Help-Seeking

The Science of Resilience

rrc@dal.ca

www.resilienceresearch.org

RRC - Evaluation
and Training Institute

Table of Contents

Definition

One of the earliest definitions of help-seeking was provided by David Mechanic (1975), who saw it as an adaptive form of coping. Later, help-seeking was defined as the behaviour of actively seeking help from other people, centred on communicating with others to obtain assistance or support in response to a problem or distressing experience. As such, it was a form of active and problem focused coping, which relied on external assistance from other people. (Rickwood et al, 2005). A working definition that encompasses many of those ideas comes from Rickwood & Thomas (2012), who define help-seeking as a process that serves an effort to achieve understanding, guidance, treatment and support when experiencing a problem, feeling troubled, or when encountering stressful circumstances. Help-seeking defined in this way represents an active, adaptive, and directed process. It might include help sought from formal services, such as counsellors and medical staff, or informal sources, such as peers or family members (Rickwood & Thomas, 2012). As Rickwood & Thomas (2012) note, help-seeking can therefore technically now include assistance from sources that do not comprise communication with an actual person, as sophisticated and dynamic help-seeking options are increasingly available through online and computer-mediated processes, making an interpersonal component less critical. However, they and other researchers (c.f., Cornally & McCarthy, 2011) also note that self-help behaviour might signal the start of the help-seeking process that involves next steps of engagement or collaboration with others – the interpersonal component - in seeking out help or support.

Central to these definitions of help-seeking is the notion that it is a problem-centered process, that a person is actively responding to some stressor or event, and that the initiating and resulting actions are all based on their interpretation of the identified problem. This therefore emphasizes the role of the help-seeker as *not* passive in their response and frames the activity of help-seeking as very intentional (Cornally & McCarthy, 2011). Within the context of general help-seeking lies three very distinct elements: the recipient, the helper, and the problem (Cornally & McCarthy, 2011; Nadler, 1987). It is also characterized by three very distinct attributes: it is problem-focused, it involves intentional action, and it promotes interpersonal communication (Cornally & McCarthy, 2011). Help-seeking is therefore a complex process that begins as an interpretative response to a certain problem that cannot be solved or improved on alone, and involves some purposeful pursuit, communication, interaction, and engagement with another party as a means of support to help remedy or solve the issue at hand.

Problem solving is fundamental to help-seeking, because without first identifying or defining what the issue or problem is that causes distress, no help can be realized, offered, or given. Some might seek help after failing to solve a problem on their own, while others might seek help as an immediate first response; regardless, every person who either formally or informally seeks help is seeking assistance with a problem that challenges their personal

abilities or capacities (Cornally & McCarthy, 2011). Both a problem focused lens and actively seeking help in a purposeful way are crucial to help-seeking behaviour (Liang et al, 2005; Rickwood et al, 2005). In seeking help, a person is acting intentionally and with agency, which is very distinct from *receiving* help from others (Cornally & McCarthy, 2011). Verbalizing or communicating the problem to another person is an important step in problem solving. However, according to Hinson & Swanson (1997), help-seeking necessitates information disclosure that may be uncomfortable for a variety of personal and cultural reasons. A lack of willingness related to interpersonal openness or a desire to disclose can discourage or negate help-seeking behaviour (Cornally & McCarthy, 2011).

Formal sources of help-seeking are generally categorized in the literature as primary and secondary care, such as medical and mental health professionals, and tertiary or community based care, such as non-profit organizations, guidance counsellors, or employee assistance programs (Clement et al, 2015; Cornally & McCarthy, 2011). However, informal social networks are often described as the first source of help which may influence or determine when or if more formal help is sought. Despite their importance, sources of help such as friends and family are often neglected in the literature, and greater value is placed on formal supports (Clement et al, 2015; Cornally & McCarthy, 2011).

Despite a large body of literature that focuses on the predictors of help-seeking, it is important to note some limitations to these studies. A widely accepted definition of help-seeking is not always clear and can lead to issues of validity (Clement et al, 2015; Nagai, 2015; Xu et al, 2018). The most important limitation is that few studies under review have focused on actual help-seeking processes and instead use help-seeking intentions as their measure. The General Help-Seeking Questionnaire (GHSQ; Wilson et al., 2005), widely used as a measurement tool of help-seeking in many studies, is designed to measure intentions to seek help from formal sources, such as mental health practitioners, and informal help, such as family members and friends (e.g., Wilson et al., 2005). According to the theory of planned behavior (Ajzen, 1991), behavior is mainly determined by behavioral intentions, which may explain why using help-seeking intentions as a measure of help-seeking behaviour has become broadly accepted by researchers. Nevertheless, help-seeking intentions are not the same as help-seeking behaviour. While measuring help-seeking intentions has certain advantages, it would helpful for more researchers to distinguish between studies that focus solely on help-seeking intentions as opposed to actual help-seeking behavior (Nagai, 2015). There is a danger of measuring different aspects of help-seeking (such as intention or even successful resolution) but grouping all findings under an umbrella category of help-seeking behaviour.

Theories of Help-Seeking

Several theories and models have been applied to help-seeking in an effort to better understand intentions and behaviour, but as Gulliver et al (2012) note, none have been widely accepted within the research community. Three of the most common include the Theory of

Planned Behaviour, the Health Belief Model, and the Behavioural Model of Health Services Use (Clement et al, 2015; Gulliver et al, 2012; Xu et al, 2018). The Theory of Planned Behavior (Ajzen, 1992) is concerned with how attitudes, subjective norms, and perceived control over the behaviour interact to influence intentions, and ultimately the resulting behaviour itself. This theory has been applied to good effect in understanding how masculinity norms may influence men and boys' help-seeking behaviour (Smith et al., 2008). The Health Belief Model states that the decision to perform a behaviour is dependent on the individual's appraisal and understanding of the perceived threat they face, and the perceived barriers and benefits of the behaviour. The Health Belief Model has previously been used as a framework for understanding mental help-seeking behaviour in the general population (Henshaw & Freedman-Doan, 2009). In order to achieve and encourage optimal behavior change around attitudes of health and mental health in the general population, research shows that messaging that targets perceived barriers, benefits, self-efficacy, and threat would prove most helpful (Jones et al, 2015). Finally, the Behavioral Model of Health Services Use (Anderson, 1995) describes a 3-stage model for health services that includes predisposing characteristics such as the individual's demographic information and beliefs, enabling resources such as cost and access to care, and illness level, which together is interpreted as the individual's perceived and evaluated need for help. This model has been applied to treatment-seeking for panic attacks in adults through community-based mental health services (Goodwin & Anderson, 2012).

Help-Seeking vs Health-Seeking

In reviewing the available literature, help-seeking behaviour at times seemed to be conflated with health-seeking behaviour, and this is problematic for a number of reasons. The Nursing Outcomes Classification defines health seeking behaviour as personal actions to promote optimum wellness, recovery, and rehabilitation (Cornally & McCarthy, 2011). In a literal sense, health seeking behaviour means to seek good health. Health-seeking behaviour can therefore occur with or without a health problem, and ranges from the potential of developing or contracting an illness or a disease to an actual symptomatic stage of a potential health problem or crisis. Health-seeking behaviour has a strong relationship to health promotion, which are processes aimed at preventing or postponing the advent of a disease, such as healthy lifestyle changes related to stress, exercise, or diet to help prevent things like heart disease or diabetes (Bish et al, 2005, Lauver, 1992). Lifestyle changes as part of health seeking can be independently driven and occur without external assistance, whereas help-seeking relies on interpersonal relationships with a helper. Health-seeking behaviour can occur in an asymptomatic state (i.e., without the presence of symptoms), is not dependant on problem-solving, and can occur for both an actual and a potential problem (Cornally & McCarthy 2011), unlike help-seeking.

