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Help-Seeking in Young Adults: Emotion Regulation and Attachment Style as Predictors

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By

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Help-Seeking Among Young Adults: Emotion Regulation and Attachment Style as Predictors

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ABSTRACT

The purpose of the present study was to investigate predictors of both formal and informal help-seeking behaviour in young adults. In particular, the present study sought to examine predictors of help-seeking behaviours using various predictors suggested in the literature (i.e., help-seeking intentions, attachment style, emotion regulation, temperament, and distress disclosure) within the same model. Two hundred and seventeen undergraduate university students, ranging from 17 to 25 years (26 males, 191 females), completed an online survey of questionnaires assessing their attachment style, difficulties in emotion regulation, tendency to self-disclose distress to others, temperament, symptomology, and help-seeking intentions and behaviours from informal (e.g., parents, friend) and formal (e.g., psychologist, social worker) sources. Participants also provided qualitative data regarding their experiences with professional help-seeking, if they had sought help in the past year. Participants ranged in age from 17 to 25 years. A series of multiple regression analyses consistently revealed that greater intentions to seek help from formal and informal sources predicted more help-seeking behaviour. Other factors that emerged as significant predictors of more formal help-seeking behaviours included difficulties with impulse control and self-disclosure of distress to others. Content analyses of the qualitative data revealed consistent findings with the help-seeking literature, and the current study. Findings shed light on applied implications for initiatives aimed to engage young adults in help-seeking behaviours, showing that increasing intentions to seek help even by a small amount may begin to engage individuals in help-seeking.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF APPENDICES

CHAPTER 1
INTRODUCTION

1.1 Overview

Although researchers have investigated the associations of attachment styles and emotion regulation on help-seeking intentions and behaviors (e.g. Cheng, McDermott, & Lopez, 2015; Wilson & Deane, 2001; Mikulincer & Shaver, 2007; Romanson, 2018) in samples of emerging adults, to the author's knowledge, no empirical studies have examined the connections between attachment style, emotion regulation, help-seeking intentions, and help-seeking behaviours as a continuous variable in one model.

The Health Belief Model (HBM; Rosenstock, 1974a) serves as an empirically supported model to understand the likelihood an individual will seek help. Since its conception, the HBM has transitioned to use not only in healthcare illnesses and diseases, but in mental health care utilization. By applying the HBM to mental health care utilization, factors have emerged to be considered in predicting help-seeking in young adults, such as, perceived barriers, and social support (O'Connor, Martin, Weeks, & Ong, 2014).

Previous research has been able to use the HBM to predict help-seeking attitudes (e.g. O'Connor et al., 2014; Gulliver, Griffiths, & Christensen, 2010) However, few studies measure help-seeking behaviour as the outcome. It has been found that although help-seeking intentions and behaviours are correlated, they are not the same construct (Nagai, 2015). The current study assessed help seeking behaviours and examined how attachment style, emotion regulation, distress, and help-seeking intentions act as predictors of help-seeking behaviours in young adults. By including both intentions and behaviours of help-seeking, the current study sought to understand the discrepancy between help-seeking intentions and behaviours. The value of research aimed at understanding predictive factors of help-seeking behaviours is that knowledge

gained can be used to develop more effective prevention and intervention strategies for young adults.

Various studies have identified relations between attachment style, emotion regulation, and help-seeking intentions (Karreman & Vingerhoets, 2012; Romanson, 2018). Karreman and Vingerhoets (2012) found that emotion regulation mediated the relationship between attachment style and well-being. Specifically, secure, fearful and dismissing attachment styles were predictive of better well-being by way of emotion regulation, and in contrast preoccupied attachment was found to have a negative effect on well-being by way of a decrease in emotion regulation (Karreman & Vingerhoets, 2012). Romanson (2018) found that, increased avoidant attachment was found to decrease intentions to help-seeking by way of a decrease in emotion regulation (Romanson, 2018). Findings from these previous studies and the HBM model were drawn upon to examine predictors of help-seeking behaviour in young adults.

1.2 Literature Review

1.2.1 Help-seeking and mental health in emerging adulthood. Help seeking for mental health problems is defined as seeking assistance or support from other people when distressed. Sources of support can be informal (e.g., parents, friends), or formal (e.g., psychologists, counsellors, doctors). Help-seeking is understood as a way of coping, using communication with support sources to gain insight into a problem, and information, advice, or treatment for a problem (Rickwood, Deane, Wilson, &Ciarrochi, 2005). Mental health problems are highly prevalent in emerging adults (Kessler & Walters, 1998), as most mental disorders have onsets in adolescence and early adulthood (Boak, Hamilton, Adlaf, Beitchman, Wolfe & Mann, 2014). Despite this prevalence, emerging adults are among the least likely to seek help for their problems (Diaz-Granados, Georgiades, & Boyle, 2010; Rickwood, Deane & Wilson, 2007;

Dubow, Lovko, & Kausch, 1990). Approximately 23% of youth are living with a mental health illness (Mental Health Commission of Canada, 2011). Only 1 in 4 young Canadians with mental health problems seek help (Bergeron, Poirier, Fournier, Roberge & Barrette, 2005). Programs that help people access early treatment can be effective in reducing the current $50 billion per year spent on treatment services in Canada (Smetanin, Stiff, Briante, Adair, Ahmad & Khan, 2011). Help-seeking is seen as an adaptive reaction to stress that often results in greater personal competency and well-being (Menna & Ruck, 2005; Wilson & Deane, 2010), and has been shown to significantly reduce the likelihood of experiencing problems later in life (Harrington, Rutter & Fombonne, 1996; Croll, Neumark-Sztainer, Story & Ireland, 2002).

