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# Factors predicting adolescents' and parents' help seeking behaviour

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FACTORS PREDICTING ADOLESCENTS' AND PARENTS' HELP SEEKING  
BEHAVIOUR

By Jennifer Lynn Cometto

A Dissertation  
Submitted to the Faculty of Graduate Studies  
through the Department of Psychology  
in Partial Fulfillment of the Requirements for  
the Degree of Doctor of Philosophy at the  
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2013

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### AUTHOR'S DECLARATION OF ORIGINALITY

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## ABSTRACT

Adolescents' perceptions and responses to mental health problems have been shown to have significant implications for their future competence, coping skills, well-being, and subsequent life choices; yet, as few as 25 percent of young Canadians with mental health problems seek help (Bergeron, Poirier, Fournier, Roberge, & Barrette, 2005). The purpose of this study was to examine the stages of adolescent help seeking (i.e., recognizing the problem, deciding to seek professional help, and seeking professional help ) to better understand why some adolescents seek help and others do not. Specific predisposing, enabling, and need factors were examined as predictors of adolescents' and parents' behaviour across the three stages of help seeking. Participants completed on-line questionnaires assessing help-seeking stages, barriers to help seeking, help-seeking attitudes, family functioning, parental stress, and symptomatology. After data screening procedures, the sample consisted of 175 adolescents and 95 parents from the Windsor-Essex community; of these participants, 21 parent-adolescent dyads were formed. Regression analyses showed that being female and perceiving mental health problems to be severe significantly improved the likelihood that an adolescent would recognize their mental health problem (Stage 1). Further, higher perceptions of problem severity and prior professional help seeking significantly improved the likelihood that an adolescent would decide to help seek (Stage 2) and actually seek professional help (Stage 3). These findings are consistent with the study's hypotheses. With regards to parental help seeking, parents' worry and concern for adolescents with mental health problems significantly improved the likelihood that a parent would recognize adolescent mental health problems (Stage 1) and decide to seek professional help for the adolescent (Stage 2). Finally, parent-reported prior family professional help seeking significantly improved

the likelihood of parents actually seeking professional help for adolescent mental health problems (Stage 3). Given the limited number of parent-adolescent dyads, the researcher was limited with regards to statistical analyses that could be performed; however, the results lend support to the idea that an adolescent and parent from the same family are likely to be in similar stages of help seeking. The results suggest that family cohesion, flexibility, and communication may have an indirect effect on adolescent help seeking by contributing to an adolescent being more or less vulnerable to mental health problems. Implications for increasing adolescent help seeking and improving adolescents' and parents' access to professional resources are discussed.

## DEDICATION

To my husband, William Johnson, whose constant support, unwavering belief in my abilities, and personal sacrifice made this possible.

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interest never failed to put a smile on my face and an idea in my head. Though I had been warned that I would dislike the topic of adolescent help seeking after working on this project for many years, my clinical work has only strengthened my interest and passion for this area of research. Thank you to the many clients who have inspired me and to prior researchers who have provided the insights that allowed me to connect with youth who may have otherwise gone without needed mental health services.

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## CHAPTER I

### Introduction

#### Study Context and Rationale for the Present Study

Adolescence is a developmental stage where independence and individualization are highly valued and can lead to choices that shape lifelong patterns of behaviour. Adolescence has also been identified as a period of the lifespan where there is an emergence and intensification of psychopathology (Kim-Cohen et al., 2003; Paus, Keshavan, Giedd, 2008; Roberts, Attkisson, & Rosenblatt, 1998; Steinberg et al., 2006). Adolescents' perceptions and responses to mental health problems have been shown to have significant implications for their future competence, coping skills, well-being, and subsequent life choices (Menna & Ruck, 2004; Rickwood, Deane, & Wilson, 2007; Seiffge-Krenke, 1993; Unrau & Grinnell, 2005). Despite this, studies show that approximately 25 percent of young Canadians with mental health problems seek help (Bergeron, Poirier, Fournier, Roberge, & Barrette, 2005) and far fewer receive specialized mental health treatment (e.g., Hazen, Hough, Landsverk, & Wood, 2004; John, Offord, Boyle, & Racine, 1995). Adolescents with severe problems (e.g., suicidality and substance abuse) have been found to be the least likely to seek help (Gould, Munfakh, Lubell, Kleinman, & Parker, 2004). These findings suggest that adolescents' coping skills may be insufficient to successfully and independently navigate normative and non-normative biological, cognitive, interpersonal, and environmental changes that occur during their transition to adulthood. For this reason, the extent to which youth seek help from informal (e.g., family and friends) and formal (e.g., professionals) resources may distinguish between those who are well-adjusted and those who are not (Cauce, Mason, Gonzales, Hiraga, & Liu, 1994; Nelson-Le Gall, 1985; Sears, 2004). The purpose of the

present study was to examine the stages of adolescent help seeking to better understand why some adolescents seek help and others do not.

Help seeking refers to any active attempts one makes to obtain assistance or intervention to help solve a problem (e.g., Batten & Dutton, 2011; Nelson-Le Gall, 1985; Schoen et al., 2012). Within the coping literature, help seeking is seen as an adaptive reaction to stress that often results in greater personal competency and well-being (Wilson & Deane, 2010). For example, longitudinal studies have shown that adolescents who obtain professional help significantly reduce their likelihood of experiencing problems later in life (Croll, Neumark-Sztainer, Story, & Ireland, 2002; Harrington, Rutter, & Fombonne, 1996; Henry, Feehan, McGee, Stanton, Moffitt, & Silva, 1993).

Researchers have examined several correlates of adolescent help seeking behaviour. The majority of these studies have compared only those who have and have not sought professional help (Sears, 2004). This line of investigation is important but does not address adolescents who are beginning the help-seeking process (e.g., contemplating seeking help) or how adolescents receiving help arrived at that point (Sears). Adolescents who report a need for help but do not go on to seek services are of interest to the present study because of the ramifications of failing to obtain help and the possibility that perceptions of unmet needs may negatively influence adolescents' future attitudes toward help seeking. By studying stages of help seeking, instead of studying help seeking as an outcome, one is likely to gain a better understanding of the circumstances that direct adolescents toward needed mental health services (Durbin, Goering, Streiner, & Pink, 2004; Sears; Zwaanswijk, Verhaak, Bensing, Van der Ende, & Verhulst, 2003).

Research has well established that adolescents favour informal sources of help to professional services (Boldero & Fallon, 1995; Kalafat, 2003; Offer, Howard, Schonert, & Ostrov, 1991; Rickwood & Braithwaite, 1994; Rickwood, Deane, Wilson, & Ciarrochi, 2005; Rickwood et al., 2007; Sheffield, Fiorenza, & Sofronoff, 2004; Sherer, 2007; Sullivan, Marshall, & Schonert-Reichl, 2002). Throughout adolescence, parents have been found to participate in adolescent help seeking by recognizing adolescent problems, facilitating adolescent help seeking behaviour (e.g., providing transportation), and directly referring adolescents to appropriate services (Bussing, Koro-Ljungberg, Gary, Mason, & Garvan, 2005; Logan & King, 2001; Wu et al., 2001; Zahner, Pawelkiewicz, DeFrancesco, & Adnopo, 1992). However, few studies have examined family members' effect on adolescent professional help seeking for mental health difficulties. In a sample of 196 adolescents (Grades 7, 9, and 11), Fallon and Bowles (2001) found that adolescents who sought professional help tended to spend less time with their parents and friends, suggesting that family experience may relate to how adolescents cope with stress and handle problems (e.g., who adolescents seek help from). Apart from this work, the family's role in adolescent help seeking and help-seeking socialization has been vastly underexplored. In particular, research on adolescent help seeking has been overshadowed by research involving only parents or adolescents.

Researchers have found that parent-reports of adolescent problems are a powerful predictor of adolescents receiving professional care. For example, in a large eight-year follow-up study of the Epidemiological Multicenter Child Psychiatric Study in Finland, Sourander et al. (2001) found that parental perceptions of adolescent problems were related to 28 percent of referrals to professional mental health services; in contrast, adolescent perceptions were related to only 13 percent of referrals. In a similar study

with Dutch adolescents, Zwaanswijk et al. (2003) found that even fewer (i.e., 7 percent) adolescents self-reported mental health difficulties prompted referrals to mental health services. These findings indicate that parents are more likely to translate adolescent mental health concerns into help-seeking behaviour. In an extensive review of the literature concerning parental involvement in adolescent mental health service use, Morrissey-Kane and Prinz (1999) found that the strongest predictor of parental help seeking for adolescent mental health problems was parents' perceived burden. Therefore, parents may be seen to act as a gateway to professional services by recognizing their adolescent's need for help and taking the necessary steps to obtain professional help when they are unable to provide adequate assistance (Shanley et al., 2007; Stiffman, Pescosolido, & Cabassa, 2004).

Research studies have also shown that children's coping efforts are associated with characteristics of the family environment, such as the quality of parent-child relationships, parents' own coping, and family communications or suggestions around coping (Kliewer, Fearnow, & Miller, 1996). Less studied is how the family unit influences adolescent help seeking; for instance, parents with adolescents with mental health problems have reported that their children have refused to attend mental health service appointments (Flisher et al., 1997); the approaches parents take to overcome such adolescent resistance does not appear to have been studied.

Several models exist to explain adult help seeking (e.g., Protection Motivation Theory, Milne, Sheeran, & Orbell, 2000; Theory of Planned Behaviour, VonDras & Madey, 2004), but only recently have researchers begun to work toward developing a model of help seeking specifically for adolescents. Cauce et al. (2002) state that adult models of help seeking fail to consider variables unique to adolescents, such as family,

which is often the most proximal and constant influence in adolescents' lives. Theoretical models of adolescent help seeking have been proposed; unfortunately few have been tested. As a result, adolescents' help seeking and the factors that facilitate or hinder adolescents' efforts to seek help remain understudied and possibly misunderstood (Cauce et al.). The present study sought to identify factors that are predictive of adolescents' help-seeking by examining three stages of help seeking: (1) recognizing the problem, (2) deciding to seek professional help, and (3) seeking professional help (Andersen, 1995; Cauce et al.; Logan & King, 2001; Sears, 2004) among adolescents and parents. The present study also aimed to identify factors that are predictive of parents' attempts to seek help for their adolescent and to examine the relations between adolescents' and parents' stage of help seeking. The proposed study is limited to professional help sought for mental health problems because the literature suggests that social, emotional, and behavioural problems causing significant distress are most effectively treated by involving professional resources (e.g., physicians, psychiatrists, psychologists, and social workers; Kazdin & Weisz, 2003).

The present study uses Andersen's (Aday & Andersen, 1974; Andersen & Newman, 1973; Andersen, 1995) Behavioral Model of Health Service Use as an organizing framework to identify factors thought to be related to adolescent help seeking and parent help seeking for adolescent problems. This model suggests that professional help seeking is a function of three interrelated constructs that can be used to characterize service users: (1) predisposing factors, (2) enabling factors, and (3) need factors.

Predisposing factors are often present before the onset of problems and are believed to be related to an individual's propensity to seek and utilize professional help (e.g., gender, age, past help seeking practices, and health care attitudes and beliefs)

(Andersen, 1995). Enabling factors directly hinder or facilitate help-seeking behaviours (Andersen). For instance, experimental and anecdotal reports suggest that adolescents are often inhibited from seeking help due to a lack of knowledge (e.g., knowing when assistance is necessary, how to ask for help, and who to seek help from), stigma (e.g., believing that people who seek help are weak or inferior), poor relationships with potential helpers, and a lack of finances or transportation (Ballon, Kirst, & Smith, 2004, Boldero & Fallon, 1995; Cometto, 2008; Sheffield, Fiorenza, & Sofronoff, 2004; Wilson & Deane, 2000). The need factor refers to the severity of the problem as perceived by the individual (i.e., perceived need) and others (e.g., parents, professionals).

The present study examined specific predisposing, enabling, and need factors as predictors of adolescents' and parents' behaviour across the three stages of help seeking; specifically, recognizing the problem, deciding to seek professional help, and seeking professional help. Adolescents' age and gender, adolescents' and parents' attitudes toward help seeking, and adolescents' and their families' previous help-seeking practices were examined as possible predisposing factors. Enabling factors that were examined include adolescents' and parents' perceived barriers to help seeking (i.e., knowledge of mental health) and adolescents' and parents' perception of family communication, cohesion, and role flexibility. Adolescent-reported psychological distress and perceived need for professional help, parental perceptions of adolescents' psychological distress and need for professional help, and parental burden attributed to raising a child with mental health problems were examined as need factors (see Table 1 and Figures 1 to 3). By studying predisposing, enabling, and need factors specific to each stage of help seeking, one is able to recognize unique obstacles to recognizing mental health problems, deciding to seek help, and actually seeking help.

Table 1

*Predisposing, Enabling, and Need Factors to be Examined*

Predisposing Factors	Enabling Factors	Need Factors
<p>Adolescents'</p> <ul style="list-style-type: none"> <li>• age</li> <li>• gender</li> <li>• attitudes toward help seeking</li> <li>• help seeking practices</li> </ul>	<p>Adolescents'</p> <ul style="list-style-type: none"> <li>• perceived barriers to help seeking (i.e., knowledge of mental health, stigma)</li> <li>• perceptions of family communication, cohesion, and role flexibility</li> </ul>	<p>Adolescents'</p> <ul style="list-style-type: none"> <li>• perceived need for professional help</li> <li>• reported psychological distress</li> </ul>
<p>Family</p> <ul style="list-style-type: none"> <li>• parents' attitudes toward help seeking</li> <li>• family help seeking practices</li> </ul>	<p>Family</p> <ul style="list-style-type: none"> <li>• parents' perceived barriers to help seeking (i.e., knowledge of mental health)</li> <li>• parents' perceptions of family communication, cohesion, and role flexibility</li> </ul>	<p>Family</p> <ul style="list-style-type: none"> <li>• parents' perceptions of adolescents' need for professional help</li> <li>• parents' perceptions of adolescents' psychological distress</li> <li>• parental burden attributed to having a child with mental health problems</li> </ul>

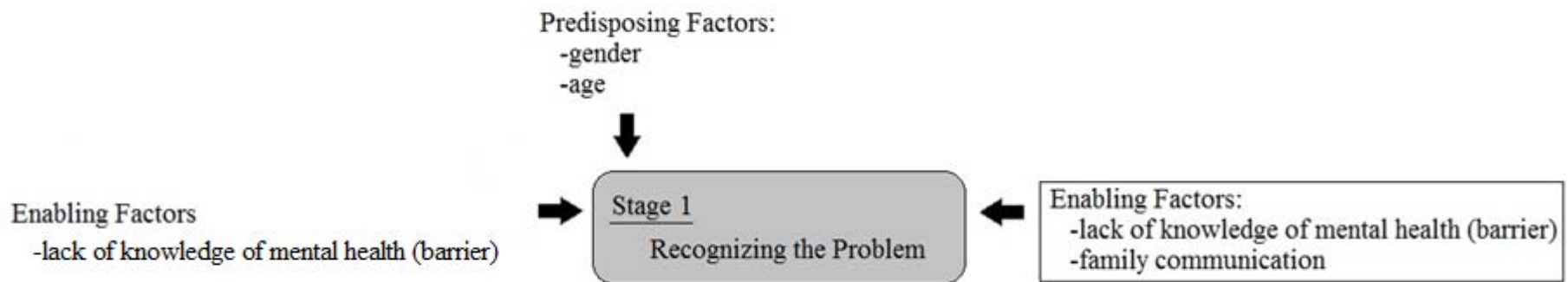


Figure 1. Factors hypothesized to influence adolescents' and parents' ability to recognize adolescent mental health problems. Factors hypothesized to influence adolescent help seeking are without boxes. Factors hypothesized to influence parents' help seeking for adolescents are shown in white boxes.



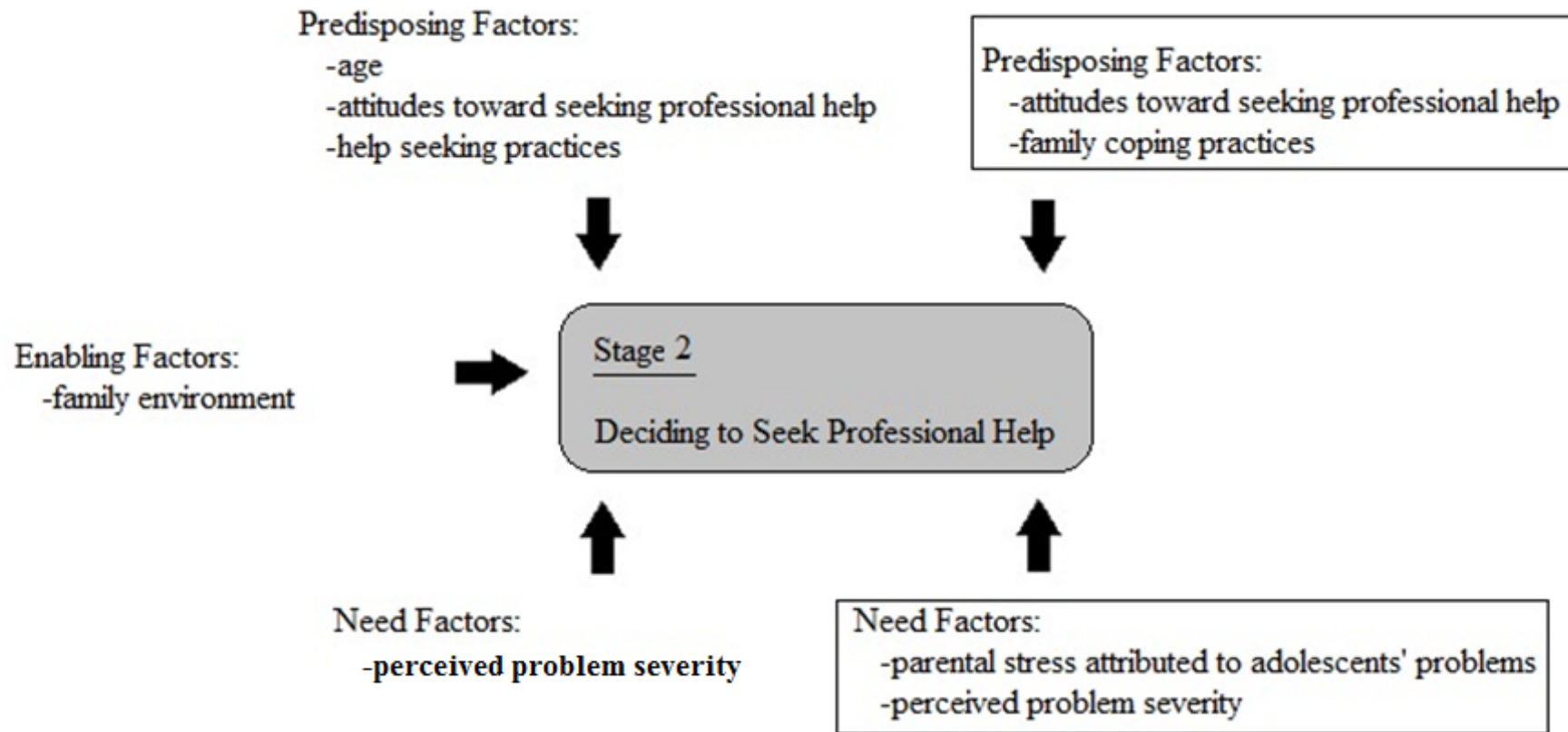


Figure 2. Factors hypothesized to influence adolescents' and parents' decision to seek professional help for adolescent mental health problems. Factors hypothesized to influence adolescent help seeking are without boxes. Factors hypothesized to influence parents' help seeking for adolescents are shown in white boxes.

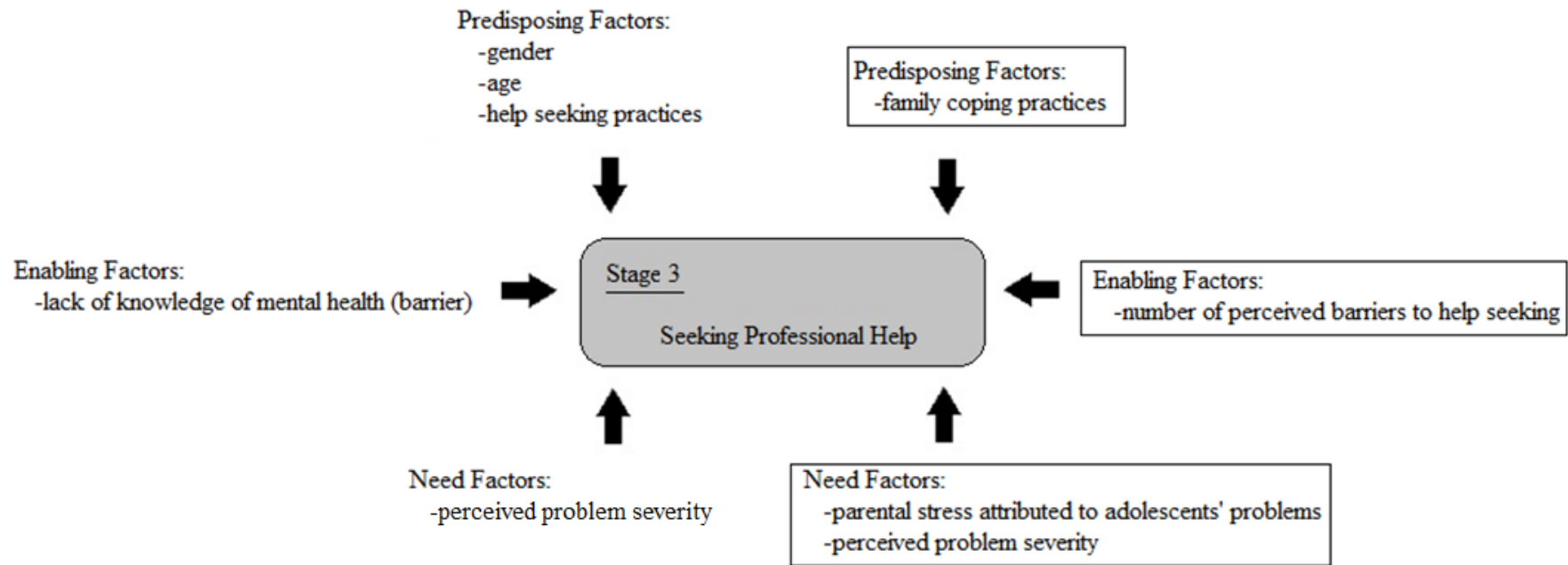


Figure 3. Factors hypothesized to influence adolescents' and parents' help seeking behaviour for adolescent mental health problems. Factors hypothesized to influence adolescent help seeking are without boxes. Factors hypothesized to influence parents' help seeking for adolescents are shown in white boxes.

The following literature review is divided into a number of sections. First, adolescent help seeking will be defined and reviewed and the results of a number of studies will be presented to provide insight into general adolescent help-seeking practices. Second, theories and models of adolescent help seeking will be presented, followed by a review of how this information has been used in research to assess individuals' stage of help seeking. Next, specific predisposing factors (i.e., gender, age, attitudes toward help seeking, and help-seeking practices), enabling factors (i.e., perceived barriers to help seeking, knowledge, family communication, family cohesion, and family role flexibility), and need factors (i.e., perceived need, psychological distress, and parental burden) will be examined with regards to their effect on adolescent help seeking. Finally, limitations of previous research will be discussed. and the present study's objectives and hypotheses presented.

## CHAPTER II

### Literature Review

#### Adolescent Help Seeking

Adolescent help seeking is conceptualized as a multi-step process that involves efforts made by adolescents or parents to seek assistance from other people to cope with problems (Cauce & Srebnik; 2003). More specifically, individuals must first recognize the problem requiring help, decide to seek help, and actually seek the help they require. Less than half of adolescents with mental health difficulties are estimated to seek professional help or access mental health services (Bergeron et al., 2005; Merikangas et al., 2011; Unrau & Grinnell, 2005; Verhulst & van der Ende, 1997; Zwaanswijk et al., 2007). In the Canadian Community Health Survey (CCHS), the overall prevalence of help seeking for individuals with symptoms of mental health problems was 8.3 percent (Sareen, Cox, Afifi, Yu, Stein, 2005). Individuals aged 12 to 19 years old represented 13 percent of those who did not seek help and 8.8 percent of those who sought help (Sareen et al.). Other studies with young Canadians (aged 15 to 24 years old) have reported that as many as 25 percent of adolescents seek professional help (Bergeron et al., 2005). However, this means that 60 to 80 percent of adolescents do not seek professional help for mental health difficulties (Burns et al., 1995; Gould et al., 2002; Schonert-Reichl, 2003).

Help seeking is an important coping behaviour that involves actively seeking out assistance from formal (i.e., professionals) or informal (i.e., family and friends) resources for a problem or concern (Fallon & Bowles, 2001). A consistent finding within the help-seeking literature is that of adolescents' preference to seek informal help (e.g., Wilson & Deane, 2001; Sherer, 2000; Sullivan et al., 2002). Raviv, Sills, Raviv, and Wilansky (2000) suggest that friends and family provide a reciprocity that minimizes the visibility of the help-seeking process

and, for this reason, may be associated with fewer barriers. Formal help is more often sought by youth when informal sources are believed to be ill equipped or unavailable to provide sufficient support. For example, adolescents who live with someone other than their parent, live in a high level of familial conflict, or feel that they cannot trust informal sources are more likely to seek professional help (Saunders, Resnick, Hoberman, & Blum, 1994).

**Social context of help seeking.** Pescosolido (1992) conceptualized how people seek help using the Social Organization Strategy (SOS) framework. SOS attempts to capture the social context that affects a person's decision making. From this perspective, interactions with members from one's social network (e.g., family members) are believed to convey attitudes, beliefs, and social norms that are used to recognize and understand health problems, seek help, and comply with professional advice (Pescosolido). In this framework, the focus is shifted from the individual to socially constructed patterns of decision making that people learn from those around them. Pescosolido asserted that previous research examined *who* was most likely to use various types of professional help and under *what* conditions, whereas more current research related to SOS has begun to investigate whether there are discernible patterns or strategies that individuals use to seek help and how these patterns are socially organized (e.g., Bussing et al., 2005; Cauce et al, 2002). The importance of family in shaping one's help-seeking practices is emphasized by Pescosolido, Brooks-Gardner, and Lubell (1998) suggesting that professional service use is shaped by the type of support provided by one's social network (e.g., family, friends, and professionals). For instance, social networks, such as the family unit, may attempt to provide care or perpetuate stigmas related to professional help as a way of discouraging the use of formal resources (Pescosolido et al.). On the other hand, social networks can identify

pathways to professional help, monitor the professional help received, and provide assistance in the form of transportation or appointment reminders (Pescosolido et al.).

**Adolescent help seeking models.** There is a consensus within the literature that help-seeking models are adult-oriented, and thus, have limited relevance to adolescents' help seeking (Murray, 2005). As such, help-seeking models were devised to acknowledge the important role that family members, the school system, and the larger community play in ensuring that adolescents are given proper care (Cauce et al., 2002). In fact, many 'individual factors' in adult models are characteristics of families when adolescents are in need of help; for example, finances, geographic region, and education (Andersen, 1995).

Murray (2005) asserts that a key limitation of models of adolescent help seeking is that they ignore 'problem legitimization' – a process whereby adolescents view their problems as important due to the reactions of important others. After analysing 55 qualitative interviews involving hypothetical and actual problems that participants (aged 13 to 14) encountered in their daily experience, Murray found that youth sought help more often for problems that adults treated seriously (e.g., bullying) compared to problems that adults tended to trivialize (e.g., relationship issues). Murray argues that problem legitimization from microenvironments (e.g., family and peer groups) and macro environments (e.g., society) should be considered when considering adolescent help seeking. Murray's research implies that adolescents may be particularly sensitive about how others will react to their problem as adolescents appear to be more sensitive to judgment and may require adult support to remedy problems. Murray's research is consistent with previous and more recent findings that adolescent difficulties are commonly underestimated or undetected by parents and teachers (Boyles, 2010, Feehan, Stanton, McGee, & Silva, 1990; Lewinsohn, Rohde, & Seeley, 1998; McGee, Feehan, & Williams, 1996;

Morrissey-Kane, & Prinz, 1999, Raviv, Raviv, Edelstein-Dolev, & Silberstein, 2003; Rutter, Graham, Chadwick, & Yule, 1976; Sayal, Goodman, & Ford, 2006; Stiffman et al., 2004; Trudgen & Lawn, 2011; Zwaanswijk et al., 2007).

**The process of adolescent help seeking.** As described earlier, help seeking stages involves recognizing the problem, deciding to seek help, and seeking help from formal or informal resources (Andersen, 1995; Sears, 2004). Models of help seeking also involve efforts to identify factors that influence each stage of the process (Bergeron et al., 2005; Bussing, Zima, Gary, & Garvan, 2003; Cauce et al., 2002; Ezpeleta, Granero, de la Osa, Domenech, & Guillamon, 2002; Logan & King, 2001; Sears; Srebnik, Cauce, & Baydar, 1996; Unrau & Grinnell, 2005; Zima, Bussing, Yang, & Belin, 2000). One well used model in the study of help seeking is that by Andersen and colleagues (Andersen; Aday & Andersen, 1974; Andersen & Newman, 1973). The model was initially developed in the late 1960s to assist in understanding why families use health care and to develop policies to promote equitable access (Andersen).

Andersen (1995) focused on the family unit based on the assumption that the medical care an individual receives is a function of demographic, social, and economic characteristics of the family; however, subsequent revisions to the model shifted the focus to individuals because of the difficulty of accounting for the heterogeneity of family members. Therefore, the model now attaches important family characteristics to individuals for the purpose of analysis (Andersen). According to Andersen, predisposing (e.g., gender), enabling (e.g., accessibility and access to services), and need (e.g., perceived need for help) factors predict professional help seeking. Andersen proposed that the strongest predictor of professional help seeking is need.

Andersen's (1995) model incorporates a concept known as 'mutability' to help identify which variables are most amenable to change, and thus, possible targets for intervention.

Demographic variables are judged as having little mutability since factors, such as, gender and age cannot be altered or directly change one's need for professional help (Andersen). Most of the other predisposing factors are judged to be relatively unchangeable since race and ethnicity are fixed and altering educational or occupational achievement is typically not a viable short-term approach for promoting access to professionals (Andersen). However, beliefs and attitudes about help seeking and professional resources are predisposing factors that are judged as having a moderate degree of mutability since they can be altered and can lead to behavioural change (Andersen). Many enabling variables are considered to be quite mutable (Andersen). For instance, individuals in need of professional help can be provided with transportation, access to information, and social supports (e.g., social services, family counselling) to increase their likelihood of obtaining needed services. Need was originally considered to be rather unchangeable until perceived and evaluated need were differentiated. In fact, people's perceived need for professional help may change as barriers to help seeking are reduced (Andersen). That is, individuals who believe that they can manage their problems independently, may decide to seek professional help after being educated about the risks and benefits associated with refusing care. Andersen's concept of mutability is important when considering which factors to target to increase help seeking.

***Models of help seeking derived from Andersen's model.*** Srebnik et al. (1996) developed the *Youth Help Seeking and Service Utilization Model*. This model consists of Andersen's (1995) three stages of help seeking; however, unlike Andersen, Srebnik et al. focus predominately on the family context within which child and adolescent help seeking occurs. According to Srebnik et al., families' social interactions to resolve adolescent emotional or behavioural problems may be predicted by the 'illness profile' (e.g., symptoms, impairment,



diagnosis), predisposing factors (e.g., demographics, values), and barriers to care (e.g., service characteristics, economic factors). Specifically, Srebnik et al. suggest that problem recognition (i.e., stage one) is directly influenced by need (i.e., clinically assessed level of need and subjectively assessed level of need) and predisposing factors, such as family size, structure, and organization. Srebnik et al. further suggest that deciding to seek help (stage two) and actually obtaining support (stage three) are directly influenced by predisposing and enabling factors.

Inspired by existing models of help seeking (Andersen, 1995; Fischer, Weiner, & Abramowitz, 1983; Pavuluri, Luk, & McGee, 1996), Logan and King (2001) present a six-step model of parent-mediated help seeking for adolescents. The model incorporates levels of readiness for change to account for both cognitive and behavioural components of help seeking. In particular, stages are described as relating more to contemplating (stages 1-3) or actively (stages 4-6) seeking help (Logan & King). The model is as follows: (1) gaining awareness of an adolescents' distress, (2) recognizing the problem as psychological in nature, (3) considering possible courses of action, (4) developing the intention to seek mental health services, (5) making an active attempt to seek services, (6) obtaining mental services for, or with, the adolescent. Like Andersen, Logan and King introduce factors that enable or inhibit help seeking at each of the six stages. Once introduced, the factors are believed to continue to impact families' and adolescents' help-seeking decisions. For example, poor communication between adolescents and parents is acknowledged to interfere with parents' ability to recognize the child's mental health problem (Stage 1) and will continue to impact subsequent stages of help seeking process if problems are realized (e.g., parents fail to share information about professional resources, the adolescents fail to tell their parents that they are in counselling, or the adolescent fails to inform their parents about thoughts of suicide or other markers of need). Logan and King

integrated prior help-seeking models and empirical studies on help seeking to provide a schematic for how family factors (i.e., parent-child relationships, parental psychopathology) affect various stages of adolescents' help seeking process; unfortunately, these stages of adolescent help seeking are primarily theoretical and untested.

***Applications of Andersen's model of help seeking.*** To better understand help-seeking behaviours of adolescents in foster and group care placements, Unrau and Grinnell (2005) analysed data from the 1985/1986 wave of the Adolescent Health Care Evaluation Study according to predisposing, enabling, and need factors. The study was conducted in North America with youth ages 13 and 19 years old. Results indicated that female adolescents are more likely to seek help than males, but may not receive a better quality of help due to tendencies to rely equally on media sources (e.g., magazines) as professional help. Minority adolescents from families with lower socio-economic status were found to be least likely to seek help compared to minority youth from families with higher socio-economic status or Caucasian youth. When race and gender were considered together, minority status was most predictive of preferences for informal help and decisions to forgo professional help (Unrau & Grinnell). When Unrau and Grinnell considered age, older adolescents appeared more likely to seek help than younger adolescents. This was attributed, in part, to older adolescents' tendency to have larger social networks of help resources (i.e., friends, family members, and professionals who can provide assistance in an effort to improve the youth's well being). Adolescents with positive attitudes about themselves or who showed greater confidence in professionals were more inclined to seek help when help was needed (Unrau & Grinnell).

Zima et al. (2000) used Anderson's model to explore how predisposing, enabling, and need factors moderated foster children's access to professional services for AD/HD. The

predisposing factors examined included age, gender, ethnicity, and foster parent education. Monthly benefits, number of caseworker visits, time in care, and number of placements were considered enabling factors. Need for professional help was determined by the type of AD/HD, comorbidity, and level of impairment. Notably, 80 percent of the children were identified as having had at least one psychiatric diagnosis (e.g., disruptive behaviour disorder, anxiety) and 47 percent were identified as having comorbid mental health conditions. The findings showed that children have a greater likelihood of accessing care if they are identified with AD/HD, have been in foster care for longer periods of time, have little placement stability (i.e., moving frequently between homes), have a comorbid disorder, or demonstrate severe impairment. Zima et al. also found that boys (n=119) had almost 19 times the odds of having caregivers view them as having a mental health problem compared to girls (n=132) and that Caucasian children (n=48) had five times the odds of using specialty mental health services than children from minority backgrounds (n=203). Zima et al. also found that foster parents with four additional years of education had three times the odds of perceiving a need for professional help than foster parents with less education. Overall, the researchers highlight how examining predisposing, enabling, and need factors in the same study enhances one's understanding of help seeking.

Bussing et al. (2003) adapted the help-seeking pathway model of Srebnik and colleagues' (1996) to examine enabling and need factors while identifying barriers to the detection of AD/HD and eventual service use for elementary school children. By controlling for health insurance coverage, regular medical care, and special education services (i.e., enabling factors) as well as problem severity (i.e., need factor), Bussing et al. isolated predisposing factors (i.e., gender, age, race, and socio-economic status) that seem to delay the identification and treatment of AD/HD. In particular, the time between parents' recognition of AD/HD symptoms

and professional help seeking for girls (n=154) and African-American children (n=170) was found to be substantially longer relative to boys (n=188) and Caucasian children (n=171).

Therefore, gender and race were shown to be related to families' identification of problems (i.e., the first stage of help seeking) to seeking services.

Drawing from existing help seeking models, Bates (2010) surveyed 193 adolescents aged 11 to 15 years old and their parents (n=110) to examine help seeking behavior and the role of predisposing, enabling and need factors. The results showed that adolescent problem recognition (Stage 1) was predicted by prior professional help seeking, stress level, and adolescents' beliefs that informal sources of help would be unhelpful. In contrast, parental problem recognition (Stage 1) was predicted by the burden adolescent problems had on family members. Perceiving a need for professional help (Stage 2) was also predicted by prior professional help seeking and the burden of adolescent problems. Seeking professional help (Stage 3) was predicted by perceived stigma. Bates also examined factors predictive of adolescent help-seeking stages. It was found that adolescent-reported stress was the most robust predictor of help seeking, suggesting that adolescent level of stress influences parental efforts to obtain professional adolescent mental health services.

**Measuring stages of adolescent help seeking.** Across studies, researchers have used similar measures to assess adolescents' stage of help seeking; however, no one measure is widely accepted or consistently used within the literature. Sears (2004) is one of the most cited studies for examining adolescents' help-seeking process. Sears identified adolescents' stages of help seeking based on their responses to an item that asked them to consider if they had experienced an emotional, behavioural, or physical problem within the past year. Youth were considered to have entered the first stage of help seeking (i.e., recognize the problem) if they indicated that

they had problems but did not feel professional help was needed, had problems but did not seek professional help, or had problems and sought professional help. Youth were considered to have entered the second stage of help seeking (i.e., decide to seek professional help) if they indicated that they needed professional help and either did or did not seek it. Youth who reported having problems and indicated seeking professional help were considered to have entered the third stage of help seeking (i.e., seek professional help). This measure lends itself well to administration as it is short and easy to understand. However, Sears points out that it is limited by the fact that it relies solely on adolescents for information and only consists of one item. Sears recommends that future studies include items to be completed once youth have selected a stage of help seeking. In an attempt to attend to this issue, CCHS researchers asked participants who failed to enter the third stage of help seeking (i.e., seek professional help) about the types of help they thought they needed and their reasons for not receiving treatment (e.g., not available in the area, not available at the time required, waiting time too long, didn't know where to go) (Sareen et al., 2005). The present study used a similar line of questioning by asking participants, regardless of their stage of help seeking, about the nature of their problem (e.g., emotional or behavioural), barriers to help seeking, and perceived problem severity (i.e., need).

CCHS participants were categorized into stages of help seeking based on their responses to questions about their contact with professionals for mental health problems (e.g., "In the past 12 months, have you seen or talked on the telephone to a health professional about your emotional or mental health?" "In the past 12 months, was there ever a time when you felt that you needed mental health care but didn't receive it?"). Participants who endorsed feeling that they needed professional care but did not receive it within the past 12 months were categorized as 'perceived need for mental health treatment' – a title that CCHS researchers used to reflect the

first and second stages of help seeking (Sareen et al., 2005). Participants who endorsed having sought help in the past 12 months from a professional about emotional or behavioural problems were categorized as ‘help seekers for mental health problems’ – a title reflective of the third stage of help seeking (Sareen et al.).

Douma (2006) improved on previous measures of the stages of help seeking by obtaining subjective and objective measures of psychological distress, which helped validate concerns and highlight possible unidentified or underestimated problems. For example, to examine parents’ stages of help seeking for children age 6 to 18 years, Douma first asked parents whether they were concerned about their children’s emotional or behavioural functioning. Parents who had subjectively perceived emotional or behavioural problems in their children *and* whose responses on a screener of child psychopathology indicated a need for a mental health professional were regarded as recognising their child’s psychopathology – thereby, successfully completing the first stage of help seeking. Douma assessed whether parents considered getting professional help for their child (i.e., the second stage of help seeking) by asking them whether they had felt a need for a specific type of help due to their child’s emotional and/or behavioural problems. Parents who reported at least some need for professional help were regarded as having taken the second step of help seeking. Douma assessed the third stage of help seeking (i.e., seek professional help) by asking parents who had indicated a need for professional help whether or not they had actually sought the help. Those who had sought help were considered to have successfully completed the three stages of help seeking. Although Douma’s methodology improved upon previous research, she relied solely on parental reports of problems as opposed to also seeking childrens’ and adolescents’ perceptions about problems and help-seeking. The present study sought both adolescent and parent perceptions of the adolescent’s mental health.

## Factors Found to Influence Professional Help Seeking

The majority of research suggests that adolescents are least likely to seek help when their problem is causing them only mild distress (Sawyer et al., 2012). In this case, adolescents have been found to associate help with many disadvantages, such as being time consuming, believing that the problem will not change upon asking for assistance, perceiving very little social pressure to seek help, or believing barriers to receiving help will only be overcome with strenuous effort (Cheng, 2009; Chandra & Minkovitz, 2006; Wilson & Deane, 2001). As described earlier, researchers have proposed relations between help-seeking behavior and specific predisposing, enabling, and need factors. These relations help to predict when adolescents will be likely to associate more advantages than disadvantages with seeking professional help.