Help-Seeking in Context

The relationship between a person's racial or ethnic background and their social class, level of education, minority status, exposure to racism, discrimination, misogyny or homophobia, geographic location, and religious affiliation and spiritual beliefs can all have important implications for help-seeking behavior (Fuller et al., 2000; Ungar et al, 2008; Vogel et al., 2004). For instance, studies show that, in general, people of African, Asian, and Spanish descent and other ethnic minority groups are less likely to access supportive counseling or mental health services (Vogel et al., 2004). In an exploratory study by Cadaret and Speight (2018), 120 men who identified as Black, African American, or biracial were interviewed relative to their help-seeking beliefs. Internalized stigma, or self-stigma, was a significant impediment to help-seeking. The study's authors highlighted the importance of professional helpers being mindful that, for men of colour, seeking psychological help likely meant also overcoming significant personal and cultural barriers. In a focus group study with Black college students in the US, Watkins et al (2010) identified that for Black men, the quality of mental health care received, beliefs about coping (e.g., "handle the problem on my own"), limited ways of coping with stress (such as substance use), and poor social support or social networks were all deterrents to seeking and receiving quality mental health care. Minority communities sometimes lack more immediate knowledge of available services and resources, while others face stigma associated with formal help-seeking due to cultural expectations or spiritual beliefs that may expressly forbid it, discourage it, or demand a reliance informal supports (Vogel et al., 2004). Studies with Asian Americans note a lack of knowledge and awareness regarding services, either because of continued stigma associated with formal help-seeking or because of cultural prescriptions against it (Magaard et al., 2017; Masuda et al., 2009).

Dropout rates from formal services related to help-seeking, particularly among African Americans/African Canadians are statistically quite high for both youth and adult populations following a first encounter in counselling. Exposure to racism and discrimination, including experiences of generational trauma, can serve to make a prospective client distrustful of providers of a different race or ethnicity (Magaard et al., 2017; Masuda et al., 2009). Once racial and ethnic minority persons do seek the help of a counseling professional, the available services they encounter propose Western, middle-class values of individuality, self-disclosure, self-awareness, and self-improvement – something that is often mismatched with their cultural beliefs. A mixed methods systematic review of ethnic minority women's experience with perinatal mental health in Europe by Walker et al, (2007) demonstrated how cultural expectations, lack of awareness about mental illness, ongoing stigma, culturally insensitive and fragmented health services and interactions with culturally incompetent and dismissive health providers all have significant impact on women's ability to receive adequate support. As a result, the majority of women in these studies are left isolated and suffering in silence. Low-income racial and ethnic minority people can often be referred by legal or medical procedures, school systems, or others to receive counseling (as opposed to self-referral). Frequently,

counseling is forced upon them and mandated as a means of social control, and sometimes offered as an alternative to jail or the threat of termination of parental rights. Studies show the threatened removal of children without compliance is disproportionately a salient issue affecting women of colour (Magaard et al., 2017). Not so surprisingly, people referred to services by others and those mandated or forced into treatment often drop out of services at higher rates than self-referred or voluntary clients, often due to a lack of knowledge about, lack of preparation for, or distrust and unease regarding the counseling process. As a result, a growing body of literature suggests that conventional services do not respond adequately to the values, needs, and cultural characteristics and preferences of racial and ethnic minorities (Alegria, 2002; Ungar et al, 2008; Vogel et al., 2013).

The literature on adolescent mental health service use indicates a relationship between economic capital (i.e., access to wealth and resources) and processes of help-seeking (Pinxten and Lievens, 2014). For example, young people from families of low income have a much higher risk of suicide when a mental health problem is present than those from higher-income families, something that is likely attributed to the way economic capital influences access to quality care (Wei, Kutcher, & Szumilas, 2011). Further to that point, another Canadian study of secondary-school based help-seeking behaviour found that the quality of care and wait times for publicly funded mental health resources can be critical barriers to help-seeking behaviours for adolescents and their families. Therefore, those with access to wealth and resources have increased capacity to by-pass the public system and access private mental health care services while those without are at risk of falling to the wayside.

There are gender differences in relation to help-seeking, with a good deal of data suggesting that dominant or hegemonic masculinity plays a role. Men are at higher risk of suicide, something that is often associated with men being less likely to seek help for mental health difficulties (Addis & Mahalik, 2003; Courtenay, 2000). Men tend to hold more negative attitudes toward the use of mental health services compared to women (Addis & Mahalik, 2003). Many men and boys, particularly those that subscribe to more rigid adherence to masculine norms such as being strong, stoic, and not in need of help, show much less willingness to seek or accept mental health support (Fisher & Goodwin, 2007). These attitudes are clearly reflected in low service use for men and boys in accessing formal services, which is consistently observed, particularly across Western countries (Courtenay, 2000; Fisher & Goodwin, 2007; Nam et al., 2010). Research data show that a large percentage of counseling relationships are initiated at the request of women, and women constitute by far the largest percentage of clients in counseling (Hill & Needham, 2013). This may be due to a variety of reasons, including different cultural patterns of emotional expressiveness and the specific roles traditionally held by women in taking more of the onus and responsibility for the relational and emotional needs of the family (Hill & Needham, 2013). From this point of view, counseling might arguably be considered more valuable to women because through its foundation of emotional expressiveness and openness to vulnerability, therapy is something that masculinity and masculine constructs might otherwise dismiss or reject. Some men, particularly in

patriarchal or hierarchical family structures, might consider talking to a stranger about intimate matters a sign of weakness, incompetence, or lack of control and something that stands in stark contrast to his construction of masculinity (Courtenay, 2000; Fisher & Goodwin, 2008; O'Neil, 2013).

Key to understanding help-seeking is the acknowledgement that these factors cannot be understood in isolation but in context with other variables (Cornally & McCarthy, 2011; Gulliver et al, 2010; Ungar et al. 2008; Vogel et al, 2013). For example, an African middle-class queer woman may approach and understand help-seeking in a starkly differently way than a white lower-class heterosexual male, and therefore care responses need to be different in order to be successful. Once clients seek help, it appears that a major factor that contributes to positive outcomes is a perceived congruence between the values of the provider of counseling services and of the client seeking help. How providers of counseling services react to the different variables involved in help-seeking behaviors, attitudes, and expectations can greatly affect the outcome of both help-seeking and the counseling relationship.

Relationship to Resilience

In reference to health and mental health, resilience may refer to the ability to avoid illness despite adversity and to strive and function above the norm when dealing with a chronic condition (Smith et al., 2008). Resilience can be measured by examining whether people are able to revert back to a previous state of functioning following a stressful incident or event, if people are able to move to a higher level of functioning to compensate, or if they are able to adjust to or overcome a new or stressful situation (Smith et al., 2008). Help-seeking would therefore be an important part of measuring resilience. There are many resilience theories that focus on a specific population (athletes, medical students, families, communities/organizations), and many of those focus on formal help-seeking with professionals. These theories share many common features in that resilience is viewed as a dynamic process that changes over time and involves many different individual factors (Fletcher & Sarkar, 2013; Ungar et al., 2011).

Appropriate help-seeking is regarded as an adaptive mode of coping with concerns or problems that can serve to buffer a person's reaction to stress and lead to reduced emotional problems and overall healthier outcomes (Fallon & Bowles, 2001). Rickwood et al (2005) note that the help-seeking behaviours of young people are fundamental to their mental health and wellbeing, and that help-seeking can have a positive impact across the lifespan. In addition, the literature is clear that help-seeking is an important factor in growth, learning, and development (c.f., Boekaerts et al, 2000). Therefore, acquiring appropriate help-seeking behaviours is an important and adaptive life skill for children and young people that can build resilience.

When examining the relationship between help-seeking and resilience, the role of informal help-seeking must also be carefully considered. Looking at a large cross section of

college age students across the United States, it was commonly reported that instead of receiving formal treatment for a mental illness, more than 78% of students preferred to turn to informal supports such as family (52%) and friends (67%) (Eisenberg et al., 2011) In addition to utilizing informal supports such as family and friends, Moreno et al. (2011) found that students often used social networking sites, such as Facebook or Instagram, as a means of reaching out to friends and family for help. In one particular study, an analysis of 200 Facebook profiles from undergraduate students revealed that 25% of students used the "status update" function to publicly display content and express feelings that were consistent with anxiety and depressive symptoms. Informal help-seeking can serve therefore as potentially a first step or a barrier to formal help-seeking which has important implications for resilience. Although it is not clear in the literature if people who seek informal help share similar or different characteristics from those who automatically turn to formal help-seeking (Wilson et al., 2011).