There are a number of ways that help-seeking attitudes and intentions are conceptualized in the literature. In a recent paper, White, Clough, & Casey (2018) present an overview of seven theoretical perspectives in the literature and mapped them to form a new conceptual framework for help-seeking intentions and attitudes. The authors use the Health Belief Model (HBM) in identifying the key elements of help-seeking intentions (HSI). The key elements of HSI are defined as: (1) conscious planning; (2) perception of effort to be exerted; (3) willingness to communicate; (4) perceptions about the problem; (5) and perceived support, advice or assistance. The HBM aligns with these key elements of HSI in particular to perceptions about the problem that provide insight into how individuals evaluate their situation, and perceptions of support or benefits (White et al., 2018).

1.2.2 The health belief model. The HBM (Rosenstock, 1974a), was developed by social psychologists to better understand why individuals fail to utilise preventative healthcare. The model hypothesizes that the likelihood an individual will engage in a given health-related behaviour is dependent on (1) their perception that they are susceptible to a given health

condition (perceived susceptibility); (2) the belief that their health condition will have serious and negative consequences (perceived severity); (3) the belief that their health behaviour will be effective (perceived benefits); (4) individual perceptions of barriers to health related behaviour (perceived barriers); and (5) incidents that serve as a reminder of the severity or threat of illness (cues to action). The model was originally developed to explain preventative health behaviour, defined as "any activity undertaken by a person who believes himself to be healthy for the purpose of preventing disease or detecting disease in an asymptomatic stage" (Rosenstock, 1974b). The HBM has also been applied to both 'sick-role behaviors' and 'illness behaviors' (Rosenstock, 1974b). Sick-role behavior is defined as activity undertaken for the purpose of getting well after a diagnosis has been made (Becker, 1974). Illness behavior is defined as "any activity undertaken by a person who feels ill, for the purpose of defining the state of his health and discovering suitable remedy" (Rosenstock, 1974b). Of these three forms of health behavior, illness behavior most aligns with mental health help seeking behaviors in young adults experiencing and seeking help for distress. This is related to the definition of help seeking behaviours by: (1) aligning feeling ill with distress; and (2) the state of health and discovering suitable remedy aligns with help seeking behaviours of support and assistance from both formal and informal sources.

In applying the HBM to illness behavior, four factors represent the decision to act given an individual's present symptoms. The key factors include: (1) health motivations brought on by symptom experience; (2) the threat to functioning posed by the symptoms; (3) the benefits or value of actions that would reduce the threat; (4) the barriers and costs of the action (Kirscht, 1974). In their review of conceptualizing mental health care utilization in light of the HBM, Henshaw and Freedman-Doan (2009), emphasize that individual characteristics can impact all

predictors of the HBM but create the most variability in the perception of susceptibility, severity, and health motivations. In the current study, severity was measured by psychological symptom severity (i.e., symptomology).

An implication of individual influences on factors of the HBM is that the HBM is not a *one size fits all* model (Smith, 2009). Specifically, demographic variables such as sex, ethnicity, education, and age have been found to influence individuals' perceptions of their own symptoms (Nykvist, Kjellberg, & Bildt, 2002: Dinges & Cherry, 1995; Coulton & Frost, 1982). For example, in a study that evaluated causal attributions of common somatic symptoms, women were found to attribute their symptoms to psychological explanations whereas men were more likely to not consider the cause of their symptoms as particularly important (Nykvist et al., 2002).

In addition to the original conceptualization of the HBM, Rosenstock, Strecher, and Becker (1988) added a component of Bandura's (1977) social cognitive theory: self-efficacy. In a systematic review of studies of perceived barriers or facilitators to help-seeking in adolescents and young adults it was found, among others, that a preference for self-reliance (or self-efficacy) was an important predictor to help-seeking (Gulliver, Griffiths, & Christensen, 2010). This finding is explained as a preference for self-reliance during difficult times which extends to a preference for self-help as a treatment for mental health difficulties. This finding highlights the need to better understand coping skills, specifically emotion regulation in young adults, as those who are self-reliant may not be effectively regulating their emotions and mood.

The health belief model and help-seeking**.** has been applied to mental health behaviours, specifically, mental health help-seeking in emerging adults. O'Connor, Martin, Weeks and Ong (2014) sought to understand factors that influence emerging adults' help-seeking behaviours. In

their study, 180 emerging adults (ages 17-25 years) completed a survey designed to measure hypothesized predictors and moderators of help-seeking behaviour. Predictors included the five core Health Belief Model (HBM) constructs (severity, susceptibility, benefits, barriers, and health motivation), and four psychosocial variables (self-efficacy, social support, extraversion, and health knowledge). The psychosocial variable of self-efficacy was included based on the finding of Gulliver et al. (2010), that one barrier to help seeking is a preference for self-reliance. The findings indicated that extraversion, perceived benefits of help seeking, fewer perceived barriers to help seeking, and greater social support predicted help-seeking behavior.

The current study sought to expand upon the study by O'Connor et al. (2014) by incorporating other known variables of help-seeking into the model –specifically attachment style and emotion regulation. In addition, the current study took a more behavioural approach to O'Connor et al.'s (2014) study by including help-seeking behaviours instead of intentions as the outcome variable. A limitation of O'Connor et al.'s (2014) study was that they did not account for gender differences in the model. Previous research has found that gender differences in attitudes towards seeking professional help (Leong & Zachar, 1999; Yeh, 2002; Komiya, Good, and Sherrod, 2000), as well as perceived social support and perceived distress level, (Nam et al., 2010) both of which are a part of the HBM. Findings from the previously studies show that compared to males, females report more positive attitudes towards seeking professional help, report more perceived social support and higher distress levels. In fact, in regards to attitudes towards help-seeking specifically, a meta-analysis of attitudes towards help-seeking in young adults, females were found to hold a more positive attitude towards help-seeking than males (Nam et al., 2010).