**Predisposing factors.** Predisposing factors are often present before the onset of problems and are believed to be related to an individual's propensity to seek and utilize professional help (Andersen, 1995). These factors include age, gender, attitudes toward help seeking, and help seeking practices. Each is discussed below.

**Age.** A number of studies investigating age differences in help-seeking behaviours suggest that older adolescents are more likely to seek professional help than their younger adolescents (Gasquet, Chavance, Ledoux, & Choquet, 1997; Leslie et al., 2000; Schonert-Reichl & Muller, 1995; Schonert-Reichl & Muller, 1996; Sears, 2004; Yap, Wright, & Jorm, 2011). To explain this finding, many researchers refer to the transitions that occur as children enter adolescence. For instance, emerging patterns of self-awareness and self-monitoring can better enable youth to recognize mental health problems and signs of stress (Pruitt, 2000; Schonert-Reichl, & Muller; Windle, Miller-Tutzauer, Barnes, & Welte, 1991; Yap et al.). Consistent with this, Boldero and Fallon (1995) found that older adolescents (15-18 years old) perceive

themselves as having serious problems more often than younger adolescents (11-14 years old). Yap et al. suggest differences in help seeking behaviours of older and younger adolescents may also reflect younger adolescents' tendency to believe that professional help will not be helpful; this has been found in some research studies (e.g., Jorm, Wright, & Morgan, 2007).

Other researchers have accounted for the propensity for older adolescents to seek help more often than younger adolescents by highlighting younger adolescents' newly discovered sense of autonomy, which may discourage help seeking efforts (Schonert-Reichl, & Muller, 1996). Smetana, Villalobos, Rogge, and Tasopoulos-Chan (2010) report that in early adolescence youth are more likely to limit self-disclosure to parents and other adults in favour of placing greater importance on affiliating with peers and striving for independence. During this time, adolescents may perceive help seeking as a threat to their autonomy. However, later in adolescence, youth tend to regain a sense of closeness with parents and other adults while maintaining relationships with peers (Smetana et al.). Wilson and Deane (2010) have shown that older adolescents report fewer barriers to help seeking as a result of lowered perceived needs for autonomy and believing that prior mental health care was helpful. Overall, the cognitive and perspective-taking abilities acquired during adolescence allow youth to engage in the more complex thought processes required to reflect on alternative courses of action, consider cost-benefit analyses of seeking help, and think more critically about resources who might be helpful (Pruitt, 2000; Spear & Kulbok, 2004; Steinberg, 2001).

**Gender.** Adolescent help seeking has been shown to be gender dependent, in that females tend to seek help more often than males (Adlaf, Paglia-Boak, Beitchman, & Wolfe, 2004; Boldero & Fallon, 1995; Ciarrochi, Wilson, Deane, & Rickwood, 2003; Dubow, Lovko, & Kausch, 1990; Farrand, Parker, & Lee, 2007; Gasquet et al., 1997; Leong & Zachar, 1999; Lin,



Goering, Offord, Campbell, & Boyle, 1996; Raviv, Raviv, Vago-Gefen, & Fink, 2009; Rickwood et al., 2005; Schonert-Reichl & Muller, 1996), appear to recognize the need for help more readily (Offer et al., 1991; Raviv et al., 2009), hold more positive attitudes towards mental health professionals (Leong & Zachar, 1999; Raviv et al., 2000; Raviv et al., 2009; Schonert-Reichl & Muller; Tishby, Turel, Gumpel, & Pinus, 2001), and place greater confidence in service providers (Leong & Zachar, 1999; Williams, 2010). The literature suggests that gender-related patterns of help seeking found in adolescence are consistent with early learning experiences in childhood. Using a sample of 213 second-, fourth-, and sixth-grade students, Barnett, Sinisi, Jaet, and Bealer (1990) showed that, beginning in early childhood, girls view help seeking to be more acceptable and appropriate than do boys. These researchers also show that gender biases may affect how useful children expect help resources to be. For example, children preferred to ask fathers for help on tasks that involved spatial-relation abilities, mechanical skill, or strength, but preferred to ask mothers for help on tasks that involved writing, reading, attending to an injury, or validating feelings (Barnett et al.).

Historically, gender has also appeared to affect how parents respond to children seeking help; in that, parents were previously found to be more likely to encourage dependence in female children by responding quickly to requests for help and were more likely to encourage independence in male children by ignoring requests for help or providing 'hints' that allow male children to reach solutions on their own (Rothbart & Rothbart, 1976). Overall, these findings suggest that boys and girls develop different attitudes and beliefs about help seeking early in childhood, at least in part, because of family socialization practices.

Several authors (e.g., Addis & Mahalik, 2003; Benenson & Koulouzian, 2008; Davies et al., 2000; Jaycox et al. 2006; Möller-Leimkühler, 2002; Timlin-Scalera, Ponterotto, Blumberg,

& Jackson, 2003) believe that child-rearing practices and gender roles teach boys to view help seeking as being incongruent with masculine norms; therefore, preventing boys from accepting the 'weak role' often associated with seeking help and suffering from mental health problems. Vogel, Webster, and Larson (2007) suggest that traditional male gender roles lead males to have stronger beliefs about their need for autonomy and personal control than females. Therefore, it is possible that men have stronger belief-based barriers than women.

Social pressures to behave in gender-appropriate ways intensify during adolescence and have been shown to be related to female tendencies to reveal problems and male tendencies to conceal problems (Papini, Famer, Clark, Micka, & Barnett, 1990). Given that help seeking can be considered a 'dependent' behaviour, it is possible that individuals see help seeking as being more consistent with traditional and stereotyped female roles. According to Rogler and Cortes (1993), the predominance of gender stereotypes in cultural groups may help to determine how and if families seek help for children and adolescents. For instance, Rogler and Cortes posit that women will be more likely to mobilize help resources and attend to matters of illness in families that emphasize gender roles and will be more likely to share help seeking responsibilities in families that are less concerned with gender roles. Although changing, Western society has long been recognized as tending to socialize males to be independent, self-reliant, and achievement-oriented while socializing females to be cooperative and dependent (Sue & Sue, 2008).

***Attitudes toward help seeking.*** Help seeking attitudes can be seen as generally positive or negative views of a person (e.g., mental health professional), place (e.g., mental health centre), thing (e.g., medication), or event (e.g., therapy) encountered in the help-seeking process. Adolescents with favourable attitudes toward professional help seeking are more likely to seek professional help than those with unfavourable attitudes (Leong & Zachar, 1999; VonDras &

Madey, 2004). Examples of positive attitudes include having confidence that service providers will be able to help alleviate problems (Leong & Zachar) and believing that help seeking can facilitate future independence (Sawyer, 2000).

Several researchers have shown that adolescents' decisions to forgo professional health help can result from beliefs that treatment will be unhelpful or that people who seek help are weak (e.g., Corrigan, 2004; Curtis, 2010; Komiti, Judd, & Jackson, 2006). This is illustrated by Yap et al. (2011), who examined the help young people (12-25 years old) provided to persons thought to be developing a mental health problem or in a mental health crisis. Participants in the study participated in telephone surveys in which they were randomly read one of four vignettes involving depression, depression with alcohol misuse, social phobia, and psychosis. The gender and age of the character in the vignette was chosen to correspond with the gender and age of the participant; for instance, participants ages 12 to 17 were read versions of vignettes portraying a person aged 15 years and in secondary school. The results suggest that young people's decision to offer assistance and recommend professional help seeking was influenced by the disorder described in the vignette; so that, social phobia was associated with higher scores on 'weak not sick' stigmatizing attitudes, reflecting the perception that people with social phobia did not require help because they were 'weak' or could control their behaviour, as opposed to being mentally ill. Overall, the findings demonstrate that young people's ability to appreciate the severity of mental health problems and respond in a supportive manner are not optimal. In particular, young people's ability to recognize the need for professional help was hindered when they perceived the person with the mental health condition to be 'weak.'

An adolescent's perception of what it means to seek help may be the strongest predictor of help-seeking behaviour. For instance, researchers have found that youth who associate mental

health problems with inferiority are more likely to hold negative attitudes toward help seeking and forgo help (e.g., Chandra & Minkovitz, 2007). In a sample of 451 Canadian high school students (14 to 19 years old), Stanhope, Menna, and Newby-Clark (2003) found that adolescents' primary barrier to seeking informal or formal help for a stressful problem was the belief that one should be able to handle the problem independently. Similarly, youth have been found to be less likely to seek help when they believe they contributed to the problem, feel the problem is unique to their experience, or fear being seen as inferior or dependent on others (Nadler, 1991, 1997).

Parental attitudes towards seeking professional help for adolescent difficulties may be influenced by additional factors. In a qualitative study, Sayal et al. (2010) conducted eight focus group discussions with parents who had concerns about their child's (age 2 to 17 years) emotional health or behaviour. The results suggest that parents' attitudes towards help seeking are influenced by their perception of adolescent problems, their ability to cope with adolescent problems, their knowledge of mental health, and the availability of services. Parents in Sayal et al.'s study also reported attitudes that help seeking may be inconvenient (e.g., limited available appointment times, appointments perceived to be too short in duration), led to feelings of embarrassment or blame, may result in children being labelled, and in extreme circumstances may result in having children removed from the family home. Negative attitudes towards professional help seeking appeared to be mitigated by parental perceptions that professionals were interested in the adolescent, good communication with professionals, continuity of care (e.g., long-term relationships with the general practitioner), and trusting the general practitioner (Sayal et al.).

***Help seeking practices.*** Murray (2005) posits that adolescents' current help seeking practices relate to their prior help-seeking experiences and asserts that this point is often

overlooked. After conducting 55 qualitative interviews focused on young participants' (aged 13 to 14) help seeking experiences, Murray classified adolescents' prior help seeking experiences and posited how this may influence their future decisions to seek or forgo help. For example, Murray identified unfavourable patterns where help sources did not offer a resolution to adolescents' problems, reframed problems such that the adolescent felt complained about or blamed, failed to respect the adolescents' privacy, or dismissed the problem. Notably, adolescents have reported more negative attitudes toward seeking professional help after service providers have evoked feelings of fear or shame, failed to seek clarification when they misunderstood the problem, or used too many technical terms (Ballon et al., 2004). Murray also identified favourable patterns in which adolescents enlisted a help source to manage their problem because they believed the help source would be taken more seriously by other people, adolescents suggested a solution to the problem and felt the solution was accepted by the adult, or adolescents were provided with help immediately after asking for help. Positive help-seeking experiences such as these and accurate knowledge of mental health have been found to improve help-seeking attitudes, suggesting that one's experiences with professionals can correct misconceptions or mistrust related to mental health care (Chandra & Minkovitz; 2007).

Prior help seeking experiences have been found to help predict whether adolescents will recognize mental health problems (Stage 1) and decide to seek professional help (Stage 2) (Bates, 2010). For this reason, prior help seeking experiences were examined in the present study.

***Family coping practices.*** The coping literature suggests that children's coping repertoires reflect the coping skills most often used by family members (Skinner & Zimmer-Gembeck, 2007). Thus, families who tend to deal with problems by seeking help may enable

adolescent help seeking whereas families who discourage help seeking or rarely seek help may hinder adolescent help seeking. Families have been found to socialize coping skills (e.g., help seeking) through practices such as, coaching, modelling, and monitoring (Darling & Steinberg, 1993).

*Coaching.* Coaching is broadly defined as a teaching, training or development process in which an individual gets support while learning to achieve a specific goal (Merriam-Webster, 2013). One way in which parents influence their children's coping choices is by offering specific strategies for how to handle problems and suggesting appropriate, effective responses to situations. According to Kliever and Lewis (1995), by giving children direct instruction on how they might think about, appraise, and manage stressful events, parents shape their children's coping repertoire. As these researchers point out, coaching can involve positive and negative messages; for instance, parents may encourage children to blame themselves or others, act out, or avoid dealing altogether with problems. Alternatively, parents may encourage children to do something about stressful situations, and in doing so, send children the message that problems can be solved, do not need to be seen as threatening, and provide opportunities to make choices and participate in the problem-solving process (Kliever & Lewis).

Relations between parental coaching and child and adolescent coping have been studied with children undergoing medical procedures (Manimala, Blount, & Cohen, 2000), experiencing parental divorce (Miller, Kliever, Hepworth, & Sandler, 1994), and coping with everyday hassles (Kliever et al., 1996). These studies have demonstrated moderate associations between the suggestions parents make and adolescents' subsequent coping choices.

To the author's knowledge, no studies have focused specifically on the relation between parental coaching and adolescents' help seeking; however, help seeking socialization can be

examined using studies that have classified help seeking as a coping behaviour. For example, maternal efforts to positively reframe problems have been found to increase children's help-seeking behaviours, whereas maternal suggestions that encourage avoiding problems have been found to increase children's efforts to distance themselves from stress by leaving situations or trying not to think about problems (Kliewer et al., 1996). Consequently, help-seeking behaviours appear to be socialized both by parenting practices and by parents' general coping style (i.e., active or avoidant). Of note, researchers have also investigated factors affecting parents' coaching of coping skills and have found that parents who see value in professional help (e.g., alleviation of symptoms and obtaining good advice) are more likely to suggest that their children consider seeking professional help (Kliewer et al., 1996; Kliwer & Lewis, 1995; Kliewer et al., 2006).

*Modelling.* A second way in which parents influence their child's coping is through providing behavioural models for dealing with problems, especially with respect to whether problems are talked about and whether help is sought from others (Kliewer & Lewis, 1995). Social Learning Theory suggests that by observing, and later imitating parental actions, children learn to interpret, appraise, and respond to stressful situations (Bandura, 1977). Parental help seeking has been shown to influence children's and adolescents' help seeking (Jorm & Wright, 2007; Kliewer, Sandler, & Wolchik, 1994). In particular, parents' religious coping and help seeking have been found to lead to greater instances of children and adolescents seeking help (Kliewer et al., 1996). Kliewer et al. reason that religious involvement may be more evident to children than other forms of coping or help seeking and may be reflective of family values that encourage supporting others and seeking guidance. However, what is less clear is the consistent positive correlation between parental active coping practices and children's avoidance coping

(Kliewer & Lewis). It may be the case that children of more controlling parents are able to assume a more passive role in responding to stressful situations because parents manage most problems or provide children with step-by-step instructions, thereby eliminating the need for children and adolescents to fully participate in problem solving efforts (Aspinwall & Taylor, 1997). Alternatively, parents who engage in active coping may also be more likely to undertake efforts, in advance of potential stressors and, in so doing, prevent or reduce problems; as a consequence, these parents are believed to prevent their children from having to experience what otherwise would have been a stressful situation (Aspinwall & Taylor). Efforts to minimize or avert potential future problems, or proactive coping, is distinct from behavioural avoidance in that it occurs before stressful situations occur, rather than in response to situations (Aspinwall & Taylor).

Researchers have shown that families and adolescents who report informal help seeking are also more likely to report formal help seeking (Raviv, Maddy-Weitzman, & Raviv, 1992). These findings may speak to the powerful influence that modeling informal help seeking can have on adolescents' professional help seeking. Positive experiences with informal help resources not only enhances the ability of others to recognize adolescent problems and suggest professional help, but serve as a model that increases adolescents' receptivity to communicating with and accepting help (Seiffge-Krenke, 1989). Notably, adolescents may observe as well as serve as models that facilitate help seeking. For instance, parents who have seen adolescents successfully deal with psychological problems using mental health services may be more likely to consider seeking professional help for themselves or other family members (Waite & Ramsay, 2010). In fact, a family history of professional help seeking has been shown to make families more likely to view professional help as a reasonable method for addressing adolescents' distress



(Saunders et al., 1994). Having a family member with a psychiatric problem has also been found to motivate individuals to come into timely contact with professional mental health services when they exhibit symptoms (Angermeyer & Matchinger, 1996; Norman, Malla, & Manchanda, 2007). From this, one begins to see the important role that family members play in socializing help-seeking behaviours.

*Monitoring.* Parental efforts to become and stay informed about adolescents' behaviours, peer groups, and activities are often referred to as monitoring. Although the nature of such efforts changes throughout children's development, monitoring practices (e.g., tracking and providing structured environments) are believed to communicate and provide reassurance of a parents' concern for their child's well-being (Hetherington, Parke, & Schmuckler, 2003). The relation between parental monitoring and developmental outcomes is one of the most robust findings in the adolescent literature. Poor parental monitoring has been related to adolescent involvement in deviant peer groups (Dishion, Patterson, Stoolmiller, & Skinner, 1991; Nebbitt, Lombe, & Lindsey, 2007) and early substance use (Baker, Keck, Mott, & Quinlan., 1993; Rodgers-Farmer, 2000).

Laird, Pettit, Bates, and Dodge (2003) assert that adolescent reports of parental knowledge may provide a more accurate assessment of parental monitoring due to the fact that adolescents are primarily responsible for the information that parents have access to about their whereabouts, companions, and behaviours. These researchers add that adolescents' perceptions of parental knowledge may have significant influence on adolescent choices; thus, creating a bidirectional relation. This is consistent with trends in the literature that suggest adolescents with patterns of delinquency and poor social adjustment discuss their activities less with parents than well-adjusted children (Parke, 2004), and thus, limit parental knowledge and opportunities

for intervention. For the mentioned reasons, Kerr and Stattin (2000) reconceptualised monitoring, which most see as a parent-driven process, to refer to a process of information sharing that parents and adolescents jointly contribute to. Within adolescent help seeking, monitoring practices appear to be most associated with parents' ability to recognize an adolescent's need for professional help, select the most appropriate help resource (e.g., psychologist, family doctor, and substance rehabilitation centres), and be informed of the adolescents ongoing involvement with professional mental health services.

**Enabling factors.** As was previously mentioned, enabling factors directly hinder or facilitate help-seeking behaviours (Andersen, 1995). Previous efforts to examine enabling factors have been somewhat limited. For instance, research has not considered how barriers to help seeking vary according to levels of psychological distress (i.e., need). CCHS participants with different levels of severity of emotional symptoms were clustered together; and thus, prevented researchers from determining whether some barriers were more or less salient at different levels of need (e.g., Urbanoski, Cairney, Bassani, & Rush, 2008). Since the majority of the CCHS sample reported being in good health and with average amounts of stress, the most commonly reported barriers to professional treatment may be related to low levels of severity or transient symptoms (e.g., Sareen et al., 2005). The present study accounts for these limitations by considering whether barriers to seeking professional help differ across the stages of help seeking. Notably, later stages of help seeking are more likely to include individuals with more severe psychological distress (Farrand et al., 2007).

**Perceived barriers to mental health.** Adolescents' underutilization of professional help has been examined by studying barriers to seeking help for mental health problems (Gulliver, Griffiths, & Christensen, 2010). Factors identified as possibly preventing adolescents from

seeking help include: a lack of knowledge of mental health (e.g., problems recognizing symptoms, poor mental health literacy), concerns regarding confidentiality, lack of resources (e.g., affordability of services, transportation, timely access to services), and belief-based barriers (i.e., self-reliance, stigma, perceived usefulness of helping source) (e.g., Del Mauro & Williams, 2013; Gulliver et al.; Woodhouse, 2006). When asked to complete questionnaires on the barriers to mental health help for adolescents, 21 percent of parents of seventh grade students reported barriers regarding perceptions about mental health problems and 23 percent reported barriers regarding perceptions about mental health services (Owens, Horrocks, & House, 2002).

Wilson and Deane (2012) examined factors associated with adolescent help seeking among 1037 individuals between the ages of 13 and 21 years old. Participants were asked to complete questionnaires designed to assess barriers to seeking professional psychological help and intentions to seek professional mental health care. Across age and gender groupings the results showed that adolescents' need for autonomy was a barrier to seeking professional mental help. Hernan, Philpot, Edmonds, and Reddy (2010) assessed barriers to seeking help for mental health problems within a rural sample consisting of 74 secondary school students (ages 14 to 16 years). Participants were asked to read a vignette involving a depressed youth and then asked to complete a self-report questionnaire designed to assess participants' perception of the helpfulness of professionals and barriers to seeking professional help. The results suggest that the need for autonomy may be stronger for rural adolescents because of the lack of anonymity in smaller communities and the tendency for smaller communities to value self-reliance. Importantly, nearly half of the participants stated that the main barrier to seeking professional mental help was related to embarrassment, shame, or self-consciousness (e.g., I am ashamed to tell the professional about my problems.).

Barriers to professional help may be infinite as they are unique to individuals; however, researchers have attempted to identify the most commonly reported barriers to professional mental help. Given the robust finding that stigma (e.g., Corrigan, 2004) and a lack of knowledge of mental health (e.g., Del Mauro & Williams, 2013) hinder individuals' ability to recognize problems and seek professional help, the present study examined these two barriers in seeking professional help.

*Knowledge of mental health.* Knowledge of mental health and help resources has been consistently recognized as a barrier to seeking help for mental health problems (Del Mauro & Williams, 2013; Sheffield et al., 2004). For example, not knowing where to receive help (Cometto, 2008; Cometto, Menna, & Lafreniere, 2009; Sheffield et al., 2004) or being unaware of the significance of an individuals' behavioural changes (Czuchta & McCay, 2001) have been reported as barriers to obtaining professional services. When given the opportunity to identify reasons for not seeking professional help, approximately 8 percent (n = 58) of the participants in CCHS indicated that their lack of knowledge of professional resources had prevented them from obtaining the help they believed they required (Sareen, et al., 2005). Notably, young people (aged 12 to 19) in CCHS were found to be more likely to report a lack of knowledge as a barrier to help seeking than were adults (Statistics Canada, 2009).

Using a questionnaire designed to measure barriers to adolescent help seeking, Kuhl, Jarkon-Horlick, and Morrissey (1997) found that high school students most often attributed their lack of professional help seeking to insufficient time, beliefs that family and peers provided sufficient help, and not knowing where to obtain professional help. Females were found to be less likely than males to report a lack of knowledge as a barrier (Kuhl et al). Adolescents with

prior experience with professional resources were the least likely to report a lack of knowledge as a barrier to help seeking (Kuhl et al.).

Models of help seeking suggest that a lack of knowledge may hinder, if not terminate, help seeking efforts. Recognition of a problem (Stage 1), relies on adolescents' awareness of symptoms of distress and adolescents' level of personal insight. That is, adolescents must have access to the knowledge required to assess whether they are experiencing known symptoms. Understandably, adolescents with problems that go undetected, or are minimized, may not consider seeking help. Furthermore, the help-seeking process may be terminated prematurely if adolescents' knowledge insufficiently prepares them to anticipate difficulties associated with waitlists, negative help-seeking experiences, and the time often needed to notice therapeutic benefits. Thus, adolescents' knowledge may not only prevent them from realizing their need for help, but may lead to their abandoning the help-seeking process if they fail to adequately prepare themselves for the barriers ahead (Nelson-Le Gall, 1981, 1985). Successful help seeking requires that adolescents know enough to appreciate what is not known, what could be known, and where information can be obtained.

Leavey, Rothi, and Paul (2011) explored adolescent awareness of mental health information using focus groups with 48 adolescents aged 14 or 15 years old. Overall, the results suggested that adolescents' knowledge of mental health services was limited to the abilities of general practitioners (e.g., family doctors). Compared to parents, adolescents were found to be more likely to think that general practitioners are not appropriate professionals to manage mental health problems and may be too judgmental and close with parents to provide the sensitivity and privacy adolescents look for in help sources (Leavey et al.); other researchers have replicated this finding (Hernan et al., 2010). Most participants were unsure of their right to consult with general

practitioners in the absence of a guardian. The adolescents were also uncertain about what information would be kept private and rarely understood what was meant by the term ‘confidentiality.’ Many adolescents also reported concerns that their personal health information would be shared with their parents. Overall, participants’ confusion about client rights and available help sources contributed to considerable delays in getting appropriate help.

Unrau and Grinnell’s (2005) found that service accessibility and characteristics of adolescents’ parents (e.g., knowledge of mental health) were prominent factors associated with adolescent service use. That is, health services designed to appeal to youth consistently attracted a larger proportion of youth and were more successful at addressing comprehensive healthcare needs compared to services designed for the general public. Further, parent education was positively associated with adolescents’ referrals to speciality services, such as child psychiatrists. The recognition of adolescent mental health problems by teachers and parents or the presence of comorbid conditions (e.g., anxiety and depression) also appeared to increase adolescents’ likelihood of seeking and utilizing professional resources (Unrau & Grinnell).

*Stigma.* Stigma is the most frequently cited barrier that prevents people from seeking professional help for mental health problems (Corrigan, 2004). The term stigma refers to the discrimination, alienation, and loss of status people with mental health problems experience due to unfavourable perceptions of mental illness (Byrne, 2000; Link & Phelan, 2001). The negative effects of public stigma have been studied extensively within the literature and highlight social processes whereby the general public perpetuates stereotypes about people with mental health problems and may distance themselves from, or limit the rights of, individuals with mental health problems (Corrigan & Watson, 2002). Crisp, Gelder, Rix, Meltzer, and Rowlands (2000) confirmed that society often relates serious mental health problems with the idea that affected

individuals are dangerous, unintelligent, and incapable of recovery. Corrigan (2005) showed that as a result of stigma, mental health problems are often misunderstood and believed to be a sign of weakness, a character flaw, or a failure to choose a healthy lifestyle. Notably, attitudes and perceptions of individuals with mental health problems have been found to vary based on the labels ascribed to an individual; in that, general labels, such as ‘consumer of mental health services’ tend to be more positively evaluated than specific diagnostic labels, such as depression (Penn & Nowlin-Drummond, 2001; Szeto, Luong, & Dobson, 2013). Similarly, more favourable views of mental illness have been reported by people who conceptualize mental health problems to be biological (e.g., chemical imbalance), as opposed to social or psychological in etiology (Deacon & Baird, 2009). In fact, researchers have found that friends and family withhold help (e.g., providing transportation) when individuals are believed to be responsible for their mental health problems (Weiner, 1995).

Stereotypes and misperceptions of individuals with mental health problems are thought to lead to discrimination and can be internalized by people suffering from mental illness. Self-stigma is a term used to refer to the process of identity transformation where individuals with mental health problems lose previously valued self identities and adopt a stigmatized view of themselves (Corrigan & Watson, 2002; Yanos, Roe, & Lysaker, 2010). Studies have shown that many people with severe mental health problems have high levels of self-stigma, which is positively related to symptoms of depression and negatively related to self-esteem (Mickelson & Williams, 2008; Ritsher & Phelan, 2004; Werner, Stein-Shachman, & Heinik, 2009). Self-stigma is believed to have negative effects on treatment engagement above and beyond the influence of public stigma (Moses, 2010) and is also believed to be the strongest indicator of an individual’s willingness or reluctance to seek professional help (Vogel et al., 2007). Overall,

there is agreement within the literature that public and self stigma create barriers that hinder help-seeking, social integration, and recovery of individuals with mental health problems (e.g., Corrigan & Wassel, 2008; Yanos, Roe, Lysaker, 2011). Importantly, intervention studies show that efforts to reduce stigma (e.g., public education) may lead to increased readiness to seek professional help (Schomerus & Angermeyer, 2008). Group interventions designed to promote healthy self-concepts have also been found to significantly reduce the effects of stigma on individuals with mental health problems, increase their sense of hope, and improve their quality of life (McCay et al., 2006; McCay et al., 2007).

Stigmatizing attitudes often fully emerge by puberty and intensify in adulthood (Hinshaw & Stier, 2008). For many youth, the fear of being treated differently by peers is a significant barrier to seeking professional help for mental health problems (Rickwood et al., 2005). In the process of examining the effectiveness of a single-session anti-stigma intervention with high school students (n = 254), Hartman et al. (2013) discovered that one in eight high school students experienced self-stigma. These researchers found low self-esteem, younger age, and a lack of familiarity with mental illness made youth more vulnerable to self-stigma. Likewise, Flett and Hewitt (2013) draw attention to a subset of youth who conceal mental health problems largely as a result of concerns about stigma. These youth were described to have elevated levels of traits such as self-concealment and perfectionist self-presentation. It may be that the characteristics that make one vulnerable to mental illness may also make one vulnerable to internalizing stigma.

***Family environment.*** Youth who experience a high number of stressors but enjoy supportive relationships are believed to be less likely to experience psychological distress or require professional help, compared to youth without supportive relationships (Jose & Kilburg, 2007). Within the literature on family support, studies have found that adolescents with less



supportive networks are more likely to experience psychological distress, use less effective coping strategies, and come into contact with professional help resources more often (Oliva, Jiménez, & Parra, 2009; Wu, Stewart, Huang, Prince, & Liu, 2011). Based on such findings it has been argued that family relationships can make one more or less vulnerable to psychological distress by providing support, informal help, and serving as a referral source to professional resources (Oliva et al.). In fact, families develop distinct climates, styles of responding, and boundaries that model and prepare children for relationships with informal and formal help resources (e.g., Kliwer et al., 1996). Researchers have attempted to isolate aspects of family functioning to study how some families positively contribute to and guide adolescent adjustment while others provide atmospheres conducive to developmental regression and maladaptation.

Moos (1974, 1986) and Moos and Moos (1994) attempted to better understand the family environment and its influence on child outcome by looking more in depth at aspects of family relationships, personal growth, and the maintenance of the family system. In this context, *family relationships* are assessed by considering the degree of commitment and support family members provide one another (i.e., cohesion), the extent to which family members are encouraged to express feelings directly to one another (i.e., expressiveness), and the amount of openly expressed anger or conflict among family members. *Personal growth* is assessed by considering the extent to which family members are independent (e.g., make their own decisions), achievement oriented (e.g., cooperative or competitive), interested in intellectual and cultural pursuits, participate in social activities, and emphasize ethical or religious values (Moos & Moos). *Family system maintenance and change* is assessed by considering how much planning family members put into activities (i.e., organization) and how many set rules and procedures the family has (Moos & Moos).

Similar to Moos and Moos (1994), other researchers have attempted to identify dimensions by which to measure the family environment. Epstein, Baldwin, and Bishop (1983) evaluated family functioning according to the family's ability to solve problems, exchange information clearly, establish patterns of behaviour, experience appropriate affect, value each other's activities, and maintain standards of behaviour. Similarly, Olson and Gorall (2003) describe families according to varying levels of *cohesion* (i.e., Disengaged, Balanced, Enmeshed) and *flexibility* (i.e., Rigid, Balanced, Chaotic). Using combinations of these two constructs, Gorall, Tiesel, and Olsen (2006) classified families as being one of six family types, which range from most healthy to most problematic. Gorall et al. viewed *communication* as a third dimension that helps families alter levels of cohesion and flexibility, but does not have to be assessed in order to classify family functioning (Olson, 2011). While each of the mentioned sets of researchers conceptualize family functioning slightly differently, family cohesion, conflict, organization, stability, and self-expression are common elements to all, suggesting that there is considerable agreement within the literature.

Using the above frameworks for assessing family functioning, studies have shown that adolescents are better adjusted when they perceive their family to be cohesive, expressive, organized, and supportive of independence (Bryant & Zimmerman, 2002; Davalos, Chavez, & Guardiola, 2005; Grolnick, Ryan, & Deci, 1991; Millikan, Wamboldt, & Bihun, 2002; Ratelle, Simon, Guay, & Senécal, 2005). Together the research findings suggest families convey a sense of available support to children and adolescents when members are cohesive, communicative, and engage in conflict rarely. Family cohesion, family communication, and family's response to stress (i.e., flexibility to adapt) can be seen as enabling factors that contribute to a family's

functioning and ability to provide adolescents with adequate support when they experience stress (e.g., Gorall et al., 2006; Moos & Moos, 2009).

*Family cohesion.* Nurturing, supportive, and warm are terms commonly used to describe cohesive family environments. Notably, exaggerated family harmony discourages individuality and is often referred to as ‘enmeshment,’ while family disengagement interferes with family members’ ability to affect one another and often leads to isolation (Quille, 2000). Several studies suggest that lower levels of family cohesion are associated with maladaptive coping strategies (e.g., such as avoidance and excessively venting negative feelings), psychopathology, social impairments, and behavioural difficulties (Brown, Mounts, Lamborn, & Steinberg, 1993; Canetti, Bachar, Galili-Weisstub, De-Nour, & Shalev, 1997; Franko, Thompson, Bauserman, Affenito, & Striegel-Morroe, 2008). In contrast, high family cohesion has been shown to serve a protective function against adolescent substance use (Johnson & Pandina, 1991) and self-blame (Stern & Zevon, 1990). The difference in adolescent outcomes found between cohesive and non-cohesive families suggests that when children and adolescents feel secure and accepted they are less likely to feel threatened by stressful events and more likely to deal with problems using active coping strategies (McKernon et al, 2001).

Family cohesion has not been directly related to adolescent help seeking; however, research indicates that adolescents prefer to seek help from people who exhibit qualities most compatible with families that are nurturing, supportive, and warm.

Martin, Romas, Medford, Leffert, and Hatchre (2006) conducted a focus group with adolescents (6 females, 1 male) aged 12 to 17 ( $M = 14.6$ ) for the purpose of identifying traits that youth desire in professionals working in therapeutic settings. Content analysis of adolescent responses revealed that youth were more willing to seek help when they believed that the help

resource would treat them with respect, listen to their concerns, and enjoy being with them. Participants indicated preferences for help resources who leave decision making to the adolescent, without applying pressure, and who hold youth accountable for behaviours (e.g., acting on decisions). Further, participants stated that they wanted to leave help resources feeling better and thought it was important that they be somewhat familiar and comfortable trusting the chosen help resource (Martin et al.). It has been suggested that the extent to which adolescents have access to desired social interactions and feel comfortable interacting with help resources is related to their experiences within the family environment and how they view the world as a result of those experiences (Cochran & Niegro, 2004). Experiences of being supported and respected are likely to encourage adolescents to expect others to provide support and respect. Adolescents from cohesive family environments may be better able to appreciate the importance of having the time and space in which to build trust and get to know professional helpers (Leave et al., 2011).

*Family flexibility.* According to the Circumplex Model, *flexibility* reflects the quality and expression of leadership and organization within the family, rules, roles and negotiations (Olson & Gorall, 2003). This dimension focuses on how well families balance stability with change and the extent to which families are able to adapt and manage stress. Extended periods of inflexibility or rigidity within families are problematic and dysfunctional (Lebow & Stroud, 2012). Establishing predictability in family life involves creating rules and enforcing them to support family stability, connectedness, and parental authority (Imber-Black, 2012). In this way, role allocation and role accountability are seen as crucial aspects of effective family flexibility and functioning (Olson & Gorall).

Families and parents under stress may become too overwhelmed by day-to-day issues to attend to the need for routines and rituals (Anderson, 2012). For this reason, many researchers have examined the effect of stress on families. High levels of family stress are often seen in families who have experienced multiple disruptions; for instance, those involving the beginning or ending of a romantic relationship of a parent, changes in caregivers, separation from a biological parent, frequent moving, or changes in income (Forman, 1999). Notably, major life transitions involve reorganization of the family relationships, organization, and roles; for example, adolescence is a period of transition in which youth may begin to think differently about their identity, their role, and their relationships inside and outside of the family unit (Cowan & Cowan, 2012). Because transitions disrupt familiar ways of being, Cowan and Cowan suggest that it is possible for transitions to be moments in which family members become open to trying new ways of coping; it is often healthy families who are most likely to demonstrate this level of flexibility.

Parental stress has consistently been linked with child development issue and mental health problems (e.g., Gross, Shaw, Burwell & Nagin, 2009; Horwits, Gary, Briggs-Gowan, & Carter, 2003) and has been shown to predict an increased likelihood of children receiving mental health services (Farmer, Stangl, Burns, Costello, & Angold, 1999). Using a random sample of 2,227 Dutch children between 4 to 18 years old, Verhulst and van der Ende (1997) identified factors related to rates of referral for mental health services and parents' ability to recognize children's need for professional help. Parents provided demographic information and completed questionnaires on child psychopathology and general family functioning. The findings revealed that parents with higher levels of education had more knowledge of child development, which facilitated the recognition of problems, and better access to professional resources. However,

education and occupation were not associated with need for or use of professional services. Instead, family stress levels appeared to determine help-seeking practices, in that families who indicated greater amounts of stress were more likely to have children referred for professional services than families of children with the same problems, but who indicated lower levels of stress. Families who reported greater amounts of stress (e.g., single-parent families and families undergoing changes in composition) also tended to report greater family dysfunction and rigidity (e.g., attempting to solve problems in the same way, despite undesired outcomes).

While the burden of accumulated stress, parental psychopathology, and adverse life events in Verhulst and van der Ende's (1997) study was found to lower parents' tolerance for problematic behaviour, well-functioning and poorly-functioning families sought professional help at similar rates when parents attributed increasing levels of familial stress to a child's or adolescent's problems. That is, when family stress was perceived to have been followed by a child's struggle with mental health problems, parents were more likely to seek professional help. Thus, just as studies have found that increased psychological distress motivates adolescents' to seek help (Chandra & Minkovitz, 2007), Verhulst and van der Ende suggest that high levels of family stress motivate parents to seek help for adolescents when parents understand increased levels of family stress to be related to adolescent mental health problems. In this way, rigid families are seen to consider new ways of coping when confronted with substantial levels of stress.

*Family communication.* Also related to how family cohesion influences adolescent help seeking is family communication. In the context of supportive family environments, research highlights that constructive family communication can help children learn valuable skills for

negotiation and resolving disagreements (e.g., assertive communication) (Cummings, Davies, & Campbell, 2000).

Contrary to the popular notion that adolescence is a highly conflictual time when parent-child communication is marked with misunderstandings and disagreement, Paikoff and Brooks-Gunn (1991) found that less than 10 percent of parent-adolescent relationships are characterized by chronic levels of conflict. This finding is supported within the literature, suggesting that tumultuous relationships and argumentative exchanges are far less characteristic of adolescence than may be believed (Collins, 1990). Quille (2000) suggests that the presence of uncharacteristic familial conflict may signal to parents that behaviours need to change in response to the developmental demands of youth. In this case, parents who are responsive to youth may encourage autonomy and communicate understanding to their adolescent, potentially strengthening parent-child bonds. Similarly, Steinberg and Silk (2002) assert that conflict is context dependent; in that, it is a positive part of adolescent individuation in harmonious family environments while having the potential to contribute to negative developmental outcomes when in excess.

Related to communications about mental health is parents' psychological sophistication, knowledge of treatment resources, and past exposure to psychopathology. To explore these things, Fisher (1992) selected every other name from high school mailing lists provided by two districts in New York City. Selected families were sent questionnaires related to demographic information, parents' perceptions of their adolescent's concerns (e.g., body image, sexuality, and mental health), parents' own experience with these concerns as teenagers and as adults, and parents' views about the importance of health issues (e.g., nutrition, substance use, sexuality, and mental health). Of the 1090 families selected, 438 parents completed questionnaires.

Fisher's (1992) findings suggest that most parents discuss substance abuse, sexuality, mental health issues, nutritional concerns, and general medical issues with youth, but depend on adolescents to indicate a need for help in these areas. Thus, parents appear to expect that adolescents will be able to recognize problems and seek help from family when they are provided with the appropriate information. This is not an uncommon finding as people in a position to provide help, such as parents and professionals, have often been found to underestimate the role that embarrassment plays in help seeking and overestimate the likelihood that individuals will ask for help (Bohns & Flynn, 2010). These errors in social judgment mean that parents may place the onus on adolescents to seek help without addressing barriers related to feelings of discomfort.

Fisher (1992) also found that most parents believed that concerns related to their adolescents could be addressed adequately by general practitioners, as opposed to professionals in specialty areas, such as psychology and psychiatry. Fewer than 40 percent of parents indicated that they would be willing to pay higher health fees to manage mental health issues often associated with specialty care. However, other research suggests that parents are more likely to view professional mental health services as necessary when adolescent problems are perceived to be beyond health problems or the scope of practice of general practitioners (Sayal et al., 2010). Notably, fewer than 10 percent of physicians provide comprehensive care to adolescents for problems related to sexuality, substance use, body image issues, and mental health concerns due to feeling uncomfortable, lacking knowledge, or lacking sufficient time (Marks, Fisher, & Lasker, 1990). Thus, it seems that while general practitioners are in a good position to provide services, their knowledge and skills to assess and intervene in adolescent mental health problems are often insufficient (Hafting & Garlov, 2009; Joukamaa, Lehtinen, &



Karlsson, 1995; Macdonald et al., 2004) and may lead to delays in referring youth for needed speciality mental health services (Laukkanen et al., 2003).

**Need factors.** The need factor described in Andersen's (1995) Model refers to psychological distress and the severity of mental health problems as perceived by the individual (i.e., perceived need). Need may also refer to the stress parents experience as a result of parenting an adolescent with mental health problems.

