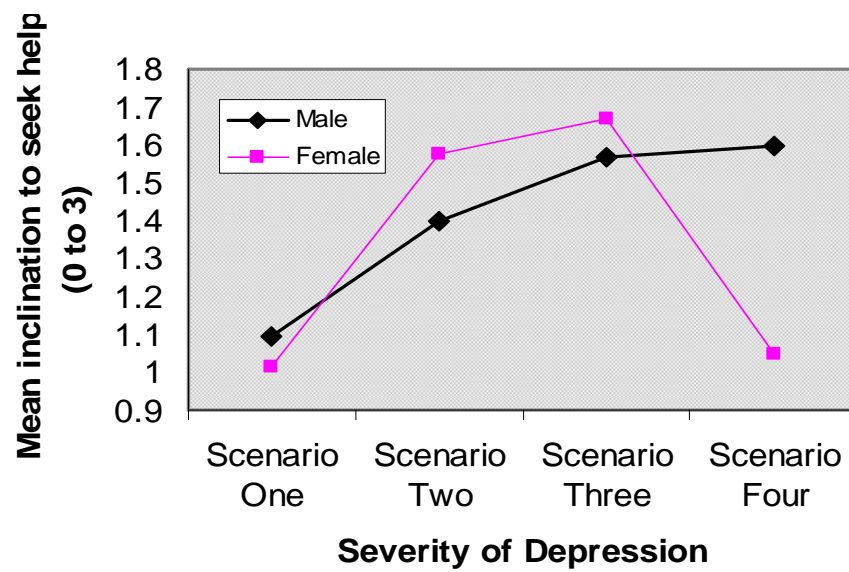
Figure 7. *Scenario by Gender Interaction for Participant's Inclination to Seek Help from a Parent*

Barriers to Help-Seeking

Dichotomous data on eight reasons why adolescents may not seek help (barriers to help-seeking) were collected for those participants who expressed they *would not* seek help from a particular source of friend, parent, medical person or mental health professional. If a participant selected 'no' to seeking help from a source for the scenario, they were asked 'Why not?' and given a list of eight potential barriers, of which they could select as many that they felt applied. Barrier data was only collected for those who indicated they would not seek help from a particular source, therefore, the number of people who provided barrier data (N) varied for each source and each scenario. For example, some participants may have reported willingness to seek help from a friend and parent for a given scenario, but not a medical person or a mental health professional meaning they only provided barrier information for those sources from which they chose *not* to seek help. As there was not full barrier information for all participants, in addition to the data being dichotomous and non-continuous, it was not possible to conduct inferential statistics; however descriptive statistics on frequencies, and Correspondence Analyses (CA) were conducted to explore the different patterns of barrier selection, over the four scenarios.

Frequencies

Due to a participant being able to select as many barriers they felt were applicable for each source, it was important to convert the frequencies into ratios, to reflect the frequency each barrier was endorsed compared to total number of participants who responded to this question (N). These ratios were graphed to examine the patterns of barriers from the four sources of help across the four scenarios. The barrier information is graphed for each source of help separately; please refer to Figures 8 to 11.
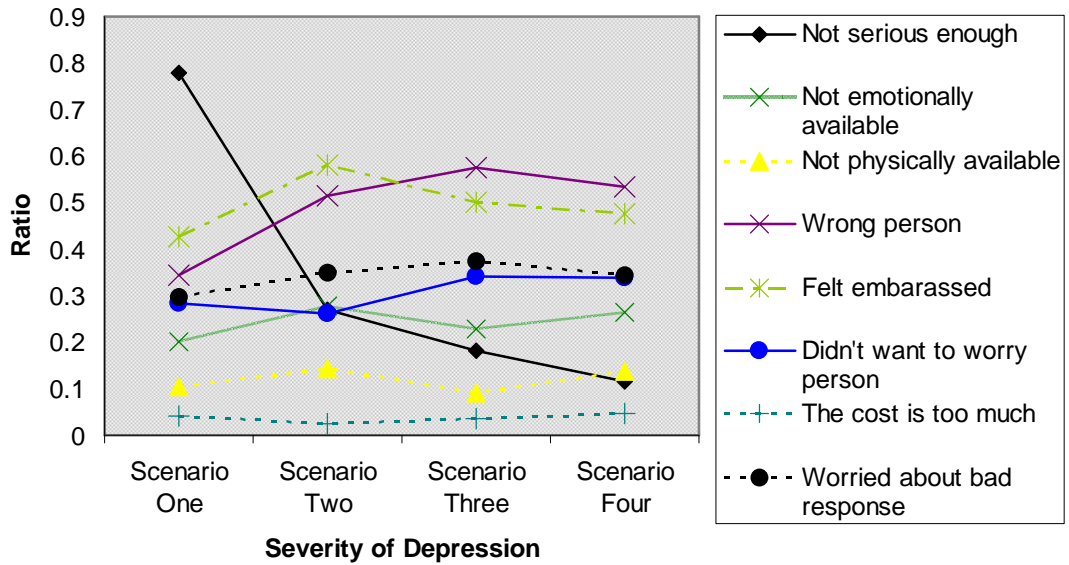
Figure 8. *Ratios of Barriers to Seeking Help from a Friend*

For help-seeking from a friend illustrated in Figure 8, the ratio of barriers endorsed remained relatively constant across the four scenarios, except for the barrier 'not serious enough' which decreased with the severity of the scenarios. Felt embarrassed and wrong person were the most frequently endorsed barriers to seeking help from a friend.
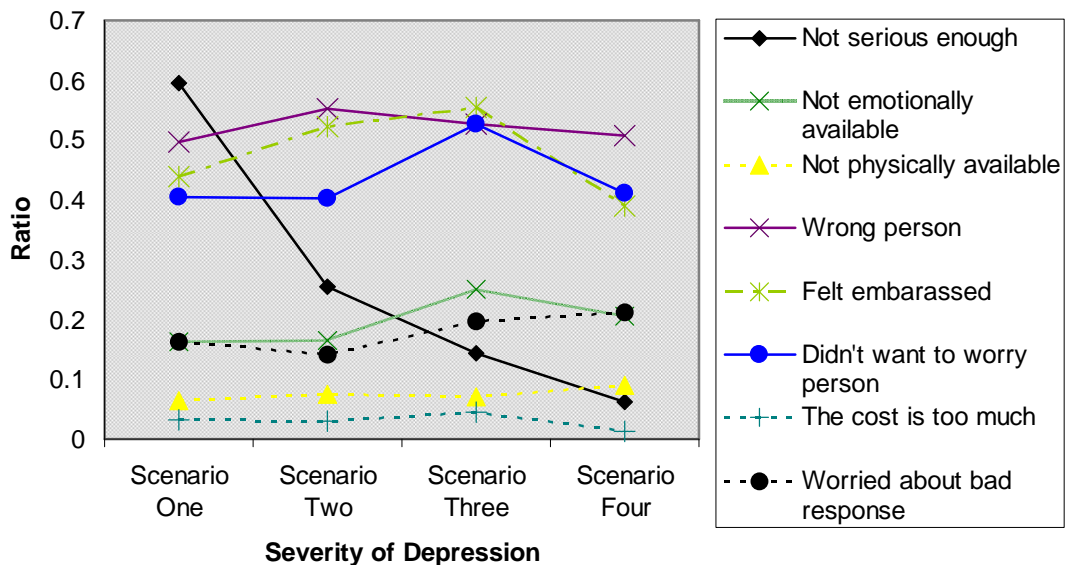
Figure 9. *Ratios of Barriers to Seeking Help from a Parent*

For help-seeking from a parent illustrated in Figure 9, the ratios of barriers endorsed also remained relatively constant across the four scenarios, except for the barrier 'not serious enough' which decreased with the severity of the scenarios. However, the three barriers 'didn't want to worry person', 'wrong person' and 'felt embarrassed', were consistently endorsed more often than the other barriers when seeking help from a parent.
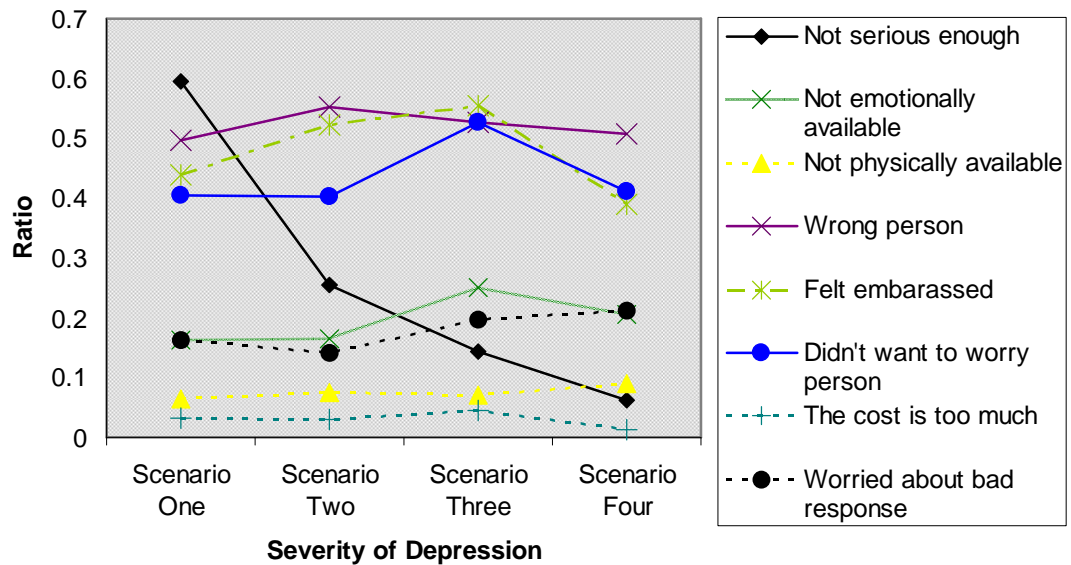
Figure 10. *Ratios of Barriers to Seeking Help from a Medical Person (e.g. GP)*

For help-seeking from a medical person, as illustrated in Figure 10, the ratios of the barriers endorsed remained relatively stable, with the exception of the barrier 'not serious enough', which decreased with the increase in severity of depression. Three barriers were consistently endorsed more for medical person than the other barriers; these included 'wrong person', 'felt embarrassed' and 'didn't want to worry person'.

The barrier 'not serious enough' also consistently decreased with the severity of depression for seeking help from a mental health professional (please refer to Figure 11). Most of the barriers to seeking help from a mental health professional slightly increased with the severity of depression until scenario three, and then dropped off again in scenario four.
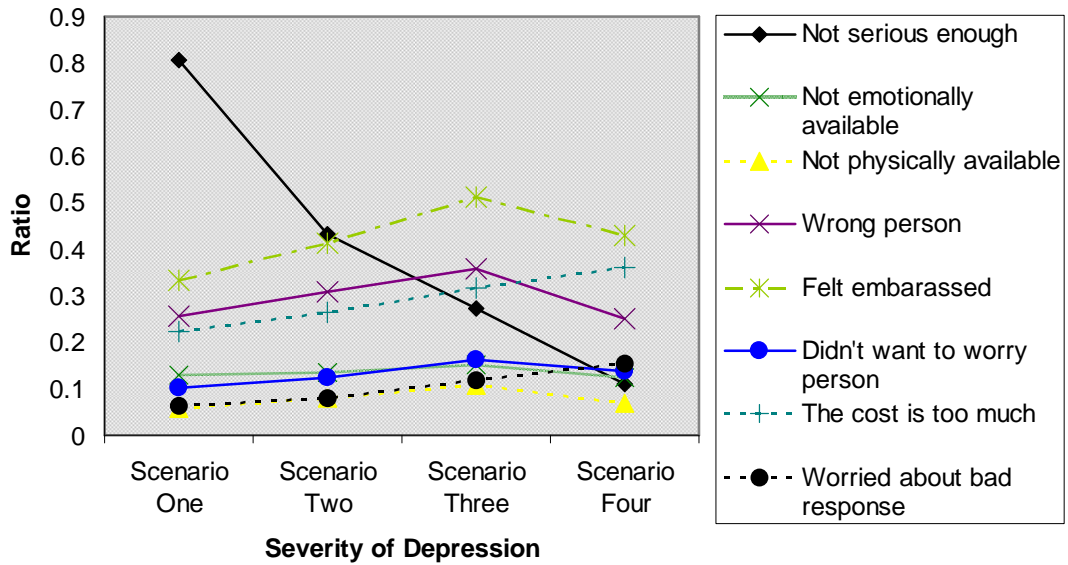
Figure 11. *Ratios of Barriers to Seeking Help from a Mental Health Professional*

The eleventh hypothesis was that as severity of depressive symptoms increased, participants would select fewer barriers to seeking help. This hypothesis was not supported, as although some barriers were endorsed more than others for particular sources of help, the ratios barriers were endorsed over the four scenarios did not differ considerably. The one exception was the barrier not serious enough, which significantly decreased over the four scenarios, regardless of the source of help, supporting the twelfth hypothesis.

The thirteenth hypothesis was that females would indicate fewer barriers to seeking help from sources than males. Descriptive data supports this prediction; males reported somewhat higher frequencies of all barriers compared to female adolescents except for scenario 4, which males had only slightly higher frequency than females as illustrated by figure 12.
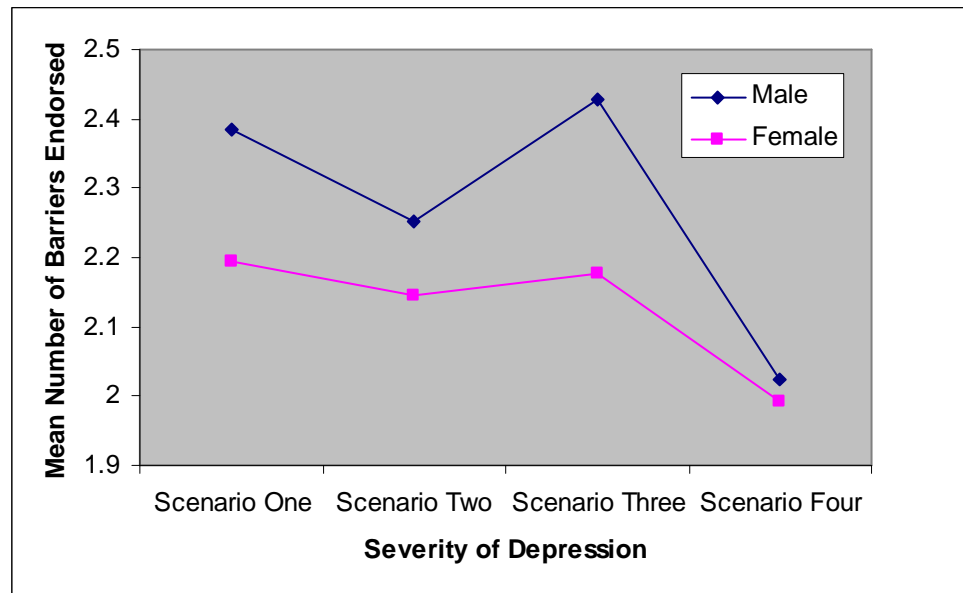
Figure 12. *Mean Frequency of Total Number of Barriers Endorsed by Males and Females*

Correspondence Analyses

Analyses were conducted with the barrier data to explore the patterns of barrier selection amongst participants using a Multi-Dimensional Scaling (MDS) technique called Correspondence Analysis (CA). MDS techniques help the analyst identify key dimensions underlying respondents' evaluations of objects or variables. MDS was originally used as a marketing tool to help identify the main aspects on which respondents' were evaluating particular products or services. Different techniques of MDS have been adapted to examine similarities and differences in psychological data (e.g. Augoustinos, 1991). MDS can be done through either decompositional or a compositional approaches. A decompositional approach helps identify object or item differences, whereas compositional methods derive the overall similarity or preferences between objects and variables.

What is CA? CA is a type of MDS that is a compositional technique, which examines interdependency between variables, and allows the 'correspondence' of categories or variables to be identified. This can be used to develop a perceptual map of the variables on two dimensions, presenting rows and columns in a joint space. The advantage of this technique is

that it provides the opportunity to examine the similarity between items or variables, as the closer two items are represented pictorially, the more similar the variables are perceived by the participants (Hair, Anderson, Tatham, & Black, 1998, pp. 485-529).

How does CA work? CA utilises non-metric data in the form of a contingency table. These data are then subjected to statistical software (in this case the SPSS ANACOR logarithm was used), which systematically relates the frequency for any row/column combination of categories to all other combinations based on the marginal frequencies. This produces a conditional probability similar to a chi-square value. That is, it calculates the difference between what you would expect by chance and what was reported by participants. These values are then normalised and reduced to two dimensions in a similar fashion to factor analysis. These 'dimensions' relate the rows and columns in a single join plot; the result being a single representation of both rows and columns in the plot.

How was it used in this study? In this study participants were asked to select one or more of eight reasons provided (barriers) for why they would not seek help from a particular source. The data produced were the frequencies for each barrier, for the four sources of help (friend, parent, medical person and mental health professional), across the four hypothetical scenarios of depression that increased in severity. As mentioned earlier; the number of people who provided barrier data (N) varied for each source and each scenario, depending on their help-seeking preferences. For example, some participants were willing to seek help from a friend and parent for scenario one, but not a medical person (e.g. GP) or a mental health professional (e.g. counsellor)[1]; therefore they only provided barrier information for those sources which they said they would not seek help. Ratios were used to reflect the frequency each barrier was endorsed, compared to total number of participants who responded to this question (N).

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[1] Please note that for ease of reference in this section, medical person will be referred to as GP, and mental health professional as counselor.

Four contingency tables were produced: ratios were presented in rows for each barrier and columns for each source of help, for scenarios one to four. Each table was presented individually to ANACOR version 0.4 (in SPSS version 14), which examined the interdependency of the barriers and the sources of help. The programme then created output of the rows and columns graphically in two dimensions for the barriers and the sources information separately. These were combined onto one perceptual map, so similarities could be examined simultaneously between the barriers and the different sources of help.

Using CA for the barrier data allowed examination of similarities between the eight barriers to help-seeking and the different sources of help. Through selecting a barrier, it was assumed that participants made a judgement about the barriers they felt particularly related to their reasons for *not* wanting to seek help from a particular person. Therefore, once participant responses were collated, hypotheses could be made about what was driving the relationships between these variables. The perceptual maps produced from CA of the barrier data are presented in Figures 13 to 16.

In Figure 13, parent and friend are pictorially displayed on the right, and GP and counsellor on the left. Therefore, dimension one distinguished between informal and formal types of support for mild depressive symptoms. Congruent with this finding, the barriers that related to the 'formality' of help-seeking for this scenario were also positioned to the left of the horizontal axis, such as 'the cost is too much', and 'not serious enough'. The barriers positioned to the right of this graph included more personal concerns, such as 'worried about a bad response' from a source, and 'don't want to worry person'. Dimension two distinguished between the two informal sources of help; with friend positioned in the bottom right quadrant, and parent positioned in the top right. In the bottom quadrant, the barriers were 'worried about a bad response', 'not physically available', and 'not emotionally available'. In the top right quadrant the barriers were 'wrong person' and 'don't want to worry person'.
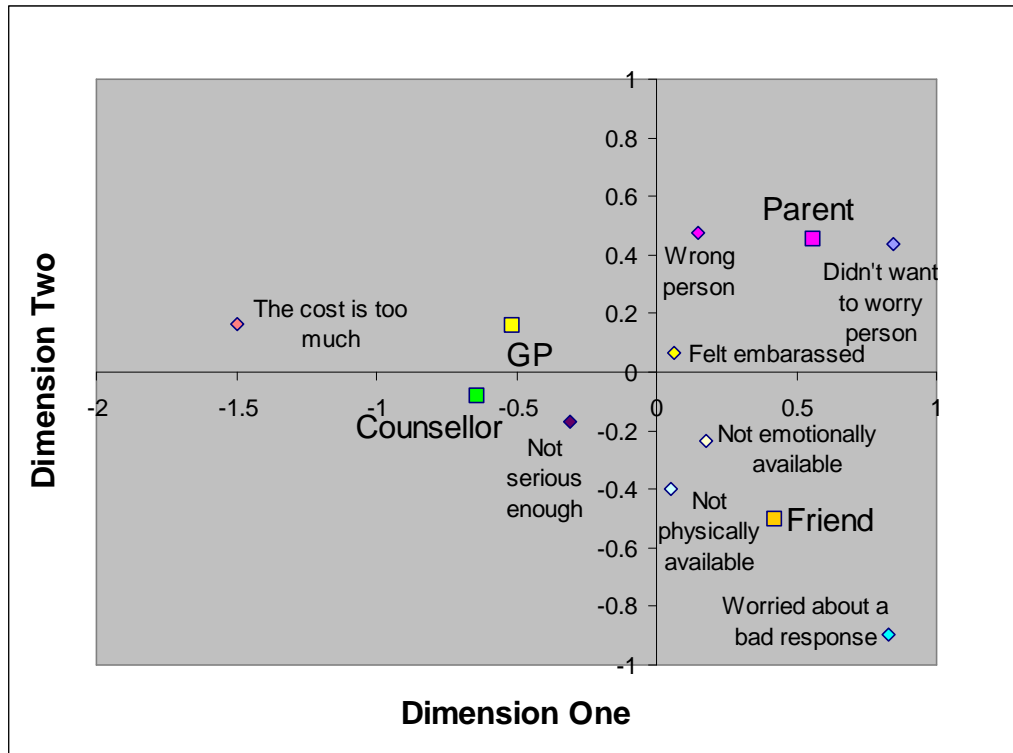
Figure 13. *Correspondence Analysis of Scenario One (mild depressive symptoms)*

This suggests that the participants were perhaps less worried about a bad response from their parents, particularly in comparison to their peers as this item was positioned much closer to friend. This is consistent with participants being adolescents, and the increasing importance placed on peer relationship during this developmental stage (Furman & Buhrmester, 1992), suggesting that 'worried about a bad response' was a more salient barrier to help-seeking from a friend. In addition, 'wrong person' was situated closest to parent, which suggests that participants often considered parents were the wrong person for scenario one, whereas being situated further away from friends indicated that they may not think this about friends.