1.2.3 Help-seeking intentions and behaviours. Help-seeking intentions and behaviours are often used synonymously in research. Help-seeking intentions is more convenient to measure cross-sectionally and in non-clinical populations. While it is intuitive that intentions would precede, and predict behaviours, this has not been found in research. Nagai (2015) aimed to clarify predictors of help seeking behaviors using a longitudinal design. Participants were 370 young adults who completed self-report measures of help seeking behaviours and intentions, social support, depressive symptoms, and subjective needs. Results found that help seeking intentions and help seeking behaviors were significantly correlated, and regression analysis indicate that help seeking intentions was the best predictor of help-seeking behaviors. These results show that the relation between help seeking intentions and behaviors is not necessarily high, suggesting that the measurement of help seeking intentions should not be substituted for assessment of help seeking behaviors. The author emphasizes that future help seeking research must examine variables that have been found to predict help-seeking intentions to confirm they have the same impact on help-seeking behaviours.

In a recent study with 354 young adults, Romanson (2018) identified strong relationships between young adults' intentions to seek help and actual help-seeking behaviours from informal sources and formal sources, respectively. Furthermore, females reported greater intentions to seek help and engaged in more help-seeking behaviours from informal sources than did males. Females also reported engaging in more help-seeking behaviours from formal sources of support for emotional and personal problems compared to males. Help-seeking behavior was assessed as a dichotomous variable that is, whether help seeking occurred or not.

The current study builds on Romanson's findings by assessing help-seeking behaviours as a continuous variable in order to better understand the complex nature of these behaviours. Specifically, the frequency at which one seeks help from others for emotional or mental health problems may be related to one's ability to regulate their emotions, their attachment style, or the satisfaction with the help-sought, among others. Using help-seeking behaviours as the outcome variable, measured as a continuous variable helps research begin to understand the nature of these relationships.

1.2.4 Attachment Style. Attachment theory offers a framework to understanding individual differences in adaptive function (Mikulincer & Shaver, 2007). According to Bowlby (1969/1991), attachment begins in childhood as early relations with caregivers become a prototype for later relationships outside the family. These prototypes or internal working models of relationships take the form of emotional, cognitive, and behavioral systems of predispositions. The attachment system is activated when individuals are distressed, effecting their support or help-seeking behaviours (Bowlby, 1991). Ainsworth (1973) developed a methodology (i.e. the Strange Situation) to empirically test Bowlby's (1969) attachment theory using infants and their parents (Ainsworth, Blehar, Waters, & Wall, 1978). Ainsworth and colleagues (1978) identified attachment patterns to describe the relationship infants had towards their parents: secure, and insecure (specifically, *avoidant*, and *ambivalent* or *resistant)*. An adult's evaluation of their childhood experiences is hypothesized to function as a relatively stable approach to attachment (Main, Kaplan, & Cassidy, 1985).

Attachment styles can be applied to understand the functioning of an individual's attachment system at a relationship-specific or global level (Mikulincer & Shaver, 2007;

Bowlby, 1991). Individuals' internal working model of attachment can be considered secure or insecure in nature (Bowlby, 1991). The securely attached individual views the self as worthy, and perceives others as good and trustworthy and in contrast, the insecurely attached individual acquires a mental representation of the self as unworthy and that others are unreliable or inconsistent in availability and responsiveness when distressed (Ainsworth, 1973). The security of attachment is influenced by the attachment figure's availability, attentiveness, and sensitivity in response to one's needs and distress (Ainsworth, 1973; Bowlby, 1991; Weinfield, Sroufe, Egeland, & Carlson, 2008).

George, Kaplan and Main (1985) introduced the Adult Attachment Interview (AAI) to assess the mental representations of attachment in adults. The AAI is a semi-structured interview that probes for descriptions of past and present relationships, and specific memories. Using the AAI these researchers identified similar attachment classifications to those identified by Ainsworth (1973), secure and insecure (i.e., preoccupied, dismissing and fearful). Bartholomew and Horowitz (1991) were instrumental in providing more efficient methods to assess Bowlby's (1969/1991) attachment theory with adults by means of a self-report measure.

Bartholomew and Horowitz (1991), expanded upon previous works to create a measure of adult attachment by emphasizing two key features of the internal working models of attachment: one's image of the self, and one's image of other people. The model of adult attachment can be conceptualized in terms of one's model of self (dependency) and one's model of others (avoidance) each on orthogonal axes, creating four quadrants, each representing an attachment prototype: (1) *secure* (low dependence, low avoidance; indicating a sense of worthiness and a perception that others are accepting and responsive), (2) *preoccupied* (high dependence, low avoidance; indicating a sense of unworthiness and a positive perception of others leading

individuals to seek acceptance from valued others), (3) *fearful* (high dependence, high avoidance; indicating a sense of unworthiness and perception of others as untrustworthy and rejecting, leading individuals to avoid close involvement with others to protect against anticipated rejection), and (4) *dismissing* (low dependence, high avoidance; indicating a sense of worthiness and a negative perception of others leading to individuals avoiding close interactions in order to maintain independence and invulnerability). Furthermore, individuals with a predominantly fearful attachment style tend to avoid developing close relationships with others, however, they do wish to have close relationships with others. Individual's with fearful attachment avoid developing close relationships with others in order to avoid the rejection they anticipate due to their sense of unworthiness.

1.2.5 ***Attachment style and help-seeking***. Attachment style has been found to be predictive of well-being (Karreman & Vingerhoets, 2012), help seeking intentions (Cheng, McDermott & Lopez, 2015; Romanson, 2018), and has been found to be related to help seeking behaviors. Specifically, Cheng and her colleagues (2015) conducted a study with 300 emerging adults to understand the relations of adult attachment style and help-seeking intentions. Attachment was conceptualized as two orthogonal, continuous dimensions which were attachment avoidance and attachment anxiety. Through structural equation modeling it was revealed that attachment anxiety positively predicted intentions to seek counselling, that is, individuals who were more anxiously attached were more likely to seek help. The current study sought to further understand how attachment style effects help-seeking behaviour by using Bartholomew and Horwitz's (1991) conceptualization of four distinct attachment styles.