***Perceived need for mental help.*** Perceived need includes parents' and adolescents' perception of the adolescents' mental well-being, ability to face day-to-day demands, and psychological distress (e.g., Bergeron, Poirier, Fournier, Roberge, & Barrette, 2005). While many factors deter adolescents from seeking professional help, increased psychological distress has been found to increase adolescents' willingness to seek professional help (Madianos, Zaraloudi, Alevizopoulos, & Katostaras, 2011; Rickwood & Braithwaite, 1994; Schonert-Reichl & Muller, 1996; Sheffield et al., 2004; Zwaanswijk et al., 2003). Adolescents have been recognized to seek professional help more when they perceive increasing levels of symptom and problem severity. In this way, distress is thought to motivate adolescents to overcome barriers to professional help that they may have previously been unable to overcome (Sheffield et al.). For example, Zwaanswijk et al. reported that approximately six percent of adolescents sought help when they perceived themselves as having minor emotional or behavioural problems, but approximately 18 percent of adolescents sought help when they perceived their problems to be serious.

The CCHS assessed participants' perceived need for professional help using self-report measures of health status, stress, and impairment to daily functioning. Results revealed that 88 percent of individuals aged 12 years of age or older (n=125,493) indicated excellent or good

health and 74 percent of the sample considered their life to be ‘a bit’ stressful at most (Sareen et al., 2005). A small minority of the sample reported having to stay in bed or cut down on regular activities for all or most of the day. Overall, only 12 percent of respondents perceived a need for mental health treatment (Sareen et al.). Despite this, measures of distress revealed that approximately 20 percent of CCHS respondents needed mental health services; suggesting that a significant number of people failed to recognize a need for help. CCHS researchers attribute the noted discrepancy to the possibility that participants were unaware of early signs of mental health problems or had a higher tolerance for distress than research suggests one should tolerate without seeking professional help (Sareen et al.). When compared to older age groups (i.e., 25 to 44 years, 45 to 64 years, and 65 years and over), respondents aged 15 to 24 years were found to have the highest rates of mental health disorders (Bergeron et al., 2005), indicating that they may be more likely to tolerate symptoms and are at a higher risk for failing to recognize mental health problems. Respondents who were aware of their needs for professional services were more likely to have co-occurring conditions, and thus, greater levels of psychological distress (Urbanoski et al., 2008).

Despite robust findings that symptoms of psychological distress serve to motivate adolescents to engage in help-seeking behaviour, studies have found that specific forms of psychological distress are related to decisions to forgo professional help. In particular, research on depression suggests that individuals may have more negative attitudes toward help seeking and may be less inclined to seek help as depression symptoms worsen (Carlton & Deane, 2000; Garland & Zigler, 1994; Sawyer et al., 2011). Withdrawal, avoidance, and hopelessness are symptoms especially believed to prevent adolescents from seeking help (Wilson & Deane, 2010; Wilson et al., 2005; Wilson, Deane, Marshall, & Dalley, 2010; Wilson, Rickwood, & Deane,

2007) and have been used to understand the inverse relation between suicidal intentions and help seeking (Carlton & Deane; Gould et al., 2004; Husky, McGuire, Flynn, Chrostowski, & Olfson, 2009; Rickwood et al., 2005).

**Parental stress.** The terms *burden* and *impact* are used interchangeably in the help-seeking literature to refer to the effect adolescent mental health problems have on family members (Angold et al., 1998). According to Farmer et al., (1997), *burden* may be more appropriately applied to families coping with severe and persistent adolescent mental health problems whereas *impact* may be more appropriately applied to families coping with less severe adolescent mental health problems. The majority of the help-seeking literature focuses on parental burden associated with raising children with developmental disabilities, attention-deficit/hyperactivity disorder, and medical conditions as opposed to depression, anxiety, conduct problems, and other mental health concerns. Across studies, ratings of parental burden are consistently associated with the severity of the child's illness or psychopathology, particularly externalizing behaviours (Hinshaw, 2008). Ratings of parental depression, marital distress, and parental health problems also appear to increase as child and adolescent problems increase (Hinshaw).

Farmer et al. (1997) provided insight into the parental burden associated with raising a child or adolescent with psychological problems. In a longitudinal study in a rural area of the Southern United States youth (9, 11, and 13 years of age) were randomly screened for emotional and behavioural problems and invited to participate in research if they fell within a set cut-off points determined to identify the 'general population' and the 'clinical population.' Of the 4500 youth screened, 1015 were eligible and participated in the project. The sample was deemed to be representative of the region in that it was predominately white, had nearly equal numbers of

females and males, had a minority of participants who fell below the poverty line, and had a slight majority of participants whose parents had educational achievements beyond high school.

Farmer et al. (1997) conducted interviews separately with parents and adolescents at the beginning of the study and then on a yearly basis for four years. Questionnaires were used to assess youths' need for professional help, service use, and family burden. Results revealed that participants between 10 and 15 years old, who used professional services, were more likely to have severe problems than adolescents who did not use services during that time. Youth with problems of greater severity were found to be the most likely to introduce burden into the family environment and, consequently, had the greatest likelihood of being referred for professional help. Areas of family functioning that appeared to be most impacted by youth's problems were parental well-being and sense of competence to handle youth's problems. Parents of youth with more severe problems were more likely to seek out professional help for themselves as well as for their child (Farmer et al.). The findings point to the burden that parents and families experience as a result of adolescent difficulties and the substantial role that this plays in parents accessing professional services for youth. These findings suggest that parents' perceived impact of adolescent problems is an important predictor of help seeking for adolescent mental health problems.

### **Relevant Methodological Issues and Limitations of Past Research**

In comparison to the vast literature on adult help seeking, adolescent help seeking remains largely unexplored by researchers. It is perhaps because of the developmental issues unique to adolescence that parents' role in professional help seeking is so difficult to identify. Researchers have begun to attempt to pull apart and understand the intermediate steps between the onset of symptoms of distress and actual help seeking for adolescent mental health problems;

however, it is proving difficult to then integrate models of adolescent help seeking within familial and social networks. As such, the current literature may be divided into two camps: theoretical help-seeking models and correlational designs investigating the relations between adolescents' actual help seeking and family and individual factors. Past studies investigating how aspects of family environments and parent-child relationships affect adolescent help seeking are limited as many have considered a single step (i.e., service use) in a help-seeking process known to involve a series of stages. At the same time, research examining the stages of adolescent help seeking is primarily theoretical and untested. Kliewer et al. (1996) attempted to test a theoretical model of parent and family influences on children's global coping, but were unable to use holistic analytic strategies, such as path analysis, due to the number of paths in their model (i.e., over 100) relative to the study's sample size. The literature suggests that adolescent help seeking is complex and difficult to tease apart. Indeed, most of the variables are only partially understood and would require very large samples to sufficiently examine relations between variables.

In order to fully merge theoretical models with empirical study, researchers must consider the need to simplify models and reduce the number of variables under investigation. For instance, help-seeking models often include steps that are, perhaps, too specific and not relevant to every adolescents' experience. There is also a tendency within the literature to examine informal and formal types of help seeking simultaneously. This practice often leads to reiterating what is already known about informal help seeking (i.e., adolescents seek help more from family and friends than from professional help resources) at the expense of learning about processes leading to professional help seeking. The fact that adolescents have been found to seek informal help more often than formal help suggests that researchers wanting to learn about

professional help seeking may benefit from looking at it in isolation; for instance, focusing on adolescents who use professional help resources and on adolescents who need professional help but have not sought it. The present study targeted adolescents who needed professional help and had not yet received it.

### **Study Objectives**

The present study had several objectives: (1) to examine adolescent professional help seeking for mental health problems using the three stages of help seeking (i.e., recognizing the problem, deciding to seek professional help, and seeking professional help); (2) to identify predisposing (i.e., gender, age, attitudes toward help seeking, and past help seeking practices), enabling (i.e., knowledge, family cohesion, family role flexibility, and family communication), and need factors (i.e., perceived need, psychological distress, and parental burden) that predict adolescents' and parents' stage of help seeking for adolescent mental health concerns; (3) to identify factors predictive of parents' attempts to seek help for adolescent mental health problems; (4) to examine the relations between adolescents' and parents' stage of help seeking.

### **Hypotheses**

Hypotheses were proposed for each help seeking stage.

#### **Stage 1: Recognizing the Problem**

**Hypothesis 1:** It was hypothesized that an adolescent's likelihood of recognizing their own mental health problems would be positively associated with being older, being female, experiencing more mental health symptoms (i.e., somatisation, worry, low mood, social isolation, restlessness, interpersonal problems, school absenteeism, behaviour problems, sleep difficulties, and inattention), perceiving their problem to be more severe, and having greater knowledge of mental health.

**Hypothesis 2:** It was hypothesized that a parent's likelihood of recognizing adolescent mental health problems would be positively associated with higher levels of objective and subjective strain, greater knowledge of mental health, and assertive family communication.

### **Stage 2: Deciding to Seek Professional Help**

**Hypothesis 3:** It was hypothesized that an adolescent's likelihood of deciding to seek professional help for mental health problems would be positively associated with being older, perceiving their problem to be more severe, having positive attitudes towards seeking professional help, and prior professional help seeking. Further, it was hypothesized that an adolescent who perceived their family environment to be cohesive and flexible would be less likely to decide to seek professional help.

**Hypothesis 4:** It was hypothesized that a parent's likelihood of deciding to seek professional help for adolescent mental health problems would be positively associated with higher levels of objective and subjective strain, perceiving adolescent problems to be more severe, positive attitudes towards seeking professional help, and prior familial professional help seeking.

### **Stage 3: Seeking Professional Help**

**Hypothesis 5:** It was hypothesized that an adolescent's likelihood of seeking professional help for mental health problems would be positively associated with being older, being female, perceiving their problem to be more severe, and prior professional help seeking. Further, it was hypothesized that an adolescent who perceived fewer barriers to seeking professional help would be more likely to engage in professional services.

**Hypothesis 6:** It was hypothesized that a parent's professional help-seeking behaviour would be positively associated with higher levels of objective and subject strain, perceiving their

problem to be more severe, and prior familial professional help seeking. Further, it was hypothesized a parent who perceived fewer barriers to professional help would be more likely to seek help from mental health professionals.

### **Relations between Parent and Adolescent Stages of Help Seeking**

*Hypothesis 7:* It was hypothesized that adolescents' help-seeking behaviours would be similar to those of their parents. In particular, it was hypothesized that a parent's or adolescent's stage of help seeking would be associated with the other's stage of help seeking. Adolescents with parents who had decided to seek professional help were expected to be further along in the stages of help seeking than adolescents with parents who were unaware of their problem or had not yet decided to seek professional help. Similarly, parents of adolescents in the latter stages of help seeking were expected to be further along in the stages of help seeking than parents of adolescents who were unaware of personal problems or have yet to decide to seek professional help.



## CHAPTER III

### Method

#### Participants

Participants were 203 adolescents and 110 parents of adolescents recruited from the Windsor-Essex community. Of these participants, there were 21 parent-adolescent dyads. As outlined in the procedure, extensive efforts were devoted to recruiting a larger sample but these efforts were only partially successful. The implications of having a smaller than expected sample size are discussed in results and discussion sections.

The adolescents ranged in age from 14 to 18 years ( $M = 16.17$  years;  $SD = 1.33$  years). There were 66 males ranging in age from 14 years to 18 years ( $M = 16.50$  years,  $SD = 1.25$  years) and 117 females ranging in age from 14 years to 18 years ( $M = 16.33$  years,  $SD = 1.33$  years); 20 adolescents elected not to provide their gender. A t-test revealed that there was no significant difference in age between male and female adolescents,  $t(162) = .60, p = .55$ . The majority of youth were Caucasian and from two-parent homes. Many of the youth also had parents who had completed some college or university education. Regarding mental health service use, 32 percent of adolescents reported that they had previously received professional counselling services and 19 percent were in counselling at the time of the present study.

Demographic and service use characteristics of the entire sample are summarized in Table 2.

The parents ranged in age from 33 to 67 years ( $M = 42.25$ ,  $SD = 6.33$  years) and 82 percent identified themselves as Caucasian. Forty-three percent indicated that they had graduated from college or university. Only 11 percent reported that they had previously received professional counselling. Sixty-four percent of parents reported an annual income between \$51,000 and \$60,000.

Table 2

*Demographic Characteristics reported by Adolescents and Parents*

	Adolescents		Parents	
	<i>N</i>	%	<i>N</i>	%
<b>Gender</b>				
Male	66	33	15	14
Female	117	58	81	74
No Response	8	4	13	12
<b>Ethnicity</b>				
Asian	12	6	3	3
Middle Eastern	6	3	4	4
Caucasian	129	64	82	75
African	7	3	1	1
Hispanic/Latino-a	8	4	3	3
Native Canadian	6	3	1	1
Biracial	14	7	1	1
Other	1	1	0	0
No Response	8	4	12	11
<b>Family Structure</b>				
Two Parent, Only Child	13	6	-	-
One Parent, Only Child	7	3	-	-
Two Parent, Siblings	112	55	-	-
One Parent, Siblings	43	21	-	-
Other (e.g., living with relatives, alone)	8	4	-	-
No Response	8	4	-	-

(continued)

Table 2 (continued)

*Demographic Characteristics reported by Adolescents and Parents*

	Adolescents		Parents	
	<i>N</i>	%	<i>N</i>	%
<b>Mother's Education</b>				
Some Elementary School	3	1	0	0
Some Secondary School	14	7	3	4
Graduated Secondary School	43	21	28	35
Some College or University	18	9	7	9
Graduated from College or University	85	42	39	48
Graduate/Professional School	13	6	4	5
Other (e.g., in school, apprenticeship)	6	3	0	0
No Response	10	5	0	0
<b>Father's Education</b>				
Some Elementary School	0	0	1	7
Graduated Elementary School	2	1	0	0
Some Secondary School	15	7	1	7
Graduated Secondary School	41	20	4	27
Some College or University	14	6	0	0
Graduated from College or University	81	40	8	53
Graduate/Professional School	22	11	1	7
Other (e.g., in school, apprenticeship)	6	3	0	0
No Response	10	5	0	0

(continued)

Table 2 (continued)

*Demographic Characteristics reported by Adolescents and Parents*

	Adolescents		Parents	
	<i>N</i>	%	<i>N</i>	%
<b>Parents' Total Annual Income</b>				
Uncertain	119	59	-	-
Under \$30,000	10	5	2	2
\$30,000-\$40,000	5	2	6	5
\$41,000-\$50,000	4	2	11	10
\$51,000-\$60,000	3	1	69	63
\$61,000-\$70,000	26	13	0	0
\$71,000-\$80,000	7	3	7	6
\$81,000-\$90,000	4	2	0	0
\$91,000-\$100,000	5	2	0	0
No Response	8	4	12	11
<b>Access to Regular Medical Care (e.g., family doctor)</b>				
Yes	170	84	89	81
No	10	5	7	6
No Response	11	5	11	10
<b>Adolescents' Current Use of Counselling Services</b>				
Yes	36	18	-	-
No	147	72	-	-
No Response	8	4	-	-

(continued)

Table 2 (continued)

*Demographic Characteristics reported by Adolescents and Parents*

	Adolescents		Parents	
	<i>N</i>	%	<i>N</i>	%
<b>Adolescents' History of Using Counselling Services</b>				
Yes	61	30	17	15
No	121	60	80	72
No Response	9	4	10	9
<b>Parents' History of Using Counselling Services</b>				
Yes	-	-	12	11
No	-	-	84	76
No Response	-	-	11	10
<b>Recruitment Source</b>				
High School	123	61	8	7
Word of Mouth	13	6	29	26
Flyer (e.g., mall, mental health centre, church)	35	17	28	25
Email	3	1	-	-
An email from my adolescent	-	-	13	12
Facebook	6	3	0	0
Other (e.g., internet ad, radio, newspaper)	4	2	18	16
No Response	7	3	11	10

**Parent-adolescent dyads.** Within the parent-child dyads, adolescents ranged in age from 14 to 18 years ( $M = 15.92$  years,  $SD = 1.25$  years). There were 7 adolescent males ranging in age from 14 years to 17 years ( $M = 15.08$  years,  $SD = 0.83$  years) and 13 adolescent females ranging in age from 14 years to 18 years ( $M = 16.25$  years;  $SD = 1.17$  years); 1 adolescent elected not to respond to the gender item. A t-test revealed that the male adolescents were slightly younger than the female adolescents,  $t(22) = .034$ ,  $p = .03$ . Eighty-three percent of youth were Caucasian and fifty-four percent were from two-parent homes. Many of the youth had mothers who had completed some college or university education (58 percent) and/or fathers who had completed college or university (68 percent). Of the adolescent participants, 21 percent had previously received professional counselling services and 19 percent were receiving professional counselling during the present study. Demographic characteristics of the parent-child dyads appear in Appendix A.

The parents ranged in age from 36 to 67 years ( $M = 44.66$  years,  $SD = 9.42$  years). Seventy-nine percent of parents identified themselves as Caucasian. Approximately half of the mothers and nearly all of the fathers had graduated from college or university. Seventeen percent of the parents had previously received professional counselling. Most of the parents reported an annual income between \$51,000 and \$60,000.

### **Adolescent Measures**

**Background information.** Adolescents completed a demographic questionnaire, which provided information on their date of birth, gender, grade, family composition, living arrangement, ethnicity, parents' education level, parents' annual income, and parents' employment status. Adolescents also reported whether they had access to a regular source of health care (e.g., family doctor), if they had or were receiving professional help, and if they were

aware of a family history of mental health problems or treatment. They also reported how they became aware of the study. This questionnaire is presented in Appendix B.

**Symptomatology.** Symptoms of emotional and behavioural problems were measured using the Youth Self-Report Pediatric Symptom Checklist (Y-PSC, Jellinek, Murphy, Robinson, Feins, Lamb, & Fenton, 1988). The Y-PSC is a screening tool designed to facilitate the recognition of cognitive, emotional, and behavioural problems in adolescents ages 11 and up. The Y-PSC consists of 35 items that are rated as *never* (0), *sometimes* (1), or *often present* (2). The total score is calculated by summing the responses on the 35 items. Items that are left blank receive a score of zero. If more than three items are left blank the measure is considered invalid; none of the completed adolescent questionnaires in the present study were omitted based on this guideline. A total score of 30 or higher on the Y-PSC suggests significant psychosocial impairment and the need for further evaluation from a qualified health or mental health professional (Pagano, Cassidy, Little, Murphy, & Jellinek, 2000). All of the adolescents in the present study had scores of 30 or higher on the Y-PSC; however, these scores cannot be used to conclude that all the adolescents had a mental illness, this determination would require professional consultation and was beyond the scope of this study. The items have been shown to have strong internal consistency and are highly correlated with clinicians' ratings of children's psychosocial dysfunction (Jellinek et al., 1988; Murphy & Jellinek, 1985; Murphy et al., 1996; Pagano et al.). For this study, the internal consistency of the Y-PSC was found to be good (Cronbach's alpha = 0.88).

**Stages of help seeking.** For the present study, a help-seeking questionnaire was designed using measures from previous research studies. First, the researcher sought permission to modify the Canadian Community Health Survey (CCHS) (Appendix C). The CCHS is a

cross-sectional survey that collects information related to health status, health care utilization and health determinants for the Canadian population (Statistics Canada, 2000). The CCHS was developed by the collaborative efforts of the Canadian Institute for Health Information, Statistics Canada, and Health Canada (Statistics Canada). In Canada, the primary use of the data is for health surveillance, such as the prevalence of disease and other forms of health research. The CCHS has been administered to individuals' ages 12 years of age and older (Statistics Canada) and is comprised of many subsections that span over 100 pages in length. The present study used items from CCHS sections designed to assess an individual's health care utilization and contact with mental health professionals.

In the *Contacts with Mental Health Professionals* section, CCHS respondents are asked: "In the past 12 months, have you seen or talked on the telephone to a health professional about your emotional or mental health?" CCHS response options for this item are limited to answering yes, no, or don't know. In the present study, this question was changed to: "In the past 12 months, have you seen, or spoke on the phone to, a professional about your emotional or mental health?" To capture the family's involvement in adolescent help seeking (e.g., Cauce et al., 2002), adolescents in the present study were able to select one or four responses: "Yes, and I did this on my own;" "Yes, but my parents told me to call or see a professional;" "Yes, but my parents called or made the appointment for me;" or "No, I have not had contact with a professional in the last 12 months."

In the *Contacts with Mental Health Professionals* section, the CCHS goes on to ask questions that address respondents' frequency of contact with professionals for mental health needs (e.g., total number of visits to a professional in the past 12 months) and type of professionals contacted (i.e., "Whom did you see or talk to?"). Only the latter question was of



interest to the present study. For this question, the CCHS provides respondents with five mutually exclusive professional groups to choose from: no contact with a professional, family doctor, psychiatrist, non-physician professional only (e.g., psychologist, nurse, social worker, counsellor), and contact with multiple professionals. The present study modified this item to better reflect the help seeking literature's distinction between informal and formal help resources; for instance, guidance counsellors are non-physician professionals but are considered to be informal help resources for mental health problems because they are not recognized to have specific training in mental health. When modifying the CCHS questionnaire items, the researcher also sought to ensure that the wording of the items was easy for adolescents to understand. As such, adolescents in the present study were asked "Who did you talk to? Check all that apply" and were able to select one of six response options: a doctor, psychologist, social worker, psychiatrist, nurse, or other (i.e., "Other- please specify").

In the *Health Care Utilization* section of the CCHS, unmet health needs are assessed by asking respondents: "In the past 12 months, was there ever a time when you felt that you needed health care but you didn't receive it." Respondents may answer yes, no, or don't know. Individuals endorsing the question are then asked, "What was the type of care that was needed?" CCHS respondents are able to select one of four choices: treatment of a physical health problem, treatment of an emotional or mental health problem, a regular check-up, other-specify. The present study modified the mentioned two items so as to make them more specific to unmet mental health needs. Adolescents in the present study were first asked: "During the past 12 months was there ever a time when you felt that you needed help coping with emotions, mental health, or the use of alcohol or drugs, but didn't receive it?" Adolescents selected "Yes, I believe that I needed help but didn't receive help" or "No, I didn't need help." Adolescents who

endorsed this question were then asked, “What did you feel you needed help for?” and were able to select as many response options as they felt applied to them from a list of nine items (e.g., emotional problems, behaviour problems, Other, please specify: \_\_\_\_\_).

The present study’s measure of help seeking will be referred to as the Help Seeking Questionnaire (HSQ, see Appendix D). In total, it consists of five items that assess adolescents’ contact with professionals for mental health problems (item 1), perceived need for help (item 2a), barriers to seeking professional help (item 2b), understanding of the problem (item 3), perceived problem severity (item 4), and preferred help source (item 5). All of the participants completed the first two items: (1) *In the past 12 months, have you seen, or spoke on the phone to, a professional about your emotional or mental health?* and (2) *During the past 12 months, was there ever a time when you felt that you needed help coping with emotions, mental health, or the use of alcohol or drugs, but didn’t receive it?* Only the participants who indicated a need for help completed the remaining items. The HSQ received a Flesch Reading Ease score in the Easy range, indicating that most Grade 5 students would find the questionnaire easy to read and understand.

The purpose of the HSQ was to classify participants into the three stages of help seeking: (1) recognizing the problem, (2) deciding to seek professional help, and (3) seeking professional help (Andersen, 1995; Cauce et al., 2002; Logan & King, 2001; Sears, 2004). To assess help seeking for recent problems, adolescents were asked the two aforementioned questions about their need for professional help within the last 12 months. The first question asked whether they had sought help from a professional for emotional or mental health concerns. Adolescents who indicated that they had sought professional help were regarded as being in the final stage of help seeking (Stage 3) and were invited to specify who they had sought help from (e.g., doctor,

psychologist, nurse). Adolescents were able to indicate whether they had sought professional help because they felt they needed it (i.e., Yes I sought professional help and I did this on my own) or because they were prompted to do so (i.e., Yes, but my parents told me to call or see the professional; Yes, but my parents called or made the appointment for me).

The second question of the HSQ asked adolescents whether they felt they needed help coping with problems, but did not receive it. Those who indicated that they required help and did not receive it were required to select the type of help they felt they needed from a list of options, including informal (e.g., family) and professional resources (e.g., mental health professional). These adolescents were divided into those who reported believing that they needed informal help (i.e., Stage 1 or recognizing the problem) and those who reported believing that they needed professional help (i.e., Stage 2 or deciding to seek professional help). Adolescents categorized in Stages 2 or 3 and who had indicated that they required help and did not receive it were also categorized as having reached Stage 1 of help seeking. Similarly, adolescents categorized in Stage 3 and who had indicated that they required professional help were also categorized as having reached Stage 2 of help seeking.

Adolescents who indicated that they did not seek help or perceive a need for help within the past 12 months were classified as non-help-seekers. Table 3 provides a summary for how the participants were classified into the stages of help seeking.

Adolescents who admitted to having a problem (i.e., Stages 1, 2 and 3) completed two additional questionnaire items designed to assess the nature and severity of the problem. The first question required adolescents to select the reason they needed help from a list (e.g., emotional problems, substance use, family problems). Adolescents were able to select more than one list item and were given the option to provide reasons not on the list (i.e., Other, please

specify: \_\_\_\_\_). The second question required adolescents to indicate whether they felt their problem(s) were very serious, somewhat serious, or not serious at all. The latter questionnaire item allowed the researcher to assess adolescents' perceived problem severity.

Table 3

*Classifications for Adolescents in the Stages of Help Seeking*

Classification	Questionnaire Item	Response
Non-Help-Seekers	In the past 12 months, have you seen, or talked on the phone to, a professional about your emotional or mental health?	No
	During the past 12 months was there ever a time when you felt that you needed help coping with emotions, mental health, or the use of alcohol or drugs, but didn't receive it?	No
Stage 1 Recognize the Problem	In the past 12 months, have you seen, or talked on the phone to, a professional about your emotional or mental health?	No
	During the past 12 months was there ever a time when you felt that you needed help coping with emotions, mental health, or the use of alcohol or drugs, but didn't receive it?	Yes
	What type of help did you feel you needed?	Informal
Stage 2 Decide to Seek Professional Help	In the past 12 months, have you seen, or talked on the phone to, a professional about your emotional or mental health?	No
	During the past 12 months was there ever a time when you felt that you needed help coping with emotions, mental health, or the use of alcohol or drugs, but didn't receive it?	Yes
	What type of help did you feel you needed?	Formal
Stage 3 Seeking Professional Help	In the past 12 months, have you seen, or talked on the phone to, a professional about your emotional or mental health?	Yes

**Barriers to help seeking.** To assess barriers to professional help, item 2b on the HSQ required all adolescents to select reasons from a list of 16 items as to why they had not or may not seek professional help (e.g., waiting times, feeling services would be inadequate or unhelpful, transportation problems, concerns that other people might have found out). One item allowed the adolescents to add their own response (i.e., Other, please specify:\_\_\_\_\_). The mentioned 16 items were developed based on prominent findings in research studies that explored the barriers to adolescent help seeking using qualitative and/or quantitative means (e.g., Del Mauro & Williams, 2013; Hernan et al., 2002; Owens et al., 2002, Sareen et al., 2005; Sheffield et al., 2004; Wilson & Deane, 2012). With the exception of adolescents' knowledge of mental health (3 items), each of the 16 items was designed to capture one of the commonly reported barriers to adolescent help seeking within the literature (e.g., waiting times, perceptions that professional help would be inadequate, a lack of trust for professionals, concerns that other people will find out).

Research has shown that it is not simply adolescents' knowledge of help resources, but rather their broader knowledge of mental health that helps to determine who will seek help (e.g., Del Mauro & Williams; Owens et al.; Sheffield et al., 2004). With this in mind, the present study included items to help assess adolescents' general knowledge of mental health (e.g., "I know very little about mental health, such as the symptoms of mental health problems.") and knowledge of mental health resources (e.g., "I didn't know where to go").

Although no items were taken from the Barriers to Adolescents Seeking Help questionnaire (BASH; Kuhl, Jarkon-Horlick, & Morrissey, 1997), this 34-item measure of the barriers to help seeking was used to help inform how to score adolescents' responses in the present study. Similar to the BASH, the present study summed the number of indicated barriers

to produce a total number of perceived barriers for each participant. The BASH was not used in the present study because it was deemed to be too long and does not measure adolescents' broader knowledge of mental health.

In total, the present study's list of reasons as to why participants had not sought professional help (item 2b) included two items designed to assess participants' knowledge of mental health (i.e., I didn't know where to go; I know very little about mental health, such as signs of problems). In addition, participants may have added a third knowledge-related barrier under the 'other' option (i.e., Other, please specify: \_\_\_\_\_). For the other item, responses were coded as being related to one's knowledge of mental health or not (e.g., "Didn't know what would happen if I saw someone for help" and "I don't know what's wrong to know where to go" were deemed to relate to adolescents' knowledge of mental health). Using these three knowledge-related items, each participant received a 'knowledge of mental health' total score (total possible score = 3).

**Family cohesion and flexibility.** Adolescents completed the Family Adaptability and Cohesion Evaluation Scales (FACES-IV, Olson, 2011), which is a 42-item self-report measure designed to comprehensively assess family functioning according to levels of cohesion and flexibility. The questionnaire employs a five-point Likert scale ranging from *Strongly Disagree* (1) to *Strongly Agree* (5). Olson defines *cohesion* as the emotional bonding between family members and *flexibility* as the quality and expression of family leadership, organization, roles, and rules. The FACES-IV has six distinct seven-item subscales that can be classified as relating to either cohesion or flexibility (Olson, 2011). The cohesion subscales are Disengaged, Balanced Cohesion, and Enmeshment, whereas the Flexibility subscales are Rigid, Balanced Flexibility, and Chaotic (Olson, 2011, 2010).

Earlier versions of the FACES IV (i.e., FACES I, FACES II, FACES III, and an observational assessment called the Clinical Rating Scale) were critiqued because they did not adequately capture the extremes of cohesion and flexibility (Olson & Gorall, 2006). Tiesel (1994) made a significant step in developing the current FACES IV by developing four scales aimed specifically at the low and high extremes of cohesion (i.e., disengaged and enmeshed) and flexibility (rigid and chaotic). Tiesel developed items by having 154 clinical members of the American Association for Marriage and Family Therapy rate the degree to which they felt a phrase was representative of cohesion or flexibility. The members then rated the phrases as falling into either high or low extremes of cohesion and flexibility. This process resulted in four scales found to be reliable, valid, and able to discriminate between problematic and healthy families (Olson, 2011). Craddock (2001) showed that higher scores on these four scales correlate with higher levels of family stress and lower levels of satisfaction. Franklin, Streeter, and Springer (2001) replicated the four scales using factor analysis.

FACES-IV was developed from an item pool that included 37 items from the original 111-item FACES I, 23 items from the 30-item FACES-II, and 24 items from Tiesel's (1994) four scales (Olson, 2011). Olson (2011, 2010) indicates that items were chosen from each of these measures based on previous research that had identified functional factor structures. The resulting 84 item pool was believed to represent the full range of the cohesion and flexibility dimensions. Results from exploratory and confirmatory analyses indicated six distinct seven-item subscales that can be classified as relating to either cohesion or flexibility. As was previously mentioned, the cohesion subscales are Disengaged, Balanced Cohesion, and Enmeshment, whereas the Flexibility subscales are Rigid, Balanced Flexibility, and Chaotic (Olson, 2011, 2010). FACES-IV has been shown to have good internal consistency (i.e.,



balanced cohesion .89, enmeshed .77, disengaged .87, chaotic .86, balanced flexibility .84, rigid .82), content validity, construct validity, and predictive validity (Olson, 2010). It has also been found to correlate highly with measures assessing similar constructs (i.e., Self-Report Family Inventory, Family Assessment Device, and Family Satisfaction Scale) (Olson, 2011).

Furthermore, balanced cohesion and balanced flexibility positively relate to healthy family functioning whereas the four unbalanced scales negatively relate to healthy family functioning (Olson, 2011).

For research purposes, FACES-IV provides Cohesion Ratio, Flexibility Ratio, and Total Circumplex Ratio scores to help indicate the level of functional versus dysfunctional behaviour perceived in the family system. The lower the ratio score below one, the more unbalanced the family system is considered to be. Conversely, the higher the ratio score above one, the more balanced the system. Reported ratio scores correspond to family types and have ranged from .24 to 2.5 in studies conducted by the test developers. The Cohesion Ratio score can be calculated by dividing the balanced cohesion subscale score by the average of the disengaged and enmeshed subscale scores. In the same way, the Flexibility Ratio can be calculated by dividing the balanced flexibility subscale score by the average of the rigid and chaotic subscale scores. Finally the Total Ratio score divides the sum of the cohesion and flexibility ratios by two.

For this study, the internal consistencies of the FACES-IV Balanced Cohesion, Balanced Flexibility, Disengaged, Enmeshed, and Chaotic subscales were found to be acceptable to good (Cronbach's alpha = 0.80, 0.80, 0.79, 0.78, 0.76, respectively). The internal consistency of the Rigid subscale was found to be unacceptable (Cronbach's alpha = 0.21); however, the alpha value improved (Cronbach's alpha = 0.77) with the removal of one item (i.e., Our family is highly organized). It was believed that this item may have been interpreted differently by

different participants (e.g., organization may have been interpreted to refer to the organization of physical space as opposed to referring to rules and routines).

**Family communication and conflict.** Adolescents completed the Family Communication Scale (Olson & Barnes, 2006), which is a 10-item measure that can be added to the FACES-IV to provide a more thorough assessment of family functioning. The Family Communication Scale uses a five-point Likert scale ranging from *very dissatisfied* (1) to *extremely satisfied* (5). It is a revised version of the Parent-Adolescent Communication Scale (Barnes & Olson, 1989) and incorporates items related to family conflict by asking participants about whether family members can discuss problems calmly, respond to one another honestly, and rarely say negative things about each other. Responses that indicate family conflict reduce the family's total communication score. In this way, the scale contrasts family communication with family conflict.

To obtain a score on this measure, all items are summed. Scores range from 10 to 50 with higher scores representing healthier levels of family communication. More specifically, scores ranging from 10 to 29 indicate very low levels of communication, 30 to 35 indicate low levels of communication, 36 to 39 indicate moderate levels of communication, 40 to 44 indicate high levels of communication, and 45 to 50 indicate very high levels of communication. For this study, the internal consistency of the Communication Scale was found to be excellent (Cronbach's alpha = 0.91).

**Familial socialization of help seeking.** To assess the socialization of help seeking, adolescents completed the Acquiring Social Support (nine items), Seeking Spiritual Support (three items), and Mobilizing Family to Acquire and Accept Help (four items) subscales from the Family Crisis Oriented Personal Scales (F-COPES, McCubbin, Olson, & Larsen, 1991). This

questionnaire was designed to identify the problem-solving and behavioural strategies used by adolescent participants' families in difficult or stressful situations. The F-COPES has a strong theoretical base in the family coping literature and allows coping to be measured as a construct that deals with plans or actions to ameliorate the experience of stress (Bramlett, Hall, Barnett, & Rowell, 1995). The F-COPES has also been used to assess families from different populations and demographics across mental health and school counselling disciplines (e.g., Manning, Wainweight, & Bennett, 2011; Sahin, Nalborne, Wetchler, & Bercik, 2010; Bonfield, Collins, Guishard-Pine, & Langdon, 2010).

The full F-COPES consists of 30 items that describe a variety of coping behaviours families may use in times of stress (e.g., sharing our difficulties with relatives, seeking encouragement and support from friends, knowing we have the power to solve major problems). Individuals decide how well each statement describes their family's typical behaviours and attitudes in response to problems by using a five-point Likert scale ranging from *strongly disagree* (1) to *strongly agree* (5). The measure consists of five subscale scores and a total score. The subscales are: Acquiring Social Support, Reframing Stressful Events to Make Them More Manageable, Seeking Spiritual Support, Mobilizing Family to Acquire and Accept Help, and Passive Appraisal. Items on the Passive Appraisal subscale are reversed scored so that subscale scores and the total score can be derived by summing the applicable items.

According to McCubbin et al. (1991) the F-COPES has very good overall reliability (Cronbach's Alpha = 0.77-0.86). Internal consistencies for individual subscales have been found to range from acceptable to good (Cronbach's Alpha = 0.63-0.83; McCubbin et al.). Overall test-retest reliability is reported to be .81, with individual scales reported to range from .61 to .95

(McCubbin et al.). The F-COPES also has very good factorial validity and good concurrent validity (Bramlett et al., 1995).

For the present study, the internal consistencies of the Acquiring Social Support subscale (Cronbach's alpha = .0.73) and the Seeking Spiritual Support subscale (Cronbach's alpha = 0.79) were found to be acceptable. The internal consistency of the Mobilizing Family to Acquire and Accept Help subscale was found to be marginally acceptable (Cronbach's alpha = 0.66); however, the alpha value improved (Cronbach's alpha = 0.72) with the removal of one item (i.e., Seeking information and advice from persons in other families who have faced the same or similar problems). The removed item referred to informal help whereas the remaining items in the scale referred to professional help; therefore, participant's score on the Mobilizing Family to Acquire and Accept Help subscale was calculated by summing the remaining three items (i.e., Seeking information and advice from the family doctor, Seeking assistance from community agencies and programs designed to help families in our situation, Seeking professional counselling and help for family difficulties).

For this study, the wording of the items on the Seeking Spiritual Support subscale were changed slightly so as to be more inclusive. Specifically, the word 'church' was changed to 'spiritual or religious activities,' 'God' was changed to 'God/gods,' and 'minister' was changed to 'spiritual leader (e.g., priest, rabbi, minister).' The Flesch Reading Ease score for this measure corresponded to the Fairly Difficult range, indicating that Grade 12 students should find the questionnaire easy to read and understand. This is consistent with the reading level of the original Seeking Spiritual Support subscale and the 30-item questionnaire; therefore, the researcher's wording changes did not affect the reading level.

**Adolescent help seeking practices.** The Adolescent Coping Orientation for Problem Experiences (A-COPE, Patterson & McCubbin, 1987) was used to assess adolescent tendencies to seek help. The A-COPE is a 54-item self-reported measure designed to assess adolescent coping skills in times of stress. Individuals rate each item on a Likert five-point scale ranging from *never* (1) to *most of the time* (5). This measure was initially developed and tested with Midwestern high school students and was deemed to have 12 subscales using factor analysis: Ventilating Feelings, Seeking Diversions, Developing Self-Reliance, Developing Social Support, Solving Family Problems, Avoiding Problems, Seeking Spiritual Support, Investing in Close Friends, Seeking Professional Support, Engaging in Demanding Activity, Being Humorous, and Relaxing. However, re-examinations of the A-COPE factor structure, using ninth-grade students from urban areas who self-identified primarily as being Caucasian or Hispanic, revealed 13 subscales: Proactive Orientation, Avoiding Problems, Externalizing Feelings, Social Activities, Family Interaction, Seeking Spiritual Support, Physical Diversions, Passive Diversions, Catharsis, Being Humorous, Seeking Professional Support, Positive Imagery, and Self-Reliance (Copeland & Hess, 1995). Subscale scores and a total score are derived by summing appropriate items.

In the present study, Copeland and Hess' (1995) 13-factor structure was chosen because it was found using an adolescent sample similar in age and size to that of Patterson and McCubbin (1987), but was also culturally diverse – a characteristic that was expected of the target sample in this study. Copeland and Hess identified three factors or subscales related directly to help-seeking behaviours: Family Interaction (five items), Seeking Spiritual Support (three items), and Seeking Professional Support (two items). Factor loadings and reliability

estimates for these three help-seeking scales are fair (i.e., .47 to .78 and .61 to .71 respectively) (Copeland & Hess).

For this study, the internal consistency of the A-COPE Family Interaction subscale was found to be marginally acceptable (Cronbach's alpha = 0.69); however, the alpha value improved (Cronbach's alpha = 0.73) with the removal of an item assessing how often participants spoke to siblings about their problems (i.e., Talk to a brother or sister about how you feel). Of note, ten percent of participants did not have siblings and may have responded 'never' to this item because 'not applicable' was not provided as a response option. For this reason, the mentioned item was removed. The internal consistency of the A-COPE Seeking Spiritual Support subscale was good (Cronbach's alpha = 0.89). The internal consistency of the A-COPE Seeking Professional Support subscale was unacceptable (Cronbach's alpha = 0.34). Notably, this latter scale consists of two items; one that measures help seeking from teachers and one that measures help seeking from mental health professionals. Therefore the measure appears to conceptualize professional help seeking differently than the present study. Consistent with the adolescent help seeking literature, the item related to seeking help from teachers was removed, producing a one-item subscale.

For the purpose of the present study, the wording of items on the Seeking Spiritual Support subscale was changed slightly so as to be more inclusive. Specifically, the word 'church' was changed to 'place of worship or religious/spiritual space,' 'pray' was expanded to 'pray or meditate,' and 'minister/priest/rabbi' was expanded to 'religious leader (e.g., minister/priest/rabbi).' The Flesch Reading Ease score for this measure corresponded to the Fairly Easy range, indicating that most Grade 6 students would find the questionnaire easy to read and understand. The original items on the Seeking Spiritual Support subscale as well as the

original 54-item questionnaire also have a Flesch Reading Ease score within the Fairly Easy range.

