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Mental health and help seeking behaviour: Qualitative study

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INTRODUCTION

Mental health is often understood as a concept related to mental disorders. However, mental health can be defined from a more general point of view that also comprises a positive dimension of the concept (World Health Organization, 2003). In this report mental health will be defined as "a state of well-being whereby individuals recognize their abilities, are able to cope with the normal stresses of life, work productively and fruitfully, and make a contribution to their communities." (WHO, 2003, p. 7).

The concept mental health can be applied to the ability of an individual to develop themselves, to deal with the circumstances of life and participate in society by making their own contribution to it (WHO, 2013). Additionally, mental health is an important concept included in the definition of health presented by the World Health Organization (2014) as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Mental illness refers to all mental disorders that can be diagnosed and "feature abnormalities in cognition, emotion or mood, and the highest integrative aspects of human behavior, such as social interactions" (U.S. Department of Health and Human Services, 2001, p. 6). Mental health and mental illness can be understood as two linked concepts that constitute two sides of a spectrum. All conditions in between mental health and mental illness can be defined as mental health problems and will compose the scope of this study.

During the 1990s the physical and mental health of students in Europe and the Unites States were an emergent subject of research (Kolbe, 1993; Nauta *et al.*, 1996; Symons *et al.*, 1997). Findings suggest that students suffer from more health-related complaints than their non-studying peers (Nauta *et al.*, 1996). These results are in conflict with the common knowledge that young and educated people would benefit from a significantly better health status compared to non-studying peers (Boot *et al.*, 2007). Likewise, findings of previous research on documented treatment records in the Netherlands has shown that the amount of students visiting a doctor with psychosomatic complaints was smaller than the amount of non-studying peers reporting psychosomatic complaints (Meijman, 1988). However, the evidence is growing for the relatively

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poor health status of students compared to non-studying young adults of the same age (Boot *et al.*, 2007; Stewart-Brown *et al.*, 2000; Vaez *et al.*, 2004). Boot (2007) and Nauta *et al.* (1996) reported more surprising findings such as the association between physical complaints and mental health problems and the impact of health related problems on study progress. Many recent studies show similar results suggesting that mental health problems among students relate to study progress, since students feel limited in their daily activities and experience feelings of stress that cause their study results to decline (Boot *et al.*, 2007; Pritchard and Wilson, 2003; Stewart-Brown *et al.*, 2000).

A key problem is that the negative effect of those unsolved problems on study progress might result in a vicious circle, in which mental health complaints and stress related to study delay reinforce each other. On top of that, students with mental health problems might be unable to finish their education at university. In the Netherlands this is also a concern for the universities, as the Dutch government has aimed to increase the completion rates and reduce the number of long-term students for many years (Nauta *et al.*, 1996; TeWinkel and Juist, 2012).

Help-seeking behaviour has been studied in the population for years. During the 1970s healthcare utilisation has been explained with conventional models, such as the Health Belief Model and the Theory of Reasoned Action (Becker, 1974). These psychological models suggested that the pathway to employing professional help is an individual process that describes the evaluating steps that people take from the start of their illness towards the moment they seek help. However, these models could not explain the low patient compliance. Sociologists tried to describe influences from the environment of the individual to explain care seeking behaviour, such as culture, interaction with family and friends, access and costs of healthcare (Andersen, 1995; Chrisman, 1977; Garro, 1988; Zola, 1973). In the twenty-first century it became clear that research to non-help-seeking behaviour was scarce and sociological and physiological studies were insufficient to clarify the resistance towards seeking professional help.

MacKian *et al.* (2004) suggested that help-seeking behaviour might be a more complex process that could not be explained by looking at disturbing factors in the pathway to care utilisation. Nowadays, research on help-seeking behaviour is focussed on the influences of social perspectives on the use of professional care. In addition to the influence from friends and family, society and governmental policy contribute to help-seeking behaviour. In the following paragraphs the common views on help-seeking behaviour will be described by explaining the theory derived from recent studies. To provide a complete overview of the theory on help-seeking, this section will describe the theories on help-seeking behaviour developed by Dutch researchers and researchers from other Western countries.