Emerging adults' intentions and behaviours of seeking help for their emotional and personal problems can be viewed from the lens of attachment theory. Specifically, the perceived

quality of close, attachment relationships can impact their decisions regarding help-seeking. The relationships individuals developed with their caregivers in infancy and childhood have now been internalized and generalized across relationships outside the family (Bartholomew & Horowitz, 1991). An individual's perception of others as a secure base may influence whether they seek support from others when distressed (Bartholomew & Horowitz, 1991). Specifically, their attachment to a secure base or caregiver may influence how an individual perceives others as a source of help. In a study by Vogel and Wei (2015), findings showed that individuals with higher levels of attachment avoidance (dismissing) were significantly more likely to deny their personal distress and were significantly less likely to seek counselling support. In contrast, individuals with higher levels of attachment anxiety (fearful) were significantly more likely to recognize their personal distress and significantly more likely to seek professional help. In general, emerging adults tend to be more willing and likely to seek help for their problems when their close relationships are characterized as secure (Rickwood, Van Dyke & Telford, 2015; Wilson & Deane, 2001; Mikulincer & Shaver, 2007).

1.2.6 Distress Disclosure. There has been evidence to show that there is a connection between attachment and self-disclosure of distress in emerging adults (e.g., Garrison, Khan, Miller & Sauer, 2014; Garrison, Khan, Sauer & Florczak, 2012). There has also been research indicating that a greater tendency to disclose psychologically distressing information to others predicts greater intentions to seek help from formal sources (Vogel & Wester, 2003). Romanson (2018) was able to examine the role of the tendency to self-disclose distress to others in relation to attachment and help-seeking behaviours and found that distress disclosure had a mediating effect on the relationship. Therefore, in the current study, distress disclosure was conceptualized as a potential control or covariate variable.

1.2.7 Emotion Regulation. Emotion regulation has been conceptualized and defined in a number of ways in the literature (Cole, Martin & Dennis, 2004; Gross, 2007; Koole, 2009). Some researchers use the term in reference to specific domains of regulation (e.g. reappraisal, rumination), whereas some researchers refer to emotion regulation as overall abilities and strategies that influence the experience of emotion, also referred to as affect regulation (Gross, 2007). Generally speaking, emotion regulation refers to "the heterogeneous set of processes by which emotions are themselves regulated" (Gross, 1999, p. 557).

Earlier conceptualizations viewed emotion regulation as a sequential, step-like phenomenon, understood as a two-factor model (Gross, 1998). Gross views emotion regulation as a continuum from explicit and effortful to unconscious and automatic on which processes such as coping, mood regulation, and defenses can be placed. Gross (1999) states that emotion regulation requires the up-regulation or down-regulation of both positive and negative emotions. This process is accomplished by using a variety of strategies that are either 'antecedent-focused' (occurring before an emotional response is fully activated, e.g. reappraisal), or 'response-focused' (occurring immediately after the activation of an emotional response, e.g. suppression; Gross, 2007). In contrast, other researchers view emotion regulation as a one-factor model in which emotion and emotion regulation occur simultaneously (Campos, Frankel & Camras, 2004). Overall, it is understood that it is very difficult to separate emotion and emotion regulation processes, as many researchers have made the argument that emotion is almost always regulated to a varying degree (Gross, 2007; Tomkins, 1984).

Gratz and Roemer (2004) have conceptualized emotion regulation in an attempt to capture the complex nature of the 'heterogeneous set of processes' as stated by Gross (1999). They define emotion regulation as a "multidimensional construct involving the awareness,

understanding, and acceptance of emotions; ability to engage in goal-directed behaviours and inhibit behaviours when experiencing negative emotions; flexible use of situationally appropriate strategies to modulate the intensity or duration of emotional responses, rather than to eliminate emotions entirely; and willingness to experience negative emotions as part of pursuing meaningful activities in life" (Gratz & Tull, 2010, p.111, paraphrased from Gratz & Roemer, 2004). The authors presented this conceptualization with an accompanying questionnaire to measure difficulties with emotion regulation (Difficulties with Emotion Regulation Scale; DERS), and view deficits in any or all of these areas as an indicator of difficulties with emotion regulation.

The importance of understanding emotion regulation has been supported by many researchers such as Cole, Martin, and Dennis (2004) who argue that emotion regulation offers insight into how emotions can impact individuals. Individual differences in emotion regulation can impact direct attention and behaviours to achieve purposeful goals, problem solving, and the maintenance of well-being, on the other hand it may cloud judgement and reasoning, impair relationships, and lead to other harmful behaviours (Cole, Martin & Dennis, 2004). Difficulties with emotion regulation have been associated with a number of negative outcomes such as, self-harm (e.g. Buckholdt, Parra & Jobe-Shields, 2009, Gratz & Roemer, 2008), binge eating (e.g., Whiteside et al., 2007), substance abuse (e.g., Fox, Axelrod, Paliwal, Sleeper & Sinha, 2007; Kun & Demetrovics, 2010), symptoms of depression and anxiety (e.g., Cisler, Olatunji, Feldner, & Forsyth, 2010; Gross & John, 2003; Tull, Stipelman, Salters-Pedneault & Gratz, 2009), and borderline personality disorder (e.g., Gratz, Rosenthal, Tull, Lejuez & Gunderson, 2006), among others. These negative mental health outcomes make studying emotion regulation in conjunction

with help-seeking behaviours important, thus the current study will consider them within the same model.

1.2.8 ***Emotion regulation and attachment style***. Emotion regulation can be understood in the context of attachment theory (Mikulincer, Shaver & Pereg, 2003). Similar to attachment styles, most individuals develop a consistent style of emotion regulation despite fluctuations of strategies used across different situations and contexts (Bridges, Denham & Ganiban, 2004). It has been found that attachment patterns impact emotion regulation, and that the differences in attachment patterns correspond with differences in emotion regulation (Cassidy, 1994; Weinfield, Sroufe, Egeland & Carlson, 2008).