Positive social support has been linked to higher self-esteem and self-efficacy and has been viewed as a buffer or protective factor to the negative effects associated with stress (Eisenberg et al., 2011; Gulliver et al., 2012). A lack of social support can be linked to mental illness by way of social isolation (Wilson et al., 2011). However, the literature demonstrates that the relationship between social support and mental health help-seeking requires more understanding. Previously, low levels of social support have been associated with formal help-seeking behaviour, but other research suggested the opposite, that high levels of perceived social support were associated with formal help-seeking behaviour as individual were encouraged or assisted in accessing more professional levels of support (Schomerus et al., 2013). Individuals with large social networks appear to seek help more often from informal resources than those with lower levels of social support. However, individuals with fewer supports may compensate by connecting with others who have similar interests. For instance, extracurricular activities may enhance one's social network, and thus, increase the number of potential resources

Facilitators of Help-Seeking

In an effort to understand and facilitate psychological help-seeking, a large body of research has focused on help-seeking barriers (Clement et al., 2015; Nam et al., 2013). Although studies examining barriers have led researchers and clinicians to insights about the characteristics, attitudes, and beliefs that should be reduced to help facilitate psychological help-seeking behaviors, researchers have relatively little information about the positive psychological factors that could facilitate this process (McDermott et al., 2017). Comparatively little research has examined informal sources of help-seeking (Rickwood, 2012), yet as noted earlier, research suggests people are more likely to seek help from informal sources than formal sources.

Some research shows that, just as negative past experiences can serve as barriers to seeking help, positive past experiences act as a facilitator. Studies show that those previously helped by a professional or who had a generally positive experience are more likely to intend to seek help in the future. In terms of professional help-seeking, knowledge of what professional help-seeking is likely to involve is also a significant facilitator. Knowledge of available services, as well as what to expect from different types of services, has significant impact on help-seeking behaviour and the ability to navigate complex systems (Gulliver et al., 2012; McDermott et al., 2007).

Research indicates that individuals experience varying amounts of social encouragement along their pathways to both health and mental health care. Seeking help is therefore clearly related to developmental processes and, consequently, different sources of help are more or less important at different stages of the lifespan. For instance, parents, teachers, and peer groups are a common influence for children and adolescents, and partners, friends, family doctors/general practitioners can have important influence on adults. Intimate partners appear to be especially important in influencing adult men towards help-seeking behaviour (Kirkwood et al., 2012). Alternatively, more anonymous forms of help-seeking that rely less on active social engagement, such as phone help-lines and, even more so, help-seeking using the internet, may be particularly effective for young people who are avoiding social contact and consequently not seeking needed help (Gulliver et al., 2012).

While many factors have been found to deter youth from seeking help, variables such as social support, increased psychological distress, greater adaptive functioning, and fewer perceived barriers have been identified as increasing adolescents' willingness to seek help for mental illness (Sheffield et al., 2004). For instance, help-seeking increases as problems or symptoms increase in intensity; therefore, distress is believed to motivate adolescents enough to overcome barriers to help-seeking (Gulliver et al., 2012). Another personality trait that affects help-seeking behaviour is openness to experience which may be understood as the ability to adjust personal beliefs and behaviour when exposed to new information or ideas. Those who are open to new experiences tend to exhibit more positive attitude toward seeking professional psychological help because it fulfils their need for curiosity (Perenc et al., 2016).

Like many other behaviours, habit and mastery are essential for effective help-seeking (Rickwood, 2005). Children need to have graded mastery experiences early in life, showing that seeking help is appropriate and necessary and can be effective in enabling them to deal with the inevitable adversities and confusing emotions they may experience. Therefore, framing help-seeking as an important life skill that needs to be learned, mastered, and used as needed is a strong facilitator to future help-seeking behaviour (Rickwood, 2005). Reframing help-seeking as a sign of strength and as a preventative action has also been explored as a way of increasing help-seeking. Indeed, seeking help to help one support or look after others has been observed as a motivator for help-seeking behaviour (Kiselica & Englar-Carlson, 2010). Some research suggests reconsidering the context in which we use help-seeking in language. For

example, an implication of seeing depression and anxiety as weakness is that 'help-seeking' can be seen as an indication of failure to 'handle the problem' as an individual. Reframing the activity of help-seeking in a more empowering way, such as 'taking action' or 'taking control' will likely resonate more strongly in those seeking help (Beyond Blue, 2020; Kiselica & Englar-Carlson, 2010).

A summary of studies that have examined the relationship between resilience and help-seeking:

Mental illness stigma, psychological resilience, and help-seeking: What are the relationships?

Crowe et al. (2015) conducted a qualitative study in the U.S. using a focus group design which explored the relationships between stigma, resilience, and help-seeking. Participants included 8 med and 9 women between the ages of 27 and 65, fifteen of which were Caucasian and two African American. In order to increase trustworthiness and dependability of the research, the research team met after the data were analyzed to discuss the findings, seek agreement, and negotiate differences in interpretation of the findings. This process of triangulation was completed as a way to enhance the credibility of qualitative methodology. Three main themes related to stigma, resilience, and help-seeking emerged: stigma leads to decreased help-seeking and decreased resilience, help-seeking leads to stigma and lowered resilience, and help-seeking leads to increased resilience and decreased stigma. Limitations discussed by the authors included a largely Caucasian sample who generally held positive views of mental health treatment before participating in the study. Furthermore, most had some experience with mental illness and seeking professional mental health help, either personally or with a family member. This familiarity with mental illness and help-seeking might have influenced attitudes expressed, so they noted that in the future research should include those without previous experience related to seeking mental health treatment.

Evolution of public attitudes about mental illness: a systematic review and meta-analysis

Schomerus et al. (2012) conducted a systematic review in Germany of studies on mental illness-related beliefs and attitudes in the general population published before 31 March 2011, examining the time trends of attitudes with a follow-up interval of at least 2 years and using national representative population samples. A subsample of methodologically homogeneous studies was further included in a meta-regression analysis of time trends.

Initial database search identified 7360 potentially relevant documents. Exclusion of duplicates, of documents not dealing with attitudes of the general population, and of documents not based on representative population samples yielded 559 potentially relevant reports, 102 of which written in a language other than English. Except for one study, sample sizes were generally >1000 respondents, but owing to splitting of samples in studies examining different conditions or using male/female case vignettes, subsample sizes varied from 230 to 6000. Studies reported response rates from 65% to 85%.

Amongst the findings, two distinct developments emerged: first, the public's literacy about mental disorders has increased. Second, at the same time, attitudes towards persons with mental illness have not changed for the better, and in many cases have even deteriorated, particularly towards persons with schizophrenia. Findings also demonstrated a robust inverse association or negative relationship between resilience and help-seeking. The authors believed it was possible that resilience, which is protective against depression in non-depressed respondents, may pose an obstacle to effective help-seeking in those who finally become depressed because of the negative influence of one's desire or intention, as a resilient person, to "tough it out" and deal with the problem alone.

The help-seeking experiences of Irish emigrant survivors of ICA

An empirical study from Ireland (Moore et al, 2015) set out to illustrate the help-seeking experiences of survivors of institutional childhood abuse. Twenty-two survivors participated in semi-structured interviews. All participants self-identified as having experienced abuse and/or neglect in industrial schools or reformatories in Ireland. Participants ranged from 53 to 67 years of age. All participants were born in Ireland and migrated to the UK in their late teens or early twenties. The data were analysed thematically allowing key themes to emerge. As a result of negative initial help-seeking experiences, most participants engaged in long periods of self-management and only disclosed information about their childhood later in life. Help-seeking from trusted peers and peer support networks played an important role in pathways towards formal interventions. Participants identified several interpersonal barriers to formal help-seeking, such as professionals' failure to share control, insensitivity to identity loss, and the lack of confidentiality.

The authors noted one serious limitation to the study was the low number of male participants (n=2), which they believed was reflective of the challenges that service providers face in engaging with males who experienced institutional abuse. They noted that their comprehensive review of the literature on men's distress shows that the dominant narrative in the literature is that men are reluctant to seek help and that an ongoing and potentially harmful narrative related to silence around men's distress assumes that men do not require more support.