**Attitudes towards seeking professional help.** The Inventory of Attitudes towards Seeking Mental Health Services (IASMHS, MacKenzie, Knox, Gekoski, & Macaulay, 2004) is a revised and expanded reversion of the Attitudes toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970). The IASMHS consists of 24 items. Of these 24 items, 17 were taken from the original 29-item ATSPPHS, based on results from factor analysis. An additional seven items were added to capture respondents' subjective norms (e.g., perceptions of stigma) and perceived behavioural control (e.g., perceived control over barriers to help seeking) related to seeking mental health services.

Studies have consistently revealed that the ATSPPHS (29 items) has respectable psychometric properties; however, it includes outdated language, does not measure constructs shown to improve predictions of help-seeking behaviour (e.g., perceived behavioural control), and was designed based upon what are now considered substandard techniques for factor analysis (MacKenzie et al., 2004). Mackenzie et al. attempted to correct these problems by updating the wording of items, expanding the definition of professional help, adding items designed to assess subjective norms (e.g., ideas about how one's family members might react if one sought help) and perceived behavioural control, and employing modern factor-analytic techniques. Mackenzie et al. also included a five-point response scale instead of a four-point response scale. Results from adult community samples reveal that the IASMHS has a three factor structure: Psychological Openness (eight items), Help-Seeking Propensity (eight items), and Indifference to Stigma (eight items). Factor scores are calculated by summing the eight

items in each factor. The factors are highly internally consistent and have been replicated using an independent adolescent sample (Munson, Floersch, & Townsend 2009, 2010).

For this study, the internal consistencies of the IASMHS subscales ranged from marginally acceptable to acceptable. More specifically, the internal consistency for the Psychological Openness and Help Seeking Propensity subscales were marginally acceptable (i.e., .59 and .63, respectively). The internal consistency for the Indifference to Stigma subscale was acceptable (i.e., .76). None of the subscale internal consistencies improved when items were removed. As such, for the present study, the total score was used and not the subscale scores. This is significantly different from previous research and may reflect the fact that, to the researcher's knowledge, the present study was the first to use the IASMHS with an online Canadian adolescent sample. The internal consistency of the full IASMHS (Cronbach's alpha = 0.87) in the current study was found to be good and consistent with the full scale internal consistency reported by MacKenzie et al. (2004).

The researcher did not modify the wording of any of the IASMHS questionnaire items; however, some words were written in capital letters or underlined to help prevent reading errors. For instance, the word 'not' was occasionally written in all capital letters (e.g., There are certain problems which should NOT be discussed outside of one's immediate family) and the word 'without' was underlined once (i.e., There is something admirable in the attitude of people who are willing to cope with their conflicts and fears without resorting to professional help). Notably, the original questionnaire item italicised the word 'without,' though this was not possible in the program used to create the present study's online questionnaire. In total, three of the eight items on the Psychological Openness Scale and two of the eight items on the Indifference to Stigma scale had modified font, as described.



## Parent measures

**Background information.** Parents completed a background questionnaire, which provided information on their date of birth, gender, ethnicity, household annual income, level of education, and employment status. Parents also indicated whether they had access to regular health care (e.g., family doctor), and if they or their adolescent children had ever received professional help. They were also asked to report how they became aware of the study (see Appendix E).

**Symptomatology.** Parents were asked to complete the Pediatric Symptom Checklist (PSC, Jellinek et al., 1988), which is a screening tool designed to facilitate the recognition of cognitive, emotional, and behavioural problems in children and adolescents. The PSC consists of 35 items that are rated as *never* (0), *sometimes* (1), or *often present* (2). The total score is calculated by summing responses on the 35 items. Items that are left blank receive a score of zero. Questionnaires with more than three incomplete items are considered invalid; this was not an issue for the data collected in the present study. For school aged children aged 6 to 16, a total score of 28 or higher on the PSC indicates significant psychosocial impairment and a need for further evaluation by qualified medical or mental health professionals (Pagano et al., 2000). Pagano et al. suggest that this cut-off can be used for parent ratings of adolescents aged 17 and 18, but note that parents' responses are likely to be less accurate than adolescents' self-reports at this age.

The PSC is a well tested and validated instrument that has been used in offices of paediatricians and family physicians (e.g., Anderson et al, 1998; Bernal et al, 2000; Borowsky, Mozayeny & Ireland, 2003; Gardner et al, 2000). The PSC has also been utilized in school-based screenings (Gall, Pagano, Desmomd, Perrin, & Murphy, 2000) and has been validated through

screenings taking place within general educational settings (Pagano et al., 2000; Murphy, Jellinek & Milinsky, 1989). In community settings, the PSC has been used as a measure of unmet need for mental health services (Centre for Addiction and Mental Health, 2009).

In a number of validity studies, PSC classifications agreed with results from the Children's Behavior Checklist (CBCL), Clinicians' Global Assessment Scale (CGAS), and ratings of impairment (Jellinek et al., 1988; Jellinek, Bishop, Murphy, Biederman, & Rosenbaum, 1991; Rauch et al., 1991; Murphy, Reede, Jellinek, & Bishop, 1992; Murphy et al., 1996).). The items have been shown to have strong internal consistency and are highly correlated with scores indicating a need for professional help (Murphy & Jellinek, 1985; Murphy et al., 1996). Test-re-test reliability of the PSC range from  $r = .84$  to  $r = .91$  (Jellinek et al.; Murphy et al., 1992). For this study, the internal consistency of the PSC was found to be good (Cronbach's alpha = 0.82).

**Parental stress.** The Caregiver Strain Questionnaire (CGSQ, Brannan, Heflinger, & Bickman, 1997) is a 21-item self-report instrument developed to measure the impact of caring for children younger than 18 years with emotional and behavioural problems. Caregivers are asked to indicate how much of a problem a list of burdensome occurrences or feelings has been in the past six months. Responses are scored on a five-point Likert scale ranging from *not at all* (1) to *very much* (5) a problem. The CGSQ assesses three dimensions of caregiver strain: objective strain, internalized subjective strain, and externalized subjective strain. The objective caregiver strain subscale includes 11 items that capture the negative consequences of caring for a child with mental health problems, such as the disruption of personal time, financial strain, neglecting responsibilities, and social isolation. The internalized subjective caregiver strain subscale consists of six items that capture negative feelings, such as worry, guilt, and

unhappiness, which are internal to the caregiver. The externalized subjective caregiver strain subscale is made up for four items that include relating poorly with the child by directing negative feelings toward the child. Scores for each of the three subscales are calculated as the mean of the items in the subscale. The global score is the mean of all the items in the CGSQ. In the present study, the objective caregiver strain subscale, internalized subjective caregiver subscale, and global score were of interest. The externalized subjective subscale was not of interest because this relates to the parent-child relationship (e.g., how well the parent relates to the child) and this aspect was more fully captured in the present study using the FACES-IV (as discussed below).

Since being developed, the CGSQ has been used widely to assess strain among caregivers of children with serious emotional and behavioural disorders (Blader, 2006; Brannan & Heflinger, 2001; Heflinger & Taylor-Richardson, 2004; Sales, Greeno, Shear, & Anderson, 2004; Taylor-Richardson, Heflinger, & Brown, 2006). The CGSQ has also been used to assess strain among caregivers of children with attention deficit/hyperactivity disorder (Bussling et al., 2003), obsessive compulsive disorder (Storch et al., 2009), autism (Khanna et al., 2012) and substance abuse disorder (Heflinger & Brannan, 2006). The full CGSQ and its subscales have demonstrated adequate validity and reliability; moreover, the measure has demonstrated high internal consistency (Lambert, Brannan, Breda, Heflinger, & Bickman, 1998). For this study, the internal consistencies of the CGSQ Internalized Subjective subscale (Cronbach's alpha = 0.86), the CGSQ Objective Strain subscale (Cronbach's alpha = 0.92), and the CGSQ Global score (Cronbach's alpha = 0.90) were found to be good.

For this study, the researcher modified all of the questionnaire items so as to only assess parental burden related to the adolescent's emotional or behavioural problems. In this way, the

terms ‘resulting from,’ ‘because of’ or ‘due to’ were added to the end of each item and followed by ‘your adolescent’s emotional or behavioural problem’ (e.g., Interruption of personal time = Interruption of personal time resulting from your adolescent’s emotional or behavioural problem). The Flesch Reading Ease score for this measure corresponded to the Easy range, indicating that most Grade 5 students would find the questionnaire easy to read and understand. The original questionnaire was also found to have a Flesch Reading Ease score within the Easy range; therefore, the researcher’s wording changes did not affect the reading level.

**Stages of help seeking.** The researcher created a parent-version of the five-item Help Seeking Questionnaire (HSQ-P), presented earlier, by changing personal references (e.g., I, I’m) to child references (e.g., “my adolescent,” “they’re”). Thus, the items are identical to the adolescent version with slight modifications (see Appendix F). Using the HSQ-P, parents’ stage of help seeking was classified in the same way as the adolescents’ stage of help seeking (refer to Table 4). Specifically, similar to the CCHS, parents who indicated having actively sought professional help for their adolescent within the past 12 months were considered to be in the third stage of help seeking (i.e., seeking professional help). Parents were able to indicate whether they had sought professional help because they felt they needed it (i.e., Yes, I sought professional help for my adolescent) or because they were prompted to do so (i.e., Yes, but it was because someone asked me to contact a professional).

Table 4

*Classifications for Parents in the Stages of Help Seeking*

Classification	Questionnaire Item	Response
Non-Help-Seekers	In the past 12 months, have you seen, or talked on the phone to, a professional about your adolescent's emotional or mental health?	No
	During the past 12 months was there ever a time when you felt that your adolescent needed help coping with emotions, mental health, or the use of alcohol or drugs, but didn't receive it?	No
Stage 1 Recognize the Problem	In the past 12 months, have you seen, or talked on the phone to, a professional about your adolescent's emotional or mental health?	No
	During the past 12 months was there ever a time when you felt that your adolescent needed help coping with emotions, mental health, or the use of alcohol or drugs, but didn't receive it?	Yes
	What type of help did you feel your adolescent needed?	Informal
Stage 2 Decide to Seek Professional Help	In the past 12 months, have you seen, or talked on the phone to, a professional about your adolescent's emotional or mental health?	No
	During the past 12 months was there ever a time when you felt that your adolescent needed help coping with emotions, mental health, or the use of alcohol or drugs, but didn't receive it?	Yes
	What type of help did you need your adolescent needed?	Formal
Stage 3 Seeking Professional Help	In the past 12 months, have you seen, or talked on the phone to, a professional about your adolescent's emotional or mental health?	Yes

The second question of the HSQ-P asked parents whether they felt they needed help coping with problems, but did not receive it. Parents who indicated that their adolescent needed professional help within the past 12 months and did not receive it were divided into those who reported believing that their adolescent needed informal help (i.e., Stage 1 or recognizing the problem) and those who reported believing that their adolescent needed professional help (i.e., Stage 2 or deciding to seek professional help). Parents categorized in Stages 2 or 3 and who had indicated that they required help and did not receive it were also categorized as having reached Stage 1 of help seeking. Similarly, adolescents categorized in Stage 3 and who had indicated that they required professional help were also categorized as having reached Stage 2. Parents who indicated that they did not seek help or perceive their adolescent to need help within the past 12 months were classified as non-help-seekers.

Parent participants who identified their adolescent to have a problem (i.e., Stages 1, 2 and 3) completed additional questionnaire items designed to assess the nature and severity of the problem. The first question required parents to select from a list what they felt their adolescent needed help for (e.g., emotional problems, substance use, family problems). Parents were able to select more than one list item and were given the option to provide reasons not on the list (i.e., Other, please specify: \_\_\_\_\_). The second question required parents to indicate whether they felt their adolescent's problem was very serious, somewhat serious, or not serious at all. The latter item allowed the researcher to assess parents' perceived problem severity.

**Barriers to help seeking.** To assess barriers to professional help, parents were asked to identify reasons from a list of 17 items as to why they had not or may not seek professional help for adolescent problems (e.g., waiting times, feeling services would be inadequate or unhelpful, transportation problems, concerns that other people might have found out). One item allowed

parents to add their own response (i.e., Other, please specify: \_\_\_\_\_). As previously described, the items were developed using research findings in the literature and the Barriers to Adolescents Seeking Help questionnaire (BASH; Kuhl et al., 1997). The number of indicated barriers was summed to produce a total number of perceived barriers for each parent. In addition, each parent also received a ‘knowledge barrier’ total score (total possible score = 3); this score was created in the same way as the adolescent knowledge barrier score (i.e., summing the number of knowledge-related barriers participants selected out of a possible three items). The three items used to assess parents’ knowledge of mental health: (1) I didn’t know where to go, (2) I know very little about mental health, such as signs of problems, (3) Other, please specify \_\_\_\_\_. For the ‘other’ item, responses were coded as being related to one’s knowledge of mental health or not (e.g., “I’m not sure if I should be concerned about my son” and “I don’t know what I should be doing” were deemed to relate to parental knowledge of mental health).

**Family cohesion and flexibility.** Parents completed the Family Adaptability and Cohesion Evaluation Scales (FACES-IV, Olson, 2011), which is the same 42-item self-report measure adolescents were asked to complete.

For the present study, the internal consistencies of the FACES-IV Balanced Cohesion, Balanced Flexibility, Disengaged, Rigid, and Chaotic subscales were found to be acceptable (Cronbach's alpha = 0.80, 0.70, 0.78, 0.69, 0.77, respectively). The internal consistency of the Enmeshed subscale was found to be poor (Cronbach's alpha = 0.50) and the alpha value decreased with the removal of any item. The Enmeshed subscale was retained as it was required to calculate the cohesion ratio. The likely effect of having a subscale with low reliability in the ratio calculation is reduced statistical power (Tabachnick & Fidell, 2007).

**Family communication and conflict.** Like the adolescent participants, parent participants completed the Family Communication Scale (Olson & Barnes, 2006), which is a 10-item measure added to FACES-IV to provide a more thorough assessment of the family environment. For the present study, the internal consistency of the Communication Scale (Cronbach's alpha = 0.91) was found to be excellent.

**Familial socialization of help seeking.** Like the adolescent participants, parents completed the Acquiring Social Support (nine items), Seeking Spiritual Support (three items), and Mobilizing Family to Acquire and Accept Help (four items) subscales of the Family Crisis Oriented Personal Scales (F-COPES, McCubbin et al., 1991) to help assess the socialization of help seeking. Since parents socialize coping skills (e.g., Kliwer et al., 1996), it was assumed that family coping practices reflected parent coping suggestions and/or practices. Parents were asked to decide how well each statement described their family's typical behaviours and attitudes



in response to problems by using a five-point Likert scale ranging from *strongly disagree* (1) to *strongly agree* (5).

For the present study, the internal consistency of the Acquiring Social Support subscale (Cronbach's alpha = .0.69) was found to be marginally acceptable; it improved slightly (Cronbach's alpha = .0.71, acceptable) with the removal of an item (i.e., Receiving gifts and favours from neighbours), but this item was kept to ensure consistency between the parent and adolescent questionnaires. The internal consistency of the F-COPES Mobilizing Family to Acquire and Accept Help improved (Cronbach's alpha of 0.61 to 0.69) with the removal of one item (i.e., Seeking information and advice from persons in other families who have faced the same or similar problems). The mentioned item was also removed from the adolescent data and was the only item in the subscale that assessed individuals' use of informal help sources as opposed to formal ones; therefore, it was not surprising that participants in the present sample answered this question differently compared to other questions in the subscale. The internal consistency of the F-COPE Seeking Spiritual Support subscale was found to be good (Cronbach's alpha = 0.83).

**Attitudes towards seeking professional help.** As with adolescent participants, the Inventory of Attitudes toward Seeking Mental Health Services (IASMHS, MacKenzie et al., 2004) was used to assess parents' Psychological Openness (eight items), Help-Seeking Propensity (eight items), and Indifference to Stigma (eight items).

For the present study, the internal consistencies for the Psychological Openness, Help Seeking Propensity, and Indifference to Stigma subscales were marginally acceptable (i.e., .65, .69, and .66 respectively). The internal consistency of the Psychological Openness subscale was acceptable when one item was removed (i.e., There are experiences in my life I would not

discuss with anyone; Cronbach's alpha = 0.70). The internal consistency for the Indifference to Stigma subscale was also acceptable when one item was removed (i.e., Had I received treatment for psychological problems, I would not feel that it ought to be 'covered up;'; Cronbach's alpha = 0.79). The internal consistency of the full IASMHS (Cronbach's alpha = 0.84) was found to be good and consistent with the full scale internal consistency reported by MacKenzie et al. (2004). Therefore, similar to the adolescent IASHMS data, the present study used the parent total score and not the subscale scores.

### **Procedure**

Permission to conduct the study was obtained from the University of Windsor Research Ethics Board, the Greater Essex Country District School Board, the Windsor-Essex Catholic District School Board, and the Windsor Essex Community Health Centre (formally known as the Teen Health Centre). High school principals were then contacted by email (see Appendices G and H) and invited to advertise the study via wall posters (see Appendix I), flyers designed for classroom distribution (see Appendix J), and audio recordings for school announcements (see Appendix K). Windsor Essex Community Health Centre reception staff were contacted by phone and medical staff were made aware of the study through information letters that reception staff distributed (see Appendix L). Packages of advertising materials were mailed to all principals and reception staff who agreed to publicize the study (see Appendix M). Additional materials were mailed upon request to re-stock supplies. Information about the study was posted in public areas at the Windsor Essex Community Health Centre and flyers were distributed by reception staff to clients who were not already receiving mental health services. As a result of low recruitment, advertising for the study was expanded to include postings on *Facebook*, *Kijij*, *Craig's List*, an on-line Windsor Essex teacher's message board, and the Windsor *Mom2Mom*

forum. Additional posters (see Appendix N) were displayed at Devonshire Mall, distributed by religious institutions, posted in the University of Windsor's Community Counselling Centre, incorporated into weekly church bulletins, and circulated amongst emergency responders (i.e., police and fire fighters). The study was also advertised in *The Windsor Parent*, a community magazine, and through interviews the researcher did with the *Windsor Star* newspaper and *CBC Radio*.

Advertisements directed participants to a website ([www.uwindsor.ca/50](http://www.uwindsor.ca/50)) to complete questionnaires about adolescent help seeking. Upon accessing the website, participants selected the appropriate questionnaires by choosing "adolescent" or "parent/caregiver." Participants were asked to read a letter of information and consent to participate by checking the 'I agree to participate' box (see Appendices O and P). In anticipation that participants would have questions about the study or feel that they experienced some discomfort as a result of the study, the researcher's and research supervisor's emails were available on the letter of information and at the bottom of the last page of the survey. Individuals who decided not to participate were able to close the website. Further, a 'withdrawal from survey' button appeared on every page of the survey so as to allow participants the option of withdrawing from the study at any time. Upon exiting the survey at any time, participants were provided with a community resource list specific to the Windsor area (see Appendix P). At the conclusion of the survey, a text box appeared encouraging participants to enter a draw and email the study's website to friends and family; in particular, adolescents were encouraged to email their parents. The letter of information clearly explained that members of parent-child dyads would not have access to each other's data.

Adolescents were automatically assigned a password using their birth month and selected letters from their first and last names. Upon arriving at the study's website, parents were prompted with questions that guided them to the password to ensure that dyad-pair data could be linked.

In order to control for possible order effects, participants completed the background information and help seeking questionnaires and were then presented with the remaining questionnaires in random order. Table 5 provides an overview of the questionnaires parent and adolescent participants completed.

Table 5

*Questionnaires to be Completed by Adolescent and Parent Participants*

Variable	Questionnaire	Participant(s)
Gender	Demographic questionnaire	Adolescent
Age	Demographic questionnaire	Both
Attitudes toward Seeking Professional Help	Inventory of Attitudes toward Seeking Mental Health Services subscales	Both
Tendencies to Seek Help	A-COPES (selected subscales)	Adolescent
Familial Socialization of Help Seeking	F-COPES (selected subscales)	Both
Barriers to Help Seeking	Help-Seeking Questionnaire	Both
Knowledge of Mental Health	Help-Seeking Questionnaire	Both
Family Cohesion and Flexibility	FACES-IV	Both
Family Communication and Conflict	Family Communication Scale	Both
Perceived Need	Help-Seeking Questionnaire	Both
Parental Strain	Caregiver Strain Questionnaire	Parent
Symptomatology	Youth Self-Report Pediatric Symptom Checklist	Adolescent
	Pediatric Symptom Checklist	Parent

Parents and adolescents who participated in the study had the opportunity to enter a draw for one of five \$50 gift certificates to a local mall; however, due to low recruitment numbers, the value of the gift certificates was increased to \$75 and advertisements were changed to reflect this. All draw winners received \$75 gift certificates, regardless of the incentive value when they completed the questionnaire. Participants entered the draw by supplying an email address and were reminded that they could create an email account for this sole purpose, should they want to protect their identity. Only the winners of the draw were contacted. Winners of the draw were given the option of receiving their prize at their home address, school address, or customer service counter at the mall. The gift certificates in no way appeared to be associated with the study. Information collected as part of the draw was kept separate from questionnaire responses and in a password-protected file that only the researcher had access to. Email addresses were deleted once the draw was completed; no other identifying information (e.g., name, address) was collected.

In order to minimize attrition rates, participants were encouraged throughout the survey with a progress bar and positive feedback at selected check points (e.g., “Great job! You’ll be done in no time”). Finally, participants had the opportunity to complete the questionnaire over multiple sittings using the ‘save and exit’ button. Participants wanting to exit the survey before completing all of the items were asked whether they wanted to save their responses to finish the survey at another time. Of note, participants were asked to complete the measure they were on if they wanted to save and exit the survey.

## CHAPTER IV

### Results

#### Planned Analyses

IBM SPSS Statistics – Predictive Analytics Software Statistics Data Editor 20 was used for all statistical analyses. To balance the risks of Type 1 and Type 11 error, alpha levels of 0.1, .05, and .01 were used, according to the sample size, to test significance; p-values are provided for statistical tests. Analyses were conducted separately for adolescent, parent, and adolescent-parent dyad data. The Help Seeking Questionnaire was used to categorize all participants into the three stages of help seeking (i.e., recognizing the problem, deciding to seek professional help, and seeking professional help) (see Tables 4 and 5). Participants who indicated that they did not seek help or perceive a need for help within the past 12 months were classified as non-help-seekers. Participants who indicated that they had sought professional help were regarded as being in Stage 3 (Actually Seeking Professional Help). Participants who indicated that they needed help and did not receive it were divided into those who reported believing that they needed informal help (Stage 1) and those who reported believing that they needed professional help (Stage 2).

Similar to other studies that have examined the stages of adolescent help seeking (e.g., Sears, 2004), the present study first examined participants' highest stage of help seeking. Also similar to previous studies, the present study also categorized participants using a cumulative approach in which participants in Stages 2 and 3, who had indicated that they had a mental health problem, were also categorized as having reached Stage 1 of help seeking (i.e., problem recognition). Similarly, participants categorized in Stage 3, who had indicated that they believed they required professional help, were also categorized as having reached Stage 2 of help seeking

(i.e., deciding to seek professional help). In this way, participants could be categorized into all of the stages of help seeking. The cumulative methodology is reflective of individuals' help seeking; for instance, an individual who has sought professional help (Stage 3) often must continue to decide to seek professional help (Stage 2) in order to participate in ongoing therapy. Further, throughout the course of service involvement an individual is expected to cultivate a better understanding of their mental health problem; for example, an adolescent might progress from vaguely recognizing that something is wrong to recognizing that they suffer from depression (Stage 1).

Pearson bivariate correlations were performed to examine relations between all study variables. When necessary, *t*-tests or chi-squared tests were used to examine age and gender differences within each stage of help seeking. T-tests were also used to examine whether adolescents who sought professional help (Stage 3) on their own differed from adolescents who sought professional help after being prompted to do so. Analysis of Variance was used to compare participants across the three stages of help seeking on their attitudes towards seeking mental health services, experience of stigma, parental strain, and perceived barriers to professional help across the stages of help seeking. Importantly, to avoid violating the assumption of Independence of Observation, participants' highest stage of help seeking was used in Analyses of Variance. For instance, participants who reached Stage 3 of the help seeking process were coded as being in only Stage 3 for the Analyses of Variance. Since the main focus of this study was to identify factors predictive of adolescents' and parents' stage of help seeking, hierarchical logistic regression analyses were conducted to examine adolescent and parent factors hypothesized to be predictive of each stage of adolescent help seeking.



## Examination of Data

Prior to all analyses the data were examined for possible duplicate protocols, ineligible participants, and protocols with over 50 percent missing data; for these reasons, 15 (7 percent) parents and 28 (7 percent) adolescents were removed from the data set. Results of the missing value analysis (MVA) indicated that the remaining adolescent (Little's MCAR test;  $\chi^2 = 9984.47, p = .48$ ) and parent data (Little's MCAR test;  $\chi^2 = 751.67, p = 1.00$ ) were missing at random; all cases were missing less than 20 percent of the data. No adolescent questionnaire was missing more than 15 percent of the data and no parent questionnaire was missing more than 10 percent of the data. Subscale scores for the Caregiver Strain Questionnaire could not be calculated unless all of the items in the respective subscale were completed; therefore, parameters with missing data were estimated using maximum likelihood imputation. As a result, Caregiver Strain Questionnaire subscales with as much as 15 percent missing data had no missing data. The mentioned data imputation method is reported to show the least amount of bias (Stevens, 2002).

Statistical assumptions of logistic regression were tested before conducting the analyses. Evaluation of scatter plots and the skewness and kurtosis scores of all the variables indicated that the data were normally distributed, except for questionnaire items that accurately captured the sample makeup. For instance, coping strategies involving professional help were skewed and reflected the expectation that participants in the present study were not receiving or in the habit of receiving professional mental health services. No univariate outliers were detected by using histograms and frequency tables or a cut-off of  $z = \pm 3.29$  (Tabachnick & Fidell, 2007). The data were screened for multivariate outliers using a cut-off of the absolute value of 2.5 standardized deviations for standardized residuals and by using the criterion  $p < .001$  for Mahalanobis

Distance (Tabachnick & Fidell, 2007). No multivariate outliers were identified. The data were also screened for influential observations using Cook's Distance with a cut-off of 1 and DFFITS with a cut-off of 2. No influential observations were found. To test for the absence of multicollinearity, several indicators were examined, including correlations larger than  $r=.90$  between predictor variables, Variance Inflation Ratios (VIF) greater than 10, tolerance values greater than 1, and Eigenvalues close to 1. Based on the described criteria, the assumption of multicollinearity was met.

Independence of observations can be assumed based on the fact that electronic time stamps built into the online questionnaire show that parents and adolescents completed their respective surveys at separate times. Additionally, siblings were not known to have participated in this study and the majority of participants were not part of a dyad. Further, participants represented different schools, socio-economic status backgrounds, and were recruited from multiple sources, which also reduces the likelihood that participants would know each other and discuss ratings or experiences. As was previously mentioned, when it was appropriate, the present study used participants' final stage of help seeking to conduct statistical analyses; this also helps to ensure the assumption of independence of observations.

The final sample consisted of 175 adolescents and 95 parents. Logistic regression requires 15 to 20 observations for each independent variable in the analyses; this study met this criteria as a maximum of four predictors were entered into any one analysis.

### **Preliminary Analyses**

Means, standard deviations and ranges for the study variables are presented in Tables 6 and 7.

Table 6

## Ranges, Means, and Standard Deviations of Variables for Adolescent Participants

Variable	Range	<i>r</i>	<i>N</i>	<i>M</i>	<i>SD</i>
Inventory of Attitudes toward Seeking Mental Health Services – Total Score	15-74	0.87	148	45.36	11.79
Family Communication Scale – Total Score	10-48	0.91	160	29.12	8.41
Family Crisis Oriented Personal Scales					
Acquiring Social Support	9-39	0.73	150	25.97	6.15
Seeking Spiritual Support	3-15	0.79	159	6.37	3.26
Mobilizing Family to Accept Help	3-15	0.72	158	6.89	2.81
Adolescent Coping Orientation for Problem Experiences					
Family Interaction	5-24	0.73	157	14.60	3.97
Seeking Spiritual Support	3-15	0.89	170	5.18	3.09
Seeking Professional Support	1-5	-	174	1.47	1.70
Family Adaptability and Cohesion Evaluation Scales					
Cohesion Ratio	0.00-5.93	0.79-0.80*	173	1.65	1.33
Flexibility Ratio	0.00-3.02	0.77-0.80*	188	1.21	.80
Pediatric Symptom Checklist	35-85	0.88	161	58.80	10.67
Help Seeking Questionnaire					
Number of Help Seeking Barriers Endorsed	0-16	-	175	3.21	2.73
Knowledge-Related Barriers Endorsed	0-2	-	175	1.02	.76

Note. *r* = reliability coefficient. \*ranges are provided when three subscales were used to calculate a ratio score.

Table 7

Ranges, Means, and Standard Deviations of Variables for Parent Participants					
Variable	Range	<i>r</i>	<i>N</i>	<i>M</i>	<i>SD</i>
Inventory of Attitudes toward Seeking Mental Health Services – Total Score	7-73	0.84	91	43.34	12.44
Family Communication Scale – Total Score	19-50	0.91	93	30.74	6.05
Family Crisis Oriented Personal Scales					
Acquiring Social Support	9-43	0.71	95	28.27	5.92
Seeking Spiritual Support	2-15	0.83	95	6.83	3.31
Mobilizing Family to Accept Help	3-15	0.69	95	8.06	3.19
Family Adaptability and Cohesion Evaluation Scales					
Cohesion Ratio	0.00-6.00	0.50-0.80*	95	2.80	1.52
Flexibility Ratio	0.00-3.00 <sup>P</sup>	0.69-0.77*	95	1.47	.74
Parental Strain Scale					
Objective Strain	1.00-3.45	0.92	95	1.85	.61
Internalized Subjective Strain	1.00-4.83	0.86	95	2.38	.85
Global Strain	1.00-3.68	0.90	95	2.10	.57
Pediatric Symptom Checklist	6-51	0.82	95	20.20	9.13
Help Seeking Questionnaire					
Number of Help Seeking Barriers Endorsed	0-17	-	95	3.36	2.32
Knowledge-Related Barriers Endorsed	0-2	-	95	1.02	.76

Note. *r* = reliability coefficient. \*ranges are provided when three subscales were used to calculate a ratio score.

## Adolescents

***Stages of help seeking.*** An examination of adolescents' highest stage of help seeking revealed that 16 percent (n=28) had recognized a problem (Stage 1), 10 percent (n=18) had decided to seek professional help (Stage 2), and 27 percent (n=47) had actually sought professional help (Stage 3). Of note, more adolescents had sought professional help (Stage 3) than had decided to seek help (Stage 2) because 13 percent (n=23) of the adolescents who did not perceive a need for help, sought professional help after being told to do so by their parents or discovering that their parents had arranged an appointment for them to meet with a mental health professional. This was assessed based on adolescents' responses when they were asked if they had contacted a professional about their emotional or mental health (i.e., Yes, but my parents told me to call or see the professional; Yes, but my parents called or made the appointment for me). With regards to informal help, 14 percent (n=24) of the adolescents identified their friends and family to be an adequate source of support for mental health concerns, as opposed to mental health professionals. Table 8 shows a brief overview of the frequencies and percentages of participants at each stage of help seeking.

Table 8

*Frequencies and Percentages for Adolescents' Highest Stage of Help Seeking*

Stage	Adolescents n(%)
Non-Help-Seekers	81(47)
Recognizing the Problem (Stage 1)	28(16)
Deciding to Seek Help (Stage 2)	18(10)
Sought Professional Help (Stage 3)	47(27)

*Note.* Based on 174 adolescents.

Using the cumulative method for categorizing adolescents into the stages of help seeking, 40 percent had recognized their own mental health problem (Stage 1), 24 percent had decided to seek professional help, and 27 percent had actually sought professional help. Figure 4 provides a detailed flow chart illustrating participants' categorization into the help seeking stages. As shown in Figure 4, 24 adolescents sought professional help (Stage 3) after they had recognized their mental health problem (Stage 1) and decided to seek professional help (Stage 2). In contrast, 23 adolescents sought professional help (Stage 3) only after being told to do so. The latter group does not appear to have progressed through Stages 1 and 2 of help seeking.

T-tests were performed using each of the present study's adolescent predictor variables (refer to Table 5) to examine whether the adolescents who progressed through the stages of help seeking significantly differed from the adolescents who sought help only after being prompted to do so. The results revealed that the adolescents who required prompting to seek help ( $M= 46.47$ ,  $SD= 14.09$ ) had more negative attitudes towards seeking professional help than the adolescents who had progressed through the stages of help seeking ( $M= 37.25$ ,  $SD= 11.05$ ),  $t=2.28$ ,  $p=.03$ . Further, the adolescents who required prompting to seek professional help ( $M= 15.63$  years,  $SD= 1.15$ ) were found to be significantly younger than the adolescents who progressed through the stages of help seeking ( $M= 16.91$  years,  $SD= 1.27$ ),  $t=-3.23$ ,  $p=.003$ .

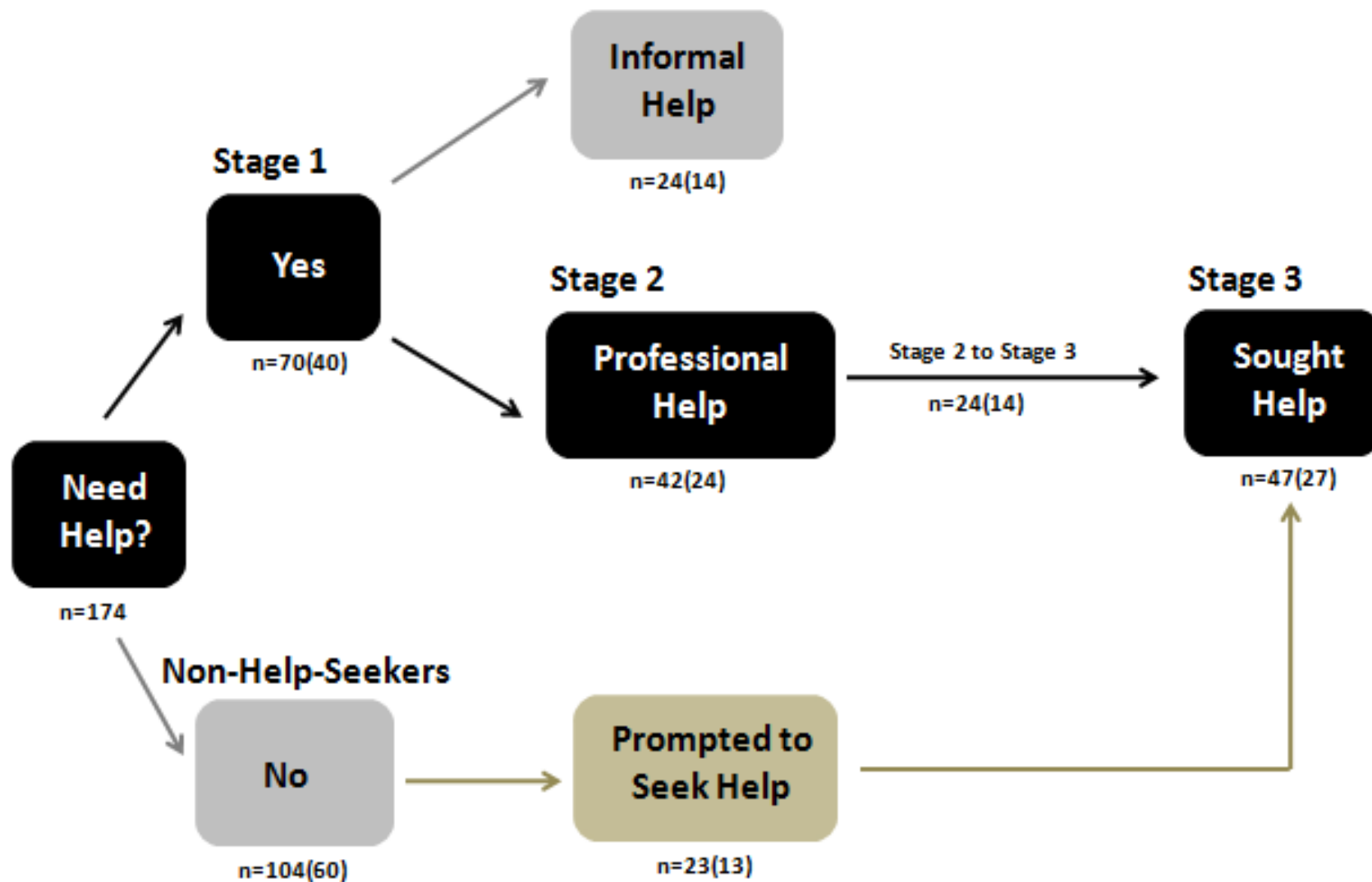


Figure 4. Adolescents' stages of help seeking. Percentages are shown in brackets. The number of participants decreases going from the left to the right of the figure because adolescents do not all progress on to the next stage of help seeking.



The mean ages and age ranges of adolescents' highest stage of help seeking are presented in Table 9. There were not enough participants within each stage of help seeking to examine gender and age differences among the adolescents. As such, the cumulative methodology for classifying adolescents into the stages of help seeking was used to compare age and gender differences (see Appendix R for the mean ages and age ranges of participants in each of the stages of help seeking according to the cumulative method). One-way ANOVAs revealed that there were no significant differences in age between male and female participants within each stage of help seeking. However, there was a significant association between an adolescent's gender and whether or not they recognized their mental health problem (Stage 1),  $X^2(1) = 9.99, p = .004$ . Based on the odds ratio, females were 2.86 times more likely to recognize their own mental health problems than males. There was also a significant association between an adolescent's gender and whether or not they decided to seek professional help (Stage 2),  $X^2(1) = 6.42, p = .04$ . Based on the odds ratio, females were 2.50 times more likely to decide to seek professional help than males. Further, a significant association was found between an adolescent's gender and whether or not they denied needing professional help (Non-Help-Seeker),  $X^2(1) = 11.67, p = .003$ . Based on the odds ratio, males were 2.82 times more likely not to seek help (Non-Help-Seekers).

Table 9

*Age Ranges, Means, and Standard Deviations for Female<sup>f</sup> and Male<sup>m</sup> Adolescents in the Stages of Help Seeking*

Highest Stage of Help Seeking	Adolescents			
	Age Range	<i>n</i>	<i>M</i>	<i>SD</i>
Non-Help-Seekers	14-18 <sup>f</sup>	45	16.32	1.34
	14-18 <sup>m</sup>	36	16.54	1.32
Stage 1	14-18 <sup>f</sup>	24	16.22	1.44
	14-17 <sup>m</sup>	4	15.50	2.12
Stage 2	14-18 <sup>f</sup>	14	16.73	1.44
	15-18 <sup>m</sup>	4	16.20	1.30
Stage 3	14-18 <sup>f</sup>	30	16.29	1.46
	14-18 <sup>m</sup>	17	16.64	1.22

Similar to other researchers who have investigated the stages of adolescent help seeking (e.g., Sears, 2004), the following results are based on the cumulative methodology for classifying adolescents into the stages of help seeking, as opposed to using adolescents' highest stage of help seeking.

**Stage 1: recognizing the problem.** As described in the methods, adolescents who endorsed having recognized their own mental health problem (n=70) were asked to select as many descriptors as they felt applied to their problem from a list of nine options (i.e., emotional, behavioural, substance use, family problems, interpersonal problems, self-confidence, stress, uncertain, and other). As Table 10 shows, the majority of adolescents (84 percent) indicated that they had an emotional problem, followed by difficulties with stress (60 percent), family problems (49 percent), low self-confidence (47 percent), interpersonal problems (41 percent), feeling unlike their usual self (i.e., "I'm not sure what it is, I'm just not like my usual self") (21 percent), behaviour problems (16 percent), and substance use (11 percent). Adolescents listed disordered eating, suicidal thoughts, school, self harm, and sex addiction under the 'other' option; this accounted for seven percent of adolescents who had identified having a mental health problem. Of the adolescents who identified having a mental health problem, 81 percent (n=20) reported having more than one problem (range= 2–8,  $M=3.40$ ,  $SD=1.87$ ). The majority of adolescents who recognized themselves to have a mental health problem rated the severity of their problem to be 'somewhat serious' (n = 43,  $M = 2.06$ ,  $SD=.63$ , range=1-3).

Table 10

*Problems Reported by Adolescents who Recognized their own Problems*

Problem	Participants n (%)
Emotional	59(84)
Behavioural	11(16)
Substance Use	8(11)
Family Problems	34(49)
Interpersonal Problems	29(41)
Self Confidence	33(47)
Stress	42(60)
Not sure	15(21)
Other	7(10)

*Note.* n= 70. Percentages will not add to 100 because participants were able to select more than one problem type.

**Stage 2: deciding to seek professional help.** Of the adolescents who decided to seek help for mental health problems, 64 percent (n=42) identified a need for professional help and 36 percent (n=24) identified a need for help from friends and family members. The help resources participants selected from a list (i.e., family, friends, teacher or spiritual leader, doctor, mental health professional, other) are presented in Table 11. As the table shows, adolescents who preferred informal help resources were most likely to decide to seek help from a friend whereas adolescents who selected formal help resources were most likely to identify a mental health professional to be an appropriate resource.