Mikulincer and Shaver (2007) write that securely attached individuals employ adaptive strategies to emotion regulation when distressed such as cognitive reappraisal. Securely attached individuals are more likely to have developed self-soothing emotion regulation strategies by observing and learning from their attachment figures (Mikulincer & Shaver, 2007). Securely attached individuals are able to remain open to and attend to their distress without fear of losing control or becoming overwhelmed (Mikulincer & Shaver, 2007), which are aspects of Gratz and Roemer's (2004) conceptualization of emotion regulation.

Individuals with avoidant attachment styles tend to inhibit or suppress distressing emotions, as such emotions (e.g. fear, anxiety, sadness) can be interpreted as a threat to their sense of strength and independence (Mikulincer & Shaver, 2007). Their tendency to supress distressing emotions also inhibits avoidant individuals' ability to problem solve or reappraisal, because these emotion regulation strategies require individuals to recognize and acknowledge their emotions (Mikulincer & Shaver, 2007).

Incongruent to avoidant and securely attached individuals who view distressing emotions as states that should be managed or suppressed, anxiously attached individuals perceive these emotions as congruent with their attachment goals (Mikulincer & Shaver, 2007). Anxiously attached individuals tend to intensify emotions that emphasize vulnerability and neediness (e.g. fear, anxiety, sadness) in order to get attachment figures to pay attention and provide an unfulfilled wish for reliable protection (Mikulincer & Shaver, 2007). This hyperactivation of distressing emotions renders problem solving irrelevant; in fact, problem solving is incongruent with the anxiously attached individual's self-construal of being helpless (Mikulincer & Shaver, 2007). Overall, in understanding the differences among attachment style and emotion regulation, insecure attachment styles lead to opposite patterns of emotion regulation (i.e. hyperactivation and suppression) both of which are dysfunctional.

1.2.9 Temperament. Temperament is defined as the underlying mechanism for the development of personal differences about oneself (Rothbart, 2007). These differences include an individual's cognitions about the self, their values, behaviours, and coping strategies (Rothbart, 2007). Temperamental differences among individuals may therefore impact their perception of an event or problem, including the emotional reactivity and subsequent response from others. Rothbart's model is composed of four main factors: Negative Affect (i.e., sadness, fear, discomfort and frustration); Extraversion/Surgency (i.e., sociability, positive affect, and high intensity pleasure); orienting sensitivity (i.e., affective sensitivity, and neural sensitivity); and Effortful Control (i.e., attentional control, inhibitory control, and activation control; Rothbart, Ahadi, Hershey & Fisher, 2000). The present study employed Rothbart's model of temperament, with a particular focus on negative affect.

Negative Affectivity has been found to predict both externalizing and internalizing problems, particularly when there are interactions with adverse factors present (Bates, 2001; Maziade, 1989; Sanson, Oberklaid, Pedlow & Prior, 1991). Specifically, Negative Affectivity has been shown to predict the severity of maladaptation (Oldehinkel, Hartman, de Winter, Veenstra & Ormel, 2004). Confirming that individuals with higher Negative Affect may exacerbate their negative disposition and associated internalizing and externalizing problems through dysfunctional patterns of interaction (Sameroff & Chandler, 1975). There is a need to consider emotion regulation when understanding the role of temperament (Derryberry & Rothbart, 1988), given that self-regulation has been found to be driven by affect (Rothbart, Ahadi & Evans, 2000). Temperament is described as the mechanism for the development of personality that begins in infancy (Rothbart, Ahadi & Evans, 2000), and associations between negative affectivity and anxious attachment styles has been determined (MacDonals, Berlow & Thomas, 2013). These patterns of temperamental differences may include difficulties with attachment or emotion regulation which affect the way we interact with others and perceive our environment. Therefore, in the current study, negative affectivity was controlled for in models including attachment and emotion regulation as predictors of help seeking behaviours.

1.2.10 Attachment style, emotion regulation, and help-seeking. Several studies have confirmed a predictive link between attachment security and self-reported support seeking as a means of regulating emotion (Mikulincer & Shaver, 2007, p. 196). Specifically, studies have shown that securely attached adults are more likely to benefit from supportive interactions when coping with stress. For example, in a study by Mikulincer & Florian (1997), after a distressing event followed by a supportive conversation (emotional and instrumental), securely attached individuals restored emotional equanimity. Insecurely attached individuals failed to improve

their affective state following the supportive conversations; specifically, emotionally supportive conversation worsened avoidant individuals' reactions, and instrumental conversation worsened anxious individuals' reactions. Overall, research has found that attachment style can play a role in fostering help-seeking attitudes and behaviors or can inhibit or interfere with effective help-seeking strategies. Specifically, avoidant attachment styles react to distress by activating the attachment system; however, their associated emotion regulation strategies inhibit help-seeking behaviours (Mikulincer & Shaver, 2007, p. 199). Distressed anxiously attached individuals activate worries and doubts about rejection and abandonment, which disorganizes and inhibits direct requests for help (Mikulincer & Shaver, 2007, p. 199).

In a recent study, Romanson (2018) found that higher levels of attachment avoidance predicted lower online help-seeking intentions and behaviours by way of greater difficulties in emotion regulation. Additionally, difficulties in emotion regulation alone did not account for the indirect effect of attachment style on intentions and behaviours to seek-help from informal and formal sources. These findings indicate that the relationship between attachment and help-seeking intentions and behaviours is complex. The current study aimed to expand upon the findings of Romanson (2018) by: (1) measuring help-seeking behaviour using a continuous variable; (2) using the HBM to inform a more inclusive model of help-seeking; (3) controlling for individual differences (i.e. negative affectivity, distress disclosure, gender, previous counselling); and (4) collecting qualitative data to better understand individual experiences with help-seeking.