Similar to Figure 13, the perceptual map for scenario two (mild to moderately severe depression) in Figure 14 distinguished between the formality of support in dimension one, and the informal support persons of parent and friend in dimension two.
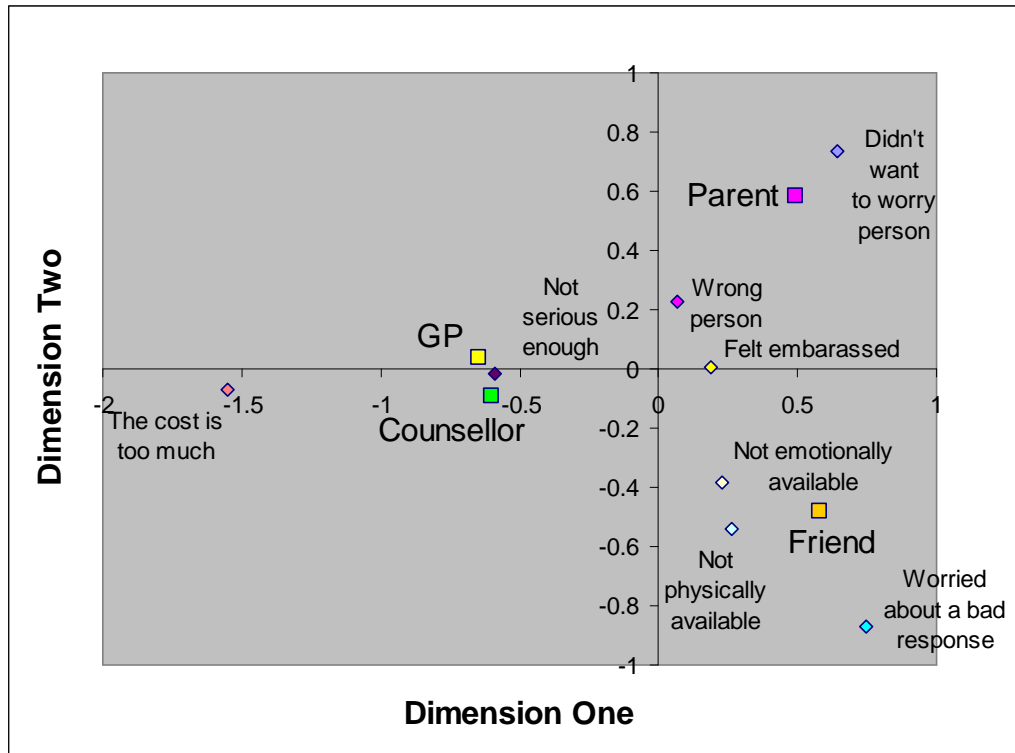
Figure 14. *Correspondence Analysis of Scenario Two (moderately-low depressive symptoms)*

The barriers were also displayed in a comparable location on the perceptual map to scenario one, where 'didn't want to worry person', 'felt embarrassed' and 'wrong person' remained in the top right quadrant, and 'not emotionally available', 'not physically available, and 'worried about a bad response' remained in the bottom right.

In Figure 15, the perceptual map of scenario three changed slightly from the previous scenarios in that the formal sources were further apart, whilst the informal sources appeared slightly closer together. However, dimension one still distinguished between the formality of the support, and dimension two still distinguished between the two informal sources of help of parent and friend. In addition, dimension two also distinguished somewhat between counsellor and GP (more than previous scenarios).
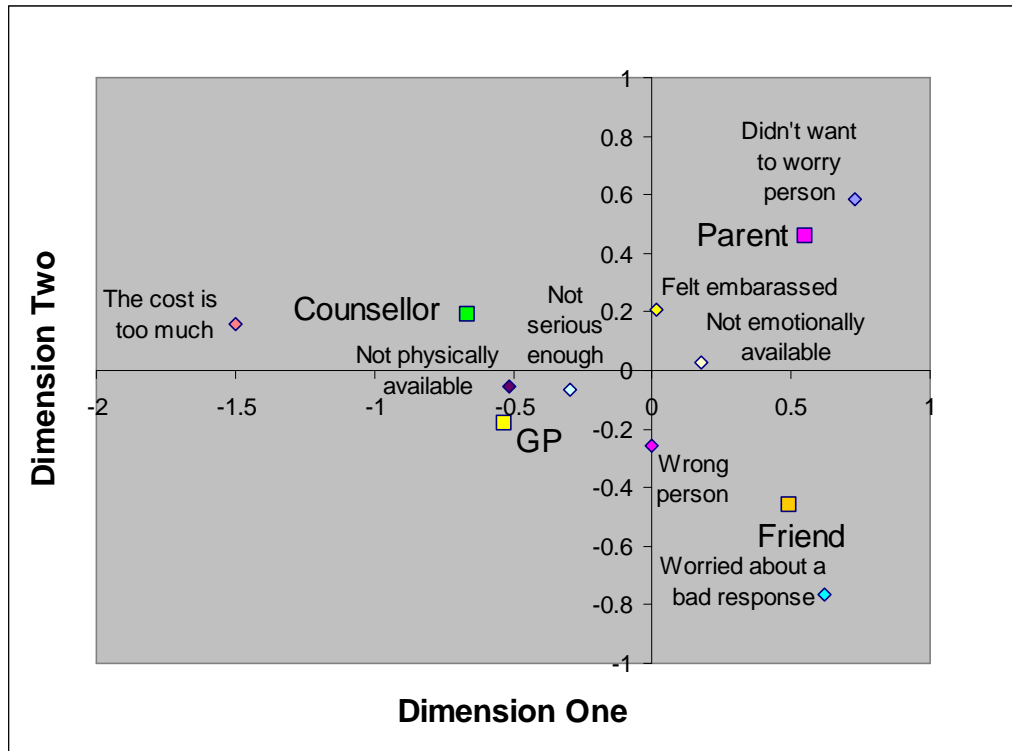
Figure 15. *Correspondence Analysis of Scenario Three (moderately-high depressive symptoms)*

In terms of barriers, these centred slightly, and 'wrong person' moved from the top right quadrant into bottom centre closer to source of friend, which suggests that friend is more closely related to 'wrong person' as the severity of symptoms increased. 'Not serious enough' moved from the left to more centre, which was consistent with the increased severity of the depression scenario, and not seeking help from a particular source. 'The cost is too much' barrier remained far left. Interestingly, the barrier of being 'not emotionally available' moved closer to parent, which suggests that friends were considered more emotionally available for moderately severe symptoms of depression, particularly in comparison to parents. The barrier 'not physically available' moved from the bottom left quadrant in scenario two to centre on dimension two and, and 'not physically available' moved left on dimension one, closer to the formal sources of help, suggesting parents and friends were considered more physically available, whilst formal sources were considered less accessible.

Figure 16 depicts the relationships between sources and barriers for severe depressive symptoms in scenario four. Dimension one continued to distinguish between the formality of the source of help-seeking, with parent and friend on the right, and counsellor and GP on the left. Interestingly, dimension two no longer distinguished between the informal sources of friend and parent (which were positioned close together), it distinguished between counsellor and GP. The barrier 'worried about a bad response' moved from the bottom left quadrant where it was situated in scenarios one to three, to the top right, and continued to be positioned close to the source of friend, indicating continued salience of this barrier regarding seeking help from a friend. However, it was also positioned closer to parent, suggesting that being worried about a bad response was an important barrier to seeking help from close ones.
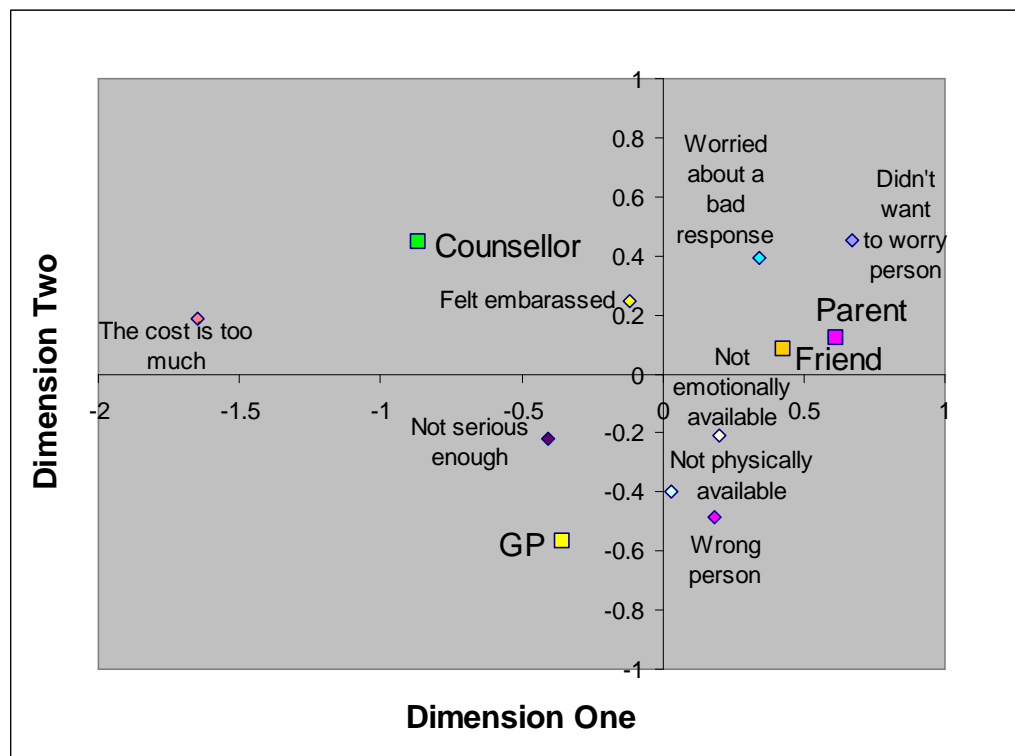
Figure 16. *Correspondence Analysis of Scenario Four (severe depressive symptoms)*

What do these patterns mean? Dimension one consistently distinguished between the formal and informal sources of help across the four scenarios; therefore it can be viewed as a

consistent evaluation of the nature of help in regards to formality. The barriers that were consistently on the extremes of this dimension, such as 'the cost is too much' on the far left, and 'don't want to worry person' on the right, support the labelling of this dimension. Concerns about the cost is more likely to be a barrier which applies to a formal source of help, whereas not wanting to worry the person is likely to be a concern which applies to someone who has a personal relationship with the person. Dimension one explained 81% of the correspondence in scenario one, 80% in scenario two, 77% in scenario three, and 82% in scenario four. This indicates that the formality of support explained a large percentage of the variance across the four scenarios, leaving dimension two with less explanatory power. This finding is consistent with the fourteenth hypothesis, that barriers to help-seeking are closely related to the source of help, in particular, the formality of the sources of help.

The role of the second dimension varied more over the scenarios, and was therefore more difficult to define. With mild, moderately-low, and moderately-high depressive symptoms (scenarios one to three), dimension two distinguished between parent and friend. However, for severe depression in scenario four, it illustrated a difference between counsellor and GP. This dimension is labelled 'appropriateness' as it appears that participants made a latent decision regarding the most appropriate type of help, for the severity of the depression scenario. That is, despite participants indicating that they would not seek help from this source, it is suggested that participants implicitly differentiated between the two most appropriate people to seek help from, considering the severity of the scenario. The pattern across the four scenarios suggests that participants took into account both the person they would seek help from and the severity of the depression when they selected barriers to seeking help from each source.

To support this, the barriers that varied on dimension two, across the scenarios were also concerned with the appropriateness of a source, such as 'worried about a bad response', and 'don't want to worry person' sitting at opposite ends of this dimension in scenario one to three,

and moving significantly in scenario four. Some barriers remained relatively centre regardless of the scenario severity, such as 'felt embarrassed', and 'not serious enough', which suggests that these barriers were not so influenced by the appropriateness of the source of help, and were perhaps considered important barriers regardless of the severity of depression. Please note that there is more than one way to interpret these results; however, what the above analysis provides a good fit for the data.

　　Verifying perceived relationships with correlations. The interpretations of CA were statistically examined by computing correlations of the dimensional coordinates. That is, the CA coordinates for the two dimensions for the barriers to help-seeking and the sources of help were correlated to examine whether they were statistically similar or different. It was expected that the perceptual maps that were similar, coordinates would be significantly correlated on the relevant dimensions. Those that presented diverging perceptual maps, such as in scenario four, were expected to yield non-significant correlations for either one or both dimensions.

Table 8. *Correlations between Scenario Dimensions and CA Coordinates*

Scenario		Scenario One		Scenario Two		Scenario Three		Scenario Four	
	Dimension	One	Two	One	Two	One	Two	One	Two
One	One	-	-0.172	.977**	0.036	.984**	0.127	.968**	0.179
	Two		-	-0.243	.934**	-0.127	.729**	-0.05	**-0.118**
Two	One			-	-0.068	.965**	-0.153	.950**	0.176
	Two				-	0.079	.792**	0.125	**0.076**
Three	One					-	-0.093	.964**	0.227
	Two						-	-0.075	**0.271**
Four	One							-	-0.009

Note: **p < .01, *p < .05

　　Table 8 provides the coordinate correlations, which support the hypothesis that the perceptual map for scenario four is qualitatively different from scenario one to three. The second dimension for scenario four is *not* significantly correlated (as indicated in bold type)

with dimension two for scenario one to three, which was expected for perceptually similar maps, where as dimension one is significantly correlated with dimension one for all scenarios. Dimension two (appropriateness), is distinct in scenario four, compared to scenarios one to three, which is evident in the perceptual maps distinguishing between the sources of counsellor and GP, whereas in scenarios one to three this dimension distinguished between the sources of help of friend and parent.

Discussion

The Effect of Severity on the Process of Help-Seeking for Depression

The first hypothesis was supported with correlations and multivariate analyses, as participants rated scenarios as more distressing and serious when the severity of depressive symptoms increased, and reported an increase in the importance and likelihood of seeking help for depressive symptoms. Consistent with the second hypothesis, the process variables were inter-correlated, and became increasingly so with an increase in severity of the depressive symptoms. This suggests that the process variables captured aspects of the process of help-seeking. Consistent with the third hypothesis, the rated distress and seriousness of depressive symptoms were most highly correlated, suggesting these variables were perceived by participants as similar, consistent with both variables being related to recognition of the depressive symptoms as a problem.

Identification of a problem does not necessarily lead to a decision to seek help (Saunders, Resnick, Hoberman, & Blum, 1994; Srebnik, Cauce, & Baydar, 1996), therefore participants were asked how important they felt it was to seek help to capture positive attitudes toward help-seeking. Positive attitudes to help-seeking have been linked to a higher willingness to seek help by young people (Sheffield, Fiorenza, & Sofronoff, 2004; Wilson, Deane, & Ciarrochi, 2005). Consistent with the fourth hypothesis, the rated importance of seeking help

was most highly correlated to reported likelihood of actually seeking help across all four scenarios.

The fifth hypothesis was also supported; female participants reported significantly higher seriousness, distress, importance, and likelihood of seeking help for scenarios three and four. This was consistent with young females being more likely to report more psychological symptoms (Rickwood & Braithwaite, 1994), that females judge events as more stressful and problematic than same age males (Jose & Ratcliffe, 2004), and females worry more about a problem and expect more negative consequences than adolescent males (Seiffge-Krenke, 1993). Interestingly, there were no significant gender differences in the perception of scenario one and two. One possible explanation was that the content and statements in scenario one and two were closer to everyday adolescent experiences (e.g. sometimes not getting along with people in scenario one, and concerns that people are avoiding them in scenario two). Therefore, these experiences might be considered more developmentally appropriate to young people, and gender differences may not emerge until more severe symptoms of depression, which females have been found to judge as more problematic than young males.

There have been mixed findings for age on the process of seeking help, with some studies finding that children and younger adolescents access more mental health services (e.g. P. Cohen & Hesselbart, 1993), whereas other studies have found that older adolescents are more likely to seek professional help, particularly for themselves (e.g. Sears, 2004). The impact of age on the process of help-seeking was exploratory in this study. There was only one significant correlation for age group, which indicated that those who were over 16 years reported higher importance of help-seeking for scenario three. This is consistent with older adolescents having more positive attitudes to help-seeking and being more aware of professional help-seeking sources available than younger adolescents (Dubow, Lovoko, & Kausch, 1990). This was an isolated correlation but it is consistent with help-seeking being a

complex multi-stage process, which factors and adolescence is an important developmental stage which can influences of the process of help-seeking (Cauce et al., 2002; Srebnik, Cauce, & Baydar, 1996).

Ethnicity is thought to impact on all stages of help-seeking, but there is little research to support this, and most studies examine utilisation of mental health services rather than the process of help-seeking for different ethnicities, (e.g. Adelman, Barker, & Perry, 1993). Therefore, the impact of ethnicity on the process of help-seeking in this study was also exploratory. Significant correlations indicated that New Zealand European participants reported higher distress, seriousness, and importance of seeking help for severe symptoms of depression (scenario four) than those of other ethnicity, suggesting that New Zealand European participants had higher recognition of depressive symptoms, and held more positive attitudes to help-seeking. Those of the majority ethnicity have been found to seek more formal help than minorities (L. A. Barker & Adelman, 1994; Wu et al., 1999), but this may be due to other variables such as socioeconomic status (Gasquet, Chavance, Ledoux, & Choquet, 1997; Power, Eiraldi, Clarke, Mazzuca, & Krain, 2005). Appreciation of mental health issues is coloured by culture, and mental health services are often designed to be suitable for the dominant culture. More than three quarters of adolescents and their families are thought to drop out of the help-seeking process before accessing mental health services, and this drop-out is more common for youths of ethnic minorities and their families. Lack of cultural competency in delivering mental health services is thought to be a significant barrier to ethnic minorities accessing services, and dropping out of treatment early (Cauce et al., 2002; Cuffe, Waller, Cuccaro, Pumariega, & Garrison, 1995; Morgan, Ness, & Robinson, 2003).

There was an interaction for age by ethnicity for participants reported likelihood of seeking help over the four scenarios (as illustrated in figure 2). Of those younger than 16 years, those of non-New Zealand European ethnicity reported significantly higher *likelihood* of

seeking help than New Zealand Europeans. Those 16 years and over reported similar *likelihood* of seeking help to those who identified themselves as New Zealand European. Surprisingly, younger adolescents whom were not New Zealand European reported higher likelihood of seeking help than those who were older. Of those who identified themselves as New Zealand European, those 16 years and older reported more help-seeking than those younger than 16 years. The pattern displayed by New Zealand Europeans is more consistent with previous findings of age, with an increase in help-seeking in older adolescents (Dubow, Lovoko, & Kausch, 1990; Gasquet, Chavance, Ledoux, & Choquet, 1997; Oliver, Reed, Katz, & Haugh, 1999; Sears, 2004).

Unfortunately, the source of help was not specified for the likelihood of seeking help variable, which makes this finding difficult to interpret. A possible explanation for this finding is that older adolescents have been found to have greater knowledge mental health services (e.g. Dubow, Lovoko, & Kausch, 1990) and may have interpreted the question more narrowly than younger adolescents, assuming the researcher was referring to formal sources of help. Younger adolescents may have interpreted this question more broadly, to include seeking help from informal sources. Consistent with this interpretation, younger adolescents report higher help-seeking from their family and other informal sources than older adolescents (e.g. Fallon & Bowles, 1999), and those from different ethnicities may have access to a greater range of informal sources of help, including ethnic-traditional and religious leaders within their community (Cauce & Srebnik, 1989). Therefore, younger ethnic minorities may have greater access to informal sources and may have reported greater likelihood of seeking help with these sources in mind.   Older ethnic minorities may be more assimilated into the dominant culture, and displaying a pattern of help-seeking which is more consistent with the dominant culture.

This interaction raises interesting questions regarding ethnicity and help-seeking which are unfortunately beyond the scope of this study. Due to all ethnicities other than New Zealand

European being grouped together, it is difficult to draw meaningful conclusions other than a distinction between majority and minority ethnic groups. However, it is possible to conclude that ethnic minorities in this sample exhibited a different pattern of help-seeking to the dominant culture (New Zealand Europeans), which is influenced by age. Due to the cultural and contextual variables identified in adolescent help-seeking, this finding could be explained by minorities seeking more help from informal sources of help.

The Effect of Severity on Inclination to Seek Help for Depression

The sixth hypothesis was that as severity of depressive symptoms increased, the inclination to seek help from formal sources would also increase. This study supported this hypothesis in relation to seeking help from a mental health professional only, with help-seeking increasing over the four scenarios in both descriptive and multivariate results (as illustrated in figure 3 and 5).

Young people prefer seeking support and help from friends and family, which was supported by descriptive statistics. For the seventh hypothesis it was expected that help-seeking from informal sources of parent and friend would be high except for severe symptoms of depression which were expected lead to a decrease in help-seeking from parents and friends for scenario four, due to the presence of suicidal thoughts. A decrease in help-seeking in relation to severe symptoms of depression including suicidal thoughts has been labelled the help-negation effect, and it has been found to be more prevalent for informal sources of help (Wilson, Deane, & Ciarrochi, 2005). Help-negation was evident for both males and females for seeking help from friends, and was evident for female help-seeking from parents (as illustrated in figures 6 and 7).

Males and females showed significantly different patterns for seeking help from a friend and parent. Females' inclination to seek help from a parent increased from scenario one to three, then suddenly dropped off for scenario four, whereas male participants reported an

increase in inclination to seek help from parents as the severity of the scenario depression increases. Females' help-seeking from a friend decreased for moderately-severe and severe symptoms of depression, whilst male help-seeking from a friend increased and was relatively stable, then slightly decreased for severe symptoms of depression (as illustrated in figure 6). Scenario four was qualitatively different due to the young person expressing hopelessness, and suicidal ideation. Deane and colleagues found that young people were more likely to seek help from anonymous sources for suicidal thoughts. Young people willing to seek help from parents were more likely to be young males than females (Carlton & Deane, 2000; Wilson, Deane, & Ciarrochi, 2005). The findings in this study are consistent with this pattern. Feelings of hopelessness, barriers to help-seeking, and negative attitudes regarding help-seeking have been found to account for some but not all of the help-negation effect (Wilson, Deane, & Ciarrochi, 2005). It is expected that concern about the response, being judged by peers, and embarrassment are significant barriers to seeking help for suicidal thoughts from informal sources.

The eighth hypothesis was that females would seek more help than males, particularly from friends. Correlation results partially supported this hypothesis; female participants reported significantly greater rates of hypothetical help-seeking from friends for scenario one and two only. When examined over the four scenarios, females reported higher rates of inclination to seek help from their friends, consistent with the findings that females have more positive attitudes to help-seeking and utilise more help from their friends (Ciarrochi, Wilson, Deane, & Rickwood, 2003; Grinstein-Weiss, Fishman, & Eisikovits, 2005; Raviv, Sills, Raviv, & Wilansky, 2000; Rickwood, Deane, Wilson, & Ciarrochi, 2005; Schonert-Reichl & Muller, 1996).

As discussed above, males and females demonstrated different likelihood of seeking help from friends and parents. Consistent with the hypothesis, females reported greater inclination

to seek help from their friends except for severe symptoms of depression. As females have been found to report greater utilisation of professional help, it is thought that this result was due to females being more comfortable with alternative and appropriate sources of help, such as mental health professionals (Cramer, 1999; Sears, 2004).

The ninth hypothesis was that younger adolescents would seek more help from parents than older adolescents, whilst older adolescents would report being more willing to seek help from friends. Interestingly, this was supported for male participants only, with younger female adolescents reporting higher inclination to seek help from friends than to older females, whilst inclination to seek help from a friend by male participants was higher among older adolescents (please refer figure 4). Younger adolescents have been found to continue to rely on family for support and help during adolescence, which is adaptive (DuBois et al., 2002; Dubow, Lovoko, & Kausch, 1990; Offer, Howard, Schonert, & Ostrov, 1991). Although well-adjusted young people may continue to rely on parents for support, there is an increased use of friends as for primary support as they mature (Furman & Buhrmester, 1992; Schonert-Reichl & Muller, 1996; Sears, 2004).

The tenth hypothesis was that older adolescents would report higher inclination to seek help from professionals than younger adolescents, which was found for medical person only. Females and older adolescents have been found to hold more positive attitudes, and are more likely to seek formal help (Carlton & Deane, 2000; Jorm et al., 2006; Leong & Zachar, 1999). Females reported higher help-seeking from their friends for scenario one and two only. An interaction of age by gender emerged when help-seeking was averaged across the four scenarios, with older female adolescents reporting less help-seeking from friends than younger adolescents. Females have been found to have more positive attitudes and fewer barriers to seeking help from formal sources of help (Kuhl, Jarkon-Horlick, & Morrissey, 1997). Therefore, it is expected that the severity of the scenario impacted on the reported inclination

to seek help from a friend, as older females were more likely to seek help from formal sources, which were more appropriate for the severity of depressive symptoms (Chandra & Minkovitz, 2006; Schonert-Reichl, Offer, & Howard, 1995).