Table 11

*Help Resources Sought by Adolescents*

Resource	Participants who Decided to Seek Help		Total (n=66)
	Preference of Informal Help (n=24)	Preference of Formal Help (n=42)	
Family	12(50)	17(41)	29(44)
Friends	19(79)	14(33)	33(33)
Teacher or Spiritual Leader	4(16)	9(21)	13(20)
Doctor	0(0)	14(33)	14(21)
Mental Health Professional	0(0)	40(95)	40(61)
Other (i.e., physiotherapist, dietician, anyone, not sure)	5(21)	2(5)	7(11)

*Note.* n(%)

**Stage 3: seeking professional help.** In total, 27 percent (n=47) of the adolescents sought professional help. Of these adolescents, 51 percent (n=24) sought help from a professional on their own whereas the remaining 49 percent (n=23) sought professional help after being prompted to do so by someone else. Of the 47 adolescents who sought professional help, with or without prompting, 49 percent (n=23) consulted a medical doctor, 36 percent (n=17) consulted a social worker, 36 percent (n=17) consulted a psychologist, 19 percent (n=9) consulted a psychiatrist, 11 percent (n=5) consulted a nurse, and 17 percent (n=8) consulted other professionals (e.g., school counsellor, staff from the Canadian Hearing Society). Of these adolescents, 32 percent (n=15) sought help from more than one professional (range 2-5,  $M=3.13$ ,  $SD=1.13$ ).

Item 2b on the HSQ required all adolescents to select reasons from a list of 16 items as to why they had not or may not seek professional help. Table 12 illustrates the frequency of reported help seeking barriers. Additional barriers, which adolescents provided under the ‘other’ option, related to the belief that friends and family members could provide adequate help, feeling scared or embarrassed, being uncertain about what service involvement would entail, desires to avoid being told what to do, feeling uncomfortable disclosing personal information to a “stranger,” the belief that a parent was more in need of professional help (as opposed to the adolescent), feeling insecure about one’s ability to discuss the problem, the belief that no one would care, the belief that people would think the problem had been exaggerated, and being unable to find a professional of the same race. Regardless of their stage of help seeking, adolescents’ most commonly endorsed barrier to seeking professional help related to a desire to be independent. Beyond this, adolescent non-help-seekers, adolescents who recognized their own mental health problem (Stage 1), and adolescents who decided to seek professional help (Stage 2) also reported that a lack of knowledge of mental health hindered their help-seeking process. In contrast, adolescents who actually sought help (Stage 3) reported that feeling professional help would be inadequate hindered their help-seeking process.

An Analysis of Variance was conducted to determine whether adolescents' total number of reported barriers significantly differed based on their stage of help seeking (i.e., Stage 1, Stage 2, and Stage 3). The results revealed no significant differences,  $F(2,86) = 1.54, p=.22$ . The number of reported barriers for adolescents in Stage 1 ( $M=3.48, SD=2.29$ ) and adolescents classified as non-help-seekers ( $M=3.08, SD=3.02$ ) was also not significantly different,  $t=-.59, p=.56$ .



Table 12

*Barriers to Help Seeking Endorsed by Adolescent Participants*

Barrier	Non-Help- Seekers n=104	Stage 1 n=70	Stage 2 n=42	Stage 3 n=47
Didn't get around to it	19(18)	18(26)	13(31)	8(17)
Waiting times were too long	11(11)	6(9)	5(12)	9(19)
Felt help would be inadequate	25(24)	32(46)	19(45)	16(34)
Help was not available when needed	4(4)	3(4)	2(5)	1(2)
Cost/money	19(18)	13(19)	9(21)	6(13)
Services were not available in the area	6(6)	2(3)	2(5)	2(4)
Too busy	26(25)	17(24)	9(21)	12(26)
Did not know where to go	31(30)	34(49)	22(52)	11(23)
Do not trust professionals	9(9)	18(26)	12(29)	7(15)
Other responsibilities got in the way	19(18)	9(13)	5(12)	10(21)
Language barrier	4(4)	1(1)	1(2)	2(4)
Transportation problems	10(10)	10(14)	4(10)	6(13)
Other people may have found out	14(14)	19(27)	10(24)	7(15)
I like to handle things on my own	60(58)	41(59)	22(53)	23(49)
I know very little about mental health	28(27)	20(29)	13(31)	9(19)
Other	16(15)	17(24)	12(29)	6(13)

Note. n(%)

## Parents

*Stages of help seeking.* An examination of parents' highest stage of help seeking revealed that 10 percent (n=10) had recognized their adolescent to have a problem (Stage 1), 15 percent (n=14) had decided to seek professional help for their adolescent (Stage 2), and 29 percent (n=27) had actually sought professional help for their adolescent (Stage 3). Of the parents who had sought professional help (Stage 3), 4 percent did so after being told to do so by someone else. This was assessed based on parents' responses when they were asked if they had contacted a professional about their adolescent's emotional or mental health (i.e., Yes, but it was because someone asked me to contact a professional). Table 13 shows a brief overview of the frequencies and percentages of participants at each stage of help seeking.

Table 13

*Frequencies and Percentages for Parents' Highest Stage of Help Seeking*

Stage	Parents n(%)
Non-Help-Seekers	43(46)
Recognizing the Problem (Stage 1)	10(10)
Deciding to Seek Help (Stage 2)	14(15)
Sought Professional Help (Stage 3)	27(29)

*Note.* Based on 94 parents.

Using the cumulative methodology for classifying participants into the stages of help seeking, 51 percent of parents had concerns that their adolescent had a mental health problem (Stage 1), 39 percent of parents had decided to seek professional help for their adolescent (Stage 2), and 28 percent of parents had actually sought professional help for their adolescent (Stage 3). Chi-square analysis revealed that the percentage of fathers and mothers at each stage of help seeking was comparable. Figure 5 provides a detailed flow chart illustrating participants' categorization into the help seeking stages.

The following descriptions are based on the cumulative methodology for classifying parents into the stages of help seeking, as opposed to using parents' highest stage of help seeking.

**Stage 1: recognizing the problem.** Parents most frequently categorized their adolescent's mental health problem to be related to behaviour problems (47 percent) followed by emotional problems (43 percent), family problems (28 percent), and substance use (21 percent). Table 14 provides a detailed breakdown of how parents classified their adolescent's mental health struggles. Parents listed disordered eating, school, sexuality, acting too old for their age, dressing inappropriately, misunderstanding social cues, and being bullied under the 'other' option; this accounted for 31 percent of parents who had identified their adolescent as having a mental health problem. Sixty-two percent ( $n=29$ ) reported that their adolescent had more than one problem (range= 2–9,  $M=2.36$ ,  $SD=1.69$ ). The majority of parents who recognized their adolescent to have a mental health problem ( $n=33$ ,  $M=2.24$ ,  $SD= .48$ ,  $r=1-3$ ) rated the severity of their problem to be 'somewhat serious.'

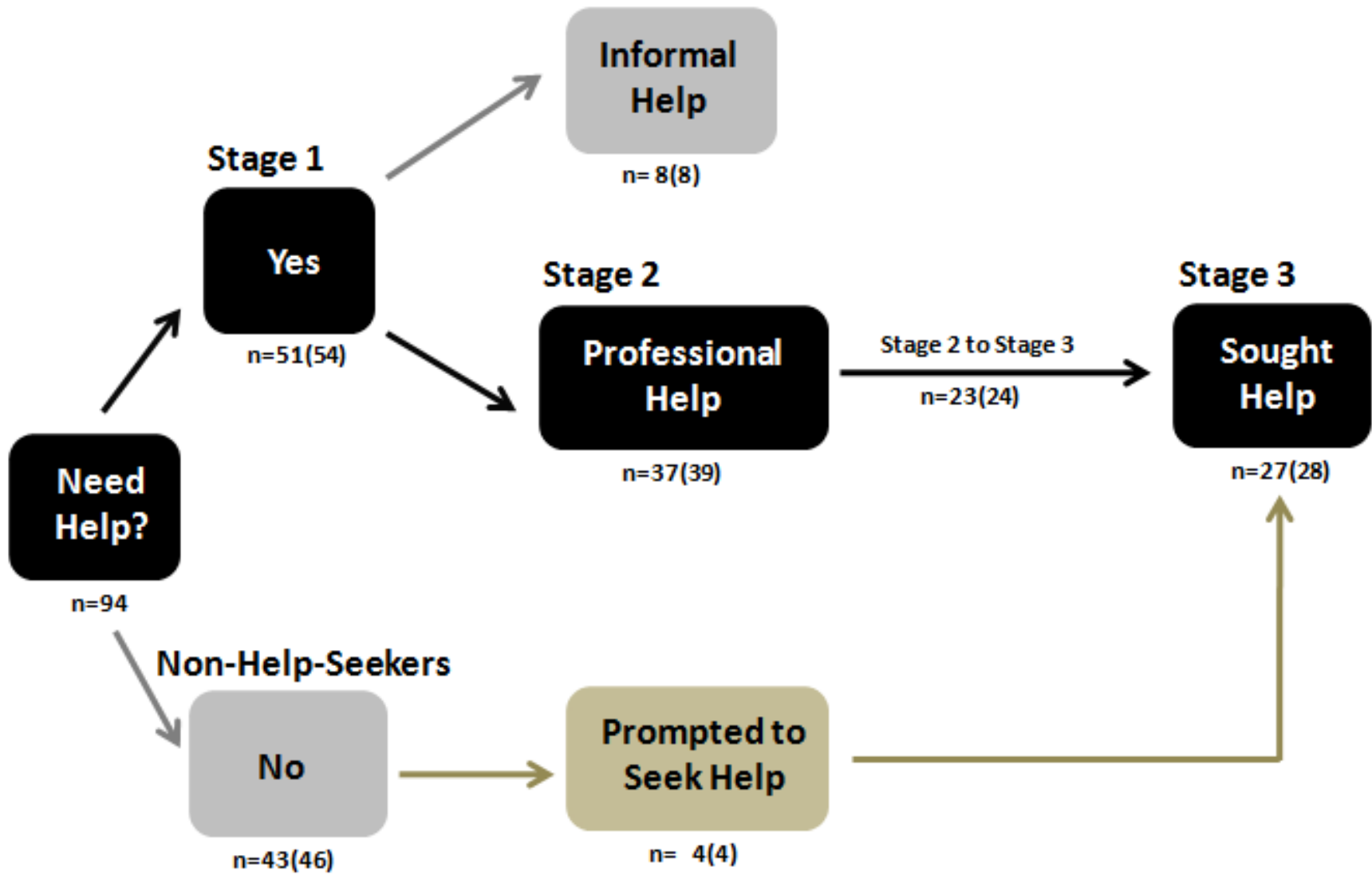


Figure 5. Parents' stages of help seeking. Percentages are shown in brackets. The number of participants decreases going from the left to the right of the figure because parents do not all progress on to the next stage of help seeking.

Table 14

*Problems Reported by Parents who Recognized Adolescent Mental Health Problems (Stage 1)*

Problem	Parents n (%)
Emotional	20(43)
Behavioural	22(47)
Substance Use	10(21)
Family Problems	13(28)
Interpersonal Problems	5(11)
Self Confidence	9(19)
Stress	9(19)
Not sure	8(17)
Other	15(31)

*Note.* n= 51. Percentages will not add to 100 because participants were able to select more than one problem type

**Stage 2: deciding to seek professional help.** Of the parents who decided to seek help for their adolescent's mental health problems, 82 percent (n=37) identified a need for professional help and 18 percent (n=8) identified a need for help from friends and family members. The help resources parents selected from a list (i.e., family, friends, teacher or spiritual leader, doctor, mental health professional, other) are presented in Table 15. As the table shows, parents who selected informal help resources were most likely to identify family members to be a good resource for adolescent mental health problems whereas parents who selected formal help resources were most likely to identify a mental health professional to be a good resource for adolescent mental health problems.

Table 15

*Help Resources Identified by Parents*

Helper	Participants who Decided to Seek Help		
	Informal Help (n=8)	Formal Help (n=37)	Total (n=45)
Family	4(50)	11(30)	15(33)
Friends	1(13)	6(16)	7(16)
Teacher or Spiritual Leader	0(0)	10(27)	18(40)
Doctor	0(0)	23(62)	23(51)
Mental Health Professional	0(0)	33(89)	33(73)
Other (e.g., “not sure”)	2(25)	5(14)	7(16)



**Stage 3: seeking professional help.** Twenty-eight percent (n=27) of parents sought professional help for their adolescent. When asked to indicate the type of professional they spoke to, 56 percent of parents reported that they consulted a medical doctor, 33 percent consulted a social worker, 33 percent consulted a psychologist, 7 percent consulted to a psychiatrist, 11 percent consulted a nurse, and 11 percent consulted other professionals (e.g., staff at a Children’s Centre, Student Disability Services at the University). Notably, 22 percent (n=6) of the parents sought help from more than one professional (range 2-6,  $M=3.33$ ,  $SD=2.07$ ).

Item 2b on the HSQ required all parents to select reasons from a list of 17 items as to why they had not or may not seek profession help for their adolescent. Table 16 illustrates the frequency of reported help seeking barriers. Additional barriers, which parents provided under the ‘other’ option, related to perceptions that professionals minimized previous mental health concerns, adolescents’ refusal to attend appointments, worries about adolescents being diagnosed as having a mental health disorder, beliefs that adolescent problems could be resolved without mental health intervention, beliefs that medications could adequately address the problem, preferences to seek help from family or friends, a lack of parental agreement regarding whether the adolescent suffered from a mental health problem, and perceptions that adolescent difficulties were the result of defiance or “manipulation.” Regardless of their stage of help seeking, parents’ most commonly endorsed barrier to seeking professional help was not knowing where to go for help (i.e., I did not know where to go). Beyond this, parent non-help-seekers, parents who recognized their adolescent’s mental health problem (Stage 1), and parents who decided to seek professional help for their adolescent (Stage 2) also reported that their knowledge of mental health hindered their help seeking for adolescent mental health problems (i.e., I know very little about mental health). In contrast, parents who actually sought help (Stage 3) reported that waiting times hindered their help seeking for adolescent mental health problems.

Parents most commonly endorsed barriers related to a lack of knowledge (i.e., I didn't know where to go, 54 percent; I know very little about mental health, 60 percent).

A one-way Analysis of Variance was conducted to determine whether parents' total number of reported barriers to seeking professional help for adolescent problems significantly differed based on the their stage of help seeking (i.e., Stage 1, Stage 2, and Stage 3). The results revealed no significant differences by stage,  $F(2,51) = 1.74, p=.19$ . However, parents in Stage 1 ( $M=5.14, SD=1.95$ ) reported more barriers to seeking professional help than parents classified as 'non-help-seekers' ( $M=3.12, SD=1.64$ ),  $t=-2.93, p=.005$ .

Table 16

*Barriers to Help Seeking Endorsed by Parent Participants*

Barrier	Non- Help- Seekers n=43	Stage 1 n=51	Stage 2 n=37	Stage 3 n=27
Didn't get around to it	1(2)	6(12)	4(11)	1(4)
Waiting times were too long	7(16)	14(27)	11(30)	10(37)
Felt help would be inadequate	14(32)	10(20)	6(16)	4(15)
Help was not available when needed	1(2)	13(25)	11(30)	9(33)
Cost/money	8(19)	13(25)	10(27)	6(22)
Services were not available in the area	0(0)	5(10)	4(11)	2(7)
Too busy	7(16)	9(18)	5(14)	2(7)
Did not know where to go	19(44)	28(55)	19(51)	10(37)
Do not trust professionals	1(2)	2(4)	2(5)	1(4)
Other responsibilities got in the way	10(23)	7(14)	4(11)	3(11)
Language barrier	1(2)	1(2)	1(2)	1(4)
Transportation problems	5(12)	10(20)	7(19)	3(11)
Other people may have found out	1(2)	2(4)	2(5)	1(4)
I like to handle things on my own	12(28)	3(6)	1(3)	3(11)
I know very little about mental health	23(53)	26(51)	20(54)	9(33)
It is my adolescents' responsibility to seek help	3(7)	3(6)	3(8)	1(4)
Other	22(51)	31(61)	26(70)	16(59)

Note. n(%).

### Correlations among Study Variables

Correlations between study variables were examined using the cumulative methodology for classifying participants into the stages of help seeking; therefore, participants could have been classified in each of the stages of help seeking if they had recognized mental health problems (Stage 1), decided to seek professional help (Stage 2), and sought professional help (Stage 3).

*Adolescents.* Correlations are presented in Table 17. Recognizing mental health problems (Stage 1) was significantly positively correlated with negative attitudes towards seeking mental health services and perceiving a greater number of barriers to professional help. Deciding to seek professional help (Stage 2) was significantly positively correlated with adolescents' prior professional help seeking. Seeking professional help (Stage 3) was significantly negatively correlated with a lack of knowledge of mental health and significantly positively correlated with adolescent-reported personal and familial prior professional help seeking.

Analysis of Variance revealed a significant effect of age on adolescent attitudes towards seeking professional help,  $F(4,129)=3.28, p<.05$ . Pair-wise comparisons revealed that 14-year-old adolescents ( $M=54.00, SD=11.51$ ) were more likely to have negative attitudes towards help seeking than 16 year olds ( $M=.42.28, SD=13.46.$ ) and 18 year olds ( $M=42.92, SD=11.97$ ). Analysis of Variance also revealed that the attitudes of adolescents in Stage 1, Stage 2, and Stage 3, were significantly different,  $F= (2,75) = 4.19, p=.02$ . Pair-wise comparisons revealed that adolescents who believed they had a mental health problem (Stage 1;  $M=50.85, SD=11.76$ ) had significantly more negative attitudes towards seeking mental health services than adolescents who had actually sought help (Stage 3;  $M=41.74, SD=13.30$ ). Negative attitudes towards seeking mental health services were significantly positively correlated with perceived barriers to professional help, indicating that adolescents with negative attitudes were more likely to report a greater number of barriers to help seeking.

Perceived barriers to help seeking were significantly negatively correlated with family cohesion, indicating that adolescents who felt that their families were emotionally connected perceived fewer barriers to professional help. Similarly, perceived barriers to help seeking were significantly negatively correlated with family flexibility, suggesting that adolescents who felt that their families demonstrated strong leadership and organizational skills perceived fewer barriers to professional help. Adolescent prior help seeking from family members (as measured by the ACOPE) was significantly negatively correlated with perceived barriers to help seeking, suggesting that adolescents who sought help from family members perceived fewer barriers to professional help seeking. Family communication was significantly negatively correlated with a lack of knowledge of mental health, indicating that adolescents who perceived their family's communication style to be assertive (i.e., people discuss problems calmly, respond honestly, and are nonjudgmental) had a greater knowledge of mental health.

Adolescent symptomatology (i.e., measured by the total score on the Y-PSC) was significantly positively correlated with adolescent prior professional help seeking and significantly negatively correlated with adolescent and family prior help seeking from family members and friends. Therefore, adolescents were more likely to seek professional help and less likely to seek informal help as they experienced a greater number of symptoms of mental health problems. Adolescent symptomatology was also significantly positively correlated with adolescent ratings of the severity of their mental health problem(s), suggesting that adolescents with a greater number of symptoms of mental health problems perceived their struggles to be more severe. Adolescent symptomatology was significantly positively correlated with perceived barriers to professional help and significantly negatively correlated with family cohesion, family flexibility, and family communication; the negative correlations indicate that adolescents who believed that their families were emotionally connected, assertive, and capable of strong leadership and organizational skills reported fewer symptoms of mental health problems. Similarly, adolescent perceived problem

severity ratings were significantly negatively correlated with family cohesion, family communication, adolescent-reported prior family help seeking from friends and family members, and adolescent prior help seeking from family members. Adolescent perceived problem severity ratings were significantly positively correlated with adolescents' professional help seeking (i.e., problem recognition, deciding to seek help, actually seeking help, and prior professional help seeking).

Family communication was significantly negatively correlated with each of the stages of help seeking (i.e., recognizing the problem, deciding to seek professional help, actually seeking professional help), indicating that adolescents may have been less likely to seek professional help when they perceived their family's communication style to be assertive (i.e., discuss problems calmly, respond honestly, and are nonjudgmental). Family communication was also significantly negatively correlated with adolescent perceived barriers to professional help seeking and adolescent symptomatology. Family communication was significantly positively correlated with adolescent-reported prior family help seeking from friends and spiritual leaders as well as prior adolescent help seeking from family members. Family histories of seeking social support were significantly positively correlated with family cohesion and family flexibility. Family coping skills were positively correlated with adolescent coping skills; for instance, family histories of seeking social support were significantly positively correlated with adolescent histories of seeking social support.

Although the psychometric properties were poor for the subscales on the Inventory of Attitudes toward Seeking Mental Health Services (IASMHS) in the present study, the adolescent Indifference to Stigma subscale showed acceptable psychometric properties. Correlations between the study variables and the adolescent Indifference to Stigma subscale were examined. Adolescents' age was significantly negatively correlated with the Indifference to Stigma subscale ( $r = -.26, p < .01$ ), suggesting that younger adolescents were more likely to feel guilty, ashamed, or embarrassed as a result of their mental health

problems. Adolescents' Indifference to Stigma subscale score was significantly positively correlated with perceived barriers to help seeking ( $r = .22, p < .01$ ) and a lack of knowledge ( $r = .23, p < .01$ ), indicating that adolescents who endorsed stigma were more likely to perceive a greater number of barriers to professional mental health services and report a lack of knowledge of mental health. Adolescents' ability to recognize mental health problems (Stage 1) and decide to seek help (Stage 2) were significantly positively correlated with the Indifference to Stigma subscale ( $r = .17, p < .05$ ;  $r = .18, p < .05$  respectively).

Table 17

*Correlations among Adolescent Variables*

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1. Gender	<i>r</i>	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	<i>n</i>																		
2. Age		-.05	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
		153																	
3. Cohesion Ratio		-.03	.11	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
		173	151																
4. Flexibility Ratio		.06	.10	.58**	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
		173	151	173															
5. Comm-unication		.04	.16	.54**	.46**	-	-	-	-	-	-	-	-	-	-	-	-	-	-
		160	142	160	160														
6. FCOPE Social		.04	-.11	.29**	.19*	.36**	-	-	-	-	-	-	-	-	-	-	-	-	-
		150	133	150	150	144													
7. FCOPE Spiritual		-.03	.10	-.04	-.03	.16*	.23**	-	-	-	-	-	-	-	-	-	-	-	-
		159	141	159	159	152	148												
8. FCOPE Professional		.00	-.09	.05	-.04	.08	.22**	.01	-	-	-	-	-	-	-	-	-	-	-
		158	140	156	156	149	146	154											
9. ACOPE Family		.10	-.06	.48**	.42**	.57**	.34**	.09	.14	-	-	-	-	-	-	-	-	-	-
		157	141	157	157	150	140	150	146										
10. ACOPE Spiritual		-.02	.13	.00	.03	.12	.08	.68**	.01	.12	-	-	-	-	-	-	-	-	-
		170	149	170	170	158	148	157	154	154									
11. ACOPE Professional		.00	.06	.00	.00	-.05	-.11	-.09	.40**	-.08	.11	-	-	-	-	-	-	-	-
		174	152	172	172	159	150	158	157	156	169								

(continued)



Table 17 (continued)

*Correlations among Adolescent Variables*

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
12. Attitudes	-.06	-.25**	-.08	-.08	-.10	.02	.13	-.06	.04	.03	-.23**	-	-	-	-	-	-	-
	148	134	146	146	141	132	141	142	140	144	147							
13. Barriers	-.01	-.01	-.18*	-.16*	-.38**	-.13	.08	-.10	-.20*	.03	-.07	.21*	-	-	-	-	-	-
	175	153	173	173	160	150	159	158	157	170	174	148						
14. Symptom- atology	-.06	.05	-.41**	-.33**	-.44**	-.35**	.00	.05	-.38**	.01	.35**	.17*	.26**	-	-	-	-	-
	161	143	159	159	150	145	153	153	149	156	160	141	161					
15. Lack of Knowledge	.12	-.15	-.06	.00	-.16*	.07	.08	-.05	.03	.04	-.17*	.13	.58**	-.08	-	-	-	-
	175	153	173	173	160	150	159	158	157	170	174	148	175	161				
16. Problem Severity	.16	.08	-.24**	-.13	-.42**	-.21*	-.02	-.07	-.33**	.02	.44**	-.05	.07	.42**	-0.02	-	-	-
	135	118	133	133	123	111	120	119	122	131	134	113	135	124	135			
17. Stage 1	-.08	.02	-.03	.00	-.20*	-.19*	-.08	-.12	-.10	-.01	.11	.16*	.15*	.26**	.14	.41**	-	-
	175	153	173	173	160	150	159	158	157	170	174	148	175	161	175	135		
18. Stage 2	-.05	.03	-.04	-.04	-.20**	-.10	-.04	.04	-.06	-.01	.28**	.02	.12	.30**	.14	.44**	.69**	-
	175	153	173	173	160	150	159	158	157	170	174	148	175	161	175	135	175	
19. Stage 3	-.07	-.01	-.11	-.13	-.18*	-.11	-.12	.25**	-.13	-.14	.60**	-.18*	-.07	.32**	-.18*	.43**	.24**	.29**
	175	153	173	173	160	150	159	158	157	170	174	148	175	161	175	135	175	175

*Note.* \*\*Correlation is significant at the 0.01 level (2-tailed), \*Correlation is significant at the 0.05 level (2-tailed). The Family Crisis Orientated Personal Scales (FCOPE) captures family coping skills whereas the Adolescent Coping Orientation for Problem Experiences (ACOPE) captures adolescent coping skills.

**Parents.** Correlations between study variables are presented in Table 18. Each of the stages of help seeking was significantly positively correlated with parent-rated symptomatology of the adolescent (PSC), prior familial professional help seeking, parental objective strain (e.g., missing work due to the adolescent's struggles), parental subjective strain (e.g., feeling sad due to the adolescents' struggles), and parental global strain. A one-way Analysis of Variance was used to test whether parental global strain was significantly different for parents in Stage 1, Stage 2, and Stage 3 of the help-seeking process. The results revealed no significant differences,  $F(2,51)=2.14, p=.13$ . However, parents in Stage 1 ( $M=2.20, SD=.29$ ) had significantly higher levels of global parental strain than parents who were classified as non-help-seekers ( $M=1.76, SD=.35$ ),  $t=-3.19, p=.00$ . Seeking professional help was significantly negatively correlated with negative attitudes towards mental health services.

Parental strain (i.e., objective, subjective internalized, and global strain) was significantly positively correlated with parent-rated symptomatology of the adolescent and parent-rated problem severity of the adolescent's mental health problem. This suggests that as their stress associated with raising a child with mental health problems increased, parents were more likely to identify their adolescent to have mental health problems and to rate their adolescent's difficulties to be severe in nature. Parental strain (i.e., objective, subjective and global strain) was also significantly positively correlated with prior familial professional help seeking. Parental subjective strain and global strain were significantly negatively correlated with negative attitudes towards seeking mental health services, indicating that parents with greater levels of stress were more likely to have positive attitudes towards seeking professional help. All forms of parental strain were significantly negatively correlated with family communication, indicating

that parents who viewed family communication to be dysfunctional (e.g., high in conflict or minimal communication) were more likely to report higher levels of caregiver burden.

Adolescent symptomatology, as rated by the parent (PSC), was significantly positively correlated with prior family professional help seeking, seeking professional help for current adolescent mental health problems (Stage 3), and parent-rated perceived problem severity for the adolescent's mental health struggle. Parent-rated symptomatology of the adolescent was also significantly negatively correlated with family communication, suggesting that parents of youth with symptoms of mental health problems were more likely to perceive family communication to be dysfunctional (e.g., high in conflict or minimal communication). Family communication was significantly negatively correlated with parents' recognition of adolescent mental health problems (Stage 1), indicating that parents of families who discussed problems calmly, responded honestly, and were nonjudgmental were less likely to recognize adolescent mental health problems.

Family cohesion, flexibility, communication, and histories of seeking social support were all significantly positively correlated. Family communication was significantly positively correlated with seeking spiritual support and significantly negatively correlated with parental strain (i.e., objective strain, subjective strain, and global strain). Family communication was significantly negatively correlated with parents' perceived barriers to seeking professional help for adolescent problems, suggesting that parents who felt that their families communicated assertively perceived fewer barriers to seeking professional help for adolescent mental health problems.

A lack of knowledge of mental health was significantly positively correlated with negative attitudes toward seeking professional help and significantly negatively correlated with

Stage 3 of the help-seeking process (i.e., seeking professional help for adolescents); stated another way, parents seemed more likely to seek help for their adolescent and have positive attitudes towards seeking mental health services if they had greater knowledge of mental health. A lack of knowledge of mental health was significantly positively correlated with perceiving a greater number of barriers to professional help, suggesting that parents with poor knowledge of mental health were more likely to perceive barriers to adolescent mental health services. Parents' recognition of their adolescent's mental health problem (Stage 1) was also significantly positively correlated with parent-reported barriers to professional help.

Negative attitudes toward seeking professional help for adolescents were significantly positively correlated with reported barriers to professional help. A *t*-test revealed that fathers ( $M=52.14$ ,  $SD=11.54$ ) were significantly more likely than mothers ( $M=41.74$ ,  $SD=11.98$ ) to have negative attitudes towards seeking professional help,  $t=3.00$ ,  $p=.003$ .

Table 18

*Correlations among Parent Variables*

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1. Gender	<i>r</i>	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	<i>n</i>																	
2. Cohesion Ratio		.02 95	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
3. Flexibility Ratio		-.05 95	.27** 95	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
4. Communication		-.11 93	.57** 93	.28** 93	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5. FCOPE Social		-.09 95	.20* 95	.26* 95	.29** 93	-	-	-	-	-	-	-	-	-	-	-	-	-
6. FCOPE Spiritual		.26* 95	-.03 95	.07 95	.30** 93	.02 95	-	-	-	-	-	-	-	-	-	-	-	-
7. FCOPE Professional		.05 95	.17 95	-.10 95	-.05 93	-.16 95	-.12 95	-	-	-	-	-	-	-	-	-	-	-
8. Attitudes		-.30** 91	-.26* 91	-.12 91	-.15 89	.09 91	-.07 91	-.45** 91	-	-	-	-	-	-	-	-	-	-
9. Barriers		-.18 95	-.20 95	-.21* 95	-.29** 93	.03 95	-.12 95	-.15 95	.36** 91	-	-	-	-	-	-	-	-	-
10. Objective Strain		-.08 95	-.14 95	.00 95	-.34** 93	-.05 95	-.16 95	.49** 95	-.20 91	.12 95	-	-	-	-	-	-	-	-
11. Internalized Sub. Strain		.01 95	-.08 95	.05 95	-.30** 93	-.17 95	-.13 95	.52** 95	-.31** 91	.02 95	.84** 95	-	-	-	-	-	-	-

(continued)

Table 18 (continued)

*Correlations among Parent Variables*

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
12. Total	.01	-.19	.00	-.37**	-.13	-.11	.48**	-.23*	.08	.91**	.93**	-	-	-	-	-	-
Stress	.95	.95	.95	.93	.95	.95	.95	.91	.95	.95	.95						
13. Symptom-	-.07	-.06	-.03	-.31**	-.11	-.20	.44**	-.16	.18	.69**	.69**	.71**	-	-	-	-	-
atology	.95	.95	.95	.93	.95	.95	.95	.91	.95	.95	.95	.95					
14. Lack of	-.14	-.09	.02	-.16	.11	-.22*	-.26*	.32**	.59**	.00	-.02	.00	.05	-	-	-	-
Knowledge	.95	.95	.95	.93	.95	.95	.95	.91	.95	.95	.95	.95	.95				
15. Problem	-.10	.00	.07	.04	.03	.09	.26	-.24	.00	.61**	.70**	.69**	.42**	.00	-	-	-
Severity	.53	.53	.53	.52	.53	.53	.53	.51	.53	.53	.53	.53	.53	.53			
16. Stage 1	-.03	-.16	-.03	-.31**	.07	-.24*	.32**	-.09	.23*	.46**	.54**	.49**	.37**	.17	-.07	-	-
	.95	.95	.95	.93	.95	.95	.95	.91	.95	.95	.95	.95	.95	.95	.53		
17. Stage 2	-.01	-.09	-.05	-.16	.04	-.20	.40**	-.18	.11	.48**	.53**	.47**	.31**	.03	-.23	.81**	-
	.95	.95	.95	.93	.95	.95	.95	.91	.95	.95	.95	.95	.95	.95	.53	.95	
18. Stage 3	.02	.06	-.01	-.18	-.17	-.15	.52**	-.21*	-.09	.51**	.49**	.43**	.37**	-.27**	-.14	.31**	.31**
	.95	.95	.95	.93	.95	.95	.95	.91	.95	.95	.95	.95	.95	.95	.53	.95	.95

*Note.* \*\*Correlation is significant at the 0.01 level (2-tailed), \*Correlation is significant at the 0.05 level (2-tailed). The Family Crisis Orientated Personal Scales (FCOPE) captures family coping skills.

## Main Analyses

Logistic regression analyses were conducted using the cumulative method for classifying participants into the stages of help seeking; for instance, participants in all of the three stages of help seeking were entered into analyses when the outcome variable was problem recognition. Also, only the predictor variables found to be significantly correlated with the outcome variable (i.e., Stage 1, Stage 2, or Stage 3 of help seeking) were entered in hierarchical logistic regression analyses. All of the regressions were conducted with and without the predictor variables that were not correlated with the outcome variable and the results did not differ. By leaving out the predictor variables that were not correlated with the outcome variable, the researcher was able to conserve statistical power. A summary of the logistic regression analyses can be found in Tables 25 and 26.

### **Hypothesis 1: Adolescents' Problem Recognition (Stage 1)**

It was hypothesized that an adolescent's likelihood of recognizing their own mental health problems would be positively associated with being older, being female, experiencing more mental health symptoms, perceiving the problem to be more severe, and greater knowledge of mental health. Variables significantly associated with adolescents' ability to recognize their own mental health problems were adolescent gender, symptomatology, and perceived problem severity.

A hierarchical logistic regression was conducted with recognition of adolescent mental health problems (Stage 1) as the outcome variable, gender as a covariate in Block 1, and adolescents' total scores on the Youth Pediatric Symptom Checklist (Y-PSC) and problem severity rating in Block 2. The overall model was significant and correctly classified 70 percent of adolescents as having recognized their problem or not. Results revealed that gender

significantly improved the model, and thus, improved one's ability to predict which adolescents' recognized their own mental health problems. Specifically, when only gender was added to the model, female adolescents were found to be nearly three times more likely to recognize their mental health problems than male adolescents. With only gender added, the model correctly classified 64 percent of adolescents. Results in Block 2 revealed that adolescents were more likely to have recognized their problem if they believed their struggles were serious in nature. More specifically, a one-unit increase in perceived problem severity was associated with a 3.85 increase in the odds that an adolescent recognized their mental health problem. Adolescents' symptomatology did not significantly improve the model. The results and test statistics are provided in Table 19.



Table 19

*Summary of the Hierarchical Logistic Regression Analysis for Adolescents' Ability to Recognize their own Mental Health Problem (N=124)*

	<i>B (SE)</i>	95% CI for exp <i>b</i>		
		Lower	Exp <i>b</i>	Upper
Gender	1.05 (.44)*	1.22	2.87	6.72
Severity	1.35(.35)**	1.93	3.85	7.64
Symptomatology	-.01(.02)	.95	1.00	1.04
Constant	-3.96 (1.45)		.02	

*Note.*  $R^2 = .18$  (Hosmer & Lemeshow),  $.22$  (Cox & Snel),  $.30$  (Nagelkerke). Model  $X^2(4) = 31.14, p < .001$ . \* $p < .05$ . \*\* $p < .001$ .

### **Hypothesis 2: Parents' Problem Recognition (Stage 1).**

It was hypothesized that a parents' likelihood of recognizing adolescent mental health problems would be positively associated with higher levels of objective and subjective strain, greater knowledge of mental health, and assertive family communication. Variables significantly associated with parents' ability to recognize adolescent mental health problems were parental strain and family communication.

A logistic regression was conducted with problem recognition (Stage 1) as the outcome variable, parental objective strain and parental subjective strain as predictor variables in Block 1, and family communication as a predictor variable in Block 2. The overall model was significant and correctly classified 75 percent of parents as having recognized an adolescent mental health problem or not. Results revealed that the model was better at predicting parents' ability to recognize adolescent mental health problems (Stage 1) when parental subjective strain was added. Specifically, a one-unit increase in parents' subjective strain (e.g., feeling sad, worried, or guilty due to the adolescents' mental health problem) was associated with a 5.56 increase in the odds that a parent recognized their adolescents' mental health problems. Family communication and parental objective strain did not significantly improve the model. The results and test statistics are provided in Table 20.

Table 20

*Summary of the Hierarchical Logistic Regression Analysis for Parents' Ability to Recognize Adolescent Mental Health Problems (N=93)*

	<i>B (SE)</i>	95% CI for exp <i>b</i>		
		Lower	Exp <i>b</i>	Upper
Objective Strain	.04 (.81)	.22	1.05	5.07
Subjective Strain	1.72 (.61)*	1.68	5.56	18.45
Communication	-.07 (.05)	.85	.93	1.02
Constant	-1.87 (2.00)		.15	

*Note.*  $R^2 = .27$  (Hosmer & Lemeshow),  $.31$  (Cox & Sneil),  $.41$  (Nagelkerke). Model  $X^2(4) = 34.62, p < .001$ . \* $p = .005$ .

**Hypothesis 3: Adolescents' Decision to Seek Professional Help (Stage 2).**

It was hypothesized that an adolescent's likelihood of deciding to seek professional help for mental health problems would be positively associated with being older, perceiving problems to be more severe, positive attitudes towards seeking professional help, prior professional help seeking, and adaptive family environments (i.e., cohesive and flexible). Variables significantly associated with adolescents' decision to seek professional help were perceived problem severity, adolescent prior professional help seeking, and overall family functioning.

A hierarchical logistic regression was conducted with adolescents' decision to seek professional help (Stage 2) as the outcome variable. Perceived problem severity and adolescent professional help seeking practices were entered as predictor variables in Block 1. The overall model was significant and correctly classified 74 percent of adolescents as having decided to seek professional help or not. The model was better at predicting adolescents' decision to seek professional help when problem severity and prior professional help seeking were added. Specifically, a one-unit increase in adolescents' perceived problem severity was associated with a 3.31 increase in the odds that an adolescent decided to seek professional help. Further a one-unit increase in adolescents' prior professional help seeking was associated with a 1.75 increase in the odds that they would decide to seek professional help. The results and test statistics are provided in Table 21.

Table 21

*Summary of the Hierarchical Logistic Regression Analysis for Adolescents' Decision to Seek Help for Mental Health Problems (N=134)*

	<i>B (SE)</i>	95% CI for exp <i>b</i>		
		Lower	Exp <i>b</i>	Upper
Perceived Severity	1.20(.34)**	1.69	3.31	6.50
History of Professional Help	.51(.23)*	1.66	1.75	2.62
Constant	-3.81(.70)		.02	

*Note.*  $R^2 = .19$  (Hosmer & Lemeshow),  $.21$  (Cox & Snel),  $.30$  (Nagelkerke). Model  $X^2(2) = 31.72, p < .001$ . \* $p < .05$ . \*\* $p < .001$ .

**Hypothesis 4: Parents' Decision to Seek Professional Help (Stage 2).** It was hypothesized that parents' likelihood of deciding to seek professional help for adolescent mental health problems (Stage 2) would be positively associated with higher levels of objective and subjective strain, perceiving problems to be more severe, positive attitudes towards seeking professional help, and prior familial professional help seeking. Variables significantly associated with parents' decision to seek professional help for adolescent mental health problems were parental strain and family histories of professional help seeking.

A logistic regression was conducted with deciding to seek help (Stage 2) as the outcome variable, parental objective strain and parental subjective strain in Block 1, and family history of professional help seeking in Block 2. The overall model was significant and correctly classified 80 percent of parents as having decided to seek professional help or not. Results revealed the model was better at predicting parents' decision to seek professional help when parental subjective strain was added. A one-unit increase in parents' subjective strain was associated with a 3.81 increase in the odds that a parent decided to seek professional help for their adolescent. No other predictor variables significantly improve the model. The results and test statistics are provided in Table 22.

Table 22

*Summary of the Hierarchical Logistic Regression Analysis for Parents' Decision to Seek Professional Help for Adolescent Mental Health Problems (N=95)*

	<i>B (SE)</i>	95% CI for exp <i>b</i>		
		Lower	Exp <i>b</i>	Upper
Objective Strain	.36(.77)	.32	1.44	6.55
Subjective Strain	1.33(.59)*	1.2	3.81	12.09
Family History of Professional Help	.14(.09)	.97	1.15	1.38
Constant	-5.54(1.20)		.01	

*Note.*  $R^2 = .26$  (Hosmer & Lemeshow),  $.30$  (Cox & Sneil),  $.40$  (Nagelkerke). Model  $X^2(2) = 33.62$ ,  $p < .001$ . \* $p < .05$ .