Resilience and attitudes toward help-seeking as correlates of psychological wellbeing among a sample of New Zealand Defence Force personnel

Hom et al. (2020) conducted a major study that examined associations between various indices of psychological wellbeing, resilience, and help-seeking stigma among New Zealand Defence Force (NZDF) personnel (*N* = 2,805). To reduce participant burden, the NZDF Defence Health Directorate used abbreviated measures, noted below, to assess several of their constructs of interest. The Brief Resilience Scale (BRS; Smith et al., 2008) is a 6-item self-report measure designed to assess resilience. An abbreviated 2-item version of the 8-item Flourishing Scale (FS) was utilized for this study. The full-scale FS was designed to assess overall

psychological flourishing. For this study, participants were asked to rate the degree to which they agreed with the following statements: "I lead a purposeful and meaningful life" and "My social relationships are supportive and rewarding" on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree). These FS items were selected for inclusion in this study to enhance coverage of facets of wellbeing assessed by the survey battery. A single item was used to assess past-year engagement in help-seeking behaviors. Participants were asked to indicate if they had sought help in the past 12 months for "concerns about their mental health and wellbeing" (0 = No, 1= Yes). The main investigation included a single-item assessment of overall mental health. Participants were asked to rate their average level of mental health, involving thoughts, feelings and emotions" in the past four weeks on a scale from 1 (Very Low) to 10 (Very High). Higher scores on this item indicate better past month overall mental health. This item was designed as a brief index of overall wellbeing for use in the main investigation. The Perceived Stigma and Barriers to Care Scale (PS) is an 11-item self-report assessment of stigma and structural barriers to care for mental health problems. The main investigation included 5 items from the 6-item PS Stigma subscale. For this study, these 5 items were used as an index of perceived stigma (i.e., perceptions of others' negative attitudes about one seeking care).

Findings indicated that greater BRS resilience ($pr^2 = .157$, $p < .001$), lower personal help-seeking stigma ($pr^2 = .038$, $p < .001$), and lower PS perceived help-seeking stigma ($pr^2 = .015$, $p < .001$) were each uniquely, significantly associated with FS psychological flourishing, controlling for the effects of each other and past-year help-seeking. Furthermore, greater BRS resilience ($pr^2 = .064$, $p < .001$), less personal help-seeking stigma ($pr^2 = .035$, $p < .001$), and less PS perceived help-seeking stigma ($pr^2 = .013$, $p < .001$) were each uniquely and significantly associated with better overall mental health, controlling for the effects of each other and past-year help-seeking. Not seeking help in the past year was also uniquely and significantly associated with better overall mental health, controlling for all other predictors ($pr^2 = .031$, $p < .001$)

Overall, greater resilience and a lower degree of help-seeking stigma were each significantly associated with better psychological wellbeing (i.e., greater psychological flourishing, less psychological distress, and better overall mental health). Though effects were relatively small, engagement in help-seeking behaviors moderated the relationship between (1) greater resilience and less psychological distress and (2) greater resilience and better overall mental health, such that these relationships were stronger among those who had sought help for their mental health in the past year. Findings suggest that greater resilience and less mental health help-seeking stigma may independently contribute to better psychological wellbeing among NZDF personnel; thus, enhancing resilience and reducing help-seeking stigma may serve to promote psychological wellbeing in this population. The authors believed that improving resilience among NZDF personnel who seek help, in particular, may contribute to better psychological wellbeing.

Interventions

A systematic review of the literature around help-seeking behaviour in adolescents and adults demonstrated some specific ways and means of encouraging or improving help-seeking. The most common interventions noted were to improve mental health literacy, particularly for youth, and to provide detailed psychoeducation around illness, risk, and supports. Combatting stigma was also key – and in many cases connected to mental health literacy – and was important in removing barriers to help and services. Addressing stigma related to mental health could be done through media campaigns and the encouragement of more open, frank discussions. For adolescents, teachers could encourage help-seeking while destigmatizing mental illness. Experiences with racism and discrimination also greatly impacted help-seeking behaviours, as did cultural and language barriers. Low self-esteem leading to poor self-efficacy was also common, particularly among adults. Availability of resources including money to access services, transportation, and childcare concers, also had significant ramifications on people's ability to address their health care needs (Cornally & McCarthy, 2011; Gulliver et al, 2012; Haavik, 2019; Xu et al., 2018).

Using six randomised controlled trials of help-seeking interventions for depression, anxiety, and general psychological distress, with participants' ages ranging from 17 to 79, Gulliver et al. (2012) found a number of barriers to help-seeking for mental health problems. These include stigma and embarrassment, problems recognising symptoms (poor mental health literacy), and a preference for self-reliance. These were prominent themes in both the qualitative and quantitative literature. However, there was some evidence that positive past experiences may serve to increase mental health literacy. Social support and encouragement from others may also reduce the stigma of help-seeking. In considering the needs of adolescents and young adults, strategies for improving help-seeking need to address young people's desire for self-reliance. One potential approach involves the provision of evidence-based psychoeducation related to mental health. A second proposed approach involves providing a structured program with evidence-based learning modules designed to increase the young person's mental health literacy, and in particular to increase their knowledge of their own symptoms. A final approach involves the provision of programs (that might include psychoeducation and activity-based learning) to young people that are designed to reduce the stigma associated with mental illness and mental health help-seeking.

A systematic review and meta-analysis by Xu et al. (2018) examined databases from England, Germany and China of adult help-seeking. Their findings showed how certain interventions yielded significant short-term benefits in terms of formal help-seeking and self-help, as well as mental health literacy and personal stigma. It also noted some positive long-term effects on formal help-seeking behaviours. The most common intervention types were strategies to increase mental health literacy and de-stigmatization (both had positive short-term effects on formal help-seeking behaviours), as well as motivational interviewing skills used

with clients in professional settings to increase and promote formal help-seeking behaviours and feelings of self-efficacy (with positive long-term effects on formal help-seeking behaviours). These interventions improved formal help-seeking behaviours if delivered to people with or at risk of mental health problems, but had less statistically significant effect among children, adolescents, or the general public. There was also no evidence that interventions increased informal help-seeking.

The Resourceful Adolescent Program

Studies have repeatedly demonstrated the high prevalence and harmful effects of depression during adolescence (Goyal et al., 2009; Haarasilta, 2004). As a result, a high priority for mental health research is to develop cost-effective prevention programs for depression in adolescents. A debate exists around whether to implement universal programs that involve whole populations, selective programs that involve adolescents with a known population risk factor (e.g., childhood trauma, a parent with a serious mood disorder) or indicated programs that involve individuals showing mild to moderate signs or symptoms of a disorder. Each method has advantages and disadvantages. Universal prevention programs have been criticized for being too expensive to mount, while the others raise ethical issues of labeling and stigmatizing, as well as potential low participation and retention rates (Shochet et al, 2001). The Resourceful Adolescent Program (RAP), developed by Shochet, Holland, & Whitefield in 1997, was intended to address this need, planned as an11-session program targeting early high school students and implemented in the classroom as part of the school curriculum. A three-session parallel program for parents was designed, with the main goal to address the risk factor of severe family conflict and explore the protective factors of a responsive parent–adolescent relationship. RAP focuses on building resilience and enhancing strengths rather than on identifying deficits. The programme integrates elements of cognitive behavioral therapy (CBT) such as stress management, problem-solving, and cognitive restructuring, with elements of interpersonal therapy, such as building personal support networks, preventing and managing conflict, and taking the perspectives of others. The overall aim of RAP is to support participants in developing strategies to maintain or recover positive self-esteem in the face of stress. A study on the efficacy of RAP (Shochet, 2001) reported significantly lower levels of depressive symptomatology and hopelessness at post-intervention and 10-month follow-up, and a retention rate of 88%.

TextToday pilot program

A multi-method evaluation was conducted by Evans et al. (2012) to assess the TextToday pilot program, the first crisis line in the US with the capacity to accept text messages. The TextToday program was developed between the Nevada Crisis Call Center, Educational Messaging Systems, and the Nevada Office for Suicide Prevention. Objectives of the evaluation included how successful the system was in meeting the needs of underserved youth and how

effectively the social marketing campaign reached the target population with information about the texting crisis service.