Consistent with this explanation, when findings were examined repeatedly for the four scenarios, severity of depressive symptoms were found to impact significantly on seeking help from a friend and mental health professional. Inclination to seek help from a friend increased from scenario one to two then dropped off for more severe depressive symptoms, whilst inclination to seek help from a mental health professional consistently increased with the severity of symptoms. The level of impairment experienced by young people, and severity of symptoms impacts on help-seeking and access to mental health services (Flisher et al., 1997; Leaf et al., 1996; Rickwood & Braithwaite, 1994; Saunders, Resnick, Hoberman, & Blum, 1994; Schonert-Reichl, Offer, & Howard, 1995). However, seeking help from a friend is thought to be more complex, influenced by age (Fallon & Bowles, 1999; Rickwood, Deane, Wilson, & Ciarrochi, 2005), gender (Dubow, Lovoko, & Kausch, 1990; Oliver, Reed, Katz, & Haugh, 1999), the expected response of a friend and the type of problem (Fallon & Bowles, 1999; Sullivan, Marshall, & Schonert-Reichl, 2002). In addition, availability and satisfaction of informal support is related to decreased help-seeking from formal sources of help (Adelman, Barker, & Perry, 1993; Cramer, 1999). Those with severe depressive symptoms are more likely to perceive need for professional help (Sears, 2004). The pattern of decreasing inclination to seek help from friends by female participants as the scenarios increase in severity is consistent with friends not being considered appropriate to seek help for more severe symptoms of depression, as well as the concern young people may have about talking to their peers about severe symptoms of depression, including being judged.

Barriers to Help-Seeking

Interestingly, severity did not impact on the reported frequency barriers were endorsed, except for the barrier 'not serious enough' which decreased with severity, supporting the twelfth hypothesis. Consistent with this study, Kuhl and colleagues found no correlation between perceived severity of symptoms and help-seeking in an adolescent sample, suggesting that the role of barriers in help-seeking is more complex (Kuhl, Jarkon-Horlick, & Morrissey, 1997). Although severity of problems is linked to an increase in help-seeking behaviour, severe symptoms can actually lead to a decrease in help-seeking, particularly for informal sources (Wilson, Deane, & Ciarrochi, 2005). Help-seeking is an adaptive strategy, used by well-adjusted young people (DuBois et al., 2002; Dubow, Lovoko, & Kausch, 1990; Garland & Zigler, 1994). Barrier data in this study were collected from those participants who chose not to seek help, and could be expected to perceive more barriers to seeking help than those participants who chose to seek help. This could account for why barrier frequencies do not decrease as the severity of symptoms increased.

Females have been found to have more positive attitudes to help-seeking, as well as knowledge of resources, and demonstrate higher professional help-seeking than males (Kuhl, Jarkon-Horlick, & Morrissey, 1997; Saunders, Resnick, Hoberman, & Blum, 1994; Sheffield, Fiorenza, & Sofronoff, 2004). Consistent with the thirteenth hypothesis, females reported fewer barriers to seeking help than male participants

The fourteenth hypothesis was that barriers would cluster around different sources of help dependent on the formality of the help. CA of barrier data found that there was a qualitative difference between scenario four and scenarios one to three. CA found that dimension one consistently differentiated between the formality of the barriers and source of help, whilst dimension two distinguished between the most appropriate sources of help. CA findings were consistent with the multivariate findings with the suitability of seeking help from friends and

parents thought to decrease for severe symptoms of depression. It is suggested that participants were making an implicit decision that informal help was not sufficient for severe symptoms of depression in scenario four. Consistent with this, young people report that help-seeking from friends and family is less useful for severe symptoms of depression (Rickwood & Braithwaite, 1994; Schonert-Reichl, Offer, & Howard, 1995), and are more likely to seek help from professional and anonymous sources for suicidal thoughts (Wilson, Deane, & Ciarrochi, 2005). It is suggested that young people recognise severe symptoms of depression and are more likely to seek help from more suitable sources, such as professionals.

Limitations

This study has several limitations that need to be noted. Firstly, the writer did not design the survey, and therefore the data collected were not ideal for the purposes of the study, with responses to seeking help from different sources dichotomous. I was particularly interested in the reasons young people chose not to seek help. Unfortunately, due to help-seeking responses being dichotomous, and the survey following a flow chart format (please refer to appendix A), data for barriers were only collected for those who indicated they would *not* seek help. Further, the barrier data were also dichotomous, with participants invited to select barriers which they felt applied to the situation (i.e. the source of help and the severity of depressive symptoms in scenario). Consequently, there was not a complete data set for all participants regarding their perceived barriers to seeking help from the different sources; hence it was not possible to conduct inferential statistics on the barrier data. Despite this, potentially interesting findings were identified through Correspondence Analysis (CA). The reader needs to keep in mind that the findings derived from the CA analyses were based on an incomplete picture of the sample as it was collected from non-helpers for each source and scenario of depression, and the sample changed dependent on young peoples' help-seeking preferences for each scenario and source of help.

The second important limitation is that survey is self-report in nature, and the scenarios are hypothetical; therefore, the findings may not be an accurate reflection of actual help-seeking behaviour. Discrepancies have been found between what depressed people believe will help their symptoms and what they will actually do in practice. Unfortunately, it is not always possible to examine actual help-seeking behaviour. A strength of this study is that it has conceptualised help-seeking as multi-stage process; and consequently asked questions regarding problem recognition, attitudes to help-seeking, and the likelihood of seeking help, as well as inclination to seek help from four different sources of help.

Third, the nature of this study was constrained by the options young people were asked about help-seeking, as well as the order they were provided in the survey. Young people were asked about friends initially and subsequently asked about help-seeking from parent/caregiver, medical doctor/nurse, and counsellor/psychologist/ psychiatrist. The order that sources of help are presented may have influenced the reported help-seeking. However, young people were given the option to seek help from 'Other', and few participants completed this section, which suggests the survey captured the important sources of help.

Fourth, young people were not provided with important definitions. In particular, young people were not given a definition of help-seeking prior to completing the survey, and may have had different interpretations of what they understood as help-seeking, particularly for the likelihood of seeking help variable. It is not known how broadly or narrowly this question was interpreted, with younger adolescents potentially considered seeking help from informal sources when responding to this question. This is also the case with the barriers to seeking help, as some of the barriers used in this research are not self-explanatory, and it is not known how broadly or narrowly these barriers have been interpreted by the participants. In particular, the barrier 'wrong person to discuss it with' is difficult to interpret by the researcher as it is not known what it is about the person that makes them the wrong person. In addition, 'feel

uncomfortable/embarrassed' has similar limitations in that it is not known what participants feel uncomfortable and embarrassed about when seeking help. The usefulness of these barriers is limited as it does not help the researcher understand what is driving the help-seeking behaviour.

Finally, due to the numerous statistical analyses that were conducted, the reader needs to keep in mind the potential for false positives, also known as type I error, where significant results are obtained by chance, rather than actual confirmation of the hypotheses. The risk of a type I error increases with the number of statistical analyses conducted.

Research Questions

Significant findings from study one include the importance of severity of depression symptoms, as well as the role of gender, age and ethnicity impacting on the young people's reported willingness to seek help from different sources of help. CA also revealed the importance of severity of depressive symptoms, impacting on the source of help young people select as well as the barriers to seeking help from these sources. Participant responses to scenario four were qualitatively different from scenarios one to three, which suggests that young people make implicit decisions about help-seeking which change with the severity of depressive symptoms. Barriers to help-seeking clustered around different sources of help, which also changed as the severity of symptoms increased. Although these significant and interesting differences emerged, due to the limitations discussed, and the restrictions interpreting this quantitative data set, it was not possible to draw conclusions regarding why young people choose particular helpers, the reasons for their preference for informal sources, and how severity of symptoms impacts on young people's willingness to seek formal help.

Two important qualitative research questions emerged from these findings: firstly, what influences young people's choice of helper including the important reasons why young people may not seek help from a source, and secondly, how does the severity of depressive symptoms

impact on the choice of helper? To answer these questions a second study was conducted in which a small number of similar-aged participants were asked open-ended and semi-structured questions to elicit answers to these questions. The second part of this study was exploratory, to help understand young people's willingness to seek help from different sources.

STUDY TWO

Method

Participants

The sample of study two consisted of 22 young people from three secondary schools in the Wellington and Kapiti region that took part in the survey in study one in 2005 (Hutt Valley High School, Kapiti College, and Wellington High School). The sample was 11 male participants and 11 female participants from year 10 to year 13 (aged 14 to 18 years), with a mean age of 15 years. Most participants (77%) identified as New Zealand or other European ethnicity. Of the remaining participants 9% identified as New Zealand Maori or New Zealand with Maori decent, 9% identified as Pacific, and 5% (one participant) identified as Fijian Indian. The male participants were on average slightly older than female participants; overall the sample of 22 participants for the second study was comparable demographically to the initial survey sample.

Materials

Participants took part in a semi-structured interview (please refer appendix F for interview schedule). Within the interview, two scenarios with depressive symptoms were presented, and participants were asked questions about seeking help from four sources of help (friend, parent, medical person, and mental health professional) for these scenarios.

The first scenario consisted of a bulleted summary of the symptoms expressed by a young person experiencing moderately-low symptoms of depression, as used in the audiotape role play of scenario two in study one (please refer appendix A, p.148). The second scenario of study one was utilised for mild to moderate symptoms of depression, as symptoms presented in scenario one were mild, and could be considered relatively normal amongst the adolescent population. The second scenario presented to the young person during the interview consisted of a bulleted summary of the symptoms expressed by a young person experiencing severe depressive symptoms, as used in the audiotape role play for scenario four of study one (please refer appendix A, p.160). The bulleted summaries were used as a prompt for young people filling out the survey in study one. They included the main points of the scenario they had just listened to, and included symptoms across the four important domains of a young person's life: school problems, relationships with others, emotional/cognitive and physical symptoms.

Other materials used included a Likert-type scale from one to seven, with the words *"not at all"* positioned under the number one, *"moderately"* positioned under number four, and *"extremely"* under number seven. This prompted how questions from the interview should be rated. In addition, the list of barriers used in study one was used a prompt for participants' regarding barriers they experience to help-seeking (please refer appendix A for the list of barriers).

Procedure

The schools that were used in study one were initially contacted by a letter to the principal (please refer appendix G), asking whether they would be interested in taking part in research that would build on the findings of the original survey that they participated in. This letter was followed up by a phone call. A monetary incentive of $5 per student that participated was offered to the schools. Three out of the five schools that participated in study one agreed to take part in study two. Interviews were coordinated through the guidance counsellor at each

high school. The guidance counsellor was asked to randomly select eight students between the ages of 14 and 18 years (which were generated by the school computer system), and an initial meeting was set up with the guidance counsellor and the selected students.

The researcher briefly presented the findings of the study one to students, and the objectives of study two, and asked whether they would be interested in taking part in an individual interview on seeking help for depression. Participant involvement was voluntary, with a movie voucher offered as an incentive for participating.

Young people who were interested in taking part in the study were given a letter with information about the study, with a consent form (for those over 16 years) and assent form (for those under 16 years) attached (please refer appendix H). Those under the age of 16 years were also provided with a letter to give to their parents or caregivers outlining the study, with a parent consent form attached (please refer appendix I). A date and time was arranged to meet with the student, and they were asked to bring their consent and assent forms with them. Interviews were not transcribed until consent was received by both the young person and their caregiver if appropriate.

The interviews took place at the young person's school, in an available room (e.g. the guidance counsellor's office). The interviews were audio recorded, and transcribed. Any reference to names, or personal information not relevant to the study was removed during transcription thus data was anonymised. Please note that as the analysis focused on the content of what was said rather than how it was said, detail such as exact phonetic pronunciation and intonation were not included in the transcript. However, commas have been included to make the text readable, and long pauses are indicated with three stops (…). Once transcribed, the audio recordings were deleted. The interviews ranged from 20 to 45 minutes.

Analysis

The responses to part two and part four of the interview schedule were used as the data set in this study. Data were analysed using thematic analysis, as described in Braun and Clark (2006). A realist epistemological stance was taken, with the themes identified at a semantic level, with the understanding that language has a largely unidirectional relationship between meaning and experience (Widdicombe & Wooffitt, 1995). That is, what participants said was thought to reflect their reality, rather than looking beyond what was said by the participants. In this study thematic analysis involved identifying patterned responses within the data set, which were examined in relation to previous findings in the help-seeking literature (Braun & Clarke, 2006). As suggested by Braun and Clarke, prevalence, or the number of times an idea was repeated did not necessarily make it a more significant idea or theme, rather themes were identified as important if it said something interesting about adolescent help-seeking, in relation to previous findings and as judged by the researcher.

Guidance was gained from Auerbach and Silverstein (2003), who provided practical advice regarding coding and identify emerging themes, breaking data analysis into three phases. In this study, the first phase of analysis was designed to make the text manageable, whilst the second phase was primarily about hearing what was said by participants, including identifying repeating ideas, followed by the third phase of identifying themes (Auerbach & Silverstein, 2003).

The first phase included reading through each interview transcript thoroughly. On second reading, text relevant to the research questions were copied and pasted into a new document. As the focus of this study was on examining the different sources of help, and the influence of severity of depressive symptoms, the relevant text for the source of help (parent, friend, medical person and mental health professional), were grouped together for each scenario (moderately-low and severe depressive symptoms). The participant number, gender and age of

the participant were attached to each relevant piece of text. Transcripts of each interview were reviewed to ensure all relevant text had been captured. Please note that from this point only the relevant text was used for analysis.

The relevant text was reviewed, with memos made in margins, regarding ideas expressed in each relevant piece of text. Pieces of text which expressed similar ideas were grouped together for each source of help. More memos were made regarding how the pieces of text were related. If more than one repeating idea emerged within a piece of text, it could be coded twice or as many times as necessary. As suggested by Auerbach and Silverstein (2003), repeating ideas were examined several times, then decisions were made whether repeating ideas could be broken up into more detailed, smaller categories, if there were more than one repeating idea, and if ideas were similar, they were grouped together to make one repeating idea (Auerbach & Silverstein, 2003). Any text that did not fit within a repeating idea was called orphan text, and a decision was made by the researcher regarding whether it captured an important idea which needed to be discussed, or whether it would be removed from the relevant text and further analysis.

A master list of repeating ideas was created for each source, which were combined for both scenarios, due to the similarity of reasons expressed by participants for approaching or avoiding help-seeking from each source for both moderately-low and severe symptoms of depression. Themes were developed by taking the first repeating idea as a starter idea, then other ideas that were closely related were grouped together to create a theme. Once no more of the repeating ideas fit with the first theme, a second starter idea was used, and all those that were identified as related to this second idea were grouped together to construct the second theme. This process was repeated for each source, with themes emerging that were unique to each source. Once themes for each source were established, they were examined across the

four sources of help for similarities and differences, through which two overarching themes were identified.

Although this process is described sequentially, coding the data was an ongoing process with changes continually made to the grouping of relevant text, ideas, and themes if the data did not hang together well. As theory development was not the object of this study, analysis was complete once the overarching themes were identified. Instead of applying the principles of reliability and validity, as in quantitative analysis, the principle of justifiability was applied to analysis and discussion of this study; through transparency, communicability, and coherence (Rubin & Rubin, 1995; as cited in Auerbach & Silverstein, 2003). Analysis of data is transparent, the themes coherent, and it has been attempted to present and communicate the themes in an understandable way to the reader. Overall, the analysis and discussion of study two attempts to organise patterns identified from participants' responses for reasons they approach and avoid particular sources of help, to aid understanding of young people's help-seeking for depression.

Analysis and Discussion

Repeating ideas for each source of help were grouped into themes by the source of help. These themes were examined across the four sources of help, and could be grouped into two overarching themes; these have been labelled *response characteristics* and *relationship characteristics*, and included the themes identified from participant responses regarding the reasons young people approach and avoid particular helpers. Response characteristics included the desired response from a helper, but also the feared response or potential negative consequences of seeking help from a source. The overarching theme of relationship characteristics included those themes in which the role of the relationship was integral to seeking help from a source; whether a person was considered trusted and suitable to seek help

from, as well as concerns about how help-seeking would impact on the relationship for friends and family only.

Table 9 is a complete list of themes and sub-themes identified during analysis, which will be addressed throughout the next section. The sources of help are indicated in blue font, the main themes are in black font, whilst sub-themes are represented in red font, with important repeating ideas of the sub-themes in green font. Those themes that were only identified in response to either the mild to moderately severe (first scenario) or the severe symptoms of depression (second scenario) are indicated in brackets: S1 referring to scenario one and S2 referring to scenario two.

It is important to note that themes for potential responses of the helper were often closely related and even overlapped with the themes identified in regard to the relationship with a helper. Despite some crossover, these themes tapped important influences in participants' responses regarding their help-seeking from the sources of help.

Within the overarching themes of response and relationship characteristics, the influence of severity emerged, and was an important consideration in the help-seeking process, when it came to selecting a helper (illustrated in the extracts). However, the overarching themes were maintained regardless of severity, with young people's choice of helper related primarily to the expected response of the helper, and their relationship with the helper. The context of being an adolescent was significant, and was found to influence young people's help-seeking, and flavoured their responses, which will also be illustrated in the extracts, and needs to be considered as part of the help-seeking dynamic.

Table 9. *Themes and Sub-themes for Young People's Help-Seeking from Parent, Friends, Medical Person and Mental Health Professional*

	Response Characteristics		Relationship Characteristics		
	Positive response	Negative response	Trust	Suitability	Impact
Parent	Advice/support Experienced Different Perspective Seek further help (S2) Take control (S2)	Negative reaction Minimise problems Impose solutions (S2)	Unconditional love Understand/know you	Feel uncomfortable /embarrassed Developmental stage Independent Don't understand	Worry about burdening parents
Friend	Supportive Relevant/youthful Experienced	Minimise problems Attention-seeking (S2) Gossiping Unhelpful response Overreact Overwhelmed (S2)	Trustworthy Understand/know you	Available (S2) Feel uncomfortable /embarrassed	Worry about burdening friends Concern about being judged
Medical person	Communicating knowledge Medication (S2)	Minimise problems Overreact Not relevant advice	Confidential Expertise	Don't know personally Feel uncomfortable /embarrassed Prefer friends and family (S1)	
Mental health professional	Professional knowledge /advice	Not relevant advice	Confidentiality Expertise	Don't know personally Feel uncomfortable /embarrassed	

In the following sections, relevant text has been selected to justify the identification of themes. The participant numbers are provided in brackets next to the extracts, and a full list of participants, their gender, age, ethnicity, and reported help-seeking from different sources of help is provided in appendix K.

Response Characteristics

Perhaps unsurprisingly, young people placed particular emphasis on the way they perceived the sources of help would respond to symptoms in the scenarios. These could be divided into potentially positive and desired responses and feared or negative consequences of seeking help from that person/source of help. Some expected responses were common across the different sources of help, with only subtle differences but there were also response characteristics that were unique to each source. Therefore, each response characteristic of the sources of help (parent, friend, medical person and mental health professional) will be examined independently, and illustrated by extracts from young people interviewed.

Parent

The positive response characteristics of parents related primarily to a parent knowing what to do and included several sub-themes, such as offering advice and support to young person, having experience, and providing a different perspective. The following extracts illustrate the advice/support sub-theme, providing different examples of parents providing advice and support for a young person:

> Extract 1. [14] You get good support, and encourage you to do better, and forget all about what's happened in the past, and yeah, go on with it in the future
>
> Extract 2. [8] She always knows what to say, like they always make sense, cos they've been younger, like they've had experience, and they know, like, how to deal with things sensibly

As mentioned in extract 2, young people reported that their parent's opinion was of value due to their life experience. This experience was thought to contribute to parents knowing how to deal with problems, and was expressed more explicitly in extracts 3 and 4:

Extract 3. [12] There's a chance that they've experienced it at some point

Extract 4. [17] She has a very neutral view again, um, very mature view, you know if anyone's bugging me at school, you know, and she has probably been through it herself, so she could give some pointers

Closely related to the life experiences that parents have had, parents were described as having an alternative perspective, a different way of looking at things from the young person, and perhaps other young people, as expressed in extracts 5 and 6 below:

Extract 5. [16] They have the experience to say 'well, you know, in the scheme of things it will get better', or like, 'maybe you're looking at it the wrong way', sort of thing

Extract 6. [17] Um, she has a very overall view, she's not biased. You know, she's not saying 'well you know, it's your fault that they're avoiding you, rararara', and she wouldn't be like 'well, you know, they're just, they're just complete, you know', I won't swear, but you know.

These sub-themes of parents offering advice and support to young persons, having experience, and providing a different perspective, were evident for both scenarios of depression. Interestingly, two further sub-themes were identified for the second scenario, when participants were asked about help-seeking for severe symptoms of depression. This included parents accessing further help or encouraging further help-seeking by the young person, and taking control, illustrated in extract 7 and 8:

Extract 7. [3] They can get you, like, actual proper help, if you need it, and stuff like that

Extract 8. [20] Parents will probably go off and get, like, ask you to go and get professional and, mull it over with teachers and stuff like that

Overall, participants suggested that their parents may be better at identifying whether more help was required, and may be more willing to access help on behalf of the young person, than they may be willing to access themselves. Consistent with this theme, models of help-seeking suggest that parents play an important role in different stages of help-seeking, from

identifying problems to gaining access to professional help (Logan & King, 2001; Srebnik, Cauce, & Baydar, 1996). Confiding in parents when experiencing severe symptoms of depression is likely to lead to an increase in access to mental health services, which is consistent with findings that young people who experience high impairment from mental health difficulties are more likely to access services (Leaf et al., 1996; Sawyer et al., 2000).

A further sub-theme identified for severe symptoms of depression was parents taking control, as illustrated in extracts 9 and 10:

> Extract 9. [15] (Parents) take some more serious action … go straight to the, ya know, the solution, get them up and running

> Extract 10. [18] my mum, she gets, she gets straight onto me if I miss ten minutes of a class, so I'd probably forced to go to school and everything…(parents) can definitely, they can probably force you to go back to class, and take you and see a doctor, make you eat and go to bed at a certain time, yeah

As suggested in the above extracts, some young people felt that parents would take an active role in their recovery if they were experiencing severe symptoms of depression, including noticing these symptoms, and directly intervening with some of the symptoms (such as skipping class, and difficulties eating and sleeping). Young people who maintain good relationships with their parents throughout adolescence have been found to be less disturbed, and parents play an important role in young people accessing professional help. Although young people increasingly seek the assistance of friends during adolescence, this is not necessarily substituting parental support (Sullivan, Marshall, & Schonert-Reichl, 2002), and those parents who actively intervene when their child is distressed may improve the outcome for the young person.

The positive or desired response characteristics expressed by young people were in contrast to the potential negative consequences of seeking help from parents. Three sub-themes were identified, two of which were present regardless of the severity of depressive symptoms: participants feared a *negative reaction* from parents, such as getting angry or upset, and they

worried that parents would *minimise* problems (please refer table 9). These sub-themes are

illustrated by the extracts 11 and 12:

> Extract 11. [21] Cos they'd get really worried, probably … and then they'd give you that knowing look, like, and it's just gets annoying after a while

> Extract 12. [5] There could be the worry about getting in trouble, like um…yeah, you know cos they could sort of like, you know, feel like their parents' jus get upset with them going 'oh what are you being like this for?' And like you know, 'you're being silly and stupid' and like, 'get over it', you know, 'toughen up'

In extract 11, a young person expressed concern about the reaction of their parents, and

suggested that upsetting their parents is a common occurrence they find difficult to deal with.