Verouden *et al.* (2010) investigated help-seeking behaviour in Dutch university students by conducting 27 in-depth interviews with students who reported anxiety, high stress levels, fatigue and eating or sleeping problems. Besides mental health problems, the students included in the study reported long periods of non-help-seeking or reported no help seeking at all. Seeking help was defined as consulting a general practitioner or other healthcare professional. The results showed four attitudes towards mental health problems and help-seeking that explained non-help-seeking behaviour. The first attitude is characterised by the concealment of study-related stress and emotional problems. This concealing behaviour correlated with the effort of living up to social expectations. Students explained they pretended to be 'normal' by engaging in 'normal' student activities such as parties, student jobs and socialising in the university library. In this way they hoped to live up to the expectations of their family, friends and colleague students. Students characterised by this concealing

attitude were unlikely to seek help for emotional problems. The second attitude that was found to explain the reluctance towards seeking professional help was the development of a new identity. Students expressed the difficulties they encountered in the transition from a safe and familiar environment to a new and unfamiliar environment. Conflicting beliefs and expectations could make them feel lonely and forced them to form a new identity and make new friends. These students that were occupied with finding out whom they felt comfortable with, were unaware of the need to seek professional help for their emotional problems. The third attitude was found in students that suffered from social isolation and distanced themselves from other students in university. They stated that they felt unique in their loneliness and emphasised that they deliberately distanced themselves from the activities most other 'normal' students engaged in. They felt they were different than other students and were unwilling to become acquainted with these other students. Although they did feel depressed and alone, they were reluctant to seek help, because they felt psychologists would break down their identity as a unique person.

Rickwood *et al.* (2005) studied help-seeking for mental health problems in adolescents through an individual approach.

Rickwood described the influence from social perspectives as the interpersonal domain of seeking help. Although, the purpose for seeking help is personal, a person has to rely on others to employ help and therefore a person has to engage in social interactions. Rickwood used the model depicted in Fig. 1, to guide her research on help-seeking behaviour of young people with mental health problems. The model describes the process of help-seeking behaviour starting with the individual that experiences problems. The first step in the process is the point where the individual becomes aware of his problems and realises help is needed. Consequently, the individual has to be able to express his problems to the outside world. Rickwood states that this ability to express emotions and symptoms is independent of the source of help an individual aims to employ, since both informal help and professional help can only be addressed by expressing symptoms and emotions to the outside world. In the next step of the process the individual has to consider the available sources. To be able to employ professional help, an individual needs to be aware of the possible interventions and treatments. Additionally, all possibilities need to be accessible for the help-seeking individual. Lastly, the help-seeker should be willing to disclose his problems to the source of help.

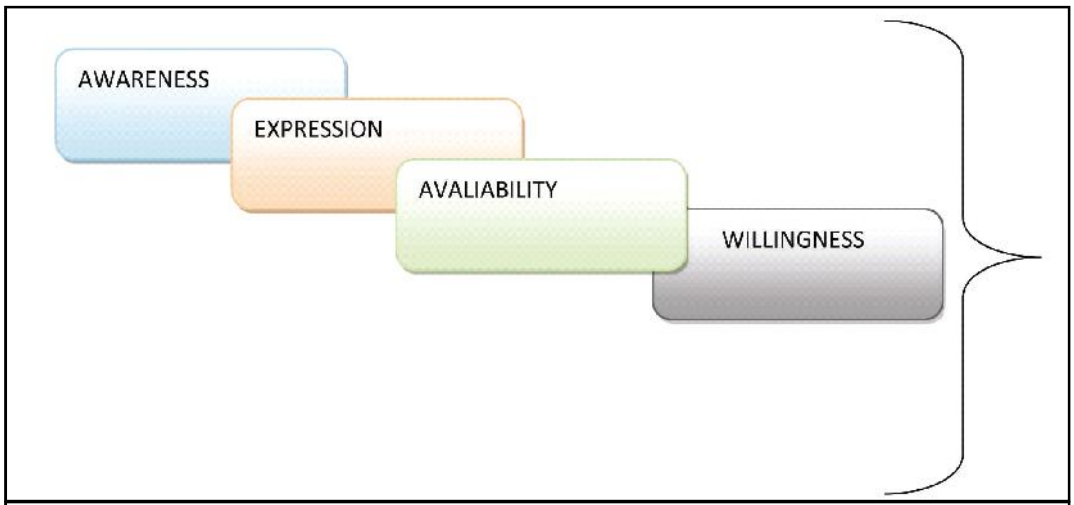

Fig. 1 : Process of help-seeking (Rickwood *et al.*, 2005)

The illness perception of the young adults participating in the study of Biddle and colleagues, demonstrates an undiscovered stigma attached to help-seeking. This undiscovered stigma is based on the assumption that the 'normal' stresses of life should be addressed by coping and require no professional help. Although Biddle and colleagues state in the discussion that "non-help-seekers may then be at risk of further morbidity from 'unhealthy' coping strategies" (p. 999), he concludes with the statement that non-help-seeking can be useful to prevent medicalisation and to prevent helpseeking for "self-remitting and unproblematic" symptoms. This conclusion illustrates the dilemma between help-seeking to prevent dreadful coping mechanisms and non-help-seeking to prevent excessive treatment.

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