Depression and suicidal behaviors among youth are a major public health concern, with suicide as the third leading cause of death among 15–24-year-old age group in 2008, and accounting for 4,298 deaths in that population each year (Centers for Disease Control and Prevention, 2011). Approximately 1.5 million students attempt suicide and another 2.9 million seriously consider committing suicide each year (Eaton et al., 2005), highlighting the need for a continuum of services to help identify at-risk youth so they might receive early and immediate help when in crisis. Suicide and crisis hotlines serve as an effective and inexpensive service to help de-escalate individuals in crisis and direct them to resources. Hotlines have been found to significantly reduce caller's feelings of hopelessness and crisis as well as their likelihood of attempting suicide (Gould et al., 2007). Although suicide/crisis hotlines have a long history as one of the most frequently utilized and effective services for adults in crisis, research shows adolescents and young adults do not generally access them at high rates. For example, in Nevada, only 2%–3% of the nearly 100,000 calls to the Crisis Call Center from 2005–2008 were from individuals aged 5–18 years (Evans et al, 2009). These statistics parallel those reported by other call centers across the country (e.g., Gould et al, 2007), and yet youth who use hotlines are almost always positive about their experiences (e.g., King et al, 2003). Low use rates indicate the need to enhance the connection of crisis services to youth. In the last decade, text messaging has become the dominant form of communication among 12–17-year-olds, with youth report that texting is a more immediate, private, and comfortable way of communicating than calling or talking face-to-face (Evans et al., 2009). In an effort to increase youth help-seeking behaviors by creating a service that uses a communication medium that youth prefer, Educational Messaging Services (EMS), the Crisis Call Center, the University of Nevada, Reno, and the Nevada Office of Suicide Prevention worked together to develop one of the nation's first crisis lines with the capacity to accept text messages.

Evaluation findings from the TextToday program reveal that this text-based crisis line has increased help-seeking behaviors of adolescents and young adults. By the spring of 2012 over 300 youth per month were accessing the system for support, representing a sharp monthly increase in youth contacts to the Center over the previous 5-year period. More than half of all texts into the system during the pilot were by "repeat texters," those who texted in more than one time, with some youth texting in as many as nine times within a 2–3-month period. A social media marketing campaign in Nevada schools advertised the new service to area students and was generally effective in encouraging them to engage (Evans et al., 2012).

Assessment

The following is a list of measures designed to consider help-seeking in adolescents and adults. As noted previously, some focus on help-seeking intentions while others consider the

overall help-seeking process. This information has been adapted generally from systematic reviews on measures conducted by Divin et al. (2018), Rickwood et al. (2012) and White et al. (2018).

Attitudes toward Seeking Professional Psychological Help Scale (ATSPPHS; Fisher & Turner, 1970) and the ATSPPHS – Short Form (Fischer & Farina, 1995; Appendix A)

The Attitudes toward Seeking Professional Psychological Help Scale (ATSPPHS), developed by Fischer and Turner in 1970, is composed of 29 items designed to assess general attitudes toward seeking professional psychological help for psychological problems and issues. The full scale has four factors: recognition of personal need for psychological help (8 items); stigma tolerance associated with psychological help (5 items); interpersonal openness regarding one's problems (7 items); and confidence in mental health professionals (9 items). Items are rated on a 4-point Likert-type scale ranging from (0) *disagree* to (3) *agree.* Items include, "If I believed I was having a mental breakdown, my first thought would be to get professional attention". Despite being widely used and credited with bringing more consistency to the examination of attitudes towards mental health help-seeking, there were a number of conceptual and methodological concerns noted in the scale that called for revisions (MacKenzie et al., 2004). For example, the standardization sample used in establishing the study was entirely made up of students under the age of 19, and therefore not representative of the range of people who might use mental health services. As well, initially the instrument only referred to psychiatrists and psychologists as mental health professionals and exclude other disciplines, including family physicians who were often described as a starting point in seeking help (MacKenzie et al., 2004). In revising the scale in 1995, Fischer shortened the form to 10 items (Attitudes toward Seeking Professional Psychological Help Scale – Short Form or ATSPPHS-SF) to accommodate what he described as simpler and more unitary measure of help-seeking (Fischer & Farina, 1995). Overall, the scale has proven flexible as a large number of adaptations have been made depending on the population under study, but as a result very few studies are fully compliant with the original measure (MacKenzie et al., 2004; Rickwood et al., 2012). In terms of measuring help-seeking behaviour, the ATSPPHS-SF considers general attitudes towards help-seeking and potential sources, both formal and informal. It centres the problem as an unspecified psychological problem, relying on terms ranging from worried or upset, emotional difficulties, or mental breakdown.

The General Help-Seeking Questionnaire (GHSQ; Appendix B) and the Actual Help-Seeking Questionnaire (AHSQ; Appendix C; Wilson et al., 2005)

The General Help-Seeking Questionnaire (GHSQ) assesses future help-seeking intentions and recent and past help-seeking experiences. Designed by Wilson, Deane, Ciarochi, and Rickwood in 2005, the GHSQ was developed to assess intentions to seek help from different sources and for different problems. Throughout the literature, the intentions measure is often referred to in the literature as the General Help-Seeking Questionnaire (GHSQ) and the past help-seeking experiences as the Actual Help-Seeking Questionnaire (AHSQ).

The GHSQ focuses on future behavioural intentions (the 'likelihood' of behaviour). Intentions are measured by listing a number of potential help sources and asking participants to indicate how likely it is that they would seek help from that source for a specified problem on a 7- point scale ranging from (1) *extremely unlikely* to seek help to (7) *extremely likely* to seek help. This measure is adaptable, meaning the specific sources of help listed, the future time-period specified, and the type of problem can change depending on the audience. For example, school guidance counselors or internet mental health resources can be made specific sources of help if these are a research focus. Sources of help can be measured and adapted to list specific sources, including formal, informal, and self-help. Problems are generally defined as personal or emotional and can be measured over different time periods.

The Actual Help-Seeking Questionnaire (AHSQ) considers recent and past behaviour and a source of help needs to be specified and adapted to consider specific sources, including formal, informal and self-help. Past help-seeking behaviour is operationalised by asking whether professional help has been sought in the past and, if help has been sought, how many times it was sought, what specific sources of help were sought, and whether the help obtained was evaluated as worthwhile on a 5-point Likert scale indicating more or less helpfulness. Recent help-seeking behaviour is determined by listing a number of potential help sources and asking whether or not help has been sought from each of the sources during a specified period of time for a specified problem. Note that the specific sources of help listed, the time period specified, and the type of problem can be modified to be appropriate to the particular research objectives. To provide additional descriptive information and to ensure that participants are responding in the appropriate way, participants are asked to briefly elaborate on the nature of the problem for which help was sought. Participants can also indicate that they have had a problem but have sought help from no one.

Wilson et al. (2005) state that the GHSQ and AHSQ have potential as a method to assist clinical practice and, in particular, mental health promotion and prevention initiatives, and can serve as a flexible measure for such assessment. They also note that further research would be helpful to assess its usefulness with other populations and different target problems and help sources; overall, the authors believe it is generalizable to other contexts.

The Multidimensional Scale of Perceived Social Support (Osman et al., 2013; Zimet et al., 1988; Appendix D)

Originally created by Zimet et al. in 1988, to measure social support in adolescents, the Multidimensional Scale of Perceived Social Support (MSPSS) has evolved into one of the most extensively used social support outcome measures (Osman et al., 2013). The MSPSS (1988) was developed to assess three distinct forms of perceived sources of social support. Specifically, the development of the MSPSS is based on defining different and specific sources of social support in relations and exploring different functions of various sources of social support. Zimet et al. (1988) conceptualized this measure as composed of three specific dimensions of perceived sources of social support—the family, friends, and significant others. Each dimension (i.e.,

source) includes items designed to assess (a) perceived availability of support (e.g., “My family is willing to help me make decisions”), and (b) function of the support (e.g., “I get the emotional help and support I need from my family”).

The original version of the MSPSS was made up of 24 items but eventually reduced to 12 in the final version of the instrument. Each subscale is made up of four items, and the response options are respecified to be scored from 1 (very strongly disagree) to 7 (very strongly agree). Responses to items within each of the subscales are summed to derive a total subscale score. Scores on all 12 items are summed to obtain a composite MSPSS scale score (i.e., global perceived social support). A high total mean score on any specific subscale indicates high levels of perceived social support from that source (Osman et al, 2013).