A young person touched on both of the sub-themes in extract 12, worrying about getting in

trouble, alongside concerns that parents would minimise their problems, by telling them to 'get

over it', or 'toughen up'. Fear that parents would minimise or not take their problems seriously

was a common concern amongst participants, such as underestimating problems due to being

an adolescent (as illustrated by extract 13), whilst extract 14 captures concerns about parents'

reaction, due to not understanding their problems.

> Extract 13. [3] They just think it's just the teenager going through a hard time, and they don't really take it that seriously, but it could be serious

> Extract 14. [7] Um, they could ask you what your, they could be more, um, saying 'why' ya know, and getting angry at you … Like, 'I dunno what it is', and just, 'just get it away', 'just grow up'

In response to the severe symptoms of depression, a further sub-theme was identified

relating to parents taking control. Patterns in participants' responses suggested that parents

taking control could also be a negative response, due to the possibility of parents' imposing

solutions on the young person, as illustrated in extract 15 and 16:

> Extract 15. [13] Oh, I guess they could they could think you're, you're not right, like, they might try to put you on, ya know, like different drugs or something like that

> Extract 16. [19] But your parents would really get worried about you, and they might, like, they might actually impose things upon you, like rules and things that like would, maybe force you to do things, see people, like psychiatrists and what not.

Relationship characteristics identified for parents were about balancing the advice and support with potentially negative reactions, including parents minimising their problems or taking control for severe symptoms of depression. Adolescence is an important transitional period between childhood and adulthood, in which young people (in Western Culture) develop independence and autonomy. Consistent with this adolescents have found to distance themselves from their parents as they mature, spending more time on their own and with friends (Ciarrochi, Wilson, Deane, & Rickwood, 2003). Consistent with these developmental changes, young people have been found to seek less help from their parents. However, those young people who continue to seek help from their parents have been found to be less disturbed (e.g. DuBois et al., 2002). Garland and Zigler (1994) proposed that there was not a dichotomy between dependence and autonomy. Consistent with this, they found that self-efficacy was positively correlated to help-seeking, and suggested that appropriate help-seeking is essential for a child to achieve independent competence (Garland & Zigler, 1994). This research points out that there is a fine balance between seeking help and maintaining autonomy for adolescence. When young people are presented with a situation when this control and autonomy is taken away, it is likely to contribute to anxiety. It is expected that young people would seek more help if they felt they had control over this process.

Friends

Throughout the interviews, patterns in data suggested that friends are an important source of help, with several qualities and responses that young people consider useful and helpful for managing depressive symptoms. The response characteristics of friends and parents were somewhat similar, for example they were both described as supportive. Some of the ways in which friends were considered supportive are illustrated in the extracts 17 to 19:

> Extract 17. [4] They want to actually help, they don't just sit there and say like oh yeah maybe you should blah blah blah. Oh maybe you could try this or that, ya know, and they'll actually come help, instead of just sit there going 'oh yeah, go do'… they make you feel better

Extract 18. [21] Um, they can give you support. And you can just talk to them about stuff

Extract 19. [11] your friends can like, just make you feel better, about yourself, cause if your thinking you'd be dead, and stuff like that, and hating yourself, but like that you have friends there, to support you, then you're not going to feel that way, ya know

An interesting pattern identified was young people compared seeking help from their friends and parents. For example, advice from friends was described as more relevant than advice offered by parents, due to also being young and having similar experiences, as illustrated in extracts 20 to 22:

Extract 20. [6] They might know what you're going through … they are like your peers and stuff, so they can offer advice that, relevant to like, you and stuff

Extract 21. [8] They can introduce you to new people and get you more involved with things, which would stop you feeling all alone, and sad

Extract 22. [17] unlike a parent, you can tell them everything, I reckon, you can, you know, all the teenage kind of things, um, they will be able to be a lot more, if you're wanting a sort of a very 'they're arseholes, rarara' kind of view, not like what my mum would say, then, if you're looking for a very sort of immature kind of like, you know

In extracts 20 and 21, participants focus on the relevance of seeking help from peers, for example, friends are thought understand what they are going through, as well as being able to provide practical solutions, such as introducing them to more people and including in activities, as described in extract 21. The preference of seeking help from friends instead of parents is described in extract 22, due to friends having a different way of responding to their difficulties. The relevance of their response is also related to the perceived suitability of the helper, which will be addressed further in relationship characteristics.

Similar to parents, friends were viewed as good sources of help due to their experience. However, it was not their previous life experience (as with parents), but rather their current experience, as a young person and a peer. Friends were identified as having a greater ability to understand what was going on for the young person than other people, as illustrated in extracts 23 and 24:

Extract 23. [4] I feel like that and you can probably work through it together, going through the same thing, and probably work through it together

Extract 24. [2] I think they can understand you better than if you asked your parents

Overall, when interviewed, young people placed emphasis on their friends being supportive, as well as their ability to understand and relate to what they are going through. The majority of participants indicated they would seek help from friends for both scenario one and scenario two, and were identified as the most prevalent source of help amongst participants (please refer appendix K). Young people have been found to increasing rely on their friends during adolescence (Dubow, Lovoko, & Kausch, 1990; Furman & Buhrmester, 1992; Schonert-Reichl & Muller, 1996) whereas younger adolescents seek more help from family members (Boldero & Fallon, 1995). One way young people adapt to developmental changes in adolescence is through seeking out support from those having similar developmental experiences (Papini, Farmer, Clark, Micka, & Barnett, 1990).

As with parents, minimising problems was identified as a sub-theme for negative response characteristics for friends. The ways in which young people feared their friends may minimise their problems is illustrated in the extracts 25 to 27:

Extract 25. [3] Because with your mates they're just, sort of, don't really get the seriousness of things, and they just tell you to get over it. You know, build a bridge.

Extract 26. [15] If it's not the right type of mate they might give you, ya know, shit, hassle you but, not many of them round, might have used to have been when you're younger but you grow up and get (laugh), ya know, closer

Extract 27. [8] Cos I also might be embarrassed, or like worried about bullying, or someone like laughing at me about it

In extract 25, the participant indicated that friends may not take symptoms seriously, whilst hassling and bullying were expressed as concerns by participants in extracts 26 and 27. Interestingly, in extract 26, the participant felt that friends would have been more likely to minimise problems when they were younger, and that his friends take these problems more seriously as they have matured and developed closer relationships, which is consistent with

developmental changes in relationships during adolescence (Furman & Buhrmester, 1992;

Papini, Farmer, Clark, Micka, & Barnett, 1990).

In response to the second scenario, a sub-theme of minimising emerged, with young

people worried that friends would think they were attention-seeking if they disclosed suicidal

thoughts. For example, there was concern about what friends may think if suicidal thoughts

were disclosed, including people assuming they were an Emo (standing for *emotive hardcore*, a

youth sub-culture, originated as a genre of music and fashion, but in recent years has become

popularised, and connected with depression, self-injury and suicide). Some participants

worried that they would not be taken seriously by their friends for this reason, as illustrated in

extract 28:

> Extract 28. [19] Cos if you think, if you that, you know, if you tell people that, you know, oh 'oh I'd rather be dead', you know with this whole new emo fad that's come in, people might think 'oh, they're only joking'. A week later you are dead, they'll be like 'holy crap'

Gossiping was an important concern for the majority of young people interviewed when

it came to seeking help from their friends. Gossiping was described by participants as

accidental (extracts 29 and 30), but also intentional and potentially harmful (extracts 31 and

32):

> Extract 29. [5] I suppose a lot of people you can't necessarily be too sure of like, you know, they can easily let something slip, even like not meaning it to make, make any harm, but like they can't necessarily be sure the person that they tell is not going to tell someone else. And so like, when, yeah, when everyone knows that you're having problems, you feel like there's no privacy in your life anymore, and so like yeah, it's like a real invasion

> Extract 30. [19] They know the people that may be involved and may gossip and what not … no one talks to anyone about it, but, you know, everyone has their doubt moment when they go 'oh, you know', and then you say it, and you're like 'no! I shouldn't have said that, damn it!', and then, and then the whole vicious circle starts

> Extract 31. [8] They could tell someone, that could lead on to bullying, and could have, like, a negative effect

> Extract 32. [6] I think friends would be the wrong person to discuss it with, in my mind. Um and also the bit about the bad response, because they might tell other people, and it ends up being, ya know, a real issue

Gossiping was a unique concern for help-seeking from friends, which is closely related to trust. Trust will be examined in more depth with regard to relationship characteristics; however it is interesting to note that patterns from participant responses indicated that a lot of this gossiping is not vindictive, and sometimes it just happens. Regardless, young people worry about what other young people may think and gossiping is thought to negatively impact on young people.

A sub-theme of negative responses from friends was identified as friends responding in a potentially unhelpful way, as illustrated in extract 33:

Extract 33. [9] Only if they're not helpful and like, mean about it, that wouldn't be helpful

As part of friends responding unhelpfully, participants reported that friends may overreact to depressive symptoms, which was found for both scenarios. In addition, participants were concerned that severe symptoms of depression would be difficult for a friend to manage, such as being overwhelmed by it and not knowing what to do. These concerns of overreacting and being overwhelmed are illustrated in extracts 34 to 36:

Extract 34. [17] They might freak out and tell you to get professional help, which I know personally would be completely stuff me over

Extract 35. [19] With a friend, they may feel a bit overwhelmed by it. And you, and you don't want to do that to your friends

Extract 36. [12] Maybe they wouldn't know what to do, which'd mean you'd have to go find someone else to help

These extracts illustrate patterns in responses and suggest that for more severe depressive symptoms young people recognise that the resources and responses of friends may not be adequate to manage the problem. This is consistent with findings that when a problem is severe, young people find seeking help from informal sources of help less useful, and will also seek help from formal sources (Rickwood & Braithwaite, 1994; Schonert-Reichl & Muller, 1996).

The themes illustrated above were identified by participants as negative responses and potentially unhelpful for a young person trying to manage symptoms of depression. In fact, it was suggested that these responses, for example gossiping, could be detrimental for the young person, further impacting on their symptoms if it leads to teasing or bullying. Interestingly, participants were able to simultaneously identify positive and negative characteristics of friends, which suggest that young people recognise that there is a fine balance when making the decision to seek help from a friend. Despite the concerns of young people, the majority of young people interviewed indicated they would seek help from friends regardless of severity of depressive symptoms (please refer appendix K) but they would be careful to choose the right type of friend (as indicated in extract 26). Further, this suggests that the positive characteristics of seeking help from friends (such as having similar experiences due to their developmental stage), are thought to outweigh the potentially negative response characteristics of friends.

Medical Person

Positive response characteristics provided by participants regarding medical persons focused primarily on the abilities and skills of a medical person. The theme of professional skills could be divided into sub-themes of communicating knowledge to young person and providing solutions (e.g. medication) to physical problems.

The role of a medical person communicating knowledge was described by young people for both scenarios, as illustrated extracts 37, 38 and 39 below:

> Extract 37. [9] They will like understand what is happening to you, and, will let you know what is happening, in case you don't
>
> Extract 38. [20] They're trained to do this sort of stuff and cope with, and, they can tell you what the best solution is
>
> Extract 39. [4] If they tell you the right things, and exactly what's happened to you or whatever, you can probably, it might help you get around whatever's happening…yeah it might give you a solution maybe to one of your problems

These extracts suggest that a medical person providing knowledge about what is going on, and offering advice, is likely to improve symptoms and elicit hope in the young person. Consistent with this, adolescents have been found to choose a helper based on their knowledge and ability to help with the problem (Wintre et al., 1988 as cited in Sullivan, Marshall, & Schonert-Reichl, 2002), and young people are more likely to seek help from a formal source if the problem is specific and severe (Grinstein-Weiss, Fishman, & Eisikovits, 2005).

In addition to the knowledge that medical persons can provide, young people talked about doctors being able to prescribe medication, particularly for severe symptoms of depression in the second scenario:

> Extract 40. [10] They usually know, probably what's wrong with you, with all the like, cause they know the technical stuff, and they might be able to help you out, with like, give you pills or something

Prescribing medication was an important theme in the dialogue of young people seeking help from a doctor. This included the doctor treating individual symptoms medically, such as expressed in extracts 41 and 42. However, there was also recognition by young people interviewed that the cluster of symptoms in the second scenario may be indicative of depression, which could be treated with anti-depression medication, described in extract 43:

> Extract 41. [6] I think it's more of the physical sort of stuff that they can help you with, um. Yeah I just think, they could, like ya know, give you something to help you sleep better or whatever

> Extract 42. [13] Like they could know the connections between the emotional and physical problem, and they could actually sort of help deal with the like, long term aches and pains, and like, being able, unable to sleep and eat, ya know

> Extract 43. [18] Well, they might be able to give you like anti-depression pills if you're feeling really sad, or tell you what's wrong with you, or tell you you need to get more sleep or this is bad in your diet so it's making you feel this sick and things like that

Overall, response characteristics by participants for a medical person focused primarily on a medical persons' ability to respond appropriately to the physical aspects of the symptoms, including sharing knowledge and expertise about health-related symptoms, and prescribing

medication. This is consistent with young people using formal sources of help as a back up to social networks, when non-professionals have failed to help (Boldero & Fallon, 1995).

Three important sub-themes were identified for negative responses for seeking help from a medical person. That doctors or medical persons may minimise problems, conversely, they may overreact, and they may not be able to offer relevant or appropriate advice. The negative responses of minimising problems or overreacting were similar to potential responses to informal sources. Concern that problems would be minimised by a doctor or medical person is illustrated below in extract 44:

> Extract 44. [21] Um, it wouldn't be serious enough, maybe. Wouldn't wanna go there for, like a reason, then find out they were like 'oh, you're just being a teenager', sort of thing

Young people expressed concern that adult helpers may think that their problem is not significant. Interestingly, in contrast to a medical person minimising a young person's depressive symptoms, there was also concern that that medical persons may overreact to these problems, as illustrated in extract 45:

> Extract 45. [3] most people wouldn't really think that the doctors would know how to deal with it, and so they could just think that they'd overreact, like that you could just (overreact) or under react or something, so you wouldn't really want to go into anything, like, like mental things, but the colds and aches and pains and sleeping and stomach aches you'd want to go for that, cos they specialise in that

Extract 45 is a good example of the flavour of the dialogue on young people seeking help from medical persons. That is, this participant was conflicted about how a medical person would respond. Essentially, young people feared medical persons may not respond most appropriately, particularly compared to friends and family. However, they understood that a medical person would perhaps be able to treat their physical or medical needs. This conflict may arise due to young people's lack of experience seeking help from a medical person.

The relevance of a helper, and the relevance of the advice they could provide, was accentuated by the young people in response to both moderately-low depressive symptoms (extracts 46 and 47) and severe depressive symptoms (extract 48):

Extract 46. [12] Well, I don't think a doctor can prescribe anything for people avoiding you, or, thinking that people avoid you

Extract 47. [19] It's more emotional problems than anything, so a doctor seems a bit over the top. Or, or, or a doctor seems like very much the wrong person, because they're there to so-, you know, they're there to make you better if you've broken a leg or something, not to help you emotionally

Extract 48. [18] They can't really help you with your difficulties with family, and teachers, and classmates and they may look down, down at you, if you have problems

The above extracts indicate that young people think that certain symptoms cannot be treated by a medical person, for example thinking they are being avoided or having difficulties with relationships. For these reasons a medical person was viewed as inappropriate. This is consistent with reported help-seeking from a medical person with only five of the 22 participants indicating that they would seek help from a medical person for the first scenario, which had less physical symptoms. Interestingly, this increased to 16 participants reporting they would seek help for the second scenario, this is thought to be due to a higher presentation of physical symptoms, as indicated by extract 47, as young people felt it was more appropriate to seek help from a medical person for physical symptoms.

Mental Health Professional

Similar to medical persons, the important positive response characteristics for a mental health professional fell within the theme of professional knowledge and advice, which included repeating ideas of knowing what to do for young person (extract 49), providing good advice (extract 50), and being specifically trained to understand depression (extract 51):

Extract 49. [7] Oh I mean they are professionals and they make you feel better, like they know how to make you feel better

Extract 50. [9] They will like, completely know like what's happening, and yeah, and you can feel good about talking to them, cause ya know, they'll keep it private

> Extract 51. [8] It could be good because obviously they've, they've trained, and they know how to deal with things like this kind of situation. So it'd be better to talk to them than say like a friend

Due to their professional training and experience, young people thought that mental health professionals would respond appropriately and be able to provide good advice. This is consistent with research by Tatar (2001), who found that adolescents placed emphasis on education and training when deciding to seek help from a school counsellor.

Only one theme was identified for negative response characteristics of a mental health professional, participants considered professionals as less likely to provide relevant advice to the young person, which is illustrated by extracts 52 and 53:

> Extract 52. [4] I have before, it doesn't help, I find, its so much easier if you talk to someone your age who might be going through the same thing. They, the one that I, the couple I saw, they didn't really seem to, like, you know they care and everything, but like, just didn't seem, how they were going about it just didn't seem right to me

> Extract 53. [19] They're there to make you feel better in a professional way. But that's the problem, it's not like it could be a girl, like somebody, you know, who can, you know, give you a hug and you feel warm inside, cos you know, it's somebody that actually, you know

Despite predicting positive responses from mental health professionals due to their skills and knowledge, young people interviewed were concerned that a mental health professional is not able to provide a response which is appropriate for the young person, particularly compared to someone they know. Interestingly, minimising and overreacting to depressive symptoms were not identified for a mental health professional, as with previous sources, suggesting that young people perceived them as more suitable, particularly compared to medical person. The relevance of response from a mental health professional was closely related to a young person's perceived suitability of seeking of a mental health professional as a helper, identified as a relationship characteristic. Several relevant pieces of text were coded for both response and relationship characteristics, which suggests significant overlap between these characteristics for a mental health professional. This is thought to be due to the professional nature of the relationship, which will be explored further in relationship characteristics.

Relationship Characteristics

In addition to the positive and negative response characteristics of each source of help, the nature of the relationship with the helper emerged as salient across the four sources of help, and has been defined as the second overarching theme. Salient themes for relationship characteristics were trust between the young person and the helper, and the perceived suitability of a helper for the severity of symptoms. A further relationship characteristic labelled impact was identified for informal sources of help only, which captured themes that impacted on the relationship between the young person and helper. These three themes and their sub-themes are examined independently for the four sources of help.

Parent

When young people talked about seeking help from a parent, it was often in the context of having a trusted relationship with their parents, regardless of the severity of depressive symptoms. The sub-themes of the trusted relationship included parents being trustworthy, providing unconditional love, and knowing and understanding their child. Parents were often considered trustworthy as they would keep their problems private and not tell anyone, illustrated by extracts 54 and 55:

> Extract 54. [11] Ya know they're not gonna go spreading it everywhere and stuff like that, and they'll always be there, and then whenever you want them

> Extract 55. [15] Just cause you can trust her, ya know, tell her not to tell anyone, she wont, she can keep a secret

Further, an important reason participants trusted their parents and would seek help from them was related to their parents caring the most about them, and that their love and affection was unconditional, as illustrated by extracts 56 and 57:

> Extract 56. [13] Its quite good cause they can understand, cause they sort of care for you probably more than anyone else, ya know, probably put the most effort into helping you

Extract 57. [17] I reckon if you talk to one of your parents, one of your guardians about it, that would be a really big thing, cos they're always gonna be there, you know, well to me personally, they're always gonna be there, and so no matter what's going on at school, or anything like that

Closely related was parents knowing and understanding their child, which emerged as the other important sub-theme of having a trusted relationship with their parent, as illustrated in extracts 58 and 59:

Extract 58. [6] The advice that they can give can be quite helpful and ya know, I just, and if they know you, they will know what to do with you

Extract 59. [7] they relate to you, they show how to live like, and if they show how to be that mentality, they'll probably have it as well, so it's really easy to relate to cause you know 'em all their life, and they know you

Negative characteristics of the relationship that affected a young person seeking help from their parents included parents not considered suitable to seek help from, and the potential impact of seeking help from parents, which included young people worried about burdening their parents with their problems.

The sub-themes identified for suitability included young people feeling uncomfortable and embarrassed about disclosing depressive symptoms with their parents. These concerns are illustrated in extracts 60 and 61:

Extract 60. [17] feel uncomfortable or embarrassed, probably, because, um, that's just the whole I won't be able to tell the full story

Extract 61. [8] Maybe (tell parents) a little bit, but I wouldn't go into too much, like, detail about it, cos I'd be quite uncomfortable

The next sub-theme was labelled developmental stage, as it included two important ideas related to adolescence: young people wanting to manage on their own, and parents not being able to understand the young person's problems. Wanting to manage problems on one's own is illustrated in the extracts 62 and 63:

Extract 62. [2] I just deal with them myself, probably… there's a definite age difference, that's a big thing, and so it's harder to ask someone as they've probably been through all that before, and um, now in a different place, so harder to ask them, you know, sort of go back

> Extract 63. [7] Because at this age it feels like sort of it's yours, and ya to sort of break away, sort of, from your family, and start building up yourself

Extract 62 captures the feeling that parents do not understand a young person's problems. It was suggested that parents are from a different generation, and they cannot relate to and understand young people's problems. A further example is provided in extract 64 below:

> Extract 64. [10] Because like your parents are like totally different from you, from the way you are, cause they're like a different generation

The fact that young people interviewed expressed wanting to manage on their own, and not seek help from their parents, is consistent with the developmental goals of individuation and independence of adolescence. Support from parents has been found to decrease from early to mid-adolescence, which coincides with an increase in conflict with parents over this period (Furman & Buhrmester, 1992). This finding was consistent with developmental theories, in which during adolescence young people engage in a struggle with parents to assert themselves and identify more closely, and seek more help from peers (Papini, Farmer, Clark, Micka, & Barnett, 1990).

The other theme was the impact on the relationship, which was identified for parents and friends. Participants suggested that seeking help from parents may impact on their relationship in a negative way, and create stress in the child-parent relationship, with the sub-theme of young people worrying about burdening their parents with their problems (please refer table 9). Young people worried about burdening parents for both scenarios, and this sub-theme included concerns that parents had enough on their plate (as illustrated by extract 65), feeling guilty about what it might mean to parents if their child was having difficulties (extract 66 and 68), and worry about the consequences of telling their parents with problems, such as overreacting (extract 67), or upsetting parents (extract 68):

> Extract 65. [19] But then you don't want to tell your parents, because, you know, they have enough trouble on their plate, and what not, from moving house and what not, and, yeah so I, I, wouldn't tell anybody

Extract 66. [16] I'm sure no parent wants to know this about their child. That'll be, I think it would be really hard for a parent to deal with it

Extract 67. [7] They could like, get real, oh, extremely worried and go overboard

Extract 68. [4] Talking to someone like your parents or something, you might feel that it might upset them more or they just, their expectations have been crushed, and they'll go, get up there after you

Just over half of the participants indicated they would seek help from their parents for the first scenario, which increased to two-thirds for the second scenario, which was considerably lower than reported help seeking from friends. The relationship characteristics between parents and child, including concerns about the impact on their relationship are thought to be significant barriers seeking help from parents, despite the trusted relationship they have.