### **Hypothesis 5: Adolescents' Actual Professional Help Seeking (Stage 3)**

It was hypothesized that an adolescent's likelihood of seeking professional help for mental health problems would be positively associated being older, being female, perceiving the problem to be more severe, and prior professional help seeking. It was also hypothesized that adolescents who perceived fewer barriers to professional help would be more likely to engage in professional services. Variables significantly associated with adolescents' actual professional help seeking were perceived problem severity and prior professional help seeking.

A hierarchical logistic regression was conducted with adolescents' professional help-seeking behaviour (Stage 3) as the outcome variable. Perceived problem severity and professional help seeking practices were entered as predictor variables in Block 1. The overall model was significant and correctly classified 86 percent of parents as having sought professional help or not. Results revealed the model was better at predicting adolescents' professional help seeking when problem severity and prior professional help seeking were added. A one-unit increase in adolescents' perceived problem severity was associated with a 2.77 increase in the odds that an adolescent sought professional help. Additionally, a one-unit increase in adolescents' prior professional help seeking was associated with a 4.61 increase in the odds that an adolescent sought professional help. Perceived barriers to seeking professional help did not significantly improve the model. The results and test statistics are provided in Table 23.



Table 23

*Summary of the Hierarchical Logistic Regression Analysis for Adolescents' Professional Help Seeking for Their Own Mental Health Problems (N=134)*

	<i>B (SE)</i>	95% CI for exp <i>b</i>		
		Lower	Exp <i>b</i>	Upper
Problem Severity	1.02(.38)*	1.32	2.77	5.85
Perceived Barriers	-.14(.10)	.72	.87	1.07
History of Professional Help Seeking	1.53(.34)**	2.35	4.61	9.04
Constant	-4.67 (.88)		.01	

*Note.*  $R^2 = .36$  (Hosmer & Lemeshow),  $.35$  (Cox & Snel),  $.51$  (Nagelkerke). Model  $X^2(3) = 58.46$ ,  $p < .001$ . \* $p < .01$ . \*\* $p < 0.001$ .

### **Hypothesis 6: Parents' Actual Professional Help Seeking**

It was hypothesized that parents' actual professional help-seeking behaviour (Stage 3) would be positively associated with higher levels of objective and subjective strain, greater perceived problem severity, and prior familial professional help seeking. It was also hypothesized that parents who perceived fewer barriers to professional help would be more likely to seek professional help for adolescent problems. Variables significantly associated with parents' actual professional help seeking for adolescent mental health problems were parent strain and family histories of professional help seeking.

A hierarchical logistic regression was conducted with adolescents' professional help seeking behaviour (Stage 3) as the outcome variable, parental objective strain and subjective strain as predictor variables in Block 1, and previous professional help seeking as a predictor variable in Block 2. The overall model was significant and correctly classified 85 percent of parents as having sought professional help or not. Results revealed that a one-unit increase in prior familial professional help seeking was associated with a 1.38 increase in the odds that parents sought professional help for their adolescent's problems. No other predictor variables significantly improved the model. The results and test statistics are provided in Table 24.

A summary of the logistic regression analyses can be found in Tables 25 and 26.

Table 24

*Summary of the Hierarchical Logistic Regression Analysis for Parents' Professional Help Seeking for Adolescent Mental Health Problems (N=81)*

	B (SE)	95% CI for exp b		
		Lower	Exp b	Upper
Objective Strain	1.33(.93)	.62	3.81	23.59
Subjective Strain	.28(.65)	.37	1.32	4.73
Family History of Professional Help Seeking	.32(.12)*	1.12	1.38	1.69
Constant	- 6.99(1.41)		.001	

*Note.*  $R^2 = .33$  (Hosmer & Lemeshow),  $.32$  (Cox & Snel),  $.46$  (Nagelkerke). Model  $X^2(3) = 36.88, p < .001$ . \* $p < .005$ .

Table 25

*Summary of Adolescent Logistic Regression Analyses*

Predictor Variable	Hypothesis Supported?	Increase in the Outcome Variable for a one-unit increase in the predictor variable
<b>Outcome Variable: Problem Recognition</b>		
Age	No	-
Gender	Yes	2.87
Symptomatology	No	-
Perceived problem severity	Yes	3.85
Knowledge of mental health	No	-
<b>Outcome Variable: Deciding to Seek Professional Help</b>		
Age	No	-
Perceived problem severity	Yes	3.31
Attitudes towards seeking professional help	No	-
Prior professional help seeking	Yes	1.75
Family functioning	No	-
<b>Outcome Variable: Seeking Professional Help</b>		
Age	No	-
Gender	No	-
Perceived problem severity	Yes	2.77
Perceived barriers	No	-
Prior professional help seeking	Yes	4.61

Table 26

*Summary of Parent Logistic Regression Analyses*

Predictor Variable	Hypothesis Supported?	Increase in the Outcome Variable for a one-unit increase in the predictor variable
<b>Outcome Variable: Recognizing Adolescent Mental Health Problems</b>		
Strain	Yes	5.56
Knowledge of mental health	Yes	-
Family communication	No	-
<b>Outcome Variable: Deciding to Seek Professional Help for an Adolescent</b>		
Strain	Yes	3.81
Perceived problem severity	No	-
Attitudes towards seeking professional help	No	-
Prior familial professional help seeking	No	-
<b>Outcome Variable: Seeking Professional Help for Adolescent Problems</b>		
Objective strain	No	-
Subjective strain	No	-
Perceived problem severity	No	-
Perceived barriers	No	-
Familial prior professional help seeking	Yes	1.38

### **Adolescent-Parent Dyads**

Of the adolescent and parent participants, there were 21 parent-adolescent dyads. Given the sample size, analyses were limited to examining frequency counts and correlations between demographic and study variables (i.e., predictor and outcome variables). Further, to reduce Type II error and increase statistical power alpha levels of .10 were used to determine statistical significance for correlations.

#### **Hypothesis 7: Relations between Parent and Adolescent Stages of Help Seeking**

It was hypothesized that adolescents' help seeking practices would be similar to those of their parents. In particular, it was hypothesized that a parent's or adolescent's stage of help seeking would be predicted by the other's stage of help seeking. Adolescents with parents who had decided to seek professional help were expected to be further along in the stages of help seeking than adolescents with parents who were unaware of their problem or had not yet decided to seek professional help. Similarly, parents of adolescents in the latter stages of help seeking were expected to be further along in the stages of help seeking than parents of adolescents who were unaware of personal problems or had yet to decide to seek professional help.

Given the small sample size, the researcher was limited with regards to statistical analyses that could be performed to examine the data. As such, analyses are limited to correlations between parent and adolescent dyad variables. Results should be interpreted with caution due to the small sample size.

An examination of participants' highest stage of help seeking revealed that five percent of adolescents and nine percent of parents had recognized a problem (Stage 1). Twenty-eight percent of adolescents and 24 percent of parents decided to seek professional help (Stage 2). Equal numbers of adolescents and parents had sought professional help (Stage 3, 24 percent) or

indicated that the adolescent did not require professional help (Non-Help-Seekers, 43 percent).

An overview is provided in Table 27. When adolescent and parent stages of help seeking were compared, frequency counts revealed that 52 percent (n=11 dyads) of the dyads were in the same stage of help seeking.

Table 27

*Frequencies and Percentages of Adolescents' and Parents' Highest Stage of Help Seeking*

Stages	Adolescent <i>n</i> (%)	Parent <i>n</i> (%)
Non-Help-Seekers	9(43)	9(43)
Recognizing the Problem	1(5)	2(9)
Deciding to Seek Help	6(28)	5(24)
Actually Seeking Help	5(24)	5(24)

*Note.* *n*=42 (21 dyad pairs)



Correlations between dyad study variables are presented in Tables 28 and 29. Given the small sample size, to reduce Type II error and increase statistical power alpha levels of .10 were used to determine statistical significance for correlations. Parents' recognition of adolescent mental health problems (Stage 1), decision to seek professional help for adolescent problems (Stage 2), and actual professional help seeking for adolescents (Stage 3) were all significantly positively correlated with adolescent-reported actual help seeking (Stage 3) and adolescent-reported prior familial professional help seeking. Further, parental problem recognition (Stage 1) was significantly positively correlated with adolescent-reported symptomatology and negatively correlated with adolescent-reported spiritual support seeking. Parental decisions to seek professional help for adolescent mental health problems (Stage 2) were significantly positively correlated with adolescent-reported prior professional help seeking and negatively correlated with adolescent-reported familial spiritual support seeking. Parental actual help seeking (Stage 3) was positively correlated with adolescent-reported prior professional help seeking and being female. In the latter case, the result suggests that parents may have been more likely to seek professional help for daughters.

Adolescent problem recognition (Stage 1) and decisions to seek professional help (Stage 2) were significantly associated with parent-reported negative attitudes towards seeking professional help. Additionally, adolescent problem recognition (Stage 1) was significantly positively correlated with parent-reported lack of knowledge of mental health and significantly negatively correlated with parent-reported spiritual support seeking. Adolescent actual professional help seeking was significantly positively correlated with parent-reported prior familial professional help seeking.

Parent-reported barriers to professional help seeking were positively correlated with adolescent-reported barriers to professional help seeking, suggesting that parents and adolescents from the same family were likely to endorse a similar number of barriers to seeking help. Parent-reported barriers to professional help seeking were also negatively correlated with adolescent-reported perceptions of family communication, adolescent-reported familial spiritual support seeking, and adolescent-reported personal spiritual support seeking. Parent-reported lack of knowledge of mental health was positively correlated with adolescent-reported barriers to professional help seeking, suggesting that adolescents were more likely to report more barriers to professional help seeking if their parent lacked knowledge of mental health. Parent-reported lack of knowledge of mental health was also negatively correlated with adolescent-reported familial social and spiritual support seeking and adolescent-reported personal spiritual support seeking.

Parent-reported attitudes towards seeking professional help for adolescent mental health problems were negatively correlated with adolescent-reported perceptions of family communication, familial spiritual support seeking, and familial prior professional help seeking. The results suggest that parents with negative attitudes toward seeking professional help for adolescent problems may have been more likely to have an adolescent who believed their family members communicated ineffectively with one another and did not seek spiritual or professional help. Parent-reported attitudes toward seeking professional help for adolescent mental health problems were also negatively correlated with adolescent-reported spiritual support seeking and prior professional help seeking. Thus, adolescent children of parents with negative attitudes towards professional help seeking seemed less likely to seek spiritual support or professional help.

Parent-reported prior familial professional help seeking was positively correlated with adolescent-reported prior professional help seeking. Similarly, parent-reported spiritual support seeking was positively correlated with adolescent-reported spiritual support seeking. Notably, parent-reported familial spiritual support seeking was significantly negatively associated with adolescent-reported barriers to seeking professional help and positively correlated with adolescent perceptions of family communication and family cohesion.

Parental stress (i.e., objective strain, subjective strain, and global strain) was significantly positively correlated with adolescent-reported familial prior professional help seeking and youth's own prior professional help seeking. Parent perceptions of adolescent symptomatology were positively correlated with adolescent-reported prior professional help seeking and adolescent-reported familial prior professional help seeking. Parental subjective strain was significantly negatively correlated with adolescents' reported age, suggesting that parents may have been more likely to experience negative feelings (e.g., worry and guilt) related to raising a younger adolescent with mental health problems. Parental objective strain was significantly positively correlated with adolescent perceptions of the severity of their mental health problem, indicating that parents may have been more likely to be inconvenienced by adolescent mental health problems when the adolescent believed that their mental health struggles were severe.

Parent perceptions of family communication were significantly positively correlated with adolescent-reported social and spiritual support seeking, but significantly negatively correlated with adolescent-reported familial and personal prior professional help seeking. Parent perceptions of family cohesion were significantly positively correlated with adolescent perceptions of family communication; such that, parents who believed that their families were emotionally connected seemed more likely to have adolescents who believed that family

members communicated assertively. Parent-reported family cohesion was also significantly negatively correlated with adolescent-reported prior professional help seeking and adolescent perceptions of the severity of their mental health problem.

Table 28

*Correlations among Dyad Variables*

Adolescent Variables		Parent Variables						
		Object. Strain	Subject. Strain	Global Strain	Problem Severity	Comm-unication	Cohes. Ratio	Flex. Ratio
Cohesion	<i>r</i>	.12	.08	.07	.33	.10	.33	.10
Ratio	<i>n</i>	19	20	18	12	21	21	21
Flexibility		-.01	.05	-.02	-.09	.14	.21	.16
Ratio		19	20	18	12	21	21	21
Comm-unication		-.02	-.16	-.21	-.02	.35	.43*	.22
FCOPE		18	19	17	11	20	20	20
Social		.08	.20	.07	.40	.10	.22	-.22
FCOPE		17	18	16	11	19	19	19
Spiritual		-.24	-.23	-.25	.03	.32	.26	.17
FCOPE		19	20	18	12	21	21	21
Professional		.54**	.41*	.43*	.05	-.43*	-.16	.07
ACOPE		19	20	18	12	21	21	21
Social		.05	-.31	-.14	.27	.47**	.16	.07
ACOPE		19	19	18	11	20	20	20
Spiritual		-.18	-.19	-.24	.41	.41*	.39*	.14
ACOPE		18	19	17	11	20	20	20
Professional		.76***	.62***	.77***	.32	-.50*	-.43*	-.11
Symptom-atology		19	20	18	12	21	21	21
Problem		.36	.38	.39	.60	-.16	.00	.43*
Severity		14	15	13	8	16	16	16
Attitudes		.49*	.44	.42	-.12	-.36	-.69***	-.22
Barriers		13	12	12	8	13	13	13
Lack of Knowledge		.26	.39	.41	.08	-.30	-.31	.40
		17	16	16	11	17	17	17
		-.02	.09	-.03	-.19	.07	-.08	.03
		19	20	18	12	21	21	21
		-.04	.05	-.14	.00	.31	.03	.12
		19	20	18	12	21	21	21

(continued)

Table 28 (continued)

*Correlations among Dyad Variables*

Adolescent Variables	Parent Variables						
	Object. Strain	Subject. Strain	Global Strain	Problem Severity	Comm- unication	Cohes. Ratio	Flex. Ratio
Age	-.08	-.43*	-.18	-.36	.25	-.19	.05
	18	18	17	10	19	19	19
Gender	.03	.14	.00	-.17	.14	-.11	.13
	38	40	36	12	21	21	21
Stage 1	-.05	.04	-.05	.10	.14	-.11	.19
	19	20	18	12	21	21	21
Stage 2	-.17	-.06	-.05	-.10	-.04	-.32	.03
	19	20	18	12	21	21	21
Stage 3	.31	.33	.22	-.10	.03	.14	-.12
	19	20	18	12	21	21	21

*Note.* \* $p < .1$ , \*\* $p < .05$ , \*\*\* $p < .01$ . The Family Crisis Orientated Personal Scales (FCOPE) captures family coping skills whereas the Adolescent Coping Orientation for Problem Experiences (ACOPE) captures adolescent coping skills.

Table 29

*Correlations among Dyad Variables II*

Adolescent Variables		Parent Variables									
		Symptom- atology	Attitudes	Barriers	FCOPE Social	FCOPE Spiritual	FCOPE Profess.	Lack of Know.	Stage 1	Stage 2	Stage 3
Cohesion	<i>r</i>	.26	-.27	-.22	.01	.45*	.27	-.32	-.11	-.20	.21
Ratio	<i>n</i>	14	20	21	21	18	21	21	22	24	21
Flexibility		-.13	-.01	-.25	-.19	.08	.12	-.02	-.06	-.02	.19
Ratio		14	20	21	21	18	21	21	22	24	21
Comm- unication		-.15	-.41*	-.55**	-.20	.64***	.11	-.28	-.24	-.21	.31
FCOPE		13	19	20	20	18	20	20	21	23	20
Social		.00	-.34	-.54**	-.30	.22	.50*	-.56**	-.25	.11	.11
FCOPE		13	18	19	19	16	19	19	20	22	19
Spiritual		-.04	-.41*	-.34	.04	.80***	-.14	-.46**	-.33	-.37*	.01
FCOPE		14	20	21	21	18	21	21	22	24	21
Professional		.57**	-.45**	-.18	-.18	.07	.67***	-.09	.52**	.44**	.60***
ACOPE		14	20	21	21	18	21	21	22	24	21
Social		-.13	.07	-.22	-.05	.33	-.02	-.07	-.10	-.01	.27
ACOPE		14	20	20	20	17	20	20	21	23	20
Spiritual		.00	-.40*	-.49**	.03	.88***	-.06	-.58***	-.41*	-.31	.00
ACOPE		14	19	20	20	17	20	20	21	23	20
Professional		.71***	-.39*	-.23	-.19	.08	.68***	-.23	.53***	.48**	.65***
		14	20	21	21	18	21	21	22	24	21

(continued)

Table 29 (continued)

*Correlations among Dyad Variables II*

Adolescent Variables	Symptom- atology	Parent Variables						Stage 1	Stage 2	Stage 3
		Attitudes	Barriers	FCOPE Social	FCOPE Spiritual	FCOPE Profess.	Lack of Know.			
Symptom- atology	.62**	-.28	-.24	-.22	.02	.40	-.32	.47*	.51**	.30
Problem Severity	11	15	16	16	15	16	16	16	16	16
Attitudes	.28	-.19	.03	.24	-.30	.19	-.16	.38	.33	.04
Barriers	.20	.34	.33	.04	-.15	-.24	.27	.21	-.12	.23
Lack of Knowledge	.03	.37	.66***	.04	-.41*	-.32	.49*	.12	.04	-.14
Age	.14	.20	.22	.21	.18	.21	.22	.23	.25	.21
Gender	-.02	.23	.34	.07	-.35	-.31	.32	.10	.03	-.13
Stage 1	.14	.20	.22	.21	.18	.21	.22	.23	.25	.21
Stage 2	-.21	-.07	-.20	.37	.28	-.34	-.01	.12	.11	-.13
Stage 3	.13	.19	.19	.19	.16	.19	.19	.20	.22	.19
Stage 1	.13	.13	-.34	-.47**	.05	.08	-.29	-.02	.04	.28*
Stage 2	-.03	.41*	.24	.30	-.55**	-.18	.38*	.28	.32	-.31
Stage 3	.14	.20	.21	.21	.18	.21	.21	.22	.24	.21
Stage 1	.05	.47*	.30	.03	-.32	-.14	.13	.12	.11	-.21
Stage 2	.14	.20	.21	.21	.18	.21	.21	.22	.24	.21
Stage 3	.31	-.31	-.18	.20	-.12	.57***	.05	.50*	.45*	.48*
	.14	.20	.21	.21	.18	.21	.21	.22	.24	.21

Note. \*p<.1, \*\*p<.05, \*\*\*p<.01. The Family Crisis Orientated Personal Scales (FCOPE) captures family coping skills whereas the Adolescent Coping Orientation for Problem Experiences (ACOPE) captures adolescent coping skills.



## CHAPTER V

### Discussion

The overall purpose of this study was to examine the stages of adolescent help seeking to better understand why some adolescents seek help and others do not. Specifically, the goal was to identify factors predictive of adolescents' and parents' help seeking for adolescent mental health concerns by examining the three stages of help seeking: (1) recognizing the problem, (2) deciding to seek professional help, and (3) seeking professional help (Andersen, 1995; Cauce et al., 2002; Logan & King, 2001; Sears, 2004). This study examined specific predisposing (i.e., gender, age, attitudes towards seeking professional help, and help-seeking practices), enabling (i.e., perceived barriers to professional help seeking, knowledge of mental health, family communication, family cohesion, and family role flexibility), and need (i.e., perceived need, psychological distress, and parental burden) factors as predictors of adolescents' and parents' behaviour across the three stages of help seeking. Overall, the results highlight the importance of specific individual and family factors that help to predict whether an adolescent will seek professional help.

#### Adolescent Help Seeking

Of the 175 adolescents surveyed regarding their highest stage of help seeking, 16 percent recognized their own mental health problems (Stage 1), 10 percent decided to seek professional help (Stage 2), and 27 percent sought help with or without prompting from someone (Stage 3). This distribution differs from previous studies as more adolescents in the present study decided to seek help (Stage 2) and actually sought professional help (Stage 3). For instance, in Sears' (2004) study, 32 percent of adolescents had reached the first stage of help seeking, 8 percent had reached the second stage, and 7 percent had reached the final stage. Sears (2004) used similar

methods to the present study; however, she employed a rural population, which may account for the difference in findings. The discrepancy between the findings may also be explained by the present study's diverse recruitment efforts (e.g., online, in-school, community advertisements such as the ones in an adolescent health centre, radio and newspaper interviews); Sears limited her efforts to in-school recruitment. Alternatively, the second annual mental health report card from The Royal Ottawa Hospital and Children's Hospital of Eastern Ontario (CHEO) suggests that Canadian adolescent help seeking has increased by as much as 64 percent in the past three years (Children's Hospital of Eastern Ontario, 2013; CBC News, 2013). The report attributes recent trends in adolescent help seeking to an increased awareness of mental health and a willingness among young people to seek help. The fact that Canadian youth may be more willing to participate in mental health treatment may enable more timely access to professional services and may help prevent adolescents from developing more severe mental health problems. The present study found that, of the 27 percent of adolescents who had sought professional help (Stage 3), 13 percent did so because they were told to do so by their parents or had parents who had arranged an appointment for them to meet with a mental health professional. This suggests that family members can facilitate an adolescent's professional help seeking.

The majority of adolescents (81 percent) in this study indicated that they had more than one mental health problem. The most commonly selected descriptors for why adolescents believed they required help were emotional problems (84 percent), stress (60 percent), family problems (49 percent), and low self-confidence (47 percent). The findings suggest that adolescents most often understood their struggles to be related to emotional pain and interpersonal relationships, as opposed to impulse control, substance use, and behaviour problems. Previous research has consistently found adolescents to report having significant

problems in their relationships with family and friends (e.g., Boldero & Fallon, 1995; Rigby & Slee, 1999).

**Barriers to professional help.** The present study found that adolescents most commonly endorsed barriers to professional help seeking related to a desire to be independent. Further, adolescents who had not sought professional help (i.e., non-help-seekers, Stage 1, and Stage 2) reported that a lack of knowledge of mental health hindered their professional help seeking whereas adolescents who had sought professional help (i.e., Stage 3) reported that believing professional help would be inadequate hindered their help seeking. Previous research has shown that adolescents' desires to solve their own problems are an important barrier to mental health services (e.g., Hernan et al., 2010; Stanhope et al., 2003; Wilson & Deane, 2012). Notably, adolescents who required prompting to seek professional help had significantly more negative attitudes towards seeking help and were younger than adolescents who had progressed through the stages of help seeking. This suggests that age and negative attitudes towards seeking professional help are barriers to help seeking that may be easily overcome with adult instruction.

No significant differences were found between the number of barriers reported by adolescent non-help-seekers and adolescents who had recognized their need for professional help (Stage 1). Similarly, no significant differences were found in the number of barriers reported by adolescents in Stage 1, Stage 2, or Stage 3 of help seeking. These findings contrast with previous research that has shown that adolescents who perceive fewer barriers to mental health services are more likely to seek professional help (Stage 3) than adolescents who perceive a greater number of barriers to mental health services (e.g., Wilson et al., 2005). However, the results of the present study suggest that adolescents who seek professional help may perceive different barriers to help seeking (e.g., thinking counselling will provide inadequate help) than

adolescents who do not seek professional help (e.g., having poor knowledge of mental health). The fact that the present study did not find a difference in the number of barriers perceived by adolescents across the stages of help seeking may be explained, in part, by considering the role of an adolescents' confidence to overcome perceived barriers to help seeking. It was the researcher's intention to measure adolescents' perceived control over barriers to seeking professional help using the Inventory of Attitudes towards Seeking Mental Health Services questionnaire (IASMHS); however, the subscale designed to do so was found to have poor internal consistency in the present study and was not used as intended. It is possible that adolescents' confidence in their own ability to overcome barriers to professional resources increases as they come closer to actually seeking professional help (Stage 3). In this way, it is possible that all of the adolescents in the present study perceived a similar number of barriers to seeking professional help, but differed in their level of confidence for overcoming these barriers. Along these lines, adolescents in the later stages of help seeking would be expected to be more confident in their ability to overcome barriers to mental health services; and therefore, be less likely to be negatively affected. It is also possible that the present study's low statistical power, related to the small sample size, prevented the researcher from detecting significant results related to the number of barriers adolescents perceived and adolescents' stage of help seeking. Of note, other researchers have increased their statistical power by classifying participants as either having sought professional help or not, as opposed to using the three stages of help seeking.

**Preferred help source.** Of the adolescents who decided to seek help (Stage 2), 64 percent identified a need for professional help and 95 percent of these adolescents identified a mental health professional to be the most desirable help resource, as opposed to medical

professionals. The majority of the adolescents who actually sought professional help (Stage 3) (49 percent) consulted with a medical doctor, followed by a social worker (36 percent), psychologist (36 percent), psychiatrist (19 percent), nurse (11 percent) and other professional (17 percent) (e.g., school counsellor). Adolescents' stated preference for a mental health professional and actual help seeking from a medical professional may be explained by the availability and accessibility of family doctors relative to mental health professionals. For instance, adolescents occasionally need to be referred to mental health professionals (e.g., Psychiatrists and mental health professionals on family health teams) via their family doctor and then wait for services.

Thirty-six percent of adolescents who decided to seek help (Stage 2) preferred informal help resources and 79 percent of these adolescents identified their friends to be the preferred help resource. This finding is consistent with previous research that shows adolescents seek help more often from informal resources, such as friends (e.g., Boldero & Fallon, 1995; Offer et al., 1991; Rickwood & Braithwaite, 1994; Wilson & Deane, 2001). The fact that more adolescents in the present study reported a need for professional help (64 percent), than informal help (36 percent), may relate to the present study's use of recruitment materials in a community adolescent health centre because youth who frequent this centre may be more familiar with mental health professionals and how to access their services. Adolescent participants' preference for professional help might also reflect more recent findings that Canadian youth are more aware of mental health problems and more willing to seek out professional help (Children's Hospital of Eastern Ontario, 2013; CBC News, 2013).

## Parent Help Seeking

The present study encouraged all adolescent participants to invite their parents to take part. Whether or not adolescents chose to invite their parents to participate is unknown to the researcher; however, 12 percent of the adolescent participants had parents who completed the parent questionnaire package. Other parents were recruited using online and community advertising. A total of 95 parents participated in the present study (14 fathers, 80 mothers, and 1 parent who did not specify their gender). Using parents' highest stage of help seeking, 10 percent had recognized a mental health problem for their adolescent (Stage 1), 15 percent had decided to seek professional help for their adolescent (Stage 2), and 29 percent had actually sought professional help for their child (Stage 3). Prior research has tended to involve parents who either have or have not sought professional help. This study extends previous research by considering parents' help seeking for adolescent mental health problems as a multi-step process.

The majority of parents (62 percent) reported that their adolescent had more than one mental health problem. Parents' most commonly selected 'behaviour problems' (47 percent) to describe their adolescent's mental health struggle(s), followed by emotional problems (43 percent), substance use (21 percent), and stress (19 percent). Of note, parents were not asked to further describe their adolescent's problem for any of the listed options and could have selected 'behaviour problem' to refer to difficulties ranging from aggression (e.g., destruction of property) and self harm (e.g., cutting) to crying spells and withdrawal (e.g., school refusal).

**Barriers to professional help.** In this study parents were asked to identify reasons from a list of 17 items as to why they had not or may not seek professional help for adolescent problems (e.g., waiting times, feeling services would be inadequate or unhelpful, transportation problems, concerns that other people might have found out). One item allowed parents to add

their own response (i.e., Other, please specify: \_\_\_\_\_). Parents most commonly endorsed barriers related to not knowing where to go to seek professional help for their adolescent. Further, parents who did not seek professional help for their adolescent reported that a lack of knowledge of mental health (e.g., knowing the symptoms of mental health problems) hindered their professional help seeking whereas parents who sought professional help for their adolescent reported that wait times hindered their ability to connect their adolescent with professional resources. The number of barriers to seeking professional help did not significantly differ for parents in Stage 1, Stage 2, and Stage 3 of help seeking. However, parents who recognized mental health problems (Stage 1) were significantly more likely to perceive barriers to adolescent professional help than parents who did not recognize adolescent mental health problems (non-help-seekers). This finding may be explained by the fact that non-help-seeking parents may not have the need or opportunity to experience barriers to adolescent help seeking. For instance, parents who are not experiencing difficulties with their child may not be concerned with matters regarding where to access mental health services or the stigma of mental health. In contrast, parents who recognize their adolescent to have a mental health problem (Stage 1) may have the experience of being unable to overcome particular barriers to mental health services (e.g., wait times, cost of private services).

**Preferred help source.** Of the parents who decided to seek professional help for their adolescent (Stage 2), 82 percent identified a need for professional help; these parents most often identified a mental health professional to be the most appropriate resource. Of the parents who actually sought professional help for their adolescent (Stage 3), the majority (56 percent) sought help from a medical doctor, followed by a social worker (33 percent), psychologist (33 percent),

psychiatrist (7 percent), nurse (11 percent) or other professional (11 percent) (e.g., student disabilities services).

### **Adolescent-Parent Dyad Help-Seeking**

Of the 175 adolescent participants and 95 parent participants, there were 21 parent-adolescent dyads. An examination of participants' highest stage of help seeking revealed that five percent of adolescents and nine percent of parents recognized an adolescent's mental health problem (Stage 1). Twenty-eight percent of adolescents and 24 percent of parents decided to seek help for adolescent mental health problems. Equal numbers of adolescents and parents sought professional help for adolescent mental health problems (Stage 3, 24 percent).

### **Factors Related to Adolescent Help Seeking**

*Predisposing factors.* Predisposing factors are often present before the onset of problems and are believed to be related to an individual's propensity to seek and utilize professional help (Andersen, 1995). The present study investigated adolescents' age, gender, attitudes towards help seeking, help seeking practices, and family coping practices as predisposing factors.

*Age.* Younger adolescents (age 14) were more likely to have negative attitudes towards help seeking than older adolescents (age 16). This is consistent with previous research that has shown that younger adolescents' believe that professional resources will not be helpful (e.g., Jorm, Wright, & Morgan, 2007). In the present study, adolescents' age was also significantly correlated with the Indifference to Stigma subscale, suggesting that younger adolescents were more likely to feel guilty, ashamed, or embarrassed as a result of their mental health problems. Researchers have accounted for this in highlighting the fact that younger adolescents appear to have a heightened sensitivity to threats of autonomy relative to older adolescents (Schonert-Reichl, & Muller, 1996; Wilson & Deane, 2010). Further, the cognitive and perspective-taking



abilities acquired during late adolescence have been proposed to allow older youth to engage in complex thought processes required to think more critically about the costs and benefits of seeking help (Pruitt, 2000; Spear & Kulbok, 2004; Steinberg, 2001).

*Gender.* Female adolescents were found to be significantly more likely to recognize mental health problems (Stage 1) and decide to seek professional help (Stage 2); this is consistent with previous research (e.g., Offer et al., 1991; Raviv et al., 2009). In contrast, male adolescents were found to be significantly more likely to report not needing help (e.g., Farrand et al., 2007; Rickwood et al., 2005; Raviv et al., 2009). Previous research has found that males are not only more likely to rely on themselves rather than seek help, but are also more likely to avoid recognising problems and deny the presence of problems altogether (Offer, Howard, Schonert, & Ostrov, 1991). Rickwood, Deane, Wilson, and Ciarrochi (2005) assert that males tend to be socialized to seek less help from informal and formal resources whereas females tend to be socialized throughout life to seek support from others. The present study found no significant gender differences for Stage 3 of the help seeking process (i.e., actually seeking help). Given that females were found to be more likely to recognize their problems and decide to seek help, the failure to find a significant gender difference for Stage 3 might suggest that male adolescents received assistance to seek professional help (e.g., being prompted to seek help, having a parent arrange for an appointment with professional resources) or that there were fewer adolescent females who sought professional help than had decided to seek professional help.

*Attitudes towards help seeking.* Adolescents with more negative attitudes towards professional help seeking were more likely to recognize their own mental health problems. The attitudes of adolescent non-help-seekers did not significantly differ from adolescents in Stage 1 of help seeking; however, adolescents in Stage 1 of help seeking had significantly more negative

attitudes towards seeking mental health services than adolescents who had sought professional help (Stage 3). The findings suggest that youth who actually seek professional help (Stage 3) may have more positive attitudes than youth who merely recognize their own mental health problems (Stage 1). This may be achieved by learning about professional resources or associating valued outcomes (e.g., symptoms relief) with professional help. The present study found that adolescents with negative attitudes towards professional help seeking were more likely to report more barriers to mental health services; this supports the idea that by developing more positive attitudes adolescents may be more likely to overcome barriers to help seeking and succeed in their efforts to seek professional help. Taken together, these findings highlight the difficulty of seeking help as they suggest that adolescents at Stage 1 are challenged with negative attitudes and an increasing awareness of barriers to professional help.

*Adolescent Help Seeking Practices.* Adolescents with prior professional help-seeking experience reported greater knowledge of mental health and mental health resources. It seems likely that adolescents' prior experience with professionals equipped them with knowledge of what to expect from professional resources, where to find professional help, and how professionals may be helpful. Perhaps as a result of this knowledge, adolescents with prior professional help-seeking experience more readily decided to seek professional help in the present study.

Adolescents who had previously sought help from family members appeared to perceive fewer barriers to professional help. This is consistent with previous research showing that positive help seeking experiences can make adolescents more likely to decide to seek help for subsequent problems. For instance, Wilson and Deane (2001) found that adolescents who believed the chosen resource heard their concern, valued their feelings, accepted them, and

treated them with respect were significantly more likely to seek professional help. Therefore, positive help-seeking experiences with informal resources may empower youth to seek professional help as interactions with family members may model the receptivity that is possible with professional resources. It is also possible that adolescents receive advice to seek professional help in their conversations with family members. In this way, family members may provide adolescents with knowledge of mental health services and promote professional resources.

*Family coping practices.* Adolescents whose families had previously sought professional help seemed more likely to seek professional help for their own mental health struggles. This supports previous research that suggested parents influence children's coping through providing behavioural models for dealing with problems (e.g., Kliewer & Lewis, 1995; Kliewer et al., 1994; Jorm & Wright, 2007). Social Learning Theory suggests that by observing and later imitating parental actions, adolescents learn to interpret, appraise, and respond to stressful situations (Bandura, 1977). Adding further support for the powerful influence of modelling, adolescent-reported family coping skills consistently correlated with adolescents' coping skills. For instance, family spiritual support seeking was positively correlated with adolescent spiritual support seeking. Likewise, family social support seeking was positively correlated with adolescent social support seeking. Therefore, there is some evidence that adolescents replicate both formal and informal help seeking practices modelled by family members. It is also possible that adolescent help-seeking practices shape the help-seeking practices of family members; for example, parents may seek social support after becoming aware that their adolescent did so. This is consistent with the findings of Waite and Ramsay (2010), who showed that parents who

had seen adolescents successfully deal with problems using mental health services were more likely to consider seeking professional help for themselves and other family members.

**Enabling factors.** Enabling factors directly hinder or facilitate help-seeking behaviours (Andersen, 1995). This study investigated two enabling factors: (1) barriers to help seeking, such as stigma and a lack of knowledge of mental health, and (2) the family environment (i.e., cohesion, flexibility, and communication).

**Barriers to professional help.** Adolescents who were mindful of the stigma of mental health problems perceived a greater number of barriers and were more likely to report a lack of knowledge of mental health. Stigma and a lack of knowledge of mental health may perpetuate one another; in that, adolescents are likely to find it difficult to overcome the shame associated with mental illness if they lack knowledge that many other individuals struggle with the same issues. Similarly, adolescents may struggle to improve their knowledge of mental health if the stigma associated with mental illness leads them to feel embarrassed to ask questions. The present study provided evidence that adolescents who felt ashamed of their mental health problems tended not to recognize their mental health struggles and/or felt too embarrassed by their struggles to decide to seek professional help (Stage 2). Taken together, the results suggest a need for ongoing anti-stigma campaigns so as to develop a culture of acceptance and support for those who are mentally ill.

**Family environment.** Adolescents who believed their families possessed strong leadership and organizational skills seemed to perceive fewer barriers to help seeking. Similarly, adolescents who rated their family's communication style to be assertive seemed to perceive fewer barriers to professional help. These findings suggest that adolescents may be less likely to perceive barriers to professional help seeking not only as a result of their faith in their own

ability to overcome barriers to professional help seeking, but their faith in their family's ability to overcome barriers to professional help seeking. For instance, families with strong leadership and organization may help their adolescent overcome barriers by providing coaching, ideas, and strategies for accessing mental health services.

Adolescents who felt their families communicated assertively appeared to be less likely to reach each of the stages of help seeking. It is possible that adolescents whose families communicate effectively are less likely to require professional help. For instance, honest and non-judgmental communication would likely enable adolescents to discuss their problems openly with family members and receive the support and validation they require to overcome mental health struggles. In this case, adolescents may share their mental health struggles with family members early enough that their symptoms are relatively minor. For example, being kept active and engaged with family members may significantly help an adolescent's struggles with low mood, but this alone is unlikely to be sufficient for adolescents with clinical depression. Overall, the results suggest that family communication may help encourage adolescents to enlist the support of informal help resources early and, by doing so, may prevent more serious mental health problems.

Adolescents whose families communicated assertively were more likely to have previously sought informal help. Further, adolescents who viewed their families to be emotionally connected and capable of strong leadership were more likely to have family members who sought social support to cope with stress. Previous research has demonstrated that, in the context of stress, supportive family relationships convey a sense of available support and can enable help seeking (Jose et al., 2007; Gorall et al., 2006; Moos & Moos, 2009).

Interactions within the family environment may not only encourage family members to expect

that other people will provide support, but may equip family members with the skill sets (e.g., sharing personal experiences, allowing one's self to be vulnerable) to interact effectively with professional resources (e.g., emotional disclosure) (Cochran & Niegro, 2004; Leavey, Rothi, & Paul, 2011).

***Need factors.*** Need factors refer to the severity of the problem as perceived by the individual (i.e., perceived need) and others (e.g., parents, professionals) (Andersen, 1995). In the present study, adolescent-reported psychological distress and perceived need for professional help were examined as need factors.

***Psychological distress.*** Adolescents with a greater number of symptoms of mental health problems seemed to perceive their struggles to be severe. This is consistent with previous research (e.g., Urbanoski et al., 2008). Adolescents who rated their problems to be more severe were more likely to describe their families' communication style to be aggressive or passive and their family members to be disengaged or enmeshed with one another. The findings indicate that adolescents may be more likely to experience severe mental health problems in the context of family dysfunction. It seems reasonable that family dysfunction may not only predispose adolescents to mental health problems but also distract family members from recognizing adolescent mental health problems. Notably, the findings may also indicate that family dysfunction increases as adolescents' mental health problems worsen; for example, it is possible that the stress of living with a mentally ill person increases the likelihood of family conflict. Adolescents' perceived problem severity was significantly correlated with adolescents' recognition of their own mental health problems (Stage 1), decision to seek professional help (Stage 2), actual help seeking (Stage 3), and prior professional help seeking. The results lend support to the idea that heightened perceptions of problem severity motivate help seeking.

Adolescents who described their families to be enmeshed, disengaged, chaotic, or rigid were more likely to report experiencing a greater number of symptoms of mental health problems. Moreover, adolescents who described their families to communicate using passive or aggressive means were more likely to report experiencing a greater number of symptoms. These findings are not to say that these family environments cause adolescent mental health problems, though family relationships may make one more or less vulnerable to psychological distress. Previous research has shown that adolescents with less supportive networks are more likely to experience psychological distress, use less effective coping strategies, and require professional help (Oliva et al., 2009; Wu et al., 2011). Related to the importance of the family environment, the results of the present study lend support to the idea that social interactions within the family can equip adolescents with skill sets and positive experiences that facilitate professional help seeking (Cochran & Niegro, 2004; Leavey, Rothi, & Paul, 2011).

*Perceived need.* Adolescents appeared more likely to seek professional help and less likely to seek informal help as they experienced a greater number of mental health symptoms. This is consistent with previous research showing that increased psychological distress often increases adolescents' perceived need for and willingness to seek professional help (e.g., Madianos et al., 2011).

## **Parents**

*Predisposing factors.* The present study investigated parents' gender, attitudes towards seeking professional help, and family coping practices as predisposing factors related to professional help seeking for adolescent mental health problems.

*Gender.* In the present study, fathers were significantly more likely than mothers to have negative attitudes towards seeking professional help. According to previous research, males may

hold more negative attitudes towards professional help because they are more likely to lack skills known to facilitate the help-seeking process, such as the ability to identify and describe emotions, understand emotions, and regulate emotions effectively (Rickwood et al., 2005). As a result of such limitations, males may experience help seeking to be a more frustrating process than their female counterparts. The described negative male attitudes towards help seeking appear to be congruent with traditional male gender roles in which accepting help can be associated with weakness and dependency (Vogel et al., 2007).