Barriers to Help-Seeking Scale (BHSS; Mansfield et al., 2005; Appendix E)

The Barriers to Help-Seeking Scale (BHSS) was originally developed to explore help-seeking behaviours in men and was intended to identify the extent to which gender-role conflict constrained men's help-seeking for specific problems. It was also intended to allow for the study of variations in the context of help-seeking, such as differences in the particular problem and the type of help that might be sought, as well as individual differences in the particular masculinity norms to which different men adhere (Mansfield et al., 2005).

Mansfield et al. (2005) constructed the BHSS to broaden the availability of instruments, as most early studies examining the use of health services relied on Fischer and Turner’s (1970) Attitudes toward Seeking Professional Psychological Help (ASPPH) Scale, which measures attitudes and not specific barriers. Therefore, Mansfield et al. created a measure that would target specific barriers to help-seeking for both physical and emotional health problems, with certain masculinity norms and roles as context-specific barriers to seeking help for a particular problem. While initially the scale was developed and used to measure the barriers to help-seeking among men, it was later found to be useful with both genders and able to be adapted to fit the study and population at hand. The authors claimed four processes of help-seeking were central to the BHSS: (1) the ego-centrality of a problem or the degree to which a problem is perceived to reflect an important quality of oneself; (2) the normativeness of a problem, or how common the concern is considered to be in the population; (3) reactance, or the tendency to reclaim autonomy when that autonomy has been threatened; and (4) reciprocity, which refers to the extent that the person receiving help will have the opportunity in the future to return the help.

The scale in comprised of 31 items. In addition to a total scale score, participants can receive scores on five subscales that were constructed based on factor analysis: Need for Control and Self-reliance (10 items); Minimizing Problem and Resignation (6 items); Concrete Barriers and Distrust of Caregivers (6 items); Privacy (5 items); and Emotional Control (4 items). The BHSS has a 5-point Likert-type response scale (0 = not at all, 4 = very much) to rate reasons for not seeking help for the problem. Calculation of the total score and the scores for the

subscales consist of totaling each item with lower numbers indicating that the item is less of a barrier to seeking help and higher numbers denoting a stronger barrier to seeking help for physical or emotional concerns.

Non-standardised measures

Many studies develop self-report questions specifically for that study based on the researchers focus or interest. Some rely on dichotomous yes/no response and others a Likert response scale from *strongly disagree* to *strongly agree* to determine their evaluation of, for instance, the source of help or the intention to follow through on finding resources. Interview-type questions might serve to determine either a general evaluation of a source of help or whether that particular type of help had been sought in the past. More in-depth information related to unique help-seeking experiences is often revealed by these studies.

Other Notes: Some General Resources Related to Help-Seeking

Anxiety Canada

A non-profit organization based in British Columbia which provides self-help, peer reviewed, and trusted resources on anxiety, including the Mind Shift App which promotes mindfulness, relaxation and coping strategies.

Online resources include educational videos on YouTube, information exchange on Facebook, and downloadable articles and resources. Anxiety Canada self-help resources are written specifically for children, youth, adults, parents, and individuals to support anxiety management.

https://www.anxietycanada.com

Beyond Blue

Beyond Blue is a non-profit agency based in Australia that works in partnership with health services, schools, workplaces, universities, media, and community organisations, as well as people living with depression/anxiety and their families to bring together expertise and provide tools and resources.

Beyond Blue's key result areas:

- increase awareness of depression and anxiety
- reduce stigma and discrimination
- improve help-seeking
- reduce impact and disability
- facilitate learning, collaboration, innovation, and research

https://www.beyondblue.org.au

TeenMentalHealth.org

TeenMentalHealth.org aims to take the best available scientific evidence in mental health and make it easy to understand and accessible for everyone. It provides quality mental health literacy information, research, education, and resources. Materials are provided in a variety of mediums that include videos, animations, brochures, e-books, face-to-face training programs, and online training programs. Materials are specifically designed to meet the needs of children, youth, young adults, families, educators, community agencies, and health care providers.

Kids Help Phone

Kids Help Phone is Canada's only 24/7, national support service. They offer professional counselling, information and referrals and volunteer-led, text-based support to young people (up to age 25) in both English and French. In their COVIC-19 response, Kids Help Phone has lifted age restrictions and is now open to everyone for supportive counselling, information finding, and referral purposes.

https://kidshelpphone.ca

References

Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help-seeking. *American Psychologist*, *58*(1), 5-14

Alegría, M., Canino, G., Ríos, R., Vera, M., Calderón, J., Rusch, D., & Ortega, A. N. (2002). Mental health care for Latinos: Inequalities in use of specialty mental health services among Latinos, African Americans, and Non-Latino whites. *Psychiatric Services*, *53*(12), 1547-1555. https://doi.org/10.1176/appi.ps.53.12.1547

Baumeister, S., Schomerus, G., & Anderson, R. (2013). Personality-related factors as predictors of help-seeking for depression: A population-based study applying the behavioral model of health services use. *Das Gesundheitswesen*, *75*(08/09). https://doi.org/10.1055/s-0033-1354236

Berkman, N. D., Sheridan, S. L., Donahue, K. E., Halpern, D. J., & Crotty, K. (2011). Low health literacy and health outcomes: An updated systematic review. *Annals of Internal Medicine*, *155*(2), 97. https://doi.org/10.7326/0003-4819-155-2-201107190-00005

Cadaret, M. C., & Speight, S. L. (2018). An exploratory study of attitudes toward psychological help-seeking among African American men. *Journal of Black Psychology*, *44*(4), 347-370. https://doi.org/10.1177/0095798418774655

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rüsch, N., Brown, J. S., & Thornicroft, G. (2014). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine*, *45*(1), 11-27. https://doi.org/10.1017/s0033291714000129

Cornally, N., & McCarthy, G. (2011). Help-seeking behaviour: A concept analysis. *International Journal of Nursing Practice*, *17*(3), 280-288. https://doi.org/10.1111/j.1440-172x.2011.01936.x

Courtenay, W. H. (2000). Constructions of masculinity and their influence on men's wellbeing: A theory of gender and health. *Social Science & Medicine*, *50*(10), 1385-1401. https://doi.org/10.1016/s0277-9536(99)00390-1

Divin, N., Harper, P., Curran, E., Corry, D., & Leavey, G. (2018). Help-seeking measures and their use in adolescents: A systematic review. *Adolescent Research Review*, *3*(1), 113-122. https://doi.org/10.1007/s40894-017-0078-8

Evans, W. P., Davidson, L., & Sicafuse, L. (2013). Someone to listen: Increasing youth help-seeking behavior through a text-based crisis line for youth. *Journal of Community Psychology*, *41*(4), 471-487. https://doi.org/10.1002/jcop.21551

Fallon, B. J., & Bowles, T. V. (2001). Family functioning and adolescent help-seeking behavior*. *Family Relations*, *50*(3), 239-245. https://doi.org/10.1111/j.1741-3729.2001.00239.x

Fleming, R., & Baum, A. (1986). Social support and stress: The buffering effects of friendship. *Friendship and Social Interaction*, 207-226. https://doi.org/10.1007/978-1-4612-4880-4_11

Fletcher, D., & Sarkar, M. (2013). Psychological resilience: A review and critique of definitions, concepts, and theory. *European Psychologist*, *18*(1), 12-23. https://doi.org/10.1027/1016-9040/a000124

Fuller, J., Edwards, J., Procter, N., & Moss, J. (2000). How definition of mental health problems can influence help-seeking in rural and remote communities. *Australian Journal of Rural Health*, *8*(3), 148-153. https://doi.org/10.1046/j.1440-1584.2000.00303.x

Gould, M. S., Kalafat, J., HarrisMunfakh, J. L., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes Part 2: Suicidal callers. *Suicide and Life-Threatening Behavior*, *37*(3), 338-352. https://doi.org/10.1521/suli.2007.37.3.338

Goyal, S., Srivastava, K., & Bansal, V. (2009). Study of prevalence of depression in adolescent students of a public school. *Industrial Psychiatry Journal*, *18*(1), 43. https://doi.org/10.4103/0972-6748.57859

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry*, *10*(1). https://doi.org/10.1186/1471-244x-10-113