Friends

The relationship characteristics identified for a friend could also be grouped under the three main relationship themes: trusted relationship, appropriate person, and impact of help-seeking on the relationship (please refer table 9). The theme of trusted relationship included the sub-themes of friends being trustworthy, and understanding and knowing them personally. Participants indicated that they would be careful about the type of friend they would seek help from for symptoms of depression, selecting friends they considered trustworthy, as illustrated by extracts 69 and 70:

Extract 69. [11] Um, if it's a good friend you can trust them

Extract 70. [20] Yip, if I was gonna go to a friend I'd make sure it's a very close friend, like someone you've known for ages

Consistent with this, participants indicated that they would not seek help from a friend if they had concerns about their ability to trust them, as illustrated by extract 71:

Extract 71. [15] um maybe they're (symptoms) pretty serious and they're not, um, ya know, ya can't trust them (friend) enough with it

Friends were considered trustworthy due to knowing each other and being able to understand and relate to each other. Participants emphasised that friends understand them, and they feel comfortable confiding in friends, primarily due to their friends being youthful and in the same developmental stage, as illustrated by extracts 71 to 73:

> Extract 71. [2] I think they can understand you better than if you asked your parents or told them you were skipping classes … they'd, they'd just, they'd probably help you out and not, you know, not get angry, which is what you parents would do if, and you'd feel more comfortable, cos I guess it's worse to feel bad, and then have your parents yell at you

> Extract 72. [16] Well they're possibly in similar situations, and they, you know, they're at school with you or whatever, so they can say 'that person's not ignoring you, you know they just had, they were listening to music or whatever, they couldn't hear you'. You know, they can just, like they're there at the time, whereas your parents just have what you've said to them

> Extract 73. [19] A friend would be able to relate to your problems, cos they, they would know your problems, cos they'd know the people involved within the problems, hopefully. And they would know why you're doing these things. And they would notice, and maybe go out of their way to actually help you, and maybe actually try and try and actually, you know, confront you about this, and actually, you know, make you talk about it

Interestingly, participants often compared friends to parents (extracts 71 and 72), suggesting that friends would not only respond differently to parents, but as they are also an adolescent and therefore are more likely to understand and provide better help than parents. This is consistent with Furman and Buhrmester's (1992) findings where same-sex friends become increasingly supportive with age and young people seek more developmentally appropriate support (Papini, Farmer, Clark, Micka, & Barnett, 1990; Wilson & Deane, 2001a).

Suitability of friends as helper was the next important theme, and sub-themes included friends being available (both physically and emotionally). This theme was principally found in response to the severe scenario of depression. Patterns in participants' responses suggested that friends would notice and go out of their way to help (as in extract 73), as well as young people finding it easy and comforting to seek help from their friends, as illustrated by extracts 74 and 75:

> Extract 74. [20] Again they're really comforting, like, ya know they're gonna be there for you

> Extract 75. [4] Um, I'm like, I think it's just easier to talk to a friend, they feel closer and stuff

Availability of friends is consistent with increased time spent with friends during adolescence (Furman & Buhrmester, 1992; Papini, Farmer, Clark, Micka, & Barnett, 1990). Young people indicated concerns that a friend might not be the best person to seek help from, as illustrated by extract 76:

> Extract 76. [10] they're like you, and you don't really know what to do sort of thing, so probably wouldn't know, they'd probably help you out with ya friends, but they're not the best

The reason that friends were considered trusted and appropriate (due to going through similar experiences), also meant they may not be the most suitable helper. In addition, friends were not trusted to keep information private, consistent with the response characteristics (as indicated in extract 77), and friends were not appropriate to seek help for depressive symptoms (extract 78):

> Extract 77. [5] Like you know, worried that they're gonna be spreading it around sort of thing

> Extract 78. [6] Um, I think friends would be the wrong person to discuss it with, in my mind. Um and also the bit about the bad response, because they might tell other people, and it ends up being, ya know, a real issues

Participants also indicated that they would feel uncomfortable and embarrassed about seeking help for depressive symptoms from their friends, which was identified as a further sub-theme:

> Extract 79. [13] Definitely feeling embarrassed about, like, having emotional problems, um, yeah and feeling that they might, sort of, you might get a bad response

> Extract 80. [11] Um, probably feel uncomfortable embarrassed

As with parents, there was concern that help-seeking from friends may affect their relationship with their friends, which was identified for both scenarios. This manifested as young people worried about burdening their friends with their problems, due tot young people potentially having their own problems to worry about, as illustrated by extracts 81 to 83:

> Extract 81. [19] Just don't want to burden them with your problems. Cos you, you have a, cos everyone feels like they're obliged to, you know, take, you know, stand up and stand for themselves, but some people find it difficult to do that

> Extract 82. [3] Wouldn't want to worry the person, cos, you know, you don't know what's going on in someone else's life.

Extract 83. [6] Um, you wouldn't want to concern the person, um, because that could make them feel really bad as well

Young people were concerned that disclosing symptoms of depression might negatively impact on their relationship through being judged by their friends. For example, young people expressed concerns that they would no longer want to be their friend, and that disclosing symptoms of depression may change the way they felt about them, or disrupt the balance of the relationship, as illustrated by extracts 84 to 86:

Extract 84. [18] Like you might worry that your friends are going to single you out, not talk to you, avoid you, things like that

Extract 85. [16] Well, they might look at, like see you slightly differently

Extract 86. [14] Like, they don't, you don't want them to be higher than you, and that, you know, you don't want to be lower them, you just want to be on the same level as they are, yeah

The primary difference in themes for friends and parents was that friends were identified as available for severe symptoms of depression. In addition, there were differences in the reasons why they were considered suitable, as well as how help-seeking may impact on the relationship. Participants worried about creating stress or tension in the relationship with parents, whilst they were more concerned about being judged by their friends and consequently losing friendships. Further, not trusting friends emerged as an important theme for friends that participants did not express about parents. The importance of a trusted relationship with a helper is consistent with Barker, Olukoya, and Aggleton (2005), who suggested that the perceptions of social support as helpful and trustworthy primarily influences young people's willingness and motivation to seek help from friends and family, and thought to be why young people prefer to seek help from informal sources over formal help (Rickwood, Deane, Wilson, & Ciarrochi, 2005; Tatar, 2001).

Medical Person

The themes of trust and suitability were also identified for medical persons; however the impact on relationship was not relevant. Having a trusted relationship with a medical person was important for young people's willingness to seek help from them but the sub-themes identified were different from the informal sources of help. That is, trust was still significant, however it focused on the sub-themes of confidentiality and expertise, which is consistent with a young person having a professional relationship with a medical person.

Young people suggested that medical persons were experts, and were able to be objective, which would encourage participants to trust and seek help from a medical person. In extract 87, the importance of trust is emphasised, along with objectivity and expertise, whilst extracts 88 and 89 focus predominantly on medical expertise, which young people suggest makes the advice of a medical person trusted:

> Extract 87. [16] Well, it would be completely confidential. If you tell, if you tell your friends, they'll probably tell at least one other friend, or with your parents they might tell, you know, your dad or whatever, or your sister. So you have that advantage. And they have, they have like the factual knowledge, you know? This, this could be depression, you know, you have, like this is actually physically wrong with you, or mentally, or whatever

> Extract 88. [15] They know what they're talking about again … more professional, yeah

> Extract 89. [13] Well, they actually, like, know it, and like, like they could know the connections between the emotional and physical problem

As mentioned in extract 87, confidentiality was an important aspect of trust, and concerns were identified that medical persons might not maintain confidentiality, as illustrated by extract 90:

> Extract 90. [19] And then they might, then, then they might break the whole doctor- parent contract thing and actually tell your parents about it, because they, I'm sure there's some exemption clause in there saying that they can do that, if it's for the, the, the better good of the person

Medical persons were identified as not suitable, primarily due to not knowing the young person, as illustrated in extract 91:

Extract 91. [16] They don't know you, or your sort of, like the people in your life, or they don't know about your life, kind of thing. They, they can't really offer you advice in this for how to handle it exactly

Not knowing a medical person meant that young people felt uncomfortable and embarrassed about seeking help from a medical person, as illustrated by extracts 92 and 93:

Extract 92. [20] Um, could feel really uncomfortable around them cause you don't really know that person

Extract 93. [2] Um, it would be uncomfortable talking to them, cos, I dunno, they just don't know you that well. And, yeah, it would be the wrong person to discuss it with, I think

Consistent with medical persons not considered suitable, young people expressed a preference for seeking help from their friends and family, particularly for the first scenario, as illustrated in extract 94:

Extract 94. [11]
Participant: You're just sort of sad inside, and like you can just, your parents or your friends could just help you with that, like you don't need professional help
Interviewer: So they're not, you don't think that they're the right type of person?
Participant: Nah, and ya don't know them, they can't like, yeah just get to the bottom of your problems and stuff

Therefore, despite young person's identifying medical person as trusted due to confidentiality and their expertise, patterns in data suggest that they would not be very likely to seek help from them, due to not knowing them personally, feeling uncomfortable and embarrassed and not feeling they were the most appropriate person to seek help from, as illustrated in extracts 95 and 96:

Extract 95. [15]
Participant: probably feel uncomfortable, or embarrassed, but then sorta you wouldn't 'cause you, ya know, don't know them enough to tell them that that you, don't know them, so you can tell them, cause you sorta wont see them again or something
Interviewer: Yeah, so slight, is it related to trust is it?
Participant: yeah, like, can you trust this person you don't know them, but then again you're never going to see them again so it probably doesn't matter

Extract 96. [16] well, they don't know you as a person, or the other people in the situation. And you're probably not gonna see then again, which can be a good or a bad thing. Because you can just confess without it being, you know, seeing them again

Interestingly, for medical persons the participants' response characteristics and the relationship characteristics overlapped somewhat more than for informal sources, making it difficult to differentiate between relevant responses and the suitability of the source. It is suggested that this result is due to young people not having a personal relationship with medical persons, with both response and relationship characteristics centring on their professional skills and expertise. However, these relationship characteristics were not as salient for more severe symptoms of depression, as young people reported an increase in help-seeking from a medical person as symptoms increased in severity.

Mental Health Professional

Not surprisingly, the relationship characteristics identified between a young person and a mental health professional were similar to those with a medical person, with the participant responses emphasised the role of trust in a relationship, including maintaining confidentiality, and being trusted due to their expertise and objectivity. Maintaining confidentiality was suggested by participants as an important reason they would seek help from a professional, as illustrated in extracts 97 and 98:

> Extract 97. [1] Um, yeah it's confi, ya know confidential or whatever and they just listen, and help you out and stuff

> Extract 98. [9] Yeah. They will like, completely know like what's happening, and yeah, and you can feel good about talking to them, cause ya know, they'll keep it private

Previous research has found breaching confidentiality is a widespread concern amongst young people, particularly for school counsellors (Lindsey & Kalafat, 1998), and confidentiality is thought to be integral to the foundation of trust between a therapist and their client (Joseph & Onek, 1999). In addition to maintaining confidentiality, participants indicated that professionals have a number of qualities which make them trustworthy helpers, including having skills and experience specific to being able to help, as expressed in extracts 99 to 101:

Extract 99. [3] um, they're usually positive people, like you don't exactly get an Emo counsellor, or anything. So you know, usually positive people, and it's good to listen to them, because, you know, they've gone through it, and they know how to get through it the best way, cos they've come out happy

Extract 100. [13] They're, they're trained in understanding the situation, which is really good, than just talking to someone else who doesn't really know what to say sometimes

Extract 101. [6] And I think that they just help you feel better about yourself, like ahh, like about feeling hopeless, and that sort of stuff, I think they can just give you, a sort of neutral open-minded advice

Participants' suggested that counsellors were suited to working with people with difficulties, and had the skills and training to manage depressive symptoms, and provide valid and appropriate advice. This is consistent with Barker, Olukoya, and Aggleton (2005), who completed a review on social support and help-seeking, and found that young people are likely to ignore health-related information if they do not trust the source.

Suitability was also identified as an important relationship characteristic for seeking help from a mental health professional, with not knowing them personally identified as the salient sub-theme. This included mental health professionals not knowing or understanding what the young person may need, and hence not able to provide the most appropriate support, particularly compared to friends and family. Extracts 103 and 104 provide examples of reasons young people did not think a mental health professional was the right person to seek help from:

Extract 103. [6] Um, like if you don't trust them, in a way, you wont feel like they're giving you the best advice they can, and you just, um, and then you might sort of think, ya know, they're not, ya know, they don't, maybe, you don't think they sort of believe in you and that sort of stuff, ya know it might just sort of be a, dunno

Extract 104. [18] They might tell people that you don't want to know, and they could, you may not like it cause they may get too involved in your life after that, because you want their help, but you don't want them to constantly help

Young people identified feeling uncomfortable and embarrassed due to not knowing a mental health professional, as illustrated by extracts 105 and 106:

Extract 105. [20] Again it'd be really uncomfortable cause you don't know that person, but they're trained in it, you'd have to sorta wanna know the person, yip

Extract 106. [21] yeah, it would be kind of uncomfortable not knowing the person, I think

Therefore, despite trusting a professional due to confidentiality and their expertise, patterns indicated that participants felt that a professional was often not the appropriate person to seek help from, particularly for the first scenario, as symptoms were not considered severe enough to seek help from a professional. Extract 102 provides a good summary of the patterns that emerged in participant responses:

> Extract 102. [17] the thing I don't like about psychiatrists is that, um, you know, you talk to them about your feelings and all that kind of thing, but they don't really tell you what to do… well you're there to listen, and ask me how I feel, you know, why would I take an hour out of my week, or something like that, you know, just to do that when I can do that with my parents, I can do that with a close friend, like you know, kind of thing?

This participant identifies issues already touched on for seeking help from a medical person; that young people prefer to seek help from their friends and parents than professionals, particularly if their problems do not exceed the capacity of their social networks, and where social networks may provide a more appropriate or relevant response (Cramer, 1999; Rickwood & Braithwaite, 1994). This extract also reflects young peoples' potentially limited knowledge of mental health professionals, assuming they all take a non-directive approach and they may not be aware of more directive approaches, such as cognitive-behavioural approaches, which are used win addressing depression in young people.

In addition to the important themes that emerged for mental health professionals not being the right person, young people were explicit about feeling conflicted regarding help-seeking from a mental health professional. That is, they identified relationship characteristics which would encourage them to seek help from them; however, some participants also expressed that mental health professional were not the right person, and did not trust them to seek help from. Extracts 107 and 108 reflect this conflict:

> Extract 107. [18] Um, you'd feel more comfortable cause they would've dealt with things like that before, although I might not though because of the not completely confidential and family find out and stuff, if it's as bad as this is, then yeah I would

Extract 108. [19] they don't know you, they really don't know you, and they, and they're being biased. So you might feel about that, you know, I'm gonna completely contradict myself here, but for every single reason I've just said, is there is a problem with it. Because they don't know you, they can't sympathise with you, and they don't sympathise with you, so you might feel slightly neglected or uncomfortable with the situation because they don't know you, and they, they, they're being unbiased and they don't know your friends, and why you're skipping classes and everything. You know, they're there to make you feel better in a professional way. But that's the problem, it's not like it could be a girl, like somebody, you know, who can, you know, give you a hug and you feel warm inside, cos you know, it's somebody that actually, you know, when you, you, you know, yeah. Oh, really struck a chord with me there.

In extract 108, it is emphasised by the participant that professionals may not be able to respond with what a young person feels they need when they are experiencing symptoms of depression. It is expected that these barriers relate to a lack of experience seeking help from a mental health professional. In addition, symptoms of adolescent depression emerge across different domains of a young person's life, including impacting on relationships with friends and family. Participants viewed having friends as salient in improving symptoms of depression, and knowing people care about you, which was not something participants felt a professional could provide.

Summary

Study two provided participants with the opportunity to discuss the different sources of help: what they felt were good about seeking help from these sources, and what they felt were bad or the reasons they would not seek help from these sources. Although findings are from a small sample of New Zealand adolescents based in the Wellington region, patterns in data provided the researcher some insight into the dynamics of the help-seeking process, with important themes identified across the data that were reported to impact on participant help-seeking. The aim of study two was to address research questions which emerged from study one, including what influences young people's choice of helper including the important reasons they may not seek help from different sources, and how severity effects who young people choose to seek help from. These two research questions are addressed below.

How do Young People Select a Helper for Symptoms of Depression?

From patterns in the data, two overarching themes, namely response and relationship characteristics, were identified across the four sources of help. That is, the expected response of a helper, as well as the relationship young people have with a helper, were identified as important for participants, and impacted on their willingness to seek help from these people. Expected responses included both positive and negative characteristics, with different sub-themes identified for different sources of help (as represented in table 9). Some overlap was identified across sources, for example both parents and friends were viewed as supportive and experienced, whereas communicating knowledge and expertise was common for the formal sources of help.

The two main themes identified for relationship characteristics were trust and suitability of source of help. A further sub-theme was identified for seeking help from parent and friend, labelled impact as this was related to participants' concerns that seeking help from friends and parents may impact on their relationship with that person. This included sub-themes of worrying about burdening their friends and parents, as well as being judged by friends. The relationship characteristics were identified as particularly salient for the informal sources of friends and family, due to the personal nature of the relationship they have with these people. For formal sources, trust was primarily related to confidentiality and the expertise of a helper. Participants identified confidentiality as an important reason for seeking help from a medical or mental health professional but they also expressed concern disclosure may not be confidential from their parents, which was identified as a barrier seeking professional help. Relationship characteristics for formal sources of help were somewhat more difficult to distinguish from the response characteristics, in particular, the relevance of advice and suitability of these sources overlapped. It is suggested that this is due to not having a personal relationship with this person, and the nature of the relationship (i.e. professional) is closely related to the response expected from this person.

How does Severity of Depressive Symptoms Impact on Help-Seeking from different Helpers?

Although overall patterns within the data were similar regardless of severity, some sub-themes were identified only for the severe symptoms of depression (as indicated in brackets in table 9). For parents, sub-themes that were unique in response to severe symptoms of depression included parents seeking further help for the young person, and taking control. Although parents taking control could be positive, concerns that parents may impose solutions was identified a potentially negative consequence of seeking help from parents. Thus, this study was able to identify an important inconsistency for participants regarding help-seeking from parents. Participants acknowledged the benefits of parents intervening alongside concerns that they may lose control of the outcome. For example, young people reported fears that parents may force them to go to doctors and take medication, despite what they may want to do. Young people experience a growing need for autonomy during adolescence, which has been found to be a significant barrier to seeking help (Ciarrochi, Wilson, Deane, & Rickwood, 2003). Although young people who can confidently use help when needed have been found to have higher self-efficacy, this is alongside maintaining independence and control around this process (Garland & Zigler, 1994).This is an important finding because it emphasises the importance of involving young people in decisions around their care when they are feeling depressed, and when possible not force treatment against their will.

Young people raised some interesting concerns about seeking help from friends for severe symptoms of depression. A sub-theme that was identified for the second scenario was worry that their friends would think they were attention-seeking if they disclosed severe symptoms of depression. On the other hand some participants had concerns that their friends would overreact or be overwhelmed by one's reports of severe symptoms of depression, which would prevent them from seeking help from their friends for these symptoms (particularly regarding suicidal thoughts). Young people report that help-seeking from friends is less useful with an increase in severity of symptoms, leading to an increase in help-seeking from

professionals (Rickwood & Braithwaite, 1994; Saunders, Resnick, Hoberman, & Blum, 1994).

However there may be more than one purpose of help-seeking, with young people disclosing

problems and seeking support from friends thought to promote a close relationship with friends

(Sullivan, Marshall, & Schonert-Reichl, 2002). Those young people who seek help primarily

from their friends for psychological problems are more likely to be disturbed (Rickwood,

1995). Interestingly, four-fifths of participants reported they would seek help from friends

regardless of severity of depressive symptoms. Although important concerns were identified, it

appears that young people offset concerns about seeking help from friends by identifying the

right type of friend (someone who is trustworthy and suitable) as emphasised in relationship

characteristics.

Although help-seeking from professional sources increases with severity of symptoms, as

illustrated in this study, young people continue to prefer to seek help from informal sources

(Gasquet, Chavance, Ledoux, & Choquet, 1997; Grinstein-Weiss, Fishman, & Eisikovits,

2005; Raviv, Sills, Raviv, & Wilansky, 2000). There are more barriers to seeking professional

help (Kuhl, Jarkon-Horlick, & Morrissey, 1997), and they are less trusted (Rickwood, Deane,

Wilson, & Ciarrochi, 2005; Tatar, 2001). Help-seeking from professionals is usually

supplementary rather than substitutive to informal sources of help (C. Barker & Pistrang,

2002), and parents and friends often act as gatekeepers to young people accessing formal help

(Logan & King, 2001; Rickwood, Deane, Wilson, & Ciarrochi, 2005).

There was an increased willingness to seek help from a medical person for severe

symptoms of depression, thought to be due to their medical and physical nature. Young people

seeking help for physical symptoms of depression is consistent with findings that young people

are more likely to seek help from formal sources when the problem is severe and specific

(Grinstein-Weiss, Fishman, & Eisikovits, 2005), and when the problem exceeds the coping

resources of friends and family (Boldero & Fallon, 1995; Rickwood & Braithwaite, 1994).

The themes identified for a mental health professional did not vary with the severity of

depressive symptoms but severe symptoms of depression in scenario two lead to an increase in reported help-seeking from a mental health professional. This suggests that young people view help-seeking from a professional as more appropriate for severe symptoms of depression.

The findings of study two suggest that the nature and severity of depressive symptoms overlap with the potential response of a helper, and the relationship a young person has with the helper. Although response and relationship characteristics tapped important aspects of young people selection of helper, these overarching themes also overlapped, particularly in regard to whether help was considered relevant and the helper suitable for the nature and severity of symptoms. This overlap is presented in figure 17, which is a pictorial representation of the findings of study two. Thus, it is suggested that when young people experience depressive symptoms, once the individual identifies them as important enough to seek help, they are then most likely to seek help from a source with which they expect a positive and relevant response, and from whom they perceive trusted and suitable for the problem.
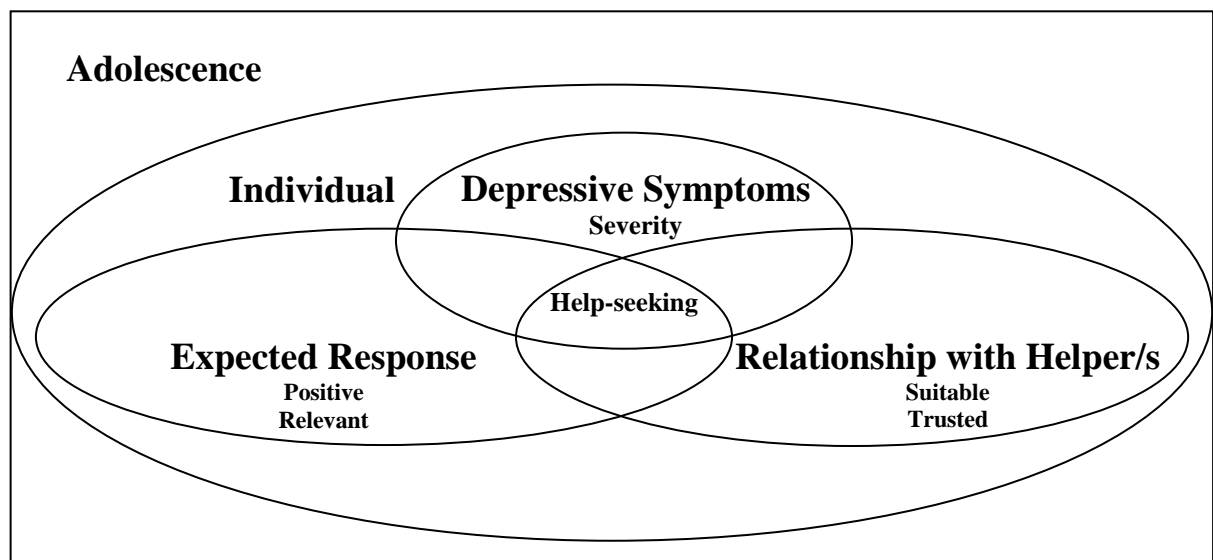

Figure 17. *Pictorial representation of the proposed overlap between severity of symptoms and response and relationship characteristics*

Individual and adolescent factors have been included in this figure, as consistent with the literature reviewed and the findings of study one, individual factors have been found to impact

on different stages of the process of help-seeking, including the selection of a helper. Developmental barriers to help-seeking include young people experiencing a growing need for autonomy, young people's lack of experience using help-seeking as a form of coping, as well as younger adolescents not having the emotional maturity to be able identify when they have a problem (Ciarrochi, Wilson, Deane, & Rickwood, 2003). When participants discussed help-seeking in study two, it was often within the context of being a young person, with adult helpers not understanding or often minimising their problems. The importance of the adolescent context is consistent with models of adolescent help-seeking, which include the developmental stage of adolescence an important contextual variable that impacts on help-seeking (Cauce et al., 2002). Therefore, adolescence has been included as the context for the factors identified figure 17.