1.3 Current Study

1.3.1 Research objectives and hypotheses. The purpose of the present study was to better understand predictors of help-seeking behaviours. In addition, the study sought to understand help seeking behaviours beyond whether or not they occurred. Based on the relationships among study variables found in the literature reviewed above (i.e. Karreman & Vingerhoets, 2012; Romanson, 2018; O'Conner et al., 2014), the following research objectives and hypotheses were proposed.

Objective 1: Examine the relation between help-seeking intentions and help-seeking behaviors

Hypothesis 1. It was hypothesized that higher levels of reported help-seeking intentions would be associated with more help-seeking behaviour.

Objective 2: Explore predictors of help-seeking behaviors

Hypothesis 2. It was hypothesized that, severity of psychological symptoms, distress disclosure, attachment style, emotion regulation, and help-seeking intentions would all significantly predict help-seeking behaviors.

Objective 3: Explore the themes of reported help-seeking experiences

In order to better understand individuals' help-seeking behaviours, participants provided qualitative information regarding their experiences with professional help-seeking. Participants were asked to complete questions regarding the service providers they sought help from, the reasons for seeking help, and experiences with professional help-seeking.

CHAPTER 2

METHOD

2.1 Participants

Participants were 217 undergraduate university students who were enrolled at a university in a midsized city in southwestern Ontario, Canada. Participants ranged in age from 17 to 25 years old (M = 20.21, SD = 1.64). The sample consisted of 191 females (M_{age} = 20.21 years, SD = 1.60), and 26 males (M_{age} = 20.20 years, SD = 1.96). Most participants identified as Caucasian (71.3%; n = 154), followed by Arab (7.3%; n = 16), South Asian (5%; n = 11), Mixed/Biracial (3.7%; n = 8), African (2.3%; n = 5), Filipino (2.3%; n = 5), Chinese (1.8%; n = 4), Caribbean (1.4%; n = 3), Southeast Asian 1.4%; n = 3), and Latin American (0.9%; n = 2). An additional 6 participants identified their ethnicity as Other (2.7%). Regarding annual family income, for the majority of participants, the median of annual family income was approximately $91,000 to $100,000. Demographic information and mental health service use of the entire sample are presented in Table 1.

Over half of the participants endorsed being single. Over one third of the participants reported they were in a relationship but not living together. With regard to mental health service use, just over 10% of participants reported that they were currently receiving services from various sources including on campus counsellor, social worker, psychologist, psychiatrist, medical doctor and other. In addition, 43.5% of participants reported that they had previously received professional mental health services, having sought help from on campus counsellors, social workers, psychologists, psychiatrists, medical doctors and others.

Table 1

Demographic Characteristics of the Sample

	n	%
Annual Family Income		
Under $30,000	11	5
$30,000 to $40,000	11	5
$41,000 to $50,000	15	6.8
$51,000 to $60,000	16	7.3
$61,000 to $70,000	15	6.8
$71,000 to $80,000	16	7.3
$81,000 to $90,000	17	7.8
$91,000 to $100,000	18	8.2
Over $100,000	47	21.5
Uncertain	51	23.3
Living Setting Growing Up		
Suburban (i.e. town)	111	50.7
Urban (i.e. city)	88	40.2
Rural (i.e. country)	18	8.2
Relationship Status		
Single	121	55.3
In a relationship but not living together	80	36.5
In a relationship and living together	11	5
Separated	2	0.9
Other	3	1.4
Currently Receiving Counselling Services		
Yes	23	10.5
No	194	88.6
Current Counselling Services Provider		
Psychologist	9	4.1
Social worker	7	3.2
Psychiatrist	5	2.3
On campus counsellor	3	1.4
Medical Doctor	2	0.9

Other	5	2.3
Previous Counselling Services		
Yes	95	43.5
No	120	54.8
Previous Counselling Service Providers		
Psychologist	49	22.4
Social worker	34	15.5
School counsellor	30	13.7
Psychiatrist	22	10
Medical Doctor	21	9.6
On campus counsellor	15	6.8
Other	4	1.8

2.2 Measures

Demographics. Background information was collected on participants' age, gender, ethnicity, relationship status, income, and living situation. Participants were also asked about current and past use of counselling services.

2.2.1 Help-Seeking Intentions and Behaviour. Participants were administered the *General Help-Seeking Questionnaire – Modified version* (Romanson, 2018). The measure was used to evaluate participants' help seeking intentions and behaviours from various sources over a 4-week period. Participants were asked to rate the likelihood of seeking help for a personal or emotional problem from a list of sources over the next 4 weeks. These 15 items were rated on a 7-point Likert scale from 1 (*extremely unlikely*) to 7 (*extremely likely*). Next, participants were asked to indicate how often they sought help for a personal or emotional problem from each respective source in the past 4 weeks. These items were rated on a 6-point Likert scale from 1 (*never*) to 6 (*very often)*.

Romanson (2018) modified the General Help Seeking Questionnaire (Wilson, Deane, Ciarrochi, & Rickwood, 2005; Rickwood, 2007) by including additional sources of help, by adapting items assessing help-seeking intentions to measure actual help-seeking behaviours, and by including an item to assess the helpfulness of previous help sought. The sources of support listed were: mother, father, sibling, grandparent, other relative (e.g. cousin, aunt, uncle), male friend, female friend, romantic partner, course instructor/GA/TA, on campus counselling/peer support services, medical doctor, mental health professional (e.g. psychologist, social worker, counsellor, psychiatrist), religious/spiritual leader (e.g. priest, rabbi, minister, imam, elder, etc.), and anonymous internet group. The following sources of help were classified as informal sources

of support: mother, father, sibling, grandparent, other relative, male friend, female friend, and romantic partner. The following sources of help were classified as formal sources of support: course instructor/GA/TA, on campus counselling/peer support services, medical doctor, mental health professional, and religious/spiritual leader.