Gulliver, A., Griffiths, K. M., Christensen, H., & Brewer, J. L. (2012). A systematic review of help-seeking interventions for depression, anxiety and general psychological distress. *BMC Psychiatry*, *12*(1). https://doi.org/10.1186/1471-244x-12-81

Haarasilta, L. M. (2004). Correlates of depression in a representative nationwide sample of adolescents (15-19 years) and young adults (20-24 years). *The European Journal of Public Health*, *14*(3), 280-285. https://doi.org/10.1093/eurpub/14.3.280

Haavik, L., Joa, I., Hatloy, K., Stain, H. J., & Langeveld, J. (2017). Help-seeking for mental health problems in an adolescent population: The effect of gender. *Journal of Mental Health*, *28*(5), 467-474. https://doi.org/10.1080/09638237.2017.1340630

Hom, M. A., De Terte, I., Bennett, C., & Joiner, T. E. (2020). Resilience and attitudes toward help-seeking as correlates of psychological wellbeing among a sample of New Zealand defence force personnel. *Military Psychology*, *32*(4), 329-340. https://doi.org/10.1080/08995605.2020.1754148

Hunt, J., & Eisenberg, D. (2010). Mental health problems and help-seeking behavior among college students. *Journal of Adolescent Health*, *46*(1), 3-10. https://doi.org/10.1016/j.jadohealth.2009.08.008

Kaplan, R. M. (1985). Social support and social health. *Social Support: Theory, Research and Applications*, 95-113. https://doi.org/10.1007/978-94-009-5115-0_6

Liang, B., Goodman, L., Tummala-Narra, P., & Weintraub, S. (2005). A theoretical framework for understanding help-seeking processes among survivors of intimate partner violence. *American Journal of Community Psychology*, *36*(1-2), 71-84. https://doi.org/10.1007/s10464-005-6233-6

Magaard, J. L., Seeralan, T., Schulz, H., & Brütt, A. L. (2017). Factors associated with help-seeking behaviour among individuals with major depression: A systematic review. *PLOS ONE*, *12*(5), e0176730. https://doi.org/10.1371/journal.pone.0176730

Masuda, A., L. Anderson, P., Twohig, M. P., Feinstein, A. B., Chou, Y., Wendell, J. W., & Stormo, A. R. (2009). Help-seeking experiences and attitudes among African American, Asian American, and European American College students. *International Journal for the Advancement of Counselling*, *31*(3), 168-180. https://doi.org/10.1007/s10447-009-9076-2

McDermott, R. C., Cheng, H., Wong, J., Booth, N., Jones, Z., & Sevig, T. (2017). Hope for help-seeking: A positive psychology perspective of psychological help-seeking intentions. *The Counseling Psychologist*, *45*(2), 237-265.

Moore, J., Thornton, C., & Hughes, M. (2015). On the road to resilience: The help-seeking experiences of Irish emigrant survivors of institutional abuse. *Child Abuse Review*, *26*(5), 375-387. https://doi.org/10.1002/car.2415

Moreno, M. A., Jelenchick, L. A., Egan, K. G., Cox, E., Young, H., Gannon, K. E., & Becker, T. (2011). Feeling bad on Facebook: Depression disclosures by college students on a social networking site. *Depression and Anxiety*, *28*(6), 447-455. https://doi.org/10.1002/da.20805

Nadler, A. (1987). Determinants of help-seeking behaviour: The effects of helper's similarity, task centrality and recipient's self esteem. *European Journal of Social Psychology*, *17*(1), 57-67. https://doi.org/10.1002/ejsp.2420170106

Nagai, S. (2015). Predictors of help-seeking behavior: Distinction between help-seeking intentions and help-seeking behavior. *Japanese Psychological Research*, *57*(4), 313-322. https://doi.org/10.1111/jpr.12091

Osman, A., Lamis, D. A., Freedenthal, S., Gutierrez, P. M., & McNaughton-Cassill, M. (2013). The multidimensional scale of perceived social support: Analyses of internal reliability, measurement invariance, and correlates across gender. *Journal of Personality Assessment*, *96*(1), 103-112.

Perenc, L., & Radochonski, M. (2016). Psychological predictors of seeking help from mental health practitioners among a large sample of Polish young adults. *International Journal of Environmental Research and Public Health*, *13*(11), 1049. https://doi.org/10.3390/ijerph13111049

Pinxten, W., & Lievens, J. (2014). The importance of economic, social and cultural capital in understanding health inequalities: Using a bourdieu-based approach in research on physical and mental health perceptions. *Sociology of Health & Illness*, *36*(7), 1095-1110. https://doi.org/10.1111/1467-9566.12154

Rickwood, D., & Thomas. (2012). Conceptual measurement framework for help-seeking for mental health problems. *Psychology Research and Behavior Management*, 173. https://doi.org/10.2147/prbm.s38707

Sheffield, J. K., Fiorenza, E., & Sofronoff, K. (2004). Adolescents' willingness to seek psychological help: Promoting and preventing factors. *Journal of Youth and Adolescence*, *33*(6), 495-507. https://doi.org/10.1023/b:joyo.0000048064.31128.c6

Shochet, I. M., & Hoge, R. (2009). Resourceful adolescent program. Treatments for Adolescent Depression, 123-158.

Smith, J. P., Tran, G. Q., & Thompson, R. D. (2008). Can the theory of planned behavior help explain men's psychological help-seeking? Evidence for a mediation effect and clinical implications. *Psychology of Men & Masculinity*, *9*(3), 179-192. https://doi.org/10.1037/a0012158

Ungar, M., Liebenberg, L., Boothroyd, R., Kwong, W. M., Lee, T. Y., Leblanc, J., Duque, L., & Makhnach, A. (2008). The study of youth resilience across cultures: Lessons from a pilot study of measurement development. *Research in Human Development*, *5*(3), 166-180. https://doi.org/10.1080/15427600802274019

Vogel, D. L., Armstrong, P. I., Tsai, P., Wade, N. G., Hammer, J. H., Efstathiou, G., Holtham, E., Kouvaraki, E., Liao, H., Shechtman, Z., & Topkaya, N. (2013). Cross-cultural validity of the self-stigma of seeking help (SSOSH) scale: Examination across Six Nations. *Journal of Counseling Psychology*, *60*(2), 303-310. https://doi.org/10.1037/a0032055

Vogel, D. L., Heimerdinger-Edwards, S. R., Hammer, J. H., & Hubbard, A. (2011). “Boys don't cry”: Examination of the links between endorsement of masculine norms, self-stigma, and help-seeking attitudes for men from diverse backgrounds. *Journal of Counseling Psychology*, *58*(3), 368-382. https://doi.org/10.1037/a0023688

Watkins, D. C., Walker, R. L., & Griffith, D. M. (2009). A meta-study of Black male mental health and wellbeing. *Journal of Black Psychology*, *36*(3), 303-330. https://doi.org/10.1177/0095798409353756

Wei, Y., Kutcher, S., & Szumilas, M. (2011). Comprehensive school mental health: An integrated “school-based pathway to care” model for Canadian secondary schools. *Articles*, *46*(2), 213-229. https://doi.org/10.7202/1006436ar

White, M. M., Clough, B. A., & Casey, L. M. (2018). What do help-seeking measures assess? Building a conceptualization framework for help-seeking intentions through a systematic review of measure content. *Clinical Psychology Review*, *59*, 61-77. https://doi.org/10.1016/j.cpr.2017.11.001

Wilson, C. J., Deane, F. P., Ciarrochi, J., & Rickwood, D. (2005). General help-seeking questionnaire. *PsycTESTS Dataset*. https://doi.org/10.1037/t42876-000

Wilson, C. J., Deane, F. P., Ciarrochi, J., & Rickwood, D. (2005). Measuring Help-Seeking Intentions: Properties of the General Help-Seeking Questionnaire. *PsycTESTS Dataset*. https://doi.org/10.1037/t42876-000

Xu, Z., Huang, F., Kösters, M., Staiger, T., Becker, T., Thornicroft, G., & Rüsch, N. (2018). Effectiveness of interventions to promote help-seeking for mental health problems: Systematic review and meta-analysis. *Psychological Medicine*, *48*(16), 2658-2667. https://doi.org/10.1017/s0033291718001265

Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1988). Multidimensional scale of perceived social support. *PsycTESTS Dataset*. https://doi.org/10.1037/t02380-000

Appendix A: Attitudes Toward Seeking Professional Help Scale – Short Form

Fischer & Farina (1995)

_____ Male _____ Female

_____ African American
_____ Asian/Asian American

_____ White/European American

_____ Latino/a

_____ Arab/Middle Eastern
_____ Other: Please specify _____

Read each statement carefully and indicate your degree of agreement using the scale below. In responding, please be completely candid.