The factors identified in study two and illustrated in figure 17 are consistent with Tatar's (2001) three-dimensional model of adolescent help-seeking for seeking help from a counsellor. Tatar's model included the adolescent realm, counsellor variables, and situational variables between the counsellor and young person. Tatar emphasised the complex dynamics of the helper and help-seeker relationship, which impacts on young people's willingness to seek help, and whether an individual considers a helper suitable to seek help from (Tatar, 2001).

Consistent with previous findings, in this study young people favoured help-seeking from informal sources, particularly their friends. The findings of study two, as presented in figure 17 can help explain the young peoples' preference for seeking help from friends. That is, young people reported that they would expect to get a relevant and positive response from their friends, including being supportive (Sullivan, Marshall, & Schonert-Reichl, 2002). Responses from friends and family are expected to be more predicable as young people have more experience seeking help from these sources and likely to have positive expectations, particularly compared to formal sources of help, with whom young people have less experience seeking help from (Sheffield, Fiorenza, & Sofronoff, 2004). Young people have a trusted

relationship with their close friends, including feeling comfortable disclosing personal information to them. Friends were also viewed as suitable due to being young, understanding, available, as well as being able to normalise the adolescent experience (Papini, Farmer, Clark, Micka, & Barnett, 1990; Wilson & Deane, 2001a).

Although young people also identified negative response and relationship characteristics for friends, young people reported seeking help from friends despite these factors. From the text, young people talked about weighing up the positive aspects with the risks of seeking help from a person when deciding whether or not to seek help from them, which is consistent with figure 17.

To conclude, study two contributes to understanding why young people prefer to seek help from friends and family. In particular, this research helped to elucidate the important role of response and relationship characteristics in selecting a helper, and how severity of symptoms overlaps with these factors influencing who young people decide to seek help from.

GENERAL DISCUSSION

The help-seeking literature supports a pathway to adolescent help-seeking with multiple stages (Logan & King, 2001; Rickwood, Deane, Wilson, & Ciarrochi, 2005; Saunders, Resnick, Hoberman, & Blum, 1994; Srebnik, Cauce, & Baydar, 1996). This process is thought to include a minimum of three stages; recognition of a problem, decision to seek help, and selection of an appropriate helper (Cauce et al., 2002; Srebnik, Cauce, & Baydar, 1996). Although severity has been found to impact on willingness to seek help, this relationship is not direct, with the perceived importance of seeking help found to impact on young peoples willingness to seek help (Adams & Bromley, 1998). Individual factors such as age and gender influence willingness to seek help, and access to mental health services (e.g. Cuffe, Waller, Cuccaro, Pumariega, & Garrison, 1995; Sears, 2004; Wu et al., 1999). Ethnicity and other contextual factors have been found to influence all stages of the help-seeking process (Cauce et

al., 2002). In the following section, the findings of study one and two will be integrated to address how this research contributes to understanding how severity of depressive symptoms impacts on help-seeking from informal and formal sources of help.

The main aim of this research was to examine how severity of depressive symptoms impacted on the process of help-seeking in young people in New Zealand, including who young people choose to seek help from. Results of study one supported a multi-stage process of help-seeking, with the process variables increasingly intercorrelated with severity of depressive symptoms, leading to an increased likelihood of seeking help (Saunders, Resnick, Hoberman, & Blum, 1994; Schonert-Reichl, Offer, & Howard, 1995). Inclination to seek help from friend, parent, medical person and mental health professional were examined in the first study, and severity was found to impact on help-seeking from these sources. Interestingly, different patterns emerged for help-seeking from different sources of help, which interacted with gender, age, and ethnicity (please refer study one for a full discussion of these results). Severity also impacted on the selection of barriers to help-seeking in study one. CA supported the hypothesis that barriers to seeking help differed dependent on the severity of symptoms and the formality of the helper. Young people distinguished between informal (friends and family) and formal (GP and counsellor) sources of help when selecting the barriers to help. It was suggested that young people made an implicit decision about the appropriateness of the helper for the severity of symptoms when selecting barriers to help-seeking for different sources.

Study two was conducted to help elucidate the reasons young people select different helpers, and examine how severity impacted on their willingness to seek help from different sources. Through thematic analysis, the expected response of a potential helper and the relationship a young person has with this helper were identified as important overarching themes. These themes influenced young peoples decision seek help from different sources and overlapped with severity of depressive symptoms. The developmental context was identified as important in the second study as it was the backdrop young peoples' decisions regarding help-

seeking as well as explains young peoples preference for seeking help from their friends going through the same developmental stage. The relationship between these factors was summarised in figure 17.

As discussed in study one, when inclination to seek help was examined over the four scenarios, young people demonstrated different patterns for the different sources of help. Results indicated a help-negation effect for seeking help from friends for males and females, and young females demonstrated help-negation for seeking help from parents for severe symptoms of depression. This was consistent with previous findings that young people are less likely to seek help from people they know for suicidal thoughts (Carlton & Deane, 2000), and of those who seek help for suicidal thoughts, young females are least likely to seek help from their family (Wilson, Deane, & Ciarrochi, 2005).

Interestingly, in the second study young people reported high help-seeking from their friends regardless of severity of depressive symptoms, however certain themes were identified that were unique for severe symptoms of depression, which can help explain the decrease in seeking help from friends and family evident in study one. Young people worried that they would get a negative reaction from their friends. This included their friends gossiping about their problems, or thinking that they were attention seeking. It has been suggested that a decrease in help-seeking from friends and family could be due to embarrassment, which is not necessarily evident for seeking help from someone they do not know, such as professionals (Ciarrochi, Wilson, Deane, & Rickwood, 2003). Participants also worried that their friends would be overwhelmed if they disclosed severe symptoms of depression, and possibly not know what to do. This is consistent with findings that friends and parents were considered less useful for severe symptoms (Saunders, Resnick, Hoberman, & Blum, 1994; Schonert-Reichl, Offer, & Howard, 1995). In addition, although friends were identified as available, young people worried about disclosing severe symptoms of depression to their friends. This was due

to worry about burdening their friends with these problems, as well as concerns about being judged by their friends.

For parents, young people in study two acknowledged that their parents would perhaps know if they needed further help and could seek help on their behalf when experiencing severe symptoms of depression. Adolescents who seek help from their parents have been found to be less disturbed (DuBois et al., 2002; Offer, Howard, Schonert, & Ostrov, 1991); however young people also suggested that parents could take control, and may impose solutions, which was a barrier to seeking help from parents. Consistent with developmental literature, it is suggested that help-seeking may conflict with developmental goals of adolescence, particularly if young people do not maintain a sense of autonomy and control when seeking help.

In the first study, young people, particularly young females, reported higher inclination to seek help from a mental health professional as symptoms increased in severity. This is consistent with findings that young people who experience a high level of impairment and distress are more likely to seek professional help (Potts, Gillies, & Wood, 2001; Sawyer et al., 2001). It was suggested that participants recognised the severity of depressive symptoms and reported increasing help from a mental health professional, as this was more appropriate. An increase in help-seeking from a mental health professional was alongside decreased help-seeking from friends and parents, particularly for females, which helps explain the decrease in reported help-seeking from parents in study one.

Results from barrier data supported this interpretation, as participants selected barriers to help-seeking dependent on the formality of the helper, and the severity of depressive symptoms. CA of barrier data found that dimension one consistently distinguished between formal and informal sources of help. Dimension two appeared to differentiate between the two most appropriate sources of help, dependent on the severity of depressive symptoms. That is, dimension two differentiated between parent and friend for mild to moderately severe symptoms of depression and between GP and counsellor for severe symptoms of depression.

The second dimension, although accounting for a smaller amount of the variance, captured something salient regarding whom participants felt were the most appropriate source of help for the severity of depressive symptoms.

Increased severity of depressive symptoms also lead to higher reported help-seeking from formal sources of help in study two (please refer to appendix K). This is consistent with the increased appropriateness of this formal help for more severe symptoms of depression, when parents and friends may be considered less helpful (Rickwood & Braithwaite, 1994; Saunders, Resnick, Hoberman, & Blum, 1994). Reported help-seeking from friends and parents did not decrease with severity in study two as it did in the first study, with help-seeking from friends was consistently high regardless of severity of depressive symptoms. This result is consistent with young people seeking help from more than one person simultaneously (C. Barker & Pistrang, 2002), suggesting informal helpers may act as gatekeepers to encourage further help-seeking, or access help on behalf of the young person (Logan & King, 2001).

Themes identified in the second study suggested that when young people experience depressive symptoms that they consider severe enough to initiate help-seeking, the expected response and relationship are important factors that impact on help seeking. Young people reported being most likely to seek help from a source from whom they expect a positive and relevant response, and who they perceive as trusted and suitable for the problem.

Trust was an important theme identified for relationship characteristics, which emerged for seeking help from all sources of help. Young people have been found to be more likely to accept help and advice from a trusted source, and trust is an important reason of why young people prefer informal sources of help over professionals (G. Barker, Olukoya, & Aggleton, 2005; Rickwood, Deane, Wilson, & Ciarrochi, 2005; Tatar, 2001). Trust can be described as an interactive process, requiring give and take from both parties (G. Barker, Olukoya, & Aggleton, 2005). For example, a helper needs to be sensitive to a young persons needs alongside a young person taking a risk to trust, and disclose to a helper, for help to be effective.

In study two, young people identified that medical and mental health professionals were trustworthy due to their expertise and knowledge. However, they also did not trust them due to not knowing them. Rickwood and colleagues (2005) found that trust, familiarity and rapport were important themes which emerged in focus groups with young people. It was suggested that having an established relationship facilitated help-seeking, whereas not trusting a professional person, feeling embarrassed about disclosing personal problems, and not knowing what to expect, or how to talk to a professional, prevented professional help-seeking (Rickwood, Deane, Wilson, & Ciarrochi, 2005). Study two contributed to understanding the nature of trust in the dynamic in help-seeking, with young people balancing their need for help, the expected response from helpers, and the trustworthiness and suitability of a helper.

The findings of study two contribute to understanding the findings of study one. That is, in study one young people illustrated different patterns of help-seeking from different sources, consistent with young people perceiving the appropriateness of a source. The results of study two provide some insight into how young people select a helper with the severity of the symptoms, response and relationship characteristics overlapping impacting on selecting an appropriate helper.

Implications

These findings provide insight into how to encourage young people to seek help from professionals. In regard to response characteristics, the expected response was identified as important when seeking help from all sources of help. As young people are likely to know what to expect from friends and family, knowing what to expect from a medical person or mental health professional would increase help-seeking from professionals. Similarly, with regard to the importance of the relationship, confidentiality and trust were sub-themes that were identified to facilitate help-seeking from formal sources of help. Therefore, being explicit about confidentiality, as well as the process of seeking help, what to expect, and the likely

consequences of disclosing personal information to a professional would make professional help-seeking less risky for young people. Deane and colleagues (2003) found that explaining the help-seeking process clearly, providing information to young people about efficacy of treatment, and placing emphasis on the pre-treatment stages of therapy (e.g. relationship building) facilitates treatment and future help-seeking (Deane, Wilson, & Biro, 2003). In addition, emphasising young people's role in treatment, gaining full consent for treatment, and giving young people control makes help-seeking more consistent with adolescent developmental goals and encourages help-seeking from professionals.

Professionals need to be encouraged to actively build protective relationships with young people, particularly those who have close contact with young people, including teachers, GPs, youth workers, and school counsellors. These professionals have well established relationships with young people, and young people are more likely to seek help through these pathways. In addition, interventions should expand the role of friends and family in providing support, as well as accessing help on behalf of young people. Educating parents and young people about mental health and professional services available has been found to reduce stigma and barriers to help-seeking, and is expected to increase willingness to seek help from professionals (Rickwood, Deane, Wilson, & Ciarrochi, 2005).

This research also identified important barriers to help-seeking, some unique to particular sources of help. For example, concerns about being judged were identified primarily regarding seeking help from friends, as well as friends being overwhelmed by severe symptoms of depression. Conversely, young people worried about burdening their already stressed parents, and they had concerns that they would not being able to maintain control of the help-seeking process if their parents became involved. Barriers to seeking help from formal sources were mostly consistent with previous findings: not being able to provide relevant advice; not knowing them personally; concerns about confidentiality; as well as a preference to seek help and support from friends and family.

Finally, another important implication of this research is the importance of the developmental context. Age was found to influence the perceived importance of seeking help in the first study, as well as interacting with ethnicity, with regard to the likelihood of seeking help. Being young and going through adolescence flavoured the dialogue of young people interviewed in study two. Young people emphasised wanting to be able to cope on own and maintain control of the help-seeking process. These findings provide a lot of cues about how best to deliver mental health services to young people. Sharing experiences with others who are going through a similar developmental stage is thought to be an important reason young people prefer help-seeking from friends, despite the risks and limitations young people identified with this help. Young people were thought to balance this risk by selecting friends whom they felt they could trust. Thus, this research emphasises the importance of utilising established help-seeking pathways including schools, parents and peers

Strengths and Limitations

The main limitation of this research was the design of study one, as data were not collected for the purpose of the study (addressed in the discussion of study one). Another limitation was that both studies asked participants to identify with the young person in the scenarios and then respond to questions regarding help-seeking. It is expected that participants' ability to imagine they were experiencing the depressive symptoms was variable. Due to the nature of depression, leading to isolation and lowering of self-esteem, it is difficult for young people to predict how they would feel and behave, especially if they have not previously experienced depressive symptoms. Therefore, the best way to examine help-seeking is to monitor actual help-seeking behaviour over time, which is a currently a significant gap in the help-seeking literature.

Although the sample for the second study was obtained from the same secondary schools, it is not possible to assume that the samples were comparable. In addition, further qualitative

analysis could have been conducted on the data from interviews to examine differences between those of different gender, age, and ethnicity. Unfortunately, due to time and space constraints, further qualitative analysis was beyond the scope of this research.

The strength of this research was the use of qualitative research to examine specific research questions which emerged out of the results of the quantitative study. Although this was an unconventional approach, it provided the researcher with an opportunity to explore help-seeking from a friend, parent, medical person and mental health professional in more depth. Previous help-seeking research has identified the need for examining young people's help-seeking qualitatively (Rickwood, Deane, Wilson, & Ciarrochi, 2005; Sullivan, Marshall, & Schonert-Reichl, 2002). Open-ended questions were beneficial as it gave young people the opportunity to present an array of possible reasons for selecting different helpers, and they were not constrained by psychological constructs and forced choice. Consequently, this research enriches our understanding of the influences on adolescent help-seeking.

Future Directions

As mentioned above, some questions were raised in this research which were beyond the scope of this research but are important areas for further research. Firstly, it would be interesting to examine in more depth the role of ethnicity in the process of help-seeking. Although ethnicity has been thoroughly examined in terms of utilisation of mental health services, ethnicity is thought to impact on the process of help-seeking; however it is currently unclear exactly how it impacts on the different stages. In particular, it would be interesting to examine the role of informal support services impacting on the process of help-seeking for those of different ethnicities. Greater access to informal support may lead to a decrease in formal services, but this needs to be examined in more depth.

Further, the sample used for this research was school-based adolescents. Of those interviewed in the second study, all participants indicated they would see help from someone

for severe symptoms of depression. Therefore, this research does not contribute to our understanding of those young people most at risk of not seeking help at all for symptoms of depression. This is the group which is most important to capture, as it is expected that these young people are at greatest risk of committing suicide.

Conclusion

In this research, young people exhibited a preference for seeking help for informal sources of help, particularly their friends. However, when examined over the four scenarios, help-seeking from informal sources decreased as severity of depressive symptoms increased, particularly for female participants. Females reported higher help-seeking from a mental health professional. It was suggested that a decrease in help-seeking from informal sources was due to female participants identifying formal sources of help as more appropriate for severe symptoms of depression including suicidal thoughts. Consistent with this finding, correspondence analysis on barrier data of study one, and thematic analysis of text in study two indicated that young people choose help dependent on the appropriateness of a helper in regard to the severity of depressive symptoms. The appropriateness of the helper was found to be influenced by the expected response of a helper, and a young person's relationship with this person in study two. This research has contributed to our understanding of the reasons young people prefer informal sources of help; that is, they are more trusted, the response is more predictable, and help is considered more relevant from informal sources, particularly friends.

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Appendix A

Appendix B

Appendix C

Appendix D

Appendix E

Appendix F

Appendix G

Appendix H

Appendix I

Appendix J

Appendix K

Appendix A
STOP! PLEASE TELL THE RESEARCHER
THAT YOU HAVE REACHED SCENARIO TWO.

NOTE: THE SCENARIO YOU ARE ABOUT TO HEAR IS FICTITIOUS. IT IS ONLY A ROLE-PLAY. HOWEVER, PLEASE TELL YOUR RESEARCH ASSISTANT IF YOU ARE DISTRESSED BY THE TAPE AND WOULD LIKE TO STOP.

Scenario One

Please answer the questions below in response to the role-played Scenario you have just heard. A summary of the scenario is presented to aid your memory.

Scenario One Summary

This individual described the following:
- Feelings of guilt and not really feeling right.
- Eating and sleeping fine.
- Sometimes not getting on with people, but fine with swimming team.
- Health okay, with occasional headaches and stomach aches.
- School marks a bit lower than usual.

How distressed or upset would you feel if you were the person on the tape?

◯　　◯　　◯　　◯　　◯　　◯　　◯

Not at all distressed　　　　　Moderately distressed　　　　　Extremely distressed

How serious a problem would you judge these feelings?

◯　　◯　　◯　　◯　　◯　　◯　　◯

Not at all serious　　　　　Moderately serious　　　　　Extremely serious

How important would it be for you to seek help?

◯　　◯　　◯　　◯　　◯　　◯　　◯

Not at all important　　　　　Moderately important　　　　　Extremely important

How likely would it be that you would actually seek help?

◯　　◯　　◯　　◯　　◯　　◯　　◯

Not at all likely　　　　　Moderately likely　　　　　Extremely likely

Please complete the flow charts below based on the Scenario that you have just heard.

If you were the person in the tape, would you seek help from a Friend?
◯ Yes   ◯ No

What do you think their reaction would be?
◯ Negative   ◯ Neutral   ◯ Positive

How helpful would you predict this person to be?
◯ Not Helpful   ◯ Somewhat Helpful   ◯ Very Helpful

Why not? (Please tick all that apply)
Not serious enough ◯
Not emotionally available ◯
Not physically available ◯
Wrong person to discuss it with ◯
Felt uncomfortable / embarrassed ◯
Didn't want to worry the person ◯
The cost is too much ◯
Worried about a bad response, e.g. teasing or telling others ◯
Other   (please specify): _____ ◯

If you were the person in the tape would you
seek help from a Parent/Caregiver?

◯
Yes

◯
No

What do you think their reaction would
be?

◯
Negative

◯
Neutral

◯
Positive

How helpful would you predict this
person to be?

◯
Not
Helpful

◯
Somewhat
Helpful

◯
Very
Helpful

Why not? (Please tick all that apply)

Not serious enough   ◯

Not emotionally available   ◯

Not physically available   ◯

Wrong person to discuss it with   ◯

Felt uncomfortable / embarrassed   ◯

Didn't want to worry the person   ◯

The cost is too much   ◯

Worried about a bad response,
e.g. teasing or telling others   ◯

Other   (please specify):

_____   ◯

If you were the person in the tape would you
seek help from a Medical Doctor (GP)/Nurse?

◯
Yes

◯
No

What do you think their reaction would
be?

◯　　　　　◯　　　　　◯
Negative　　　Neutral　　　Positive

How helpful would you predict this
person to be?

◯　　　　　◯　　　　　◯
Not　　　Somewhat　　　Very
Helpful　　Helpful　　　Helpful

Why not? (Please tick all that apply)

Not serious enough　　　　　　　　　　◯

Not emotionally available　　　　　　　◯

Not physically available　　　　　　　　◯

Wrong person to discuss it with　　　　◯

Felt uncomfortable / embarrassed　　　◯

Didn't want to worry the person　　　　◯

The cost is too much　　　　　　　　　◯

Worried about a bad response,　　　　　◯
e.g. teasing or telling others

Other   (please specify):

_____　◯

If you were the person in the tape would you seek help from a Counsellor, Psychologist or Psychiatrist?

◯
Yes

◯
No

What do you think their reaction would be?

◯
Negative

◯
Neutral

◯
Positive

How helpful would you predict this person to be?

◯
Not
Helpful

◯
Somewhat
Helpful

◯
Very
Helpful

Why not? (Please tick all that apply)

Not serious enough ◯

Not emotionally available ◯

Not physically available ◯

Wrong person to discuss it with ◯

Felt uncomfortable / embarrassed ◯

Didn't want to worry the person ◯

The cost is too much ◯

Worried about a bad response,
e.g. teasing or telling others ◯

Other   (please specify):

_____ ◯

Would you seek help from anyone else?

◯
Yes

◯
No

Please specify who:_____

What do you think their reaction would be?

◯
Negative

◯
Neutral

◯
Positive

How helpful would you predict this person to be?

◯
Not
Helpful

◯
Somewhat
Helpful

◯
Very
Helpful

Why not? (Please tick all that apply)

Not serious enough ◯

Not emotionally available ◯

Not physically available ◯

Wrong person to discuss it with ◯

Felt uncomfortable / embarrassed ◯

Didn't want to worry the person ◯

The cost is too much ◯

Worried about a bad response,
e.g. teasing or telling others ◯

Other   (please specify):

_____ ◯

Please answer the question below:

Based on the decisions you have made in the flowcharts for this scenario, how do you think you would feel 6 months later?

◯
Worse

◯
The same

◯
Better

STOP! PLEASE TELL THE RESEARCHER
THAT YOU HAVE REACHED SCENARIO TWO.

NOTE: THE SCENARIO YOU ARE ABOUT TO HEAR IS FICTITIOUS. IT IS ONLY A ROLE-PLAY. HOWEVER, PLEASE TELL YOUR RESEARCH ASSISTANT IF YOU ARE DISTRESSED BY THE TAPE AND WOULD LIKE TO STOP.

Scenario Two

Please answer the questions below in response to the role-played Scenario you have just heard. A summary of the scenario is presented to aid your memory.

Scenario Two Summary

This individual described the following:
- Concerns that people were avoiding him/her.
- Hanging out alone a lot.
- Feeling shaky, but otherwise health was okay.
- Feeling sad and not liking the way he/she looks.
- Difficulty concentrating.