*Attitudes towards help seeking.* Parents who sought professional help (Stage 3) tended to have more positive attitudes towards professional resources. It may be that parental attitudes towards seeking professional help become more favourable as adolescent mental health problems worsen or seem beyond what a parent feels capable of managing (e.g., Farmer et al., 1997; Hinshaw, 2008). Consistent with this theory, the present study found that parents who experienced greater burden related to raising a child with a mental illness were more likely to have positive attitudes towards seeking professional help.

*Family coping practices.* Parents whose families had previously sought professional help were more likely to recognize adolescent mental health problems (Stage 1), decide to seek professional help for the adolescents' mental health problem (Stage 2), and actually seek professional help (Stage 3). Overall, the findings suggest that individuals may struggle most to seek professional help upon first becoming involved with services; however, once a pattern of professional help seeking has been established, individuals seem more likely to consider professional help for subsequent problems.

*Enabling factors.* This study investigated two enabling factors related to professional help seeking for adolescent mental health problems: (1) barriers to help seeking, such as stigma



and a lack of knowledge of mental health, and (2) the family environment (i.e., cohesion, flexibility, and communication).

*Barriers to professional help.* Parents with poor knowledge of mental health (e.g., symptoms of mental health problems, where to receive mental health services) were found to be more likely to perceive a greater number of barriers to professional help seeking. This suggests that knowledge of mental health and mental health resources is a powerful tool for overcoming barriers to professional help seeking. Parents who recognized their adolescent to have a mental health problem were more likely to perceive more barriers to professional resources. This is consistent with the present study's findings from the adolescent data as parents in Stage 1 also appear to be challenged with an increasing awareness of barriers to professional resources. The number of reported barriers for parents in Stage 1 was significantly greater than the number of reported barriers for parent non-help-seekers; however, the number of reported barriers did not significantly differ between parents in Stage 1, Stage 2, and Stage 3. Overall, the results indicate that parents may be most aware of the barriers to adolescent professional help seeking when they first recognize their adolescent has a mental health problem (Stage 1) and these barriers may hinder their ability to move beyond the first stage of help seeking.

Parents who had less knowledge of mental health were less likely to have family histories of seeking professional help and were less likely to have actually sought professional help for their adolescent (Stage 3). It seems likely that individuals learn about mental health services based on prior professional help seeking experiences and may perceive fewer barriers to future professional help seeking as a result of their learning. The findings highlight the need for public education. For this reason, it is imperative that gatekeepers to mental health services (e.g., family doctors) be well informed of mental health issues and services.

*Family environment.* Parents of families who communicated assertively were less likely to recognize adolescent mental health problems (Stage 1). The findings suggest that families who discuss problems calmly, respond honestly, and listen nonjudgmentally may be more likely to have adolescents who do not struggle with mental health problems; and therefore, do not demonstrate symptoms that parents need to recognize. In the present study, higher levels of parental strain and parent-reported adolescent symptomatology were associated with higher levels of family conflict or very little communication between family members. Overall, dysfunctional family communication appears to hinder a family's ability to address adolescent mental health problems; for instance, adolescents may not feel comfortable sharing their experiences with their parents if conversations lead them to feel invalidated or distressed (Miller, Rathus, & Linehan, 2007). Adolescents may also withhold information about their mental health struggles to prevent further family conflict. Alternatively, adolescent symptoms of mental health problems (e.g., withdrawn and isolated; Gayman, Cuddeback, & Morrissey, 2011) can serve as obstacles for family communication and help seeking.

Parents who felt that their families communicated assertively appeared to perceive fewer barriers to professional resources. Similar to the adolescent data, this suggests that parents may perceive themselves to be better able to overcome barriers to professional help as a result of family discussions where knowledge of mental health and mental health resources may be shared and strategies for accessing services may be devised.

*Need factors.* In the present study, parental stress attributed to raising a child with mental health problems and parental perceptions of adolescents' psychological distress were examined as need factors.

*Parental stress.* As parental strain increased parents were more likely to recognize adolescent problems (Stage 1), decide to seek professional help (Stage 2) and actually seek professional help (Stage 3). This is consistent with previous research that found that increasing levels of parental stress predicted a greater likelihood of children receiving mental health services (Farmer et al., 1997).

Parents who had recognized adolescent mental health problems (Stage 1) were found to have significantly higher levels of global parental strain than parents who were classified as non-help-seekers. However, parental strain did not differ significantly across the stages of help seeking, specifically recognizing adolescent mental health problems (Stage 1), deciding to seek professional help (Stage 2), and actually seeking professional help. Overall the findings suggest that higher levels of parental strain motivated parents to enter the help seeking process (e.g., recognizing adolescent problems). The fact that parental strain did not differ amongst parents in Stage 1, Stage 2, and Stage 3 of help seeking was surprising as previous research indicates that just as adolescent symptomatology tends to intensify by the third stage of help seeking (e.g., Bates, 2010), so too does parental strain (e.g., Morrissey-Kane & Prinz, 1999). The present study's findings may be explained by low statistical power related to the small sample size.

Results from correlations revealed that increases in parental strain were associated with increases in parent-reported adolescent symptomatology and parental perceptions of the severity of the adolescent's mental health problem(s). This is consistent with prior research (Hinshaw, 2008) and suggests that parents may experience increasing levels of stress related to parenting an adolescent as they recognize their adolescent to have mental health problems, particularly mental health problems that the parent perceives to be severe in nature. Farmer et al. (1997) show that youth with mental health problems of greater severity are most likely to introduce burden into

the family environment and, consequently, tend to have the greatest likelihood of being referred for professional help. In the research of Farmer and colleagues, the areas of family functioning that appeared to be most impacted by youth's problems were parental well-being and sense of competence to handle youth's problems.

Global parental strain was significantly positively correlated with parent-reported prior family histories of professional help seeking. Given that only 11 percent of parents reported that they had received professional counselling, it is quite likely that prior family professional help seeking related to prior family efforts to seek help for the adolescent or other children within the home. Therefore, parental strain may reflect chronic adolescent mental health difficulties or having to care for multiple children with mental health problems.

*Parental perceptions of adolescent needs for professional help.* Parents who perceived their adolescent to have a greater number of symptoms appeared more likely to recognize adolescent mental health problems (Stage 1), decide to seek professional help (Stage 2), and seek professional help (Stage 3). This is consistent with previous research that has shown that adolescents are more likely to receive professional help for mental health problems when parents perceive the adolescents' problem to be severe (e.g., Sourander et al., 2001; Zwaanswijk et al., 2003).

### **Adolescent Stages of Help Seeking**

**Problem recognition (Stage 1).** As expected, the results suggest that female adolescents were nearly three times more likely to recognize their mental health problems than male adolescents. Additionally, for every one-unit increase in perceived problem severity, adolescents' problem recognition increased by 3.85 units. These are robust findings within the help-seeking literature; for instance, females have consistently been found to recognize their

mental health problems more readily and more willingly than males (Offer et al., 1991; Raviv et al., 2009).

Contrary to what was expected, adolescents' age and symptomatology were not associated with their ability to recognize mental health problems (Stage 1). There have been mixed findings regarding the relationship between age and help seeking in adolescence. While some researchers have found that younger adolescents seek professional help more often than older adolescents (e.g, Schonert-Reichl & Muller, 1995), others have found that older adolescents seek professional help more readily than younger adolescents (e.g., Dubow et al., 1990). Furthermore, some researchers have found no association between age and professional help seeking. With regards to the present study, it is possible that the age range of the adolescents (14 to 18 years old) was too narrow to identify significant differences in participants' ability to recognize problems. The present study chose to focus on high school students because secondary school was thought to be a time when it is developmentally appropriate for adolescents to exert more autonomy over their decisions to seek or forgo help; however, given that children as young as 12 year old can receive professional counselling without a parent's consent under the Ontario Consent and Capacity Board (Ontario Hospital Association, 2012), future research may benefit from including children younger than 14 years old.

The fact that adolescent symptomatology was not associated with problem recognition (Stage 1) may be explained by the fact that self-report measures were used to assess symptomatology. Adolescents with little awareness of their own mental health problems may lack insight into whether they demonstrate symptoms of mental health problems. Potential confounding variables should also be considered as it is possible that adolescents' ability to recognize their own mental health problem was affected by self-monitoring abilities. Attempts

were made to collect both self- and parent-reports of adolescent symptomatology; however, only 21 parent-child dyads participated in the study and this significantly limited the statistical analyses and conclusions that could be drawn.

The failure to find a significant link between adolescent knowledge of mental health and problem recognition may be explained by weaknesses in the measure used to assess mental health literacy. Only three items were used to assess adolescent knowledge of mental health and these items did not capture the extent of information relevant to adolescent help seeking.

Previous research has tended to assess adolescent knowledge of mental health qualitatively in focus groups or quantitatively with self-report measures designed to assess a variety of barriers to professional help (e.g., Barriers to Adolescent Seeking Help Questionnaire, BASH). Future research may benefit from developing a questionnaire specifically designed to assess the various aspects of mental health literacy.

**Decisions to seek professional help (Stage 2).** As expected, adolescents' who decided to seek professional help were more likely to report greater problem severity and a prior history of professional help seeking for mental health problems. Specifically, for every one-unit increase in perceived problem severity or prior professional help seeking, adolescent decisions to seek professional help increased by 3.31 units and 1.75 units, respectively. This is consistent with previous research (e.g., Bates, 2010; Chandra & Minkovitz, 2007; Wilson & Deane, 2001; Wilson et al., 2002), where problem severity and prior help seeking have been associated with professional help seeking. Surprisingly, no significant links were found between adolescents' decision to seek professional help and age, attitudes towards seeking mental health services, and perceptions of family functioning. Previous research had generally found that adolescents with negative attitudes towards help seeking are less likely to seek professional help (e.g., Wilson &

Deane, 2001); to the researcher's knowledge the present study was the first to use the IASMHS with an online Canadian adolescent sample. Previous research has demonstrated that adolescents who feel less emotionally connected and supported by their families are more likely to come into contact with professional help resources (Oliva et al., 2009; Wu et al., 2011); however, the present study suggests that family functioning may not be directly related or predictive of adolescents' decisions to seek professional help, rather family functioning may simply make one more or less vulnerable to experiencing mental health problems. For instance, high levels of family conflict may exacerbate mental health problems.

### **Professional help seeking behaviour (Stage 3).**

As hypothesized, adolescent professional help seeking was associated with adolescent perceptions of problem severity and being previously involved with professional resources. In particular, for every one-unit increase in perceived problem severity or prior professional help seeking, adolescents professional help seeking increased by 2.77 units and 4.61 units, respectively. Again, this may speak to the importance of having experience overcoming barriers to professional help. Previous research has shown that adolescents who have previously had a positive professional help-seeking experience are more likely to intend to seek help in the future (Wilson et al., 2002) and have lower belief-based barriers to mental health services (Wilson & Deane, 2001).

Contrary to what was expected, no significant associations were found between adolescents' professional help seeking and their age, gender, or perceived barriers to professional help seeking. As was previously mentioned, prior studies related to adolescent age and help seeking have produced inconsistent results; the present study does not help to clarify these prior findings. Given that previous research has reliably found the females seek professional help

more often than males (e.g., Ciarrochi et al., 2003; Farrand et al., 2007; Raviv et al., 2009; Rickwood et al., 2005), it was surprising that gender was not associated with adolescent professional help seeking. This may be explained partially by the present study's limited statistical power due to its small sample size. The failure to find a significant link between adolescent help seeking (Stage 3) and adolescent barriers to help seeking may be accounted for as the present study assessed adolescents' perceptions of barriers, which may not be reflective of the barriers adolescents actually experience. Regardless of whether adolescents accurately identified barriers to help seeking, the consistent association between problem severity and the stages of help seeking suggest that adolescents are motivated to overcome barriers to help seeking when their mental health problems become unmanageable and are associated with high levels of distress.

### **Parent Stages of Help-Seeking**

**Problem recognition (Stage 1).** As was expected, parents' problem recognition was positively associated with parental strain, indicating that parents' were more likely to recognize adolescent mental health problems as they experienced more negative feelings (e.g., guilt and worry) related to raising a child with mental health problems. For every one-unit increase in subjective strain, parents problem recognition increased by 5.56 units. Therefore subjective strain may play a larger role in parents' ability to recognize adolescent mental health problems than objective strain or global strain. This result may help to narrow targets for intervention; for instance, public education might focus more on helping parents to relate negative feelings associated with raising children with mental illness to the idea that their adolescent may be struggling and in need of professional help, instead of suggesting that adolescents are 'difficult'



or 'defiant.' In this way, parents' may begin to relate differently to their adolescent, perhaps with compassion instead of frustration.

Parental objective strain did not affect the likelihood of parental problem recognition. This may be explained if parents related negative consequences associated with caring for a child with mental health problems to 'typical' adolescent behaviour, and thus, had a lower score on the Caregiver Stress Questionnaire because the measure specifically asked parents to consider the extent to which their adolescent's emotional or behaviour problems interfered with personal time, caused financial strain, or resulted in the parent neglecting personal responsibilities (e.g., going to work). Examples of disruptions that parents may not attribute to the adolescents' mental health problems include academic suspension, substance use, and extreme shyness (e.g., requiring parents to order for youth at restaurants).

As was previously mentioned, the failure to find a significant link between knowledge of mental health and problem recognition may be explained by the limited number of items used to assess mental health literacy as the items did not fully capture this variable well. With regards to family communication, parents' ability to recognize adolescent mental health problems was not associated with family communication. Based on the aforementioned associations between family functioning (i.e., cohesion, flexibility, and communication) and adolescent symptomatology and perceived problem severity, it is quite likely that family communication is not predictive of problem recognition but may play a role in the adolescents' vulnerability to developing mental health problems. Conflictual and infrequent family communication may also be a consequence of adolescent mental health problems (e.g., withdrawal, social isolation, irritability).

**Decisions to seek professional help (Stage 2).** As expected, a parent's decision to seek professional help was associated with subjective strain. For every one-unit increase in subjective strain, parent decisions to seek help for adolescent mental health problems increased by 3.81 units. This is consistent with previous research; most notably by Farmer and colleagues (1997).

Unexpectedly, parental decisions to seek professional help were not associated with parents' perception of problem severity, attitudes towards seeking mental health services, or parent-reported prior familial professional help seeking. Negative attitudes towards seeking mental health services were negatively correlated with parental decisions to seek professional help (Stage 2), though negative attitudes were not a significant predictor of parents' decisions to seek professional help. It is possible that parental attitudes have an indirect effect on help seeking for adolescent mental health problems; for instance, parental negative attitudes towards seeking professional help may hinder an adolescent's help seeking if the parent's attitudes interfere with their willingness to support the adolescent's decision to receive mental health services.

**Professional help seeking behaviour (Stage 3).** In accordance with the hypothesis, prior family professional help seeking was associated with parents' professional help seeking for adolescent mental health problems. For every one-unit increase in prior familial professional help seeking, parents professional help seeking for adolescent problems increased by 1.38 units. Contrary to what was expected, parental professional help seeking for adolescent mental health problems was not associated with parental strain, perceived problem severity, or perceived barriers to professional help. The failure to find a significant link between parental help seeking and parental perceived barriers to professional help may be accounted for by persistent efforts to seek help when adolescent mental health problems seem unmanageable and are associated with

high levels of distress. Due to the fact that previous research has found parental strain and perceived problem severity to be highly related to professional help seeking for adolescent problems (Farmer, 1997; Morrissey-Kane & Prinz, 1999), it was surprising that these factors did not significantly predict parental professional help seeking for adolescent mental health problems. However, the results may be explained by low statistical power related to the small sample size of participating parents. In the present study, correlations suggested that parental strain and perceived problem severity may indirectly influence parental help seeking for adolescent mental health problems because both of these variables were significantly positively correlated with family histories of seeking professional help.

### **Parent-Adolescents Dyads**

When adolescent and parent stages of help seeking were compared, frequency counts revealed that 52 percent (n=11 dyads) of the dyad pairs were in the same stage of help seeking. Taken together, the results lend limited support to the idea that an adolescent's help seeking practices are similar to those of their parent. Although there were a limited number of parent-adolescent dyads, relations between the stages of help seeking, predisposing, enabling, and need factors were explored. Given the small sample size, to reduce Type II error and increase statistical power alpha levels of .10 were used to determine statistical significance for correlations.

### **Predisposing Factors**

**Gender.** There was evidence to suggest that the parents in the present study may have been more likely to seek mental health services for daughters than for sons. This is consistent with prior research that has shown that parents may be more likely to encourage dependence in female children (Rothbart & Rothbart, 1976) and use child-rearing practices that socialized boys

to view help seeking to be inconsistent with masculine norms (e.g., Benenson & Koulkazarian, 2008). Greater professional help seeking for female children may also be explained by female tendencies to reveal problems and male tendencies to conceal problems (Papini et al., 1991). Overall, the findings of the present study highlight the need for improved community outreach related to male help seeking.

***Attitudes towards Help Seeking.*** Parents who reported negative attitudes towards seeking professional help seemed more likely to have an adolescent who perceived family member's communication to be conflictual or very limited, as opposed to assertive and open. Furthermore, parents with negative attitudes towards professional help appeared to be more likely to have adolescent children who had no prior involvement with professional mental health services or spiritual counselling. Taken together, the results suggest that negative parental attitudes towards professional resources may hinder adolescents' involvement with not only mental health services but general counselling supports as well.

***Adolescent Help Seeking.*** Parents in the present study were more likely to decide to seek professional help for their adolescent (Stage 2) and actually seek professional help for adolescent problems (Stage 3) if their children had already been involved with professional resources. This is consistent with this study's results from the parent and adolescent data, which suggested that individuals are more likely to seek professional help if they have prior experiences of overcoming the barriers to professional resources.

***Family coping.*** Adolescents and parents were more likely to seek professional help (Stage 3) if their family had sought professional help previously. As was previously mentioned, this is consistent with Social Learning Theory (Bandura, 1977) and previous research on parental modelling (Kliewer, Fearnow, & Miller, 1996; Kliewer et al., 1994; Jorm & Wright, 2007) as the

results of this research indicate that individuals learn and develop their coping skills based on the coping skills they observe others using.

Adolescent-reported spiritual support seeking appeared to decrease as parent-reported professional help seeking for adolescent problems (Stage 3) increased, this provides some evidence that adolescents may view spiritual support to be less appropriate for their problems when their parents are able to identify struggles to be related to mental health. Similarly, parents' spiritual support seeking seemed to decrease as parents decided to seek professional help for adolescent mental health problems (Stage 2). Overall, the findings indicate that families are able to seek appropriate help when they are able to identify the nature of the problem.

Adolescents seemed to perceive fewer barriers to professional help seeking when they were aware of their family members' efforts to seek spiritual support. This is consistent with previous suggestions that parents may facilitate adolescent professional help seeking by modeling help seeking with informal resources. The results suggested that families who sought social and spiritual support (based on parent-reports) were more likely to have adolescents who viewed the family to be emotionally connected and assertive. From the present study, it is difficult to determine whether a family's informal help seeking facilitates positive family dynamics (e.g., by alleviating family stress) or whether positive family dynamics encourage family members to seek informal help (e.g., by modelling cooperative relationships that individuals may come to expect from people outside the family unit).

### **Enabling Factors**

***Barriers to professional help seeking.*** Parents and adolescents from the same family were likely to have the same number of perceived barriers to professional help. This may be explained by the fact that family characteristics may predispose parents and adolescents to

experience similar barriers to help seeking; for instance, financial resources, transportation, language barriers, the available services in a given geographic location, and busy schedules.

Parents who endorsed a greater number of barriers to adolescent mental health services seemed more likely to have adolescents who depicted family communication patterns to be ineffective, limited, or conflictual. This lends support to the idea that family dynamics may impact professional help seeking for adolescent mental health problems, perhaps by creating an environment where family members are more or less likely to communicate their problems and work together to overcome barriers. Parents who reported a greater number of barriers appeared to be more likely to have adolescent children who had not sought spiritual support. This suggests parent perceptions of barriers to seeking professional help may influence an adolescent's informal help seeking.

Parents who indicated that they had little knowledge of mental health were more likely to have adolescents who perceived a greater number of barriers to seeking professional help. Additionally, parents who indicated that they had little knowledge of mental health seemed more likely to have adolescents who reported never having sought spiritual support and never having been aware of familial attempts to seek social or spiritual support. Overall, the results provide some evidence that parental knowledge of mental health may not only affect adolescents' perceptions of barriers, but adolescents' and families' informal help seeking. It may be that families with less knowledge of mental health forgo informal help due to tendencies to underestimate the severity of their problem.

***Family environment.*** Parents who perceived family members to be emotionally disconnected or enmeshed were more likely to have adolescents who believed that their mental health problems were serious in nature. This finding supports the idea that adolescent mental

health may strongly relate to family functioning, among other factors. The fact that family functioning was significantly associated with adolescent help seeking across parent, adolescent, and dyad data sets suggests that this finding is robust in the present study.

Interestingly, adolescents tended to endorse a greater number of symptoms when they had parents who believed that the family could easily adapt to new situations. It is possible that adolescents with mental health problems find it less distressing to live in an environment with consistent and predictable routines. For instance, individuals with anxiety often value routine and resist change. Children who struggle with inattention and behavioural problems have also been found to benefit from consistency and limited variation in daily routines.

### **Need Factors**

***Adolescent-reported psychological distress.*** The findings revealed that parents were more likely to recognize adolescent mental health problems (Stage 1) and decide to seek help (Stage 2) as adolescents reported higher levels of symptomatology. In this way, parents can be seen to be responsive to adolescent needs. This is consistent with previous research (e.g., Bates, 2010; Farmer et al., 1997; Morrissey-Kane & Prinz, 1999).

***Parent-reported adolescent symptomatology.*** As parent-reports of adolescent symptomatology increased adolescent-reported personal and familial prior professional help seeking increased. This suggests that youth with recognized symptoms of mental health problems were more likely to have been involved with professional services or have family members involved with professional services.

***Parental stress.*** Negative consequences associated with raising a child with mental illness (e.g., missing work) were associated with greater adolescent perceptions of problem severity, adolescent-reported prior professional help seeking, and adolescent-reported prior

familial help seeking. This is consistent with the robust finding that high levels of adolescent distress and/or parental stress often result actual help seeking behaviour (e.g., Madianos et al., 2011). In the present study, parents with younger children seemed more likely to experienced subjective strain.

### **Summary**

Overall the present study suggests that youth are recognizing mental health problems (Stage 1), deciding to seek professional help (Stage 2), and actually seeking professional help (Stage 3) more than was reported in previous research and this appears to reflect recently documented Canadian trends (Children's Hospital of Eastern Ontario, 2013). The present study extends previous research by considering parents' help-seeking for adolescent mental health problems as a multi-step process; other studies have considered whether parents have or have not sought professional help. Adolescents most frequently reported experiencing emotional problems whereas parents more frequently reported having adolescents with behavioural problems. Adolescents most commonly reported desires for independence and a lack of knowledge of mental health to be barriers to their professional help seeking. Parents also most commonly reported a lack of knowledge of mental health as a barrier to professional help seeking for adolescent mental health problems. For both the parent and adolescent data, barriers to help seeking and negative attitudes towards seeking professional help appeared to be highest at Stage 1 (i.e., recognizing mental health problems) and seemed lowest at Stage 3 (i.e., actual help seeking), suggesting that individuals who seek help do so, in part, by overcoming barriers to professional resources. Younger adolescents were found to report more perceived barriers to professional help seeking, have more negative attitudes towards seeking professional help, and



were more aware of the stigma related to mental illness. Thus, younger adolescents appear to be at a disadvantage in the help-seeking process.

Regression analyses showed that being female and perceiving mental health problems to be severe significantly improved the likelihood that an adolescent would recognize his or her mental health problem (Stage 1). Further, higher reported problem severity and prior professional help seeking significantly improved the likelihood that an adolescent would decide to help seek (Stage 2) and actually seek professional help (Stage 3). These findings are consistent with the study's hypotheses. With regards to parental help seeking, greater concern and worry for adolescents with mental health problems significantly improved the likelihood that a parent would recognize adolescent mental health problems (Stage 1) and decide to seek professional help (Stage 2). Finally, parent-reported prior familial professional help seeking somewhat improved the likelihood of parents actually seeking professional help for adolescent mental health problems (Stage 3). Given the limited number of parent-adolescent dyads, the researcher was limited with regards to statistical analyses that could be performed; however, the results lend some support to the idea that an adolescent and parent from the same family are likely to be in similar stages of help seeking. Overall, the results suggested that family members may encourage one another to seek professional help for adolescent problems by modelling professional help seeking and accurately identifying the nature of the adolescents' problem (e.g., mental health struggles as opposed to spiritual challenges). The family environment was consistently associated with adolescent mental health problems; however, the results suggest that family cohesion, flexibility, and communication are more likely to have an indirect effect on adolescent help seeking by contributing to an adolescent being more or less vulnerable to mental health problems (e.g., family conflict may exacerbate mental health problems).

## Study Limitations

This study has several limitations worth noting. First, the extent to which these results are generalizable beyond local or regional settings is unknown. The sample was fairly homogeneous, given that the majority of participants were Caucasian and from two-parent families. While some of the parents had limited educational backgrounds and reported being of lower socio-economic status, most parents had completed some college or university education and reported a minimal household annual income of \$51,000. With respect to external validity, there is also a possibility of selection bias because adolescents were mostly recruited from advertisements in high schools (e.g., morning announcements, classroom flyers) and adolescents who consume these advertisements may be more likely to attend classes and arrive to school on time. With regards to selection bias, a number of adolescent and parent participants emailed the researcher to express their gratitude for having been given an opportunity to speak about adolescent mental health problems and perhaps contribute to improving the help seeking experiences of other people. These letters suggest that participants with an interest in adolescent mental health may have been more likely to have participated in the study. Related to this may be the fact that all of the adolescents in the present study obtained scores on the Youth Self-Report Pediatric Symptom Checklist that suggested they required additional professional consultation to assess for mental illness. Of note, it is possible that the age range of the adolescents (14 to 18 years old) was too narrow to identify significant differences in participants' ability to recognize problems. Because participants were not clinic-referred and adolescent symptomatology was assessed using a screening measure, the degree to which results can be extended to severe emotional and behavioural problems (i.e., adolescents meeting diagnostic criteria for a mental health condition) is uncertain. Given that all of the adolescents in the

present study obtained high scores on the Pediatric Symptom Checklist (suggesting significant psychosocial impairment and the need for further evaluation), it is possible that the scores were high due to the sensitivity of the measure.

With respect to internal validity, there are several issues that should be considered. One important consideration is that of common method variance, which could affect Type 1 error. All of the variables were assessed using questionnaires, some of the associations between these variables might be explained by the fact that they were all assessed using a similar format. Nevertheless, there were associations between child-report and parent-report measures. For example, significant correlations were found using parent-adolescent dyad data. To improve accuracy, future studies should also include interviews and take steps to ensure parent- and self-report measures are obtained for each adolescent. Furthermore, while there are advantages to using the cumulative methodology, this approach may create more heterogeneous groups; for example, participants who were given credit for reaching the first stage of help seeking (i.e., recognizing the problem) included individuals who had subsequently stopped the help seeking process, decided to seek informal help, decided to seek formal help (Stage 2), or actually sought professional help (Stage 3). To better understand and differentiate these groups, studies with larger samples might limit analyses to only using participants' final stage of help seeking.

With respect to the context validity of the measure of help seeking, there is currently no widely accepted measure of help seeking and, as a consequence, progress in this area of research has been hampered by inconsistencies of measurement and definition. The present study developed the Help-Seeking Questionnaire by using measures that have been developed over a number of years and are widely accepted in the field of professional help seeking. Rickwood et al. (2005) identified three essential components for a comprehensive measurement of help

seeking and the present study included each of these elements, including time context (e.g., in the past 12 months), source of help (e.g., identifying the help resource), and type of problem. Future behavioural intentions were not addressed in this study. The present study may have benefited from a more detailed assessment of participants' past help-seeking experiences. The present study may also have benefited from determining the relative strength of different barriers and whether participants' professional help seeking (Stage 3) related to the adolescent mental health concerns that participants initially endorsed. Additionally, participants may have been asked to elaborate on the nature of the problem for which help was sought.

The present study places the psychometric properties of the Inventory of Attitudes towards Seeking Mental Health Services into question, only as it applies to online Canadian samples. The poor internal reliability of the subscales prevented the present study from conducting planned analyses, and thus, limited the researcher's ability to comment on this aspect of adolescent help seeking. This problem may be specific to the present study or may warrant exploratory factor analyses as more online data is gathered.

In this study, the parental FACES-IV Enmeshed subscale had poor internal consistency. This limited the researcher's ability to detect significant findings; however, efforts to improve the internal consistency failed and the omission of this subscale would have rendered the ratio scores unusable. To this researcher's knowledge, no other studies have reported such difficulty; however, ongoing problems may warrant exploratory factor analyses for online samples, particularly parent samples.

Another internal validity concern is that the small number of parent-adolescent dyads limited the researcher's ability to investigate the relation between parents' and adolescents' stage of help seeking. As a result, correlations were used and it is difficult to make inferences

regarding causality (e.g., that a parent's stage of help seeking *causes* the adolescent to progress or regress in the help-seeking process). Future research may increase the number of parent-adolescent dyads by increasing incentives. Type II error is also a consideration. This study has power limitations related to sample size; future studies using larger samples may uncover significant relations that were missed here.

### **Applied Implications of the Present Study**

This study extends previous research in several ways. First, it examined adolescent help seeking as a multi-step process that is influenced by family factors, such as parental stress and knowledge of mental health. Prior research has focused predominately on adolescents who have sought help (Stage 3) and have not sought help (non-help-seekers). By recognizing help seeking as a multi-step process, adolescents who would otherwise be considered non-help-seekers are recognized as possibly having recognized mental health problems and decided to seek help. By better understanding where adolescents' stop in the help seeking process interventions may be specifically targeted to help adolescents overcome obstacles to professional help. For instance, this study suggests that adolescents who are stuck in the first stage of help seeking (i.e., problem recognition) would likely benefit from support and information that allows them to believe they can overcome barriers to help seeking and develop positive relationships with professionals.

Second, the present study makes use of both adolescent- and parent-report measures of barriers to professional help, adolescent symptomatology, family coping strategies, family functioning, stages of professional help seeking, and attitudes towards seeking mental health services.

Previous research has tended to involve only parent- or only adolescent-reports. Third, this study examined the influence of different aspects of parental strain (i.e., objective strain, subjective strain, and global strain) on the help-seeking process, whereas previous research tended to

examine only parental global strain. This proved particularly valuable as subjective strain (e.g., feelings of worry and guilt related to raising a child with mental health problems) appears to be more important for adolescent help seeking than other forms of parental strain, which suggests that adolescents may be more likely to receive professional help if parents become appropriately concerned about their children's emotional and behavioural struggles as opposed to inconvenienced by adolescent mental health problems. Lastly, this study quantitatively identified predictors of problem recognition, deciding to seek professional help, and actually seeking professional help; much of previous research was theoretical or qualitative in nature.

Based on the findings of the present study, several recommendations can be considered. First and foremost, mental health literacy appears to be of utmost importance as both parents and adolescents reported a lack of knowledge to be a significant barrier to professional resources. Further, there appears to be a consistent association between an individual's knowledge of mental health and their ability to overcome barriers to professional resources and improve their own attitudes towards seeking professional help; this seems to be particularly relevant to moving beyond problem recognition (Stage 1). Because mental health gatekeepers are most likely to be speaking with adolescents about mental health services, it seems important to offer them training specifically targeted to their attitudes towards youth and mental health care, so as to facilitate positive outreach and prevention outcomes. For instance, teachers are an easily accessible source of support for adolescents and may play a role in connecting adolescents to appropriate mental health services; however, teachers have been found to be more likely to refer youth to informal resources due, in part, to concerns regarding the competency of clinicians, the effectiveness of treatment, fears of stigma, and anxiety about the professional help-seeking experience (Wilson & Deane, 2000). It is important for mental health professionals to engage in

widespread community outreach efforts to educate and collaborate with gatekeepers, teachers, parents, and adolescents. In order to improve adolescent mental health services, it is also important to educate society about the barriers to adolescent help seeking so that public advocacy for improved accessibility is strong and parents are better prepared for what to expect should their adolescent struggle with a mental health problem.

In the present study, adolescents frequently reported that a lack of mental health knowledge hindered their ability to access professional resources; this is consistent with previous research (e.g., Leavery et al., 2011; Del Mauro & Williams, 2013). To this end, mental health literacy might better serve youth by including information about what professional help seeking may involve in a particular community, what may happen in an encounter with a professional, service availability (e.g., whether individual, group or family therapy is offered in the community), service accessibility (e.g., is the service on a bus route), symptoms of mental health problems, and when it is necessary to seek help.

The fact that adolescent participants most commonly reported desires for independence to be a barrier to professional help suggests that mental health literacy must be sensitive to adolescents' desire for increased autonomy and might attempt to present information in a way that encourages youth to view help seeking as a means to gain mastery and independence. Framing help seeking as an important life skill, rather than evidence of personal weakness, may be particularly important to encourage youth to seek help. Ideally, a culture of mental health literacy could be created so that children's attitudes and beliefs towards professional mental health could be positively developed over time; it is more difficult to change negative attitudes once they have formed. Cornally and McCarthy (2011) highlight the importance of also

strengthening youth's emotional competency, communication skills, problem solving abilities, and family relationships because these are important skills that enable adolescents to seek help.

The present study also provides suggestions for which populations should be targeted by outreach efforts and highlights important content for mental health literacy initiatives. For instance, younger adolescents were found to have significantly more negative attitudes towards professional help seeking. Male adolescents were also consistently found to forgo professional help, suggesting that in-school psychoeducational groups targeted to males may be warranted. Moreover, given the finding that greater perceived problem severity increased the likelihood that adolescents would recognize mental health problems (Stage 1), decide to seek professional help (Stage 2), and actually seek professional help (Stage 3), the present study suggests that public education efforts could positively impact youth if they help adolescents better evaluate problem severity and refrain from minimizing the importance of their struggles.

In this study, parents and adolescents indicated a preference to seek help for adolescent mental health problems from mental health professionals, though the findings suggested that participants most often sought help from medical professionals. This may be explained by the fact that individuals may require a referral from their family doctor to access professional mental health services (e.g., psychiatry services and mental health professionals on family health teams). Adolescents may also rely on family doctors to provide information as to where youth can receive publically funded mental health services. According to the Canadian Institute for Health Information (2012), Canadians wait an average of six or more days for an appointment with their family doctor and four or more weeks for an appointment with a mental health professional. However, wait times have been shown to be significantly longer for children and adolescents seeking mental health services and are believed to be an average of six months (Health Service



Executive, 2011-2012). These delays in treating mental illness have several negative consequences, including the deterioration of an individual's condition, decisions to forgo professional help, fragmentation in services, and a preference to seek informal help (Canadian Institute for Health Information). Current wait times suggest that mental health professionals are unable to meet public demand for adolescent mental health services (Canadian Institute for Health Information; Health Service Executive). With this in mind, it is important that efforts to increase adolescent professional help seeking ensure that professional mental health providers can respond to adolescent needs within a timely manner. This has implications for the funding of both public and private mental health services because it suggests more mental health professionals are required and/or better promotion of the location of professional resources is needed. Additional funding may require lobbying government officials for a greater allocation of funds to pediatric mental health as well as seeking improved extended health care benefits (e.g., Employee Assistance Programs) from employers.

The mere experience of having difficulty contacting a mental health professional is likely to create a negative mental health experience and discourage future help seeking, due to feelings of disappointment and anger. To this end, the Ministry of Community and Social Services released a policy called *Making Services Work for People* (Ministry of Community and Social Services, 2006). This policy was created because the Ministry continued to receive public feedback that contacting professional resources was very difficult and confusing and that they didn't know who to call. As a result, *Making Services Work for People* directed communities to find solutions to help facilitate professional help seeking (Ministry of Community and Social Services). For instance, many cities now have central intake agencies (e.g., CONTACT Hamilton, CONTACT Niagara, CONTACT Brant) that collect people's information, use this

information to refer individuals to the most appropriate professional resources (e.g., individual counseling, family counseling, medication consultation, in-home services, out-of-home placements for adolescents), and share this information with the professional resources. In cities using one central point of intake, clients cannot access any mental health services beyond their family doctor's office and the emergency department without going through the central intake process. This eliminates the need for self-referral, helps to prevent a duplication of services for a particular individual, and ensures that the same criteria is applied to all people to access available services. Of note, the present study was limited to the Windsor-Essex community, which does not yet have this form of a central referral agency. As such, people are able to self-refer to most professional resources and may feel more of an onus to learn about the various mental health agencies and determine the best fit for them. The findings of the present study suggest that the Windsor-Essex community may reduce barriers to mental health service by considering the role of a central referral agency or making it easier for individuals to learn about professional resources within the community and which resource is likely to best suit their needs.

The fact that parents most often reported adolescent mental health concerns related to behaviour problems is consistent with studies that have found adolescent internalized problems are less likely to receive help than externalizing problems (Garland & Zigler, 1994). However, the present study did not ask parents to explain the adolescents' behaviour and may have discovered that parents are observing behavioural problems that reflect internalized behaviour problems (e.g., crying spells) just as much as externalized behaviour problems (e.g., property destruction). Most mental health parent education programs focus on teaching caregivers about the symptoms of various mental health problems so that they might better recognize adolescent problems and needs for help. For instance, *Alternatives for Youth* is a drug and alcohol program

for adolescents that includes parenting workshops focused on learning about normative adolescent behaviour and behavioural indicators that suggest an adolescent may be using a particular drug (*Alternatives for Youth*, n.d.). The present study lends support for continuing these efforts. The present study also suggests that there may be value in increasing parental awareness of the complex relation between adolescent behaviours and emotions (e.g., adolescents may act angry when they feel sad) and how parents' may best respond to adolescents so as to positively impact their adolescents' behaviour (e.g., using validation to help adolescents feel understood and safe to talk about their problems). Moreover, parents may benefit from knowing that they are more likely to influence their adolescent's behaviours by modelling adaptive coping skills, as opposed to simply telling the adolescent how to manage problems.

The present study also suggest that there is value in providing parents with strategies for how the family environment can help to reduce an adolescent's vulnerability to mental health problems by establishing a supportive, non-judgmental, and assertive dynamic that promotes healthy interpersonal boundaries (e.g., being emotionally connected with family members, but not overly dependent on family members). Similarly, parents may benefit from learning about the role that their feelings, related to raising a child with mental health problems, might play in the adolescent help-seeking process. Parents who experience anger and sadness related to their children's mental health needs may experience shame and feel embarrassed to discuss such reactions with medical and mental health professionals. However, these negative feelings can be harnessed to facilitate an adolescent's access to professional resources and do not appear to be something to feel ashamed by, but rather considered from the perceptive of being an adaptive response. Along these lines, it may be useful for professionals to begin asking parents about

their feelings toward parenting as this may help inform children's mental health screenings and motivate recommendations for professional help seeking.

Concerning the provision of adolescent mental health services, the present study suggests that mental health services may be made more appealing to youth by making it clear to youth how treatments are designed to specifically address the adolescent's problem of interest. For instance, depressed teens may become more engaged in Cognitive Behaviour Therapy if they understand how exploring the connections between their thoughts, feelings, and behaviours will allow them to have more control over their mood (e.g., getting active to improve one's mood) and develop a more balanced way of thinking (e.g., considering the negative and positive factors in any given situation to help ensure a realistic and reasonable perspective). Likewise, clients in Dialectical Behaviour Therapy may benefit from learning that they can choose to prioritize learning the skills that are most relevant to their treatment goals (e.g., distress tolerance, emotion regulation, interpersonal effectiveness). The findings of the present study suggest that it may be especially important that younger adolescents feel they are working collaboratively with mental health professionals and ultimately able to make their own decisions. This may be achieved by allowing adolescents to decide what sessions will focus on and offering adolescents choices with regards to how they might manage particular stressors. Finally, mental health professionals may strengthen their rapport with youth by calling the youth's attention to moments when they demonstrate appropriate maturity, decision making skills, and autonomy (e.g., standing up to peer pressure).

### **Directions for Future Research**

Further research is needed to develop a widely accepted measure of help-seeking behaviour and a conceptual framework for understanding help seeking at the level of both

macro- (e.g., social encouragement, family functioning, available mental health resources) and micro- (e.g., individual's mental health literacy, emotional competence, attitudes and beliefs about professional resources) factors. Future research may benefit from examining how personal assets and limitations help or hinder the help seeking process; for instance, being aware of one's internal experiences and having the language with which to express it to other people seems to be an essential skill that the help seeking literature has underexplored. Related to this, MacLean, Hunt, and Sweeting (2013) assert that little is known about how adolescents understand specific symptoms of mental health problems, such as feeling sad, and how such an understanding may impact adolescent help seeking. This is a much needed line of investigation as these symptoms may represent initial manifestations of more serious problems, such as depression, and may motivate youth who understand the significance of symptoms to seek assistance.