0 = Disagree 1 = Partly disagree 2 = Partly agree 3 = Agree

_____ 1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.

_____ 2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.

_____ 3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.

_____ 4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.

_____ 5. I would want to get psychological help if I were worried or upset for a long period of time.

_____ 6. I might want to have psychological counseling in the future.

_____ 7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.

_____ 8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.

_____ 9. A person should work out his or her own problems; getting psychological counseling would be a last resort.

_____ 10. Personal and emotional troubles, like many things, tend to work out by themselves.

Scoring

Reverse score items 2, 4, 8, 9, and 10, then add up the ratings to get a sum. Higher scores indicate more positive attitudes towards seeking professional help.

Appendix B: General Help-Seeking Questionnaire

Wilson et al. (2005)

General Help-Seeking Questionnaire

Below is a list of people who you might seek help or advice from if you were experiencing a personal or emotional problem.
Please circle the number that shows **how likely is it** that you would seek help from each of these people for a personal or emotional problem during the **next 4 weeks**?

		Extremely Unlikely						Extremely Likely
1a)	Partner (e.g., significant boyfriend or girlfriend)	1	2	3	4	5	6	7
1b)	Friend (not related to you)	1	2	3	4	5	6	7
1c)	Parent	1	2	3	4	5	6	7
1d)	Other relative / family member	1	2	3	4	5	6	7
1e)	Mental health professional (e.g., school counsellor, psychologist, psychiatrist)	1	2	3	4	5	6	7
1f)	Phone help line (e.g., Lifeline, Kids Help Line)	1	2	3	4	5	6	7
1g)	Family doctor / GP	1	2	3	4	5	6	7
1h)	Teacher (year advisor, classroom teacher)	1	2	3	4	5	6	7
1i)	Someone else not listed above (please describe who this was) _____	1	2	3	4	5	6	7
1j)	I would not seek help from anyone	1	2	3	4	5	6	7

2a) Have you ever seen a mental health professional (e.g., school counsellor, counsellor, psychologist, psychiatrist) to get help for personal problems? (Circle one)
Yes No

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

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

2c) Do you know what type of mental health professional(s) you've seen? If so, please list their titles (e.g., counsellor, psychologist, psychiatrist)

_____

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

Extremely Unhelpful				Extremely Helpful
1	2	3	4	5

Appendix C: Actual Help-Seeking Questionnaire

Actual Help-Seeking Questionnaire

Below is a list of people who you might seek help or advice from if you were experiencing a personal or emotional problem.
Tick any of these who you have gone to for advice or help in the **past 2 weeks** for a personal or emotional problem and briefly describe the type of problem you went to them about.

		Yes	Briefly describe the type of problem
3a)	Partner (e.g., significant boyfriend or girlfriend)	☝	
3b)	Friend (not related to you)	☝	
3c)	Parent	☝	
3d)	Other relative / family member	☝	
3e)	Mental health professional (e.g., school counsellor, psychologist, psychiatrist)	☝	
3f)	Phone help line (e.g., Lifeline, Kids Help Line)	☝	
3g)	Family doctor / GP	☝	
3h)	Teacher (year advisor, classroom teacher)	☝	
3i)	Someone else not listed above (please describe who this was) _____	☝	
3j)	I have not sought help from anyone for my problem	☝	

Appendix D: Multidimensional Scale of Perceived Social Support

Osman et al. (2013)

Multidimensional Scale of Perceived Social Support

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Circle the "1" if you **Very Strongly Disagree**
Circle the "2" if you **Strongly Disagree**
Circle the "3" if you **Mildly Disagree**
Circle the "4" if you are **Neutral**
Circle the "5" if you **Mildly Agree**
Circle the "6" if you **Strongly Agree**
Circle the "7" if you **Very Strongly Agree**

	Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
1. There is a special person who is around when I am in need.	1	2	3	4	5	6	7
2. There is a special person with whom I can share joys and sorrows.	1	2	3	4	5	6	7
3. My family really tries to help me.	1	2	3	4	5	6	7
4. I get the emotional help & support I need from my family.	1	2	3	4	5	6	7
5. I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7
6. My friends really try to help me.	1	2	3	4	5	6	7
7. I can count on my friends when things go wrong.	1	2	3	4	5	6	7
8. I can talk about my problems with my family.	1	2	3	4	5	6	7
9. I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7
10. There is a special person in my life who cares about my feelings.	1	2	3	4	5	6	7
11. My family is willing to help me make decisions.	1	2	3	4	5	6	7
12. I can talk about my problems with my friends.	1	2	3	4	5	6	7

Appendix E: Barriers to Help-Seeking Scale

Mansfield et al. (2005)

Barriers To Help Seeking Scale: Below are some reasons why people do **NOT** seek help for a psychological problem (e.g. feeling down or depressed, feeling anxious, having anxiety attacks, and/or personal difficulties such as relationship problems or stress at work). Please read each of the following reasons and decide how important each would be in keeping **YOU** from seeking help. Your answers will be kept confidential.

	Not at all	A little bit	Moderately	Quite a bit	Very much
1. I would think less of myself for needing help.	0	1	2	3	4
2. I don't like other people telling me what to do.	0	1	2	3	4
3. Nobody knows more about my problems than I do.	0	1	2	3	4
4. I'd feel better about myself knowing I didn't need help from others.	0	1	2	3	4
5. I don't like feeling controlled my other people.	0	1	2	3	4
6. It would seem weak to ask for help.	0	1	2	3	4
7. I like to make my own decisions and not be too influenced by others.	0	1	2	3	4
8. I like to be in charge of everything in my life.	0	1	2	3	4
9. Asking for help is like surrendering authority over my life.	0	1	2	3	4
10. I do not want to appear weaker than my peers.	0	1	2	3	4
11. The problem wouldn't seem worth getting help for.	0	1	2	3	4
12. The problem wouldn't be a big deal; it would go away in time.	0	1	2	3	4
13. I wouldn't want to overreact to a problem that wasn't serious.	0	1	2	3	4
14. Problems like this are part of life; they're just something you have to deal with.	0	1	2	3	4
15. I'd prefer to just suck it up rather than dwell on my problems.	0	1	2	3	4
16. I would prefer to wait until I'm sure the health problem is a serious one.	0	1	2	3	4

17. People typically expect something in return when they provide help.	0	1	2	3	4
18. I would have real difficulty finding transportation to a place where I can get help.	0	1	2	3	4
19. I wouldn't know what sort of help was available.	0	1	2	3	4
20. Financial difficulties would be an obstacle to getting help.	0	1	2	3	4
21. I don't trust doctors and other health professionals.	0	1	2	3	4
22. A lack of health insurance would prevent me from asking for help.	0	1	2	3	4
23. Privacy is important to me, and I don't want other people to know about my problems.	0	1	2	3	4
24. This problem is embarrassing.	0	1	2	3	4
25. I don't want some stranger touching me in ways I'm not comfortable with.	0	1	2	3	4
26. I don't like taking off my clothes in front of other people.	0	1	2	3	4
27. I wouldn't want someone of the same sex touching my body.	0	1	2	3	4
28. I don't like to get emotional about things.	0	1	2	3	4
29. I don't like to talk about feelings.	0	1	2	3	4
30. I'd rather not show people what I'm feeling.	0	1	2	3	4
31. I wouldn't want to look stupid for not knowing how to figure this problem out.	0	1	2	3	4

R2

For more information about R2 or to discover how you can bring the program to your organization, business or educational setting, please contact us.

Paul McGuinness
Operations Manager

rrc@dal.ca
(902) 494-8482

Michael Ungar, PhD
Director

michael.ungar@dal.ca
(902) 229-0434

RRC - Evaluation and Training Institute