How distressed or upset would you feel if you were the person on the tape?

Not at all distressed   Moderately distressed   Extremely distressed

How serious a problem would you judge these feelings?

Not at all serious   Moderately serious   Extremely serious

How important would it be for you to seek help?

Not at all important   Moderately important   Extremely important

How likely would it be that you would actually seek help?

Not at all likely   Moderately likely   Extremely likely

Please complete the flow charts below based on the Scenario that you have just heard.

If you were the person in the tape, would you seek help from a Friend?

◯ Yes

◯ No

What do you think their reaction would be?

◯ Negative   ◯ Neutral   ◯ Positive

How helpful would you predict this person to be?

◯ Not Helpful   ◯ Somewhat Helpful   ◯ Very Helpful

Why not? (Please tick all that apply)

Not serious enough ◯

Not emotionally available ◯

Not physically available ◯

Wrong person to discuss it with ◯

Felt uncomfortable / embarrassed ◯

Didn't want to worry the person ◯

The cost is too much ◯

Worried about a bad response,
e.g. teasing or telling others ◯

Other   (please specify):

_____ ◯

If you were the person in the tape would you seek help from a Parent/Caregiver?

◯ Yes   ◯ No

What do you think their reaction would be?

◯ Negative   ◯ Neutral   ◯ Positive

How helpful would you predict this person to be?

◯ Not Helpful   ◯ Somewhat Helpful   ◯ Very Helpful

Why not? (Please tick all that apply)

Not serious enough   ◯

Not emotionally available   ◯

Not physically available   ◯

Wrong person to discuss it with   ◯

Felt uncomfortable / embarrassed   ◯

Didn't want to worry the person   ◯

The cost is too much   ◯

Worried about a bad response,
e.g. teasing or telling others   ◯

Other   (please specify):

_____   ◯

If you were the person in the tape would you
seek help from a Medical Doctor (GP)/Nurse?

◯
Yes

◯
No

What do you think their reaction would be?

◯
Negative

◯
Neutral

◯
Positive

How helpful would you predict this person to be?

◯
Not
Helpful

◯
Somewhat
Helpful

◯
Very
Helpful

Why not? (Please tick all that apply)

Not serious enough   ◯

Not emotionally available   ◯

Not physically available   ◯

Wrong person to discuss it with   ◯

Felt uncomfortable / embarrassed   ◯

Didn't want to worry the person   ◯

The cost is too much   ◯

Worried about a bad response,   ◯
e.g. teasing or telling others

Other   (please specify):

_____   ◯

If you were the person in the tape would you seek help
from a Counsellor, Psychologist or Psychiatrist?

◯
Yes

◯
No

What do you think their reaction would
be?

◯   ◯   ◯
Negative   Neutral   Positive

How helpful would you predict this
person to be?

◯   ◯   ◯
Not   Somewhat   Very
Helpful   Helpful   Helpful

Why not? (Please tick all that apply)

Not serious enough   ◯

Not emotionally available   ◯

Not physically available   ◯

Wrong person to discuss it with   ◯

Felt uncomfortable / embarrassed   ◯

Didn't want to worry the person   ◯

The cost is too much   ◯

Worried about a bad response,   ◯
e.g. teasing or telling others

Other   (please specify):

_____   ◯

Would you seek help from anyone else?

◯
Yes

◯
No

Please specify who:_____

What do you think their reaction would be?

◯
Negative

◯
Neutral

◯
Positive

How helpful would you predict this person to be?

◯
Not
Helpful

◯
Somewhat
Helpful

◯
Very
Helpful

Why not? (Please tick all that apply)

Not serious enough ◯

Not emotionally available ◯

Not physically available ◯

Wrong person to discuss it with ◯

Felt uncomfortable / embarrassed ◯

Didn't want to worry the person ◯

The cost is too much ◯

Worried about a bad response,
e.g. teasing or telling others ◯

Other   (please specify):

_____ ◯

Please answer the question below:

Based on the decisions you have made in the flowcharts for this scenario, how do you think you would feel 6 months later?

◯   ◯   ◯
Worse   The same   Better

STOP! PLEASE TELL THE RESEARCHER
THAT YOU HAVE REACHED SCENARIO THREE.

NOTE: THE SCENARIO YOU ARE ABOUT TO HEAR IS FICTITIOUS. IT IS ONLY A ROLE-PLAY. HOWEVER, PLEASE TELL YOUR RESEARCH ASSISTANT IF YOU ARE DISTRESSED BY THE TAPE AND WOULD LIKE TO STOP.

Scenario Three

Please answer the questions below in response to the role-played Scenario you have just heard. A summary of the scenario is presented to aid your memory.

Scenario Three Summary

This individual described the following:
- Difficulty getting on with a couple of friends and his/her sister.
- Feels teacher is picking on him/her.
- Struggling to concentrate.
- Feeling tired a lot and not having any energy.
- Feeling like a "disappointment".
- Feeling sad and wondering what it would be like to hurt one's self.

How distressed or upset would you feel if you were the person on the tape?

◯ ◯ ◯ ◯ ◯ ◯ ◯

Not at all distressed   Moderately distressed   Extremely distressed

How serious a problem would you judge these feelings?

◯ ◯ ◯ ◯ ◯ ◯ ◯

Not at all serious   Moderately serious   Extremely serious

How important would it be for you to seek help?

◯ ◯ ◯ ◯ ◯ ◯ ◯

Not at all important   Moderately important   Extremely important

How likely would it be that you would actually seek help?

◯ ◯ ◯ ◯ ◯ ◯ ◯

Not at all likely   Moderately likely   Extremely likely

Please complete the flow charts below based on the Scenario that you have just heard.

If you were the person in the tape, would you seek help from a Friend?

◯ Yes   ◯ No

What do you think their reaction would be?

◯ Negative   ◯ Neutral   ◯ Positive

How helpful would you predict this person to be?

◯ Not Helpful   ◯ Somewhat Helpful   ◯ Very Helpful

Why not? (Please tick all that apply)

Not serious enough ◯

Not emotionally available ◯

Not physically available ◯

Wrong person to discuss it with ◯

Felt uncomfortable / embarrassed ◯

Didn't want to worry the person ◯

The cost is too much ◯

Worried about a bad response, e.g. teasing or telling others ◯

Other   (please specify):

_____ ◯

If you were the person in the tape would you seek help from a Parent/Caregiver?

◯ Yes

◯ No

What do you think their reaction would be?

◯ Negative   ◯ Neutral   ◯ Positive

How helpful would you predict this person to be?

◯ Not Helpful   ◯ Somewhat Helpful   ◯ Very Helpful

Why not? (Please tick all that apply)

Not serious enough ◯

Not emotionally available ◯

Not physically available ◯

Wrong person to discuss it with ◯

Felt uncomfortable / embarrassed ◯

Didn't want to worry the person ◯

The cost is too much ◯

Worried about a bad response, e.g. teasing or telling others ◯

Other   (please specify):

_____ ◯

If you were the person in the tape would you
seek help from a Medical Doctor (GP)/Nurse?

◯
Yes

◯
No

What do you think their reaction would
be?

◯
Negative

◯
Neutral

◯
Positive

How helpful would you predict this
person to be?

◯
Not
Helpful

◯
Somewhat
Helpful

◯
Very
Helpful

Why not? (Please tick all that apply)

Not serious enough   ◯

Not emotionally available   ◯

Not physically available   ◯

Wrong person to discuss it with   ◯

Felt uncomfortable / embarrassed   ◯

Didn't want to worry the person   ◯

The cost is too much   ◯

Worried about a bad response,   ◯
e.g. teasing or telling others

Other   (please specify):

_____   ◯

If you were the person in the tape would you seek help
from a Counsellor, Psychologist or Psychiatrist?

◯
Yes

◯
No

What do you think their reaction would
be?

◯   ◯   ◯
Negative   Neutral   Positive

How helpful would you predict this
person to be?

◯   ◯   ◯
Not   Somewhat   Very
Helpful   Helpful   Helpful

Why not? (Please tick all that apply)

Not serious enough   ◯

Not emotionally available   ◯

Not physically available   ◯

Wrong person to discuss it with   ◯

Felt uncomfortable / embarrassed   ◯

Didn't want to worry the person   ◯

The cost is too much   ◯

Worried about a bad response,   ◯
e.g. teasing or telling others

Other   (please specify):

_____   ◯

Would you seek help from anyone else?

○
Yes

○
No

Please specify who:_____

What do you think their reaction would be?

○
Negative

○
Neutral

○
Positive

How helpful would you predict this person to be?

○
Not
Helpful

○
Somewhat
Helpful

○
Very
Helpful

Why not? (Please tick all that apply)

Not serious enough ○

Not emotionally available ○

Not physically available ○

Wrong person to discuss it with ○

Felt uncomfortable / embarrassed ○

Didn't want to worry the person ○

The cost is too much ○

Worried about a bad response,
e.g. teasing or telling others ○

Other   (please specify):

_____ ○

Please answer the question below:

Based on the decisions you have made in the flowcharts for this scenario, how do you think you would feel 6 months later?

○
Worse

○
The same

○
Better

STOP! PLEASE TELL THE RESEARCHER
THAT YOU HAVE REACHED SCENARIO FOUR.

NOTE: THE SCENARIO YOU ARE ABOUT TO HEAR IS FICTITIOUS. IT IS ONLY A ROLE-PLAY. HOWEVER, PLEASE TELL YOUR RESEARCH ASSISTANT IF YOU ARE DISTRESSED BY THE TAPE AND WOULD LIKE TO STOP.

Scenario Four

Please answer the questions below in response to the role-played Scenario you have just heard. A summary of the scenario is presented to aid your memory.

Scenario Four Summary

This individual described the following:
- Difficulty getting on with family, teachers, and classmates.
- Frequently skipping classes.
- Having a long-term cold and heaps of aches and pains.
- Being unable to sleep and eat.
- Having stomach aches and a constant headache.
- Thinking they would be better off dead.
- Feeling hopeless, hating one's self, and feeling that things will not get better.

How distressed or upset would you feel if you were the person on the tape?

◯　　◯　　◯　　◯　　◯　　◯　　◯

Not at all distressed　　　　Moderately distressed　　　　Extremely distressed

How serious a problem would you judge these feelings?

◯　　◯　　◯　　◯　　◯　　◯　　◯

Not at all serious　　　　Moderately serious　　　　Extremely serious

How important would it be for you to seek help?

◯　　◯　　◯　　◯　　◯　　◯　　◯

Not at all important　　　　Moderately important　　　　Extremely important

How likely would it be that you would actually seek help?

◯　　◯　　◯　　◯　　◯　　◯　　◯

Not at all likely　　　　Moderately likely　　　　Extremely likely

Please complete the flow charts below based on the Scenario that you have just heard.

If you were the person in the tape, would you seek help from a Friend?

◯ Yes   ◯ No

What do you think their reaction would be?

◯ Negative   ◯ Neutral   ◯ Positive

How helpful would you predict this person to be?

◯ Not Helpful   ◯ Somewhat Helpful   ◯ Very Helpful

Why not? (Please tick all that apply)

Not serious enough ◯

Not emotionally available ◯

Not physically available ◯

Wrong person to discuss it with ◯

Felt uncomfortable / embarrassed ◯

Didn't want to worry the person ◯

The cost is too much ◯

Worried about a bad response, e.g. teasing or telling others ◯

Other   (please specify):

_____ ◯

If you were the person in the tape would you seek help from a Parent/Caregiver?

◯ Yes   ◯ No

What do you think their reaction would be?

◯ Negative   ◯ Neutral   ◯ Positive

How helpful would you predict this person to be?

◯ Not Helpful   ◯ Somewhat Helpful   ◯ Very Helpful

Why not? (Please tick all that apply)

Not serious enough ◯

Not emotionally available ◯

Not physically available ◯

Wrong person to discuss it with ◯

Felt uncomfortable / embarrassed ◯

Didn't want to worry the person ◯

The cost is too much ◯

Worried about a bad response, e.g. teasing or telling others ◯

Other   (please specify):

_____ ◯

If you were the person in the tape would you
seek help from a Medical Doctor (GP)/Nurse?

◯
Yes

◯
No

What do you think their reaction would
be?

◯   ◯   ◯
Negative   Neutral   Positive

How helpful would you predict this
person to be?

◯   ◯   ◯
Not   Somewhat   Very
Helpful   Helpful   Helpful

Why not? (Please tick all that apply)

Not serious enough   ◯

Not emotionally available   ◯

Not physically available   ◯

Wrong person to discuss it with   ◯

Felt uncomfortable / embarrassed   ◯

Didn't want to worry the person   ◯

The cost is too much   ◯

Worried about a bad response,   ◯
e.g. teasing or telling others

Other   (please specify):

_____   ◯

If you were the person in the tape would you seek help from a Counsellor, Psychologist or Psychiatrist?

◯
Yes

◯
No

What do you think their reaction would be?

◯　　　　◯　　　　◯
Negative　　Neutral　　Positive

How helpful would you predict this person to be?

◯　　　　◯　　　　◯
Not　　　Somewhat　　Very
Helpful　　Helpful　　Helpful

Why not? (Please tick all that apply)

Not serious enough　　　　　　　　　◯

Not emotionally available　　　　　　◯

Not physically available　　　　　　　◯

Wrong person to discuss it with　　　◯

Felt uncomfortable / embarrassed　　◯

Didn't want to worry the person　　　◯

The cost is too much　　　　　　　　◯

Worried about a bad response,　　　　◯
e.g. teasing or telling others

Other   (please specify):

_____　◯

Would you seek help from anyone else?

◯
Yes

◯
No

Please specify who:_____

What do you think their reaction would be?

◯
Negative

◯
Neutral

◯
Positive

How helpful would you predict this person to be?

◯
Not
Helpful

◯
Somewhat
Helpful

◯
Very
Helpful

Why not? (Please tick all that apply)

Not serious enough ◯

Not emotionally available ◯

Not physically available ◯

Wrong person to discuss it with ◯

Felt uncomfortable / embarrassed ◯

Didn't want to worry the person ◯

The cost is too much ◯

Worried about a bad response,
e.g. teasing or telling others ◯

Other   (please specify):

_____ ◯

Please answer the question below:

Based on the decisions you have made in the flowcharts for this scenario, how do you think you would feel 6 months later?

◯
Worse

◯
The same

◯
Better

THANK YOU FOR YOUR PARTICIPATION.

Appendix B

[NAME OF SCHOOL]
[ADDRESS OF SCHOOL]

[DATE]

To the principal of [NAME OF SCHOOL],

RE: Help-Seeking in New Zealand Youth

Victoria University of Wellington is currently conducting a research project on adolescent help-seeking for symptoms of depression. We have been conducting this research in youth centres in the Hawke's Bay and Wellington area, and now we are planning to extend this research to schools.

We are concerned that sometimes teenagers do not ask for help when they need it, and we are interested in when and why they consider it appropriate to seek help. In this research we hope to identify factors that prevent or encourage adolescents to ask for help.

We would like to invite your school to be part of this project. Participation will involve students (14-18 years) filling out anonymous questionnaires administered by a research assistant at your school.

If you agree to participate in the research, the following steps will be taken:

1) Consent forms will be sent out to your school. These forms will need to be taken home by the students, signed by their parents or legal guardians if they are younger than 16 years, and returned to the school.

2) After the forms have been returned, we will visit your school and administer a booklet of questionnaires. The booklet will take approximately one hour to complete.

It would be helpful for us if one person in the school, for example a teacher or a school counsellor, could be nominated as our contact person. This would allow us to liaise with that person on appropriate times and classes during which we can administer the questionnaires, and to monitor the progress of the consent forms.

We believe that this study will provide a wealth of knowledge about help-seeking and well-being of New Zealand adolescents, and it is for this reason we ask for your participation.

At the end of the study we will send a brief report to you. This research will also be made available to the Principals' Association and published nationally and internationally in journals. As a sign of our appreciation we would like to donate $2 to your school for each student participating. If you have any queries regarding this study, please feel free to contact us.

Please email or telephone us if you wish to participate in the study. If we have not heard from you within the next week, one of us will be in touch to ascertain whether you wish to participate in the study.

Yours sincerely,

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Appendix C

[DATE]

To the parents and caregivers of students attending [NAME OF SCHOOL]

RE: Help-Seeking in New Zealand Youth

My name is Kerstin Schoger and I am a postgraduate student in psychology at Victoria University of Wellington completing my master's degree. I am conducting a study on how adolescents react to the problems they encounter in life. There have been many studies concerned with how adults cope with their problems, but few studies on how teenagers cope. I am concerned that sometimes teenagers do not ask for help when they need it. I am interested in knowing when and how they consider it appropriate to seek help and what barriers they experience when seeking help. I am conducting a study on adolescents in schools in the south part of the North Island, and I would like to include your child in my study.

I would like to explain what your child will do if you give permission for him or her to participate in this study. We would ask for him or her to complete a booklet that includes measures of stress, coping strategies, and well-being (such as self-esteem and depression). Your child will also listen to an audiotape that contains fictional interactions between an adolescent and a counselor. After listening to the tape, your child will complete questions in the booklet about who they would seek help from if they were the adolescent on the tape. In other words, we will ask teenagers to imagine being in different situations and how they would respond to those situations; we will **not** ask your son or daughter to describe or discuss situations that they are actually experiencing. The purpose of this study will be to examine the thinking processes that teenagers use when they evaluate a situation where they are experiencing hypothetical difficulties. Who will they seek help from? Who will they not seek help from? What are their reasons for choosing these sources of help?

Your child would complete this booklet in a group setting in school, and they will take about 45 minutes to complete. The information your child provides will be private and anonymous. This means that all students will be seated so that they cannot see each other's responses, and they will **not** include their name or any identifying information on the questionnaire, as we would like our participants to remain anonymous. Your child will also be asked to give consent him/herself and can withdraw from the study at any time without penalty.

The measures in our booklet are commonly used and although they include a few items that assess sensitive topics such as stress and depression, they are not offensive. Over 2,000 adolescents have completed these measures in the past and we have not received complaints from children or parents. Our previous participants enjoyed completing these booklets because it gives them a chance to tell someone about things happening in their lives. If you would like to review the measures before giving permission, I would be happy to send you copies for your examination. The principal and guidance counselor(s) at your school will also hold a copy that you can view.

As a sign of our appreciation for participation, we would like your child to receive a little token (e.g., pen) and we will donate $2 to your school for each student participating in our study. The results of our study will be published in different journals, and we will also present them to your school and the Principals' Association.

I hope that this explanation is informative. Please feel free to contact me with any questions you have either by phone or email. If you wish to give permission, please complete the consent form attached and have your child return it to school. We very much appreciate you considering our request.

Yours sincerely,

Kerstin Schoger
Research Assistant
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Victoria University of Wellington
Phone: (04) 463-5401
Email: schogekers@student.vuw.ac.nz

Dr. Paul Jose
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School of Psychology
Victoria University of Wellington
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Appendix D

[DATE]

To the students attending [NAME OF SCHOOL]

RE: Help-Seeking in New Zealand Youth

My name is Kerstin Schoger and I am a postgraduate student in psychology at Victoria University of Wellington conducting my master's research. I am conducting a study on how adolescents react to the problems they encounter in life. There have been many studies concerned with how adults cope with their problems, but few studies on how teenagers cope.

Let me explain what you will do if you decide to participate in this study. I would ask you to complete a booklet that includes measures of stress, coping strategies, and well-being (such as self-esteem and depression). You will also listen to an audiotape that contains a fictional interaction between a teenager and a counsellor. After listening to the tape, I will ask you to answer a few more questions in your booklet. After looking at the answers from many students your age we will be able to determine how New Zealand teenagers cope with their problems and how this makes them feel.

You will complete this booklet with other students in your class and it will take about 50 minutes. We ask that you **do not** include your name or any identifying information on the booklet, as we would like you to remain anonymous. This means that your answers will only be traced back to you if we are concerned about your well-being. The questionnaires in the booklet are used commonly with people your age, and many students have completed these and have found them interesting.

As a sign of our appreciation you will receive a little token (e.g., pen) for your participation and we will donate $2 to your school for each student who participates. However, you can choose to stop completing the booklet at any time without penalty.

I hope that this explanation is clear. If you have any questions please call me or email me. If you wish to participate and you are sixteen years or older, please complete the consent form attached. I really appreciate you considering my request.

Yours sincerely,

Kerstin Schoger
Victoria University of Wellington
Email: schogekers@student.vuw.ac.nz
Phone: (04) 463-5401

Help-Seeking in New Zealand Youth

Consent Form

PLEASE RETURN TO YOUR CLASS TEACHER OR RESEARCHER

I would like to participate in the **Help-Seeking in New Zealand Youth** study being conducted at [NAME OF SCHOOL]. I have read the information attached to this sheet, and I understand that I will complete a booklet that includes measures about stress, coping efforts, psychological well-being, and help-seeking. I have been instructed that I can leave particular questions blank if I wish and that I may stop participation at any time without penalty.

Name: _____

Signature: _____

Date: _____

Information for Students from [NAME OF SCHOOL]

Dear Student,

I would like to thank you for being a part of this research. I appreciate the time and effort you have put into this project.

I am very interested in help-seeking in adolescents. We are concerned that many adolescents do not seek help when they are feeling emotionally distressed. We are aware that it can sometimes be difficult to ask for help, or even to know who to ask. I am very interested in knowing who teenagers turn to in times of trouble? Who are the preferred people to talk to when experiencing being blue and sad? Do teenagers tend to turn to friends or to parents? When symptoms of depression become more severe, do teenagers turn to GPs or psychologists? The information you have provided us today helps us understand when and why some adolescents feel more okay with asking for help than others. Your answers will allow us to understand these decisions better.

I would like you to know that help is available if you feel you need to talk to someone. The questionnaire and role-played scenarios that you heard may have reminded you that you're upset about something. If you feel that you do need to talk to someone about your reactions to this study or you want to talk about things that are going on in your own life at present, we suggest you contact the following people:

[SCHOOL COUNSELLOR NAME]
[CONTACT DETAILS]

Youth Line:
0800 376 633
Open between 4pm and 11pm.

These people can give you ideas as to how to help solve your problems (or emotionally deal with them) or advise you on other useful people to contact.

Again, thank you for helping us with this study. If you have any questions regarding the study, we would appreciate hearing from you.

Yours sincerely,

Kerstin Schoger
Victoria University of Wellington
Email: schogekers@student.vuw.ac.nz
Phone: (04) 463-5401

Appendix F

ID Number:
Interviewer:
Personal Introduction

Sex (don't ask):   Male / Female
What school are you at?
How old are you?
So what year at school does that make you?
And can you tell me what ethnicity are you?
Personal Introduction

Introduction
o We are interested in finding out how and when young people choose to seek help when they are having personal problems. We are interested in finding out why young people sometimes don't seek help despite struggling with life.

o Firstly, I will ask you some questions about who you seek help from, for different type of problems. Secondly, I will provide you with two scenarios of a young person who is currently experiencing issues with their life, and ask you some questions about what you think you would do if you were this person, and whether you would seek help.

o Thirdly, I will ask some questions about how comfortable you feel about friends approaching you for help, and you approaching a friend for help.