For the present study, Romanson's (2018) measure was modified to measure help-seeking behaviours on a Likert scale 1 (*never*) to 6 (*very often)* instead of a dichotomous (Yes/No) response. For intentions, mean scores were calculated for intentions to seek help from informal sources and formal sources, with higher scores indicating greater intentions to seek help. For behaviors, mean scores were created for how often help was sought from both informal and formal sources, with higher scores indicating more often help seeking behaviours.

The modified version of the GHSQ (Romanson, 2018) produced adequate reliability with Cronbach's alphas ranging from $\alpha = .81$ for Help-Seeking Intentions with Informal Sources to $\alpha = .84$ for Help-Seeking Intentions with Formal Sources. In the current study the Cronbach's alphas were adequate: $\alpha = .75$ for Help-Seeking Intentions from Informal Sources, $\alpha = .80$ for Help-Seeking Intentions from Formal Sources, $\alpha = .80$ for Help-Seeking Behaviours with Informal Sources, and $\alpha = .87$ for Help-Seeking Behaviours with Formal Sources.

2.2.2 Attitudes Towards Mental Health Help Seeking. The Inventory of Attitudes Towards Seeking Mental Health Services (IASMHS; Mackenzie, Knox, Gekoski & Macaulay, 2004) was administered to participants to evaluate their attitudes towards seeking mental health services. The IASMHS was created as an adaptation and extension of the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970). The IASMHS assessed overall attitudes and subscales associated with help-seeking attitudes and behavior. The three subscales are *Psychological Openness* (i.e., the extent to which participants

were open to acknowledging psychological problems and the possibility of seeking professional help for them), *Help-Seeking Propensity* (i.e., the extent to which participants believed they were willing and able to seeking professional help), and *Indifference to Stigma* (i.e., the extent to which participants were concerned about what others close to them might think if they found out that the participant was seeking professional help). The measure consists of 24-items scored on a 5-point Likert scale from 0 (*disagree*) to 4 (*agree*). Sample items include "People with strong characters can get over psychological problems by themselves and would have little need for professional help" and "I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems". For the current study, the IASMHS was used to create both a total score and subscale scores with higher scores indicating more positive attitudes towards seeking mental health services (Mackenzie et al., 2004).

The IASMHS has been shown to have good psychometric properties in samples of young people and adults. With internal reliability ranging from .74 to .87, and acceptable model fit for the three-factor solution (*RMSEA* ranging from .040 to .043; *CFI* of .86; Hyland et al., 2015; Mackenzie et al., 2004). In the present study, the IASMHS was found to have adequate reliability: $\alpha = .87$ for the Total scale, $\alpha = .72$ for the Openness subscale, $\alpha = .75$ for the Propensity subscale, and $\alpha = .83$ for the Stigma subscale.

2.2.3 Attachment style. Participants were administered the Relationships Questionnaire (RQ; Bartholomew & Horowitz, 1991), which is a self-report measure to assess adult attachment styles in close relationships. The RQ prompted the participants to indicate which of the four attachment styles (i.e., secure, fearful, preoccupied, and dismissing) best describes them. Then, participants were asked to indicate how well each attachment style fits their relationship style using a 7-point Likert scale from 1 (*disagree strongly*) to 7 (*agree strongly*). Overall, the RQ has

proven to be reliable and valid measures of attachment styles in young adults with moderate to high test–retest reliability and stability over an 8-month period, ranging from r = 0.72 to 0.85 (Schafer & Bartholomew, 1994).

In the current study, 39.3% of participants endorsed a fearful attachment style (*n* = 83), 36.5% of participants endorsed a secure attachment style (*n* = 77), 12.8% of participants endorsed a dismissing attachment style (*n* = 27), and 11.4% of participants endorsed a preoccupied attachment style (*n* = 24). This distribution is in line with previous research using the RQ (e.g., Bartholomew & Horowitz, 1991; Kapeleris & Paivio, 2011).

Relationship Style Questionnaire. Participants also completed a 30-item questionnaire used to assess attachment style (RSQ; Griffin & Bartholomew, 1994b). Participants were asked to indicate the level to which they identify with statements regarding relationship style on a 5-point Likert scale from 1 (*not at all like me*) to 5 (*very much like me*). Scores for each of the four attachment styles were created by calculating the mean of items representing each attachment style prototype. In a review of multiple measures of attachment style, Ravitz, Maunder, Hunter, Sthankiya, & Lancee (2010) found the RSQ to have adequate reliability with Cronbach's alphas ranging from .75 to .86, and good validity (Fortuna & Roisman, 2008; Scarfe & Bartholomew, 1994; Bäackström & Holmes, 2001). It should be noted that while the RQ and RSQ have been shown to have consistent construct validity, the RSQ has been shown to be more reliable (Bäackström & Holmes, 2001). In the present study, internal reliability was found to be $\alpha = .79$ for the whole questionnaire, $\alpha = .57$ for the Secure Attachment subscale, $\alpha = .76$ for the Fearful Attachment subscale, $\alpha = .35$ for the Preoccupied Attachment subscale, and $\alpha = .59$ for the Dismissing Attachment subscale. These reliability statistics are in line with previous research using the RSQ (Ognibene & Collins, 1998; Griffin & Bartholomew, 1994b), and represent the

orthogonal dimensions of the attachment styles. However, as expected the RQ attachment style ratings were all statistically significantly correlated with their corresponding RSQ subscales, ranging from .29 to .56.