Future research may also benefit from examining the process in which adolescents develop more positive attitudes towards professional help seeking and whether this significantly diminishes the number of barriers to adolescent professional help seeking. Similarly, it would also be of interest to explore how significant adults can effectively prompt adolescent help seeking and how parents navigate available professional resources; the findings to date suggest that parents often contact multiple agencies, which places a greater burden on the mental health system and may reduce the likelihood that families will receive the most appropriate treatment (Reid et al., 2011; Shanley, Reid, & Evans, 2008; Boulter & Rickwood, 2013). A better understanding of parents' actual help seeking behaviour may lead to a more user-friendly mental health system.

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## APPENDIX A

*Demographic Characteristics of Parent-Child Dyads*

	Adolescents		Parents	
	<i>N</i>	%	<i>N</i>	%
<b>Gender</b>				
Male	7	29	8	33
Female	16	67	13	54
No Response	1	4	1	4
<b>Ethnicity</b>				
Asian	0	0	0	0
Middle Eastern	0	0	0	0
Caucasian	20	83	19	79
African	1	4	0	1
Hispanic/Latino-a	0	0	1	4
Native Canadian	2	8	0	0
Biracial	0	0	1	4
Other	0	0	0	0
No Response	1	4	3	13
<b>Family Structure</b>				
Two Parent, Only Child	4	17	-	-
One Parent, Only Child	6	25	-	-
Two Parent, Siblings	9	37	-	-
One Parent, Siblings	4	17	-	-
Other (e.g., living with relatives, alone)	0	0	-	-
No Response	1	4	-	-

(continued)

*Demographic Characteristics of Parent-Child Dyads (continued)*

	Adolescents		Parents	
	<i>N</i>	%	<i>N</i>	%
<b>Mother's Education</b>				
Some Elementary School	0	0	0	0
Some Secondary School	1	4	0	0
Graduated Secondary School	5	21	5	21
Some College or University	14	58	1	4
Graduated from College or University	2	8	7	29
Graduate/Professional School	1	4	0	0
Other (e.g., in school, apprenticeship)	0	0	0	0
No Response	1	4	0	0
<b>Father's Education</b>				
Some Elementary School	0	0	0	0
Graduated Elementary School	0	0	0	0
Some Secondary School	0	0	0	0
Graduated Secondary School	3	13	2	8
Some College or University	3	13	0	0
Graduated from College or University	16	67	5	21
Graduate/Professional School	0	0	1	4
Other (e.g., in school, apprenticeship)	1	4	0	0
No Response	1	4	0	0

(continued)



*Demographic Characteristics of Parent-Child Dyads (continued)*

	Adolescents		Parents	
	<i>N</i>	%	<i>N</i>	%
<b>Parents' Total Annual Income</b>				
Uncertain	18	75	-	-
Under \$30,000	0	0	0	0
\$30,000-\$40,000	0	0	0	0
\$41,000-\$50,000	0	2	1	4
\$51,000-\$60,000	0	2	17	71
\$61,000-\$70,000	2	8	0	0
\$71,000-\$80,000	3	13	3	13
\$81,000-\$90,000	0	0	0	0
\$91,000-\$100,000	0	0	0	0
No Response	1	4	1	4
<b>Access to Regular Medical Care (e.g., family doctor)</b>				
Yes	22	92	21	88
No	0	0	0	0
No Response	2	8	3	13
<b>Adolescents' Current Use of Counselling Services</b>				
Yes	4	19	-	-
No	19	79	-	-
No Response	1	4	-	-
<b>Adolescents' History of Using Counselling Services</b>				
Yes	5	21	7	29
No	18	75	15	63

(continued)

*Demographic Characteristics of Parent-Child Dyads (continued)*

	Adolescents		Parents	
	<i>N</i>	%	<i>N</i>	%
Adolescents' History of Using Counselling Services				
No Response	1	4	2	8
Parents' History of Using Counselling Services				
Yes	-	-	4	17
No	-	-	17	71
No Response	-	-	3	13
Family History of Mental Health Problems				
Present	11	46	-	-
Unaware	12	50	-	-
No Response	1	4	-	-
Recruitment Source				
High School	4	17	0	7
Word of Mouth	5	21	3	13
Flyer (e.g., mall, mental health centre, church)	12	50	3	13
Email	1	4	0	-
An email from my adolescent	-	-	12	50
Facebook	0	0	0	0
Other (e.g., internet ad, radio, newspaper)	1	4	3	13
No Response	1	4	3	13

## APPENDIX B

**Teen Background Information Questionnaire**

When is your birthday?

Birth Month:  Birth Year:

What gender are you?

- Male
- Female
- Other (e.g., transgender, intersex)

How did you hear about this study?

- My school
- Word of Mouth (i.e., someone told me about it)
- A flyer I saw or got at a public place (e.g., recreation centre)
- An email or message from a friend
- An email from a coach
- Facebook
- Other - Please specify:

What race or ethnicity do you most identify with?

- Asian
- Middle Eastern
- Caucasian
- African
- Hispanic/Latino-a
- Native Canadian
- Biracial - Please specify:
- Other - Please specify:

How many brothers and sisters do you have? Please indicate how many of each.

older brother(s)       older sister(s)

younger brother(s)       younger sisters

Are your parents:

- Married
- Divorced
- Separated
- Living together
- Remarried
- None of the above - - Please specify:

Who do you live with most of the time? Check all that apply.

- Mother
- Father
- Older sister(s)
- Younger sister(s)
- Older brother(s)
- Younger brother(s)
- Step-father
- Step-mother
- Younger Step-sibling(s)
- Older Step-sibling(s)
- Other family members (e.g., Grandparents, cousins)
- Other Please Specify:

What is your mother's education level?

- Some elementary school
- Completed elementary school (Grade 8)
- Some high school
- Graduated from high school or equivalent high school diploma
- Some college or university
- Graduated from college or university
- Graduate/professional school (e.g., Master's, Ph.D.)
- Other - Please specify:

What is your father's education level?

- Some elementary school
- Completed elementary school (Grade 8)
- Some high school
- Graduated from high school or equivalent high school diploma
- Some college or university
- Graduated from college or university
- Graduate/professional school (e.g., Master's, Ph.D.)
- Other - Please specify:

Is your mother currently working?

- Yes - What is/was your mother's job?
- No

Is your father currently working?

- Yes - What is/was your father's job?
- No

Estimate your parents' total annual income.

- I don't know. I'd be guessing.
- Under \$30,000
- \$30,000 to \$40,000
- \$41,000 to \$50,000
- \$51,000 to \$60,000
- \$61,000 to \$70,000
- \$71,000 to \$80,000
- \$81,000 to \$90,000
- \$91,000 to \$100,000
- Over \$100,000

Do you have a regular source of medical care, such as a family doctor?

- Yes  No

Are you currently receiving any counselling services?

Yes  No

If yes, please describe the service(s) and indicate who provides them (e.g., school counsellor, social worker, psychologist, psychiatrist).

Have you ever received any counselling services?

Yes  No

If yes, who provided the service(s) (e.g., school counsellor, social worker, psychologist, psychiatrist)?

Do any of your family members have a mental health condition (e.g., depression, anxiety, problems with aggression) that you are aware of? Consider your parents, siblings, aunts, uncles, cousins, and grandparents.

Yes  No

Please only write down the mental health condition(s). You do not have to write people's name or how they are related to you.

## APPENDIX C

**Consent to Modify the Canadian Community Health Survey**

The researcher received the following email after speaking to a representative at Statistics Canada (Ms. Natasha Isloor) about whether the researcher could modify items in the Canadian Community Health Survey.

Hello,

Thank you for contacting Statistics Canada.

Subject to **Statistics Canada's Open License Agreement**, Statistics Canada grants you a worldwide, royalty-free, non-exclusive license to:

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Regards,

Natasha Isloor

On behalf of Infostats | Au nom d'Infostats

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## APPENDIX D

**Help-Seeking Questionnaire: Adolescent Version**  
(Modified and printed with permission from Statistics Canada)

1. In the past 12 months, have you seen, or talked on the phone to, a professional about your emotional or mental health?

- Yes and I did this on my own.
- Yes, but my parents told me to call or see the professional.
- Yes, but my parents called or made the appointment for me.
- No, I have not had contact with a professional in the last 12 months.

If yes, who did you talk to? Check all that apply.

- Doctor
- Psychologist
- Social worker
- Psychiatrist
- Nurse
- Other - Please specify:

2. During the past 12 months was there ever a time when you felt that you needed help coping with emotions, mental health, or the use of alcohol or drugs, but didn't receive it?

- Yes, I needed help but didn't receive help.
- No, I didn't need help.

Please check all of the factors that may have prevented you from seeking the help you needed?

- Didn't get around to it
- Waiting times were too long
- I felt the help would be inadequate or unhelpful
- Help was not available at the time I needed it
- Cost/money
- Services were not available in my area
- I was too busy
- I didn't know where to go



- I do not trust professionals
- Other responsibilities got in the way
- Language barrier
- Transportation problems
- Other people might have found out
- I like to handle things on my own
- I know very little about mental health (e.g., signs of problems)
- Other - Please specify:

**\*\*ONLY PARTICIPANTS WHO ANSWER 'YES' TO QUESTION 2 WILL COMPLETE QUESTIONS 3, 4, AND 5.**

3. What did you feel you needed help for? Check all that apply to you.

- Emotional problems
- Behaviour problems
- Substance use (e.g., cigarettes, drugs, alcohol)
- Family problems
- Problems with friends or romantic relationships
- Problems with self-confidence or nerves
- Dealing with stress
- I'm not sure what it is, I'm just not myself
- Other - Please specify:

4. How serious did you feel the problem was?

- Very serious
- Somewhat serious
- Not serious at all

5. What type of help did you feel you needed? Check all that apply to you.

- Help from family
- Help from friends
- Help from a teacher or spiritual leader (e.g., priest, rabbi, minister)
- Help from a doctor

- Help from a mental health professional (e.g., social worker, psychologist, psychiatrist)
- Other - Please specify:

## APPENDIX E

**Parent Background Information Questionnaire**

When is your birthday?

Birth Month:  Birth Year:

What gender are you?

- Male
- Female
- Other (e.g., transgender, intersex)

How did you hear about this study?

- My adolescent's school
- Word of mouth (e.g., someone told me about it)
- A flyer I saw or received at a public place (e.g., the mall)
- An email from my adolescent
- Facebook
- A recreational activity for teens (e.g., sports team, dance studio)
- Other - Please specify:

What race or ethnicity do you most identify with?

- Asian
- Middle Eastern
- Caucasian
- African
- Hispanic/Latino-a
- Native Canadian
- Biracial - Please specify:
- Other - Please specify:

How often does your adolescent live with you?

- All of the time
- Every weekend
- Every other weekend
- Monday to Friday
- Other Please Specify:

What is your education level?

- Some elementary school
- Completed elementary school (Grade 8)
- Some high school
- Graduated from high school or equivalent high school diploma
- Some college or university
- Graduated from college or university
- Graduate/professional school (e.g., Master's, Ph.D.)
- Other - Please specify:

Please approximate your household's total annual income.

- Under \$30,000
- \$30,000 to \$40,000
- \$41,000 to \$50,000
- \$51,000 to \$60,000
- \$61,000 to \$70,000
- \$71,000 to \$80,000
- \$81,000 to \$90,000
- \$91,000 to \$100,000
- Over \$100,000

Do you have a regular source of medical care, such as a family doctor?

- Yes  No

Does your partner have a regular source of medical care, such as a family doctor?

- Yes  No

Have you or your partner ever received counselling services?

Yes  No

If yes, who provided the service(s) (e.g., social worker, psychologist, family doctor)?

Has your adolescent ever received counselling services?

Yes  No

If yes, who provided the service(s) (e.g., family doctor, social worker, psychologist)?

## APPENDIX F

**Help-Seeking Questionnaire: Parent Version**  
(Modified and printed with permission from Statistics Canada)

1. In the past 12 months, have you seen, or spoke on the phone to, a professional about your adolescent's emotional or mental health?

- Yes.
- Yes, but it was because someone asked me to contact a professional.
- No.

Who did you talk to? Check all that apply.

- Doctor
- Psychologist
- Social worker
- Psychiatrist
- Nurse
- Other - Please specify:

2. During the past 12 months was there ever a time when you felt that your adolescent needed help coping with emotions, mental health, or the use of alcohol or drugs, but didn't receive it?

- Yes, I believe that they needed help but didn't receive help.
- No, they didn't need help.

Please check all of the factors that may have prevented you from seeking the help you felt your adolescent needed?

- Didn't get around to it
- Waiting times were too long
- I felt the help would be inadequate or unhelpful
- Help was not available at the time my adolescent needed it
- Cost/money
- Services were not available in my area
- I was too busy
- I didn't know where to go
- I do not trust professionals

- Other responsibilities got in the way
- Language barrier
- Transportation problems
- Other people might have found out
- I like to handle things on my own
- I know very little about mental health (e.g., signs of problems)
- I believe that it is my adolescent's responsibility to seek help if they need it
- Other - Please specify:

PARTICIPANTS WHO ANSWER 'YES' TO QUESTION 2 WILL CONTINUE WITH QUESTIONS 3, 4, AND 5

3. What did you feel your adolescent needed help for? Check all that apply to you.

- Emotional problems
- Behaviour problems
- Substance use (e.g., cigarettes, drugs, alcohol)
- Family problems
- Problems with friends or romantic relationships
- Problems with self-confidence or nerves
- Dealing with stress
- I'm not sure what it is, they're just not themselves
- Other - Please specify:

4. How serious did you feel your adolescent's problem was?

- Very serious
- Somewhat serious
- Not serious at all

5. What type of help did you feel your adolescent needed? Check all that apply to you.

- Help from family
- Help from friends
- Help from a teacher or spiritual leader (e.g., priest, rabbi, minister)
- Help from a doctor

- Help from a mental health professional (e.g., social worker, psychologist, psychiatrist)
- Other - Please specify:



## APPENDIX G

**Letter to Catholic School Principals**

Dear Principal \_\_\_\_\_,

This email is in follow-up to information you received from Ms. \_\_\_\_\_, Executive Assistant to Associate Director – Student Achievement K – 12 and Superintendents of Education of the Windsor-Essex Catholic District School Board.

As you know, the Windsor-Essex Catholic District School Board has given approval for (insert school's name) to advertise a research study on adolescent help seeking titled "Factors Predicting Adolescents' and Parents' Help Seeking." The decision for (insert school's name) to advertise the study is at your discretion. The participation of the students will be on a strictly voluntary basis. If you agree, (insert school's name) will be asked to post information and periodically play brief recordings during morning announcements (these materials will be provided to you). The advertised information will direct students to a website to complete a survey (i.e., [www.uwindsor.ca/50](http://www.uwindsor.ca/50)). Since this is an online study, students participate outside of school time and without interfering with the normal progress of education in schools. The Windsor-Essex Catholic District School Board may benefit from the study in a number of ways, including:

- providing high school students and parents with an opportunity (via questionnaire items) to recognize adolescent mental health concerns, which may allow youth to seek professional help sooner and reduce the risk of school failure/dropout
- making a Mental Health Community Resource List more accessible to parents and students
- demonstrating the Windsor-Essex Catholic District School Board's commitment to student mental health and community efforts to improve mental health services
- providing students with the opportunity to earn two community service hours (with permission from the Windsor-Essex Catholic District School Board)
- encouraging a dialog among students and educators about mental health problems and help sources

In addition to the aforementioned benefits, the results of this study will be made available to the Windsor-Essex Catholic District School Board upon the study's completion (expected in October 2012). The results will in no way be associated with the Windsor-Essex Catholic District School Board, but will reflect the mental health opinions and concerns of adolescents and parents in the Windsor area.

The purpose of this study is to examine predictors of help seeking in a sample of adolescents (Grades 9 to 12) and parents. Although research findings suggest that an adolescent's family experience relates to how they cope with stress and handle problems (Fallon & Bowles, 2001), the family's role in adolescent help seeking and help-seeking socialization has been vastly underexplored. The present study will contribute to the existing literature by concentrating on stages of help seeking and how help seeking is socialized within the family. For instance, the

study may suggest that adolescents are able to recognize their need for professional help but often decide not to seek help because of the stigma associated with mental illness. The study may reveal how families help youth overcome such stigma in order to receive the help they require.

The attached document includes a sample of the advertising materials you would be asked to have in (insert school's name). I would be happy to provide you with any additional information you require.

Thank you for considering this opportunity. Please contact me at (insert phone number) or (insert email address) to indicate your interest in advertising the study and if you would be interested in additional information on Factors Predicting Adolescents' and Parents' Help Seeking.

I look forward to hearing from you, Principal \_\_\_\_\_.

Sincerely,  
Jennifer Cometto, M.A.  
Ph.D. Candidate  
Child Clinical Psychology  
University of Windsor

## APPENDIX H

**Letter to Public School Principals**

Dear Principal \_\_\_\_\_,

The Research Review Committee for the Greater Essex County District School Board has given approval for (insert school's name) to advertise a research study on adolescent help seeking titled "Factors Predicting Adolescents' and Parents' Help Seeking". The decision for (insert school's name) to advertise the study is at your discretion. The participation of the students will be on a strictly voluntary basis. If you agree, (insert school's name) will be asked to post information and periodically play brief recordings during morning announcements (these materials will be provided to you). The advertised information will direct students to a website to complete a survey (i.e., [www.uwindsor.ca/50](http://www.uwindsor.ca/50)). Since this is an online study, students participate outside of school time and without interfering with the normal progress of education in schools. The Greater Essex County District School Board may benefit from the study in a number of ways, including:

- providing high school students and parents with an opportunity (via questionnaire items) to recognize adolescent mental health concerns, which may allow youth to seek professional help sooner and reduce the risk of school failure/dropout
- making a Mental Health Community Resource List more accessible to parents and students
- demonstrating the Greater Essex County District School Board's commitment to student mental health and community efforts to improve mental health services
- providing students with the opportunity to earn two community service hours (with permission from the Greater Essex County District School Board)
- encouraging a dialog among students and educators about mental health problems and help sources

In addition to the aforementioned benefits, the results of this study will be made available to the Greater Essex County District School Board upon the study's completion (expected in October 2012). The results will in no way be associated with the Greater Essex County District School Board, but will reflect the mental health opinions and concerns of adolescents and parents in the Windsor area.

The purpose of this study is to examine predictors of help seeking in a sample of adolescents (Grades 9 to 12) and parents. Although research findings suggest that an adolescent's family experience relates to how they cope with stress and handle problems (Fallon & Bowles, 2001), the family's role in adolescent help seeking and help-seeking socialization has been vastly underexplored. The present study will contribute to the existing literature by concentrating on stages of help seeking and how help seeking is socialized within the family. For instance, the study may suggest that adolescents are able to recognize their need for professional help but often decide not to seek help because of the stigma associated with mental illness. The study

may reveal how families help youth overcome such stigma in order to receive the help they require.

The attached documents include a copy of the approval obtained from the Greater Essex County District School Board and a sample of the advertising materials you would be asked to have in (insert school's name). I would be happy to provide you with any additional information you require.

Thank you for considering this opportunity. Please contact me at (insert phone number) or (insert email address) to indicate your interest in advertising the study and if you would be interested in additional information on Factors Predicting Adolescents' and Parents' Help Seeking.

I look forward to hearing from you, Principal \_\_\_\_\_..

Sincerely,  
Jennifer Cometto, M.A.  
Ph.D. Candidate  
Child Clinical Psychology  
University of Windsor

## APPENDIX I

## Advertisement: Wall Poster

## Get YOUR chance to win 1 of 5 \$50 gift certificates to Devonshire Mall

Jennifer Cometto, a graduate student at the University of Windsor, invites you to participate in a **research study** about how teens cope with problems and what, if anything, stops teens from asking for help.

### Who can get involved?

**Teens** 14 to 18 years old and **parents** of 14 to 18 year old children who live in the Windsor area.

### What do I have to do?

Go to [www.uwindsor.ca/50](http://www.uwindsor.ca/50) to complete a survey. Your answers will be confidential.

### Why should I?

Although the survey typically takes one hour to complete, you don't have to complete it in one sitting and those who do get an extra ballot for the draw. **Your participation is likely to help to improve community services for adolescents and their families.**

**For more information** contact Jennifer Cometto ([cometto@uwindsor.ca](mailto:cometto@uwindsor.ca)) or Dr. Rosanne Menna ([rmenna@uwindsor.ca](mailto:rmenna@uwindsor.ca)) by email or phone (519-253-3000 ext. 2230).

This research received clearance from the University of Windsor Research Ethics Board

The displayed poster was printed on ledger-sized paper. The incentive was increased to \$75 during the course of the study, and the poster was changed to reflect this.

## APPENDIX J

## Advertisement: Flyer

**Teens 14-18 years old and Their Parents**

Get **YOUR** chance to **win 1 of 5 \$75** gift certificates to Devonshire Mall

**Raffle!**

*Jennifer Cometto, a graduate student at the University of Windsor, invites you to participate in a **research study** about how teens cope with problems and what, if anything, stops teens from asking for help.*

**What do I have to do?**

Complete a survey at **[www.uwindsor.ca/50](http://www.uwindsor.ca/50)**

*Your answers will be confidential – you don't need to give your name, address, or phone number.*

**Why should I?**

*Your participation will help improve community services for adolescents and their families. Have your voice heard and help to create services that teens deserve!*

**For more information**

*Contact Jennifer Cometto ([cometto@uwindsor.ca](mailto:cometto@uwindsor.ca)) or Dr. Rosanne Menna ([rmenna@uwindsor.ca](mailto:rmenna@uwindsor.ca)) by email or phone (519-253-3000 ext. 2219).*

*This research received clearance from the University of Windsor Research Ethics Board*

The displayed flyer was printed on vibrantly coloured paper and made into prescription-sized pads of 150 flyers. This enabled reception staff and physicians to have access to a large amount of advertisements and require little space. Teachers distributed the pads in their classes and encouraged interested students to tear flyers off.

## APPENDIX K

**Advertisement: Sample Audio Recording**

The following is an announcement that was provided to high schools in writing and on audio compact disc. The advertisement was changed throughout the course of the study to maintain the students' interest.

This announcement is for the **Factors Predicting Adolescents' and Parents' Help Seeking Behaviour** study. The Research Ethics Board of the University of Windsor and (insert school principal's name here) have provided clearance for this advertisement.

You may read the following announcement or play it using the attached cd. Thank you for your time and for using an enthusiastic tone of voice ☺

*“Jennifer Cometto, a Ph.D. student at the University of Windsor, is giving you an opportunity to win one of five \$50 certificates for Devonshire Mall. All you have to do is complete an online survey that is part of her research. Jennifer is trying to understand how teens recognize problems and get help. By participating in this research project you will help teach other people about why teens may have a hard time asking for help and how families can encourage or discourage teens from asking for help. Your answers will be kept confidential and you can contact Jennifer with any questions you have. To get more information and have your chance to win go to [www.uwindsor.ca/50](http://www.uwindsor.ca/50) or get the website and more information on posters around the school. Good luck in the draw for one of five \$50 gift certificates.”*

Note: The following lyric was played for 15 seconds at the beginning of the cd recording. The song is *Help* by The Beatles.

*Help, I need somebody,  
Help, not just anybody,  
Help, you know I need someone, help.*

*When I was younger, so much younger than today,  
I never needed anybody's help in any way.*

## APPENDIX L

**Letters for Introducing the Study to Physicians**

*Your help is needed to recruit teens (14-18 yrs.) and parents for a research study on the barriers to seeking professional mental help*

Hello,

I am a doctoral student in Clinical Psychology at the University of Windsor. I have received approval from the Windsor-Essex Community Health Centre and University of Windsor Research Ethics Board to recruit participants for my dissertation research at your site. I would greatly appreciate your efforts to help distribute recruitment ads to teens (14 to 18 years old) and their parents. The ads will direct individuals to a website where they can complete a survey about what, if anything, stops teens from seeking professional mental help (e.g., counselling services).

Please only distribute the provided advertisement to teens who you believe are not currently receiving professional counselling (e.g., from a psychologist, social worker, etc).

The provided pad of advertisements is for your use. You may keep it in your office where you'd typically see teens and their parents. Should you feel uncomfortable advertising the study for any reason please return the pad to any of the reception staff at your site.

The results of this study will be made available to the Windsor-Essex Community Health Centre upon the study's completion (expected in October 2012). The results will in no way be associated with your site, but will reflect the mental health opinions and concerns of adolescents and parents in the Windsor area.

Thank you for your help. If you are interested, I am happy to provide you with additional information on the study. Please contact me at (insert phone number) or (insert email address).

Sincere thanks,

Jennifer Cometto, M.A.  
Ph.D. Candidate  
Child Clinical Psychology  
University of Windsor



## APPENDIX M

**Letter Mailed with Package of Advertising Materials**

Dear Principal \_\_\_\_\_,

Thank you again for your support for the Factors Predicting Adolescents' and Parents' Help Seeking study. Please find enclosed ten posters to place around the school and a CD with a 60 second advertisement to promote the study to students, which can be played during regular school announcements.

Other schools have found it useful to place the posters in the following areas:

- cafeteria
- high-traffic hallways
- main office
- guidance office
- library
- bathrooms
- change rooms
- main entrance

As per your request, please also find enclosed 400 flyers that educators may hand out to students to promote the study. The flyers have been designed so that teachers can pass them around in their classrooms in order to allow interested students to take a flyer. Other schools have found it useful to target one core subject to help prevent the same student from taking more than one flyer. For instance, you may decide to only have English or Mathematics teachers distribute the flyers in each of their classes.

Please contact me at (insert phone number) or (insert email address) with any questions or to request additional materials.

Many thanks,

Jennifer Cometto, M.A.  
Ph.D. Candidate  
Child Clinical Psychology  
University of Windsor

## APPENDIX N

## Advertisement Posted in Devonshire Mall

**Teens 14-18 years old and Their Parents**

Get **YOUR** chance to win 1 of 5 \$75 gift certificates to Devonshire Mall



**Raffle!**

*Jennifer Cometto, a graduate student at the University of Windsor, invites you to participate in a research study about how teens cope with problems and what, if anything, stops teens from asking for help.*

***What do I have to do?***

***Complete a survey at [www.uwindsor.ca/50](http://www.uwindsor.ca/50)***  
*Your answers will be confidential - you don't need to give your name, address, or phone number.*

***Why should I?***

*Your participation will help improve community services for adolescents and their families. Have your voice heard and help to create services that teens deserve!*

**For more information**

***Contact Jennifer Cometto ([cometto@uwindsor.ca](mailto:cometto@uwindsor.ca)) or Dr. Rosanne Menna ([rmenna@uwindsor.ca](mailto:rmenna@uwindsor.ca)) by email or phone (519-253-3000 ext. 2219).***

*This research received clearance from the University of Windsor Research Ethics Board*

## APPENDIX O

**Adolescent Letter of Information for Consent to Participate in Research (online)**

J. Cometto & Dr. Rosanne Menna

**Title of Study:** Factors Predicting Adolescents' and Parents' Help Seeking

You are invited to participate in a research study conducted by Jennifer Cometto, Doctoral Candidate in Child Clinical Psychology at the University of Windsor in Windsor, Ontario, Canada. Dr. Rosanne Menna, Clinical Psychologist and Professor from the Department of Psychology, is supervising this research.

If you have any questions or concerns about the research, please feel free to contact Jennifer (insert email address), or Dr. Menna (insert email address) by email or phone (insert phone number).

**PURPOSE OF THE STUDY**

This study was designed to help understand how teens recognize problems, decide to get professional help, and work with professionals to solve problems. Since many teens do not seek professional help (e.g., help from a doctor, psychologist, social worker), this study is interested in understanding what stops teens from asking professionals for help. This study is also interested in how parents and families help or make it harder for teens to get the help they need.

**PROCEDURES**

If you volunteer to participate in this study, you will be asked to complete questionnaires about: you (e.g., your birth date) and your family (e.g., how many siblings you have), how you think and feel about mental health professionals, (e.g., doctors, psychologists, social workers), things that may have stopped you from asking for help in the past, challenges or stress you have, how you normally deal with stress and problems, and how you get along with your family. If your parent/caregiver didn't send you this survey, you will also be asked whether you would like to send a parent version of this survey to them. If you do this, your parent will not be able to see how you answered the questions. You will not be able to see how your parent answers the questions either. We want to learn about how your parents think and feel about mental health professionals and how they view your family. If you and your parent participate in the study we want to see how similar your parent's answers are to your answers. **You can still participate in this study if you decide not to email your parents this survey.**

This survey takes about an hour to complete. We ask you to complete the survey in a private space to help make sure that other people cannot see your answers.

**\*By completing and submitting the study survey on-line, your consent to participate is implied.\***

### POTENTIAL RISKS AND DISCOMFORTS

Some of the questions that you will be asked might make you feel a little uncomfortable about yourself or your relationships with your family because they ask you to think about good and bad times. You may leave the survey at any time by clicking on the 'withdraw from study' button at the bottom of your computer screen. You do not have to answer any questions that you do not want to. If a question makes you feel uncomfortable, you can skip it.

### POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

Completing this study may help you become more aware of yourself and how professionals can work with teens to solve problems and lower stress. Your answers to the survey will help other people understand teens' experiences and how families and professionals can better meet the needs of teens and their families.

### COMPENSATION FOR PARTICIPATION

When you finish the survey, you will be able to enter your email address in a draw for one of five \$50.00 gift certificates to your local mall (e.g., Devonshire Mall). If you complete all of the questionnaires without having to log back into the survey, you will be able to enter the draw twice. It's okay if you need to save your answers and come back to the survey later, but if you want more than one entry for the draw, try to make sure that you have an hour to complete the survey.

### CONFIDENTIALITY

Any information collected as part of this study that can be identified with you (e.g., your email) will remain confidential. **You will not be asked for your name, address, or phone number** and you can create an email account to enter the draw if you don't want to share your regular email address with us. The email address that you give will be kept separate from your answers and in a password-protected file that only the researchers see. Keeping your answers separate from your email address helps make sure that **only you will know how you answer the questions** - the researcher will not know because you never give your name. Once the draw is complete, the file with your email address will be destroyed.

Your answers to the survey will be kept on the University of Windsor server until everyone participating in the study finishes the survey. At that time, everyone's answers will be downloaded and will be stored on password-protected computers or other electronic data storage devices. Once everyone's answers have been down-loaded on to the researchers' computer, your information will be deleted from the university server website.

The data collected in this study will be stored for a period of 5 years, or until all possible publications have been completed.

### PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you can withdraw at any time without consequences of any kind. You may refuse to answer any questions you don't want to answer and still remain in the study. The researcher may take your answers out of the study if circumstances arise which warrant doing so. For example, if you are not 14,15,16,17, or 18 years old.

Remember, you can exit the survey at any time and save your answers to finish the survey later. You can also decide to withdrawal from the study (which means that your answers would be deleted).

Because your email address is kept in a separate file from your survey answers, we cannot tell which answers are yours. This means that you are not able to withdraw or erase your answers after you have completed the survey.

#### FEEDBACK OF THE RESULTS OF THIS STUDY TO THE SUBJECTS

A summary of the results of this study will be posted on the University of Windsor website: [www.uwindsor.ca/reb](http://www.uwindsor.ca/reb) by October 2012. After that time, click on "study results" on the left hand side menu.

#### SUBSEQUENT USE OF DATA

This data will be used in subsequent studies on adolescent help seeking and families.

#### RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and stop participating without penalty. If you have questions regarding your rights as a research subject, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario N9B 3P4; Telephone: 519-253-3000, ext. 3948; e mail: [ethics@uwindsor.ca](mailto:ethics@uwindsor.ca)

#### AGREEMENT OF INVESTIGATOR

These are the terms under which I will conduct research.

Jennifer Cometto, March 2011

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\*Please click this link to PRINT a copy of this letter of information for consent to participate in research for your records.

\*\*Please click the I AGREE TO PARTICIPATE button below to login anonymously and confidentially to the online questionnaire:

Login Instructions:

USER ID Login name: teen

Login password: survey

**I AGREE TO PARTICIPATE  
I AM RETURNING TO AN EXISTING SURVEY**

## APPENDIX P

**Parent Letter of Information for Consent to Participate in Research**

Jenn Cometto & Dr. Rosanne Menna

**Title of Study:** Factors Predicting Adolescents' and Parents' Help Seeking

You are invited to participate in a research study conducted by Jennifer Cometto, Doctoral Candidate in Child Clinical Psychology at the University of Windsor in Windsor, Ontario, Canada. Dr. Rosanne Menna, Clinical Psychologist and Professor from the Department of Psychology, is supervising this research.

If you have any questions or concerns about the research, please feel free to contact Jennifer (insert email address), or Dr. Menna (insert email address) by email or phone (insert phone number).

**PURPOSE OF THE STUDY**

This study was designed to help understand how parents recognize adolescent problems, decide to seek professional help with or for their adolescent, and work with professionals to solve problems related to their adolescent's challenges. Since many people do not seek professional help (e.g., help from a doctor, psychologist, social worker), this study is interested in understanding what stops families from asking professionals for help and how families help or make it harder for adolescents to get the help they need.

**PROCEDURES**

If you volunteer to participate in this study, you will be asked to complete questionnaires about: you and your family (e.g., whether you and your adolescent have a regular source of medical care, such as a family doctor), your thoughts and feelings about mental health professionals (e.g., doctors, psychologists, social workers), things that may have stopped you from asking for help in the past, challenges or stress you believe your adolescent experiences, how your family deals with stress and problems, how you feel about parenting your adolescent, and how your family interacts. If your adolescent didn't send you this survey, you will also be asked whether you would like to send an adolescent version of this survey to them. If you do this, they will not be able to see how you answered the questions. You will not be able to see how they answered the questions either. We want to learn about how adolescents think and feel about mental health providers and how they view their own mental health and your family. If you and your adolescent participate in the study we want to see how similar their answers are to yours. **You can still participate in this study if you decide not to email your adolescent this survey.**

This survey takes about an hour to complete. We ask you to complete the survey in a private space to help make sure that other people cannot see your answers.

**\*By completing and submitting the survey on-line, your consent to participate is implied.\***

### POTENTIAL RISKS AND DISCOMFORTS

Some of the questions that you will be asked might make you feel a little uncomfortable about yourself or your relationships with your family because they ask you to think about good and bad times. You may leave the survey at any time by clicking on the 'withdraw from study' button at the bottom of your computer screen. You do not have to answer any questions that you do not want to. If a question makes you feel uncomfortable, you are free to skip it.

### POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

Completing this study may help you become more aware of your adolescent's strengths and challenges, how you have or can help your adolescent, and how professionals can work with adolescents and families to solve problems and reduce stress. Your answers to the survey will help professionals understand adolescents' experiences and how families and professionals can better meet the needs of adolescents and their families.

### COMPENSATION FOR PARTICIPATION

When you finish the survey, you will be able to enter your email address in a draw for one of five \$50.00 gift certificates to your local mall (e.g., Devonshire Mall). If you complete all of the questionnaires without having to log back into the survey, you will be able to enter the draw twice. It's okay if you need to save your answers and come back to the survey later, but if you want more than one entry for the draw, try to make sure that you have an hour to complete the survey.

### CONFIDENTIALITY

Any information collected as part of this study that can be identified with you (e.g., your email) will remain confidential. **You will not be asked for your name, address, or phone number** and you can create an email account to enter the draw if you don't want to share your regular email address with us. The email address that you give will be kept separate from your answers and in a password-protected file that only the researchers see. Keeping your answers separate from your email address helps make sure that **only you will know how you answered the questions** - the researcher will not know because you never give your name. Once the draw is complete, the file with your email address will be destroyed.

Your answers on the survey will be kept on the University of Windsor server until everyone participating in the study finishes the survey. At that time, everyone's answers will be downloaded and will be stored on password-protected computers or other electronic data storage devices. Once everyone's answers have been down-loaded on to the researchers' computer, your information will be deleted from the university server website.

The data collected in this study will be stored for a period of 5 years, or until all possible publications have been completed.

### PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you can withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The researcher may take your answers out of the study if circumstances arise which warrant doing so. For example, if you do

not have a 14,15,16,17, or 18 year old child.

Remember, you can exit the survey at any time and save your answers to finish the survey later. You can also decide to withdrawal from the study (which means that your answers would be deleted).

Because your email address is kept in a separate file from your survey answers, we cannot tell which answers are yours. This means that you are not able to withdraw or erase your answers after you have completed the survey.

#### FEEDBACK OF THE RESULTS OF THIS STUDY TO THE SUBJECTS

A summary of the results of this study will be posted on the University of Windsor website: [www.uwindsor.ca/reb](http://www.uwindsor.ca/reb) by October 2012. After that time, click on "study results" on the left hand side menu.

#### SUBSEQUENT USE OF DATA

This data will be used in subsequent studies on adolescent help seeking and families.

#### RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and stop participating without penalty. If you have questions regarding your rights as a research subject, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario N9B 3P4; Telephone: 519-253-3000, ext. 3948; e mail: [ethics@uwindsor.ca](mailto:ethics@uwindsor.ca)

#### AGREEMENT OF INVESTIGATOR

These are the terms under which I will conduct research.

Jennifer Cometto, March 2011

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\*Please click this link to PRINT a copy of this letter of information for consent to participate in research for your records.

\*\*Please click the I AGREE TO PARTICIPATE button below to login anonymously and confidentially to the online questionnaire:

Login Instructions:

USER ID Login name: parent

Login password: survey

I AGREE TO PARTICIPATE  
I AM RETURNING TO AN EXISTING SURVEY



## APPENDIX Q

**Community Resource List**

Thank you for your time and energy!

After answering the questions in this survey you may begin to think about your well-being and levels of stress. You may also begin to think about the well being and stress of your family and friends. At these times, it is important to remember that it is normal and healthy to feel a range of emotions - happiness, sadness, anxiety or fear, anger, and other emotions. If you are concerned that your thoughts and/or feelings have been getting in the way of your everyday life or stopping you from living your life as you would like, you may benefit from talking to someone. Family and friends can be great supports, but it can also be helpful to talk privately to a professional who is trained to help people learn how to cope with their emotions in healthy ways and find solutions to problems. Below is a list of some services within the Windsor-Essex community for adolescents and their parents.

Please remember that mental health professionals (e.g., psychologists, social workers, doctors) are here to help. If you feel that a professional is telling you what to do without considering your opinion, we suggest that you see another professional who you feel comfortable with. Once again, please contact Jennifer (insert email address) or Dr. Menna (insert email address) by email or phone (insert phone number) if you have questions about this study or would like more information.

Information and referral services:

**Mental Health Service Information Ontario**

Website: [mhsio.on.ca](http://mhsio.on.ca)

Phone: 1-866-531-2600

No fee, confidential, anonymous, and 24 hours

**Windsor-Essex Community Information**

Website: <http://windsor-essex.cioc.ca/>

Phone: 519-973-4636 (if in the City of Windsor dial 211)

No fee, confidential services

**Helplink Access Services**

Phone: 519-257-5437

Referral information provided for no fee

Youth Helpline:

**Kids Help Phone**

Website: <http://www.kidshelpphone.ca>

No fee, confidential, and 24 hours

Community Mental Health Services:

**Windsor Essex Community Health Centre (aka: Teen Health Centre)**

Website: [www.teenhealthcentre.ca](http://www.teenhealthcentre.ca)

Address: 1585 Ouellette Ave, Windsor ON N8X 1K5

Satellite Offices in Amherstberg, Belle River, Essex, Kingsville, and Leamington.

No fee (with OHIP), confidential, provides referral information, counselling, medical care, etc.

**Children Health Care Network**

Phone: 519-948-3961

Address: 7717 Wyandotte St E, Windsor, ON N8S 1S6

No fee, confidential, assessment, diagnosis, and treatment

**Windsor Regional Children's Centre(RCC)**

Phone: 519-257-5215

Address: Huot Building, 3901 Connaught St., Windsor, ON. N9C 4H4

Satellite Offices in Amherstberg, Belle River, Essex, Kingsville, and Leamington.

No fee, confidential, crisis walk-in services and counselling for ages 6 to 16 years of age.

## APPENDIX R

*Age Ranges, Means, and Standard Deviations for Female<sup>f</sup> and Male<sup>m</sup> Adolescents in the Stages of Help Seeking*

Stage of Help Seeking	Adolescents n(%)			
	Age Range	<i>N</i>	<i>M</i>	<i>SD</i>
Non-Help-Seekers	14-18 <sup>f</sup>	56	16.26	1.36
	14-18 <sup>m</sup>	46	16.53	1.34
Stage 1	14-18 <sup>f</sup>	54	16.44	1.43
	14-18 <sup>m</sup>	16	16.38	1.19
Stage 2	14-18 <sup>f</sup>	33	16.48	1.48
	15-18 <sup>m</sup>	9	16.38	1.06
Stage 3	14-18 <sup>f</sup>	31	16.24	1.45
	14-18 <sup>m</sup>	17	16.64	1.21

## VITA AUCTORIS

NAME: Jennifer Lynn Cometto

PLACE OF BIRTH: Hamilton, Ontario

YEAR OF BIRTH: 1983

EDUCATION: University of Windsor, Windsor  
2008-2013 Ph.D.

University of Windsor, Windsor  
2006-2008 MA

McMaster University, Hamilton  
2002-2006 BA

St. Jean de Bréfeuf Catholic Secondary School, Hamilton  
1997-2002