Part One
o There are different things that people choose to do when they are struggling with a problem. For example, you may read a book, use the internet or ask someone for help. 'Help-seeking' is when you go and seek support from someone else to help you with your problem. This can be from a friend or a family member, or it could be from a professional, like a doctor or a counsellor. So when I ask you about help-seeking it can be help from anyone.
o There are a number of different types of problems you can have. Such as a physical or health problem, a psychological or emotional problem, a school problem, or a relationship problem.
  o What do you think you would do if you were experiencing a physical problem (a problem with your body), for example pains in your chest or a problem with your leg?
  o What do you think are the reasons people wouldn't seek help (we call them barriers) for a physical or health problem?

  o What do you think you would do if you were experiencing a psychological or emotional problem, for example, if you were sad, or angry, or having problems coping with life?
  o What do you think are the reasons people wouldn't seek help for a psychological or emotional problem?

  o What do you think you would do if you were experiencing a school problem, for example, a problem with your school work or problems with a teacher?
  o What do you think are the reasons people wouldn't seek help for a school problem?

o What do you think you would do if you were experiencing a relationship problem with one or your friends, or maybe a parent or someone from your family?
o What do you think are the reasons people wouldn't seek help for this type of problem?

o Out of these four types of problems; physical, emotional, school and relationship problem, what type of problem do you think you would be most likely to keep to yourself and not seek help for?

Part Two

I am going to give you a scenario of young person who is experiencing some difficulties with their life. Then I am going to ask you some questions about help-seeking for these difficulties.

Please remember to tell me what you think you *would* do, rather than what you think you *should* do, because I am interested in why young people might choose **not** seek help for these problems.

A friend comes to you and described experiencing all of the following:
• Concerns that people were avoiding him/her
• Hanging out alone
• Feeling shaky, but otherwise health is okay
• Feeling sad and not liking the way he/she looks
• Difficulty concentrating

• How serious do you think this persons issues are?
  o Can you tell me on a scale of one to seven; one being not serious at all, four being moderately serious and seven being extremely serious? I have created this scale to help you decide how serious you think these issues are

• How important do you think it is to seek help for these issues?
  o *Once they have responded, get them to rate it:* Can you tell me on this scale again how important you think it is to seek help for these issues?

• And how likely is it that you would seek help for these issues if this was you?
  o *Once they have responded, get them to rate it:* Can you tell me on this scale again, how likely if you were this person, that you would seek help for these issues?

• Who do you think you would be most likely to seek help from if you were experiencing these issues?
  o *Whoever they say follow up with*: What are the good things about seeking help from this person?
  o And what about the bad things or the reasons you might not seek help from this person?

• *Then go through the four sources that we are interested in if they haven't already mentioned:* If you decided to seek help for these issues
  o Would you seek help from a friend for these issues?
  o *If they say yes:* What are the good things about seeking help from this person?
  o And what about the bad things?

- o *If they say no*: Can you tell me the reasons you wouldn't want to seek help from a friend for these issues?
- o *Wait to see what they can think up for themselves, once they are stuck:* I have a list of barriers that other researchers have found out; *present list use the language below to explain them:*

  - The problem is not serious enough
  - The person is not emotionally available (you don't feel close enough to the person or they are not sensitive enough to talk to about these issues)
  - The person it not physically available (on hand)
  - It is the wrong person to discuss it with
  - You would feel uncomfortable / embarrassed
  - You don't want to worry the person
  - You are worried about a bad response from the person

- o Would you seek help from a parent for these issues?
- o *If they say Yes:* What are the good things about seeking help from this person?
- o What about the bad things?
- o *If they say no*: Can you tell me the reasons you wouldn't want to seek help from a parent for these issues?
- o Using this list of barriers again, are there any other reasons you would not seek help from a parent for these issues? Which is the main reason for you?

- o Would you seek help from a medical person like a doctor or a nurse for these issues?
- o *If they say Yes:* What are the good things about seeking help from this person?
- o What about the bad things?
- o *If they say no*: Can you tell me the reasons you wouldn't want to seek help from a parent for these issues?
- o Using the list of barriers again, are there any other reasons you would not seek help from a medical person? Which is the main reason for you?

- o Would you seek help from a counsellor, psychologist or psychiatrist for these issues?
- o *If they say Yes:* What are the good things about seeking help from this person?
- o What about the bad things?
- o *If they say no*: Can you tell me the reasons you wouldn't want to seek help from a counsellor or psychologist for these issues?
- o Using the list of barriers again, are there any other reasons you would not seek help from a counsellor or psychologist for these issues? Which is the main reason for you?

Part Three

I am now going to ask you some more questions about seeking help from a friend, and how you feel about approaching a friend for help, or them approaching you for help. Please listen carefully as some of these questions are quite similar, if you get confused just let me know and I can repeat the question:

- How would you feel about talking to a *same sex (insert male or female)* friend about these issues? Anything else you may feel?
- How likely is it that you would seek help from a *male/female* friend on a scale of one to seven about these issues; one being not at all likely, four being moderately likely and seven being you definitely would?
- How do you think a male/female friend would feel about you approaching him/her with these issues?
- What do you think a male/female friend would say or do if you approached them with these issues?

- How would you feel about approaching an *opposite sex (insert male or female)* friend about these issues? Anything else you may feel?
- How likely is it that you would seek help from a *male/female* friend on a scale of one to seven about these issues; one being not at all likely, four being moderately likely and seven being you definitely would?
- How do you think a male/female friend would feel about you approaching him/her with these issues?
- What do you think a male/female friend would say or do if you approached them with these issues?

Now I am interested in how you would respond to a friend who *approached you* with these issues:
- How would you feel about a *same sex (insert male or female)* friend approaching you with these issues?
- How do you think a male/female friend would feel about approaching you with these issues?
- If a male/female friend came to you with these issues, what do you think would you say or do?
- How would you feel about an *opposite sex (insert male or female)* friend approaching you with these issues?
- How do you think a male/female friend would feel about approaching you with these issues?
- If a male/female friend came to you with these issues, what do you think would you say or do?

Part Four
I am going to give you another scenario of young person who is experiencing some difficulties with their life. Then I am going to ask you some questions about help-seeking for these difficulties.

Please remember to tell me what you think you *would* do, rather than what you think you *should* do, because I am interested in why young people might choose **not** seek help for these problems.

A friend comes to you and described experiencing all of the following:
- Difficulty getting on with family, teachers, and classmates
- Frequently skipping classes
- Having a long-term cold and heaps of aches and pains
- Being unable to sleep and eat
- Having stomach aches and a constant headache
- Thinking they would be better off dead

- Feeling hopeless, hating one's self, and feeling that things will not get better

- How serious do you think this persons issues are?
  - Can you tell me on a scale of one to seven; one being not serious at all, four being moderately serious and seven being extremely serious? I have created this scale to help you decide how serious you think these issues are

- How important do you think it is to seek help for these issues?
  - *Once they have responded, get them to rate it:* Can you tell me on this scale again how important you think it is to seek help for these issues?

- And how likely is it that you would seek help for these issues if this was you?
  - *Once they have responded, get them to rate it:* Can you tell me on this scale again, how likely if you were this person, that you would seek help for these issues?

- Who do you think you would be most likely to seek help from if you were experiencing these issues?
  - *Whoever they say follow up with*: What are the good things about seeking help from this person?
  - And what about the bad things?

- *Then go through the four sources that we are interested in if they haven't already mentioned:* If you decided to seek help for these issues
  - Would you seek help from a friend for these issues?
  - *If they say yes:* What are the good things about seeking help from this person?
  - And what about the bad things?
  - *If they say no*: Can you tell me the reasons you wouldn't want to seek help from a friend for these issues?
  - *Wait to see what they can think up for themselves, once they are stuck:* I have a list of barriers that other researchers have found out; *present list use the language below to explain them:*
    - The problem is not serious enough
    - The person is not emotionally available (you don't feel close enough to the person or they are not sensitive enough to talk to about these issues)
    - The person it not physically available (on hand)
    - It is the wrong person to discuss it with
    - You would feel uncomfortable / embarrassed
    - You don't want to worry the person
    - You are worried about a bad response from the person
  - Can you tell me if any of these are reasons you would not seek help from a friend? You can choose more than one. *Wait until participant responds, if they select more than one:* Out of all the reasons you have mentioned, which is the main reason for you that you would not seek help for these issues?

  - Would you seek help from a parent for these issues?
  - *If they say Yes:* What are the good things about seeking help from this person?
  - What about the bad things?

- *If they say no*: Can you tell me the reasons you wouldn't want to seek help from a parent for these issues?
- Using this list of barriers again, are there any other reasons you would not seek help from a parent for these issues? Which is the main reason for you?

- Would you seek help from a medical person like a doctor or a nurse for these issues?
- *If they say Yes:* What are the good things about seeking help from this person?
- What about the bad things?
- *If they say no*: Can you tell me the reasons you wouldn't want to seek help from a parent for these issues?
- Using the list of barriers again, are there any other reasons you would not seek help from a parent? Which is the main reason for you?

- Would you seek help from a counsellor, psychologist or psychiatrist for these issues?
- *If they say Yes:* What are the good things about seeking help from this person?
- What about the bad things?
- *If they say no*: Can you tell me the reasons you wouldn't want to seek help from a counsellor or psychologist for these issues?
- Using the list of barriers again, are there any other reasons you would not seek help from a counsellor or psychologist for these issues? Which is the main reason for you?

How do you think counselling services (both in and out of school) could make it okay and easier for young people to seek professional help?

Appendix G

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI

VICTORIA
UNIVERSITY OF WELLINGTON

[NAME OF SCHOOL]
[ADDRESS OF SCHOOL]

[DATE]

To the principal of [NAME OF SCHOOL],

RE: Help-Seeking in New Zealand Youth

Your school participated in the Help-Seeking in New Zealand Youth study conducted by Kerstin Schroger, Dr Paul Jose and myself in 2005. I am doing my Masters degree in psychology, and conducting a research project on adolescent help-seeking for symptoms of depression to build on this research. I hope to identify the factors that prevent adolescents from asking for help when they are feeling depressed. We would like to invite your school to be part of this project again.

If you decided to participate in this research, it would involve another researcher and I conducting interviews with about 10 of your students between the age of 14 and 18 years. It is important to let you know that any information a student discloses to our researchers is confidential, except in the circumstance where they disclose any symptoms of depression. In this event, the researchers would assist the student in getting support from the guidance counsellor or a clinical psychologist.

I would work with a contact person from your school to arrange the research. Due to the sensitive nature of the research, we recommend the involvement of a guidance counsellor, as they can also provide on-site support if a student finds the interview upsetting. I would work with this contact to find a good time to present information about the study, and provide interested students with an information sheet and consent form to be taken home to their parents/caregivers (please note that students over 16 years can provide their own written consent to participate in the study).

We would prefer the interviews take place at your school (e.g. in a classroom or a small space), at a time that suits both teacher/s and the students (such as lunchtime, a free period, or possibly after school).

We believe that this study will provide a wealth of knowledge about help-seeking and well-being of New Zealand adolescents. Students who participate in the study will receive a $10 book or movie voucher. We will also donate $5 to the school for each student that participates. Once the study is completed we will send you a summary of the results. This research may also be published in an academic journal; however, any information obtained from your students will be strictly anonymous.

If you have any questions, please feel free to contact us. If you would prefer I make contact with another person to discuss the study further, please let me know the appropriate person. Due to the importance of beginning research as soon as possible, if we have not heard from you within two weeks, I will be in touch by telephone to ascertain whether you wish to participate in the study.

Yours sincerely,

Phillipa Peacocke
Masters Student
School of Psychology
Victoria University of Wellington
PO Box 600
Wellington

Email: phillipa.peacocke@vuw.ac.nz

Dr. Paul Jose
Senior Lecturer
School of Psychology
Victoria University of Wellington
PO Box 600
Wellington

Email: paul.Jose@vuw.ac.nz
Tel: (04) 463-6035

Appendix H

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI

VICTORIA
UNIVERSITY OF WELLINGTON

[DATE]

To the students attending [NAME OF SCHOOL]

RE: Help-Seeking in New Zealand Youth

My name is Phillipa Peacocke and I am doing my Masters degree in psychology at Victoria University. Sometimes young people do not get the help they need for situations that trouble, worry or bother them. Unfortunately we don't know much about young New Zealanders' help-seeking for their troubles. I am interested in finding out more about this; including when young New Zealanders decide to seek help, who they would seek help from, and the reasons young people might chose not to seek help.

If you decide to take part in this study;

- You will be interviewed by a researcher at [NAME OF SCHOOL], and it will take about 30 minutes.

- You will **not** be expected to describe or discuss any of your own experiences.

- You will be asked some questions about help-seeking for various types of problems that the researcher presents to you.

- You will be given a $10 book or movie voucher for helping us with our study.

- All information you provide is confidential, that means we won't tell anyone else. The only reason we would tell anyone is if you become very upset by the interview. If this happens, we will discuss the best thing to do together, and if necessary, we can help arrange for you to see the school guidance counsellor or someone from outside your school to help you with any problems you may be experiencing.

- This interview will be audio recorded and a transcript made of it to make sure I have an accurate record of what you say. The recording is wiped once the transcript is made and your name will not be used on the transcript to protect your privacy.

If you have any questions about the study please email me. If you wish to take part and you are 16 or older please complete the Consent Form attached. If you wish to take part and you are under 16, a parent or caregiver will need to sign consent for you. However, even if your parent agrees to you taking part you do not have to, and so if you wish to participate then please complete the Assent Form attached.

Thank you for taking the time to read this.

Yours sincerely,

Phillipa Peacocke
Masters of Psychology Student
Victoria University of Wellington
Email: phillipa.peacocke@vuw.ac.nz

Help-Seeking in New Zealand Youth
Individual Consent Form (if 16 years or older)

PLEASE RETURN TO THE RESEARCHER
Please tick

☐   I have read the information about the study and I understand that I will be interviewed about help-seeking for symptoms of depression. I can choose not to answer any questions and may stop the interview at any time.

☐   I understand that the interview will be audio-recorded, but that my name will be kept confidential and this information will only be used for the purposes of the Help-Seeking in New Zealand Study.

☐   I understand the only instance when this information is not confidential is when I disclose feelings of depression to the researcher. In this situation, we will discuss what to do together, and the researcher will help me access some help for these feelings.

☐   I understand that once the interview has been written down, the audio-recording will be destroyed, and any information I have given the researcher will become anonymous (so no one will know who took part in the study).

☐   I have had the chance to ask any questions about the study.

☐   I agree to take part in an audio-recorded interview.

Name: _____

Signature: _____

Date: _____

[NAME OF SCHOOL] has agreed to participate in the study as they believe it will provide valuable research into the health and well-being of New Zealand adolescents. If you have any queries relating to the study please feel free to contact:

[NAME OF GUIDANCE COUNSELLOR]
[DETAILS]

I would like a copy of the summary of the results of this study   YES / NO

Please send summary to the following address (please write address below) or email:

_____

_____

_____

**Help-Seeking in New Zealand Youth
Assent Form (if between 14 and 16 years)**

PLEASE RETURN TO THE RESEARCHER

Please tick

☐   I have read the information about the study and I understand that I will be interviewed about help-seeking for symptoms of depression. I can choose not to answer any questions and may stop the interview at any time.

☐   I understand that the interview will be audio-recorded, but that my name will be kept confidential and this information will only be used for the purposes of the Help-Seeking in New Zealand Study.

☐   I understand the only instance when this information is not confidential is when I disclose feelings of depression to the researcher. In this situation, we will discuss what to do together, and the researcher will help me access some help for these feelings.

☐   I understand that once the interview has been written down, the audio-recording will be destroyed, and any information I have given the researcher will become anonymous (so no one will know who took part in the study).

☐   I have had the chance to ask any questions about the study.

☐   I agree to take part in an audio-recorded interview.

Name: _____

Signature: _____

Date: _____

[NAME OF SCHOOL] has agreed to participate in the study as they believe it will provide valuable research into the health and well-being of New Zealand adolescents. If you have any queries relating to the study please feel free to contact:

[NAME OF GUIDANCE COUNSELLOR]
[DETAILS]

          I would like a copy of the summary of the results of this study   YES / NO

Please send summary to the following address (please write address below) or email:

_____

_____

_____

Appendix I

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI

VICTORIA
UNIVERSITY OF WELLINGTON

[DATE]

To the parents and caregivers of students attending [NAME OF SCHOOL]

RE: Help-Seeking in New Zealand Youth

My name is Phillipa Peacocke and I am a completing my Masters degree in psychology at Victoria University of Wellington. I am conducting a study on adolescent help-seeking in the Wellington region, and I would like to include your teenager in my study.

There have been many studies concerned with how adults cope with their problems, but few studies on how young people cope when something troubles or bothers them. I am interested in knowing how and when a young person seeks help, and what barriers they experience when seeking help.

If you give permission for your teenager to participate in this study;

- Your child will be interviewed about help-seeking, it will take approximately 30 minutes and take place at [NAME OF SCHOOL]

- We will provide a scenario of a young person who is experiencing normal troubles in their life, and another scenario of a young person who is experiencing severe depression.

- The most serious statements your teenager will encounter in the depression scenario consist of "I hate myself sometimes", and "I feel like I don't have anything to look forward to in my life"

- Your teenager will be asked their opinion about whether he or she would seek help if he or she were experiencing these feelings, who he or she would seek help from, and the reasons he or she may not seek help.

- Your teenager will **not** be asked to describe or discuss situations that they are actually experiencing.

- The interview will be audio recorded and then transcribed by the researchers. Once the interview is transcribed the audio-recording will be destroyed, and any information that can identify your teenager will be removed.

- Anonymous interviews will be analysed by the researchers. These data will be kept in the locked developmental lab in the psychology department at Victoria University for up to five years. This data may be made available to other competent researchers who request access, on a case by case basis.

The information your child provides will be **private** and **anonymous**, and the research and any results will **<u>not</u>** include their name or any identifying information. Results of our study may be published in an academic journal. The only instance we will break confidentiality is if your child identifies strongly with the research material, or reports symptoms of depression to the researcher. In this situation, these feelings will be explored with the young person, and if appropriate, a plan will be made to access support from the school guidance counsellor or a clinical psychologist.

Should your child choose to participate with your consent he/she would receive a $10 movie or book voucher to thank them for participating in the study. We will also donate $5 to their school. If you are interested in receiving feedback on the results of the study please indicate this on the consent form. We will also be notifying the school of the results of this study.

If you have any questions about the study please contact my supervisor Paul Jose, or myself. If you wish to give permission for your child to participate, please complete the consent form attached and have your child return it to school. Please note that children over 16 years can provide their own consent.

Yours sincerely,

Phillipa Peacocke   Dr. Paul Jose
Masters Student   Senior Lecturer
School of Psychology   School of Psychology
Victoria University of Wellington   Victoria University of Wellington
Email: phillipa.peacocke@vuw.ac.nz   Email: paul.Jose@vuw.ac.nz
                        Phone: (04) 463-6035

Help-Seeking in New Zealand Youth

Parent Consent Form

PLEASE RETURN TO THE RESEARCHER

I have read the information concerning the proposed study and I give permission for my son or daughter to be interviewed about help-seeking for symptoms of depression. I understand that my teenager may refuse to answer any questions and may stop the interview at any time.

I understand that the interview will be audio-recorded, and confidential, and will only be used for the purposes of the Help-Seeking in New Zealand Study. However, in the instance that my child identifies strongly with the research material, or indicates symptoms of depression, the school guidance counsellor or a clinical psychologist will be advised to offer additional support. Once the audio-recording of the interview is transcribed, it will be destroyed, and any information my child has provided will be anonymous.

I have had the chance to ask questions about the research and have those questions answered to my satisfaction. I agree to _____ ____ taking part in an audio-recorded interview.

Name of Parent/Caregiver: _____

Signature of Parent/Caregiver: _____

Date: _____

[NAME OF SCHOOL] has agreed to participate in the study as they believe it will provide valuable research into the health and well-being of New Zealand adolescents. If you have any queries relating to the study please feel free to contact:

[NAME OF GUIDANCE COUNSELLOR]
[DETAILS]

        I would like a summary of the results of this study   YES / NO

Please send a summary to the following address (please write address below) or email:

Appendix J

Information for Students from [NAME OF SCHOOL]

Dear Student,

I would like to thank you for being a part of this research. I appreciate the time and effort you have put into this project.

I am very interested in help-seeking in adolescents. We are concerned that many adolescents do not seek help when they are feeling emotionally distressed. We are aware that it can sometimes be difficult to ask for help, or even to know who to ask. I am very interested in knowing who teenagers turn to in times of trouble? Who are the preferred people to talk to when experiencing being blue and sad? Do teenagers tend to turn to friends or to parents? When symptoms of depression become more severe, do teenagers turn to doctors or psychologists? When I analyse the responses of all the students who took part, the information will contribute to our understanding of help-seeking in young New Zealanders.

I would like you to know that help is available if you feel you need to talk to someone.
During the discussion you may heard or have been reminded that you're upset about something. If you feel that you do need to talk to someone about your reactions to this study or you want to talk about things that are going on in your own life at present, we suggest you contact the following people:

[SCHOOL COUNSELLOR NAME]
[CONTACT DETAILS]

Youth Line:
0800 376 633
Open between 4pm and 11pm.

These people can give you ideas as to how to help solve your problems (or emotionally deal with them), or advise you on other useful people to contact.

Again, thank you for helping us with this study. If you have any questions regarding the study, we would appreciate hearing from you.

Yours sincerely,

Phillipa Peacocke
Victoria University of Wellington
Email: phillipa.peacocke@vuw.ac.nz

Appendix K

Participant number	Gender	Age	Ethnicity	Seek friends help? Scenario 1	Seek friends help? Scenario 2	Seek parents help? Scenario 1	Seek parents help? Scenario 2	Seek medical help? Scenario 1	Seek medical help? Scenario 2	Seek professional help? Scenario 1	Seek professional help? Scenario 2
1	Male	16	New Zealand European	No	Yes	Yes	Yes	No	No	Yes	Yes
2	Female	16	Fijian Indian	Yes	Yes	No	Yes	No	No	No	No
3	Male	14	New Zealand Maori	No	Yes	No	No	Yes	Yes	Yes	Yes
4	Male	16	New Zealand European	Yes	Yes	No	No	No	Yes	No	Yes
5	Female	14	New Zealand European	Yes	n/a	No	n/a	No	n/a	Yes	n/a
6	Female	16	New Zealand European	Yes	No	Yes	No	No	Yes	No	Yes
7	Male	15	New Zealand European	Yes	Yes	Yes	Yes	No	No	Yes	No
8	Female	16	English European	Yes	Yes	Yes	Yes	No	Yes	No	No
9	Male	14	New Zealand European	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
10	Female	16	New Zealand European	Yes	Yes	Yes	Yes	No	No	No	No
11	Female	15	New Zealand European	Yes	Yes	Yes	Yes	No	Yes	No	No
12	Male	17	New Zealand European	Yes	No	No	Yes	No	No	No	Yes
13	Male	17	New Zealand European	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
14	Female	15	Pacific New Zealand	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
15	Male	16	New Zealand European/Maori	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
16	Female	14	New Zealand European	Yes	Yes	Yes	Yes	No	Yes	No	Yes
17	Female	15	New Zealand European	Yes	Yes	No	Yes	No	Yes	No	Yes
18	Female	14	Pacific New Zealand	Yes	Yes	No	No	No	Yes	Yes	Yes
19	Male	18	English European	No	Yes	No	No	No	Yes	Yes	Yes
20	Male	15	New Zealand European	No	Yes	Yes	Yes	No	Yes	No	No
21	Female	17	New Zealand European	Yes	Yes	No	No	No	Yes	No	Yes
22	Male	15	Canadian European	Yes	No	No	Yes	Yes	Yes	No	Yes
Number of participants that would seek help from source				18	18	12	15	5	16	10	15