2.2.4 Emotion Regulation. Participants were administered the Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004), a 36 item self-report questionnaire, to measure difficulties in emotion regulation. Participants were asked to indicate the frequency in which items apply to themselves on a 5-point Likert scale form 1 (*almost never*) to 5 (*almost always*). The DERS is comprised of six subscales: *Non-Acceptance of Emotional Responses* composed of items reflecting the tendency to react to emotional distress negatively or unaccepting (e.g., "When I'm upset, I become angry with myself for feeling that way"); *Difficulty Engaging in Goal-Directed Behavior* composed of items reflecting difficulties concentrating and completing tasks when experiencing negative emotions (e.g., "When I'm upset, I have difficulty concentrating"); *Impulse Control Difficulties* composed of items reflecting difficulties in controlling behavior when experiencing negative emotions (e.g., "When I'm upset, I feel out of control"); *Lack of Emotional Awareness* composed of items reflecting the tendency to attend and acknowledge emotions (e.g., "When I'm upset, I take time to figure out what I'm really feeling"); *Limited Access to Emotion Regulation Strategies* composed of items reflecting the belief that one has little agency in regulating emotions once upset (e.g., "When I'm upset, I believe I will remain that way for a long time"); and *Lack of Emotional Clarity* composed of items reflecting the extent to which individuals know the emotions they are experiencing (e.g., "I am confused about how I feel"). Higher scores indicate greater difficulties in emotion regulation (Gratz & Roemer, 2004).

The DERS has been shown to have good psychometric properties with young adults (e.g., Han & Pistole, 2014; Giromini, Ales, de Campora, Zennaro, & Pignolo, 2017; Romanson, 2018). The original measure was constructed and tested in two samples (n= 357 and n = 194) of undergraduate students (M_{age} = 23.10 years old and M_{age} = 25.95 years old; Gratz & Roemer, 2004). The study found good internal consistency (Cronbach's alpha ranging from .80 to .89 at the subscale level, and .93 for the entire questionnaire), good test-retest reliability (ρ_I values ranging from .57 to .89 at the subscale level).,

In the present study, the DERS was found to have good reliability: α = .95 for the Total Score, α = .83 for the Lack of Emotional Awareness scale, α = .94 for the Non-Acceptance of Emotional Problems scale, α = .88 for the Difficulty Engaging in Goal-Directed Behavior scale, α = .88 for the Impulse Control Difficulties scale, α = .93 for the Limited Access to Emotion Regulation Strategies scale, and α = .86 for the Lack of Emotional Clarity scale.

2.2.5 Temperament. Participants completed the short form of the Adult Temperament Questionnaire (ATQ; Rothbart et al., 2000). The ATQ is a 77-item self-report questionnaire used to measure temperamental disposition understood as an aspect of personality. Participants were asked to indicate how true/untrue statements are for themselves on a 7-point Likert scale from 1 (*extremely untrue*) to 7 (*extremely true*), with the additional option of "*Not Applicable*." The ATQ is comprised of four general subscales: Effortful Control composed of items reflecting attention and focus (e.g. When interrupted or distracted, I usually can easily shift my attention back to whatever I was doing before); Negative Affect composed of items reflecting negative emotions such as fear and sadness (e.g. Sometimes minor events cause me to feel intense sadness); Extraversion/Surgency composed of items reflecting sociability and positive affect (e.g. I usually like to spend my free time with people); and Orienting Sensitivity composed of

items reflecting sensitivity to external and internal environmental stimuli (e.g. I often notice mild odors and fragrances). Within each general subscale there are sub-scales measuring sub-constructs of temperament. For the current study, the factor of primary interest is negative affect The Negative Affect scale is composed of subscales that measure sadness, fear, and frustration.

The ATQ has been shown to have good psychometric properties in samples of young adults, specifically undergraduate populations. The ATQ short form has shown internal adequate reliability for general scales with Cronbach's Alphas ranging from .78 to .85 (Evans and Rothbart, 2007), and a recent study using the University of Windsor participant pool had adequate internal reliability with Cronbach's Alphas ranging from .72 to .77 (Lafreniere, Menna & Cramer, 2013). In the current study, ATQ subscales of interest were found to have adequate reliability: $\alpha = .79$ for the Negative Affect subscale.

2.2.6 Psychological Symptom Severity. Participants were administered the General Health Questionnaire – 12 Items (GHQ-12) (Goldberg, Williams, & University of London, 1991) to assess the severity of a variety of mental health problems, including symptoms of depression, anxiety, somatic complaints, and social withdrawal. Participants were asked to indicate the extent to which they have experienced various symptoms over the past 4 weeks on a 4-point Likert scale from 0 (*not at all*) to 3 (*much more than usual*). Sample items include "Been able to enjoy your normal day-to-day activities" and "Been able to concentrate on what you're doing". An overall score of psychological symptom severity was computed by summing items with higher scores indicating more severe psychological symptoms.

The GHQ-12 has been used extensively with undergraduate populations and has been shown to have good psychometric properties. This includes high internal consistency (Cronbach's alpha ranging from .85 to .92), acceptable model fit when adapted from the original

GHQ measure (*RMSEA* ranging from .05 to .06; *CFI* ranging from .93 to .98), and adequate predictive and convergent validity when compared with other measures of well-being (r = -.56, p < .001; e.g. Biddle, Gunnell, Sharp, & Donovan, 2004; Gelaye et al., 2015; Montarezi, Harirchi, Shariati, Garmaroudi, Ebadi, & Fateh, 2003; Rey, Abad, Barrada, Garrido, & Ponsoda, 2014; Rickwood & Braithwaite, 1994). In the present study, the GHQ was found to have good reliability (Cronbach's alpha = .88).

2.2.7 Distress Disclosure. Participants completed the Distress Disclosure Index (DDI; Kahn & Hessling, 2001). The DDI is a 12-item self-report measure used to assess young adults' tendency to disclose distressing information about their thoughts, emotions, and personal problems to others. The measure includes items such as "I typically don't discuss things that upset me" (reverse scored). The measure is scored on a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree). A total score was calculated by summing items, with lower scores signifying a greater tendency to disclose psychologically distressing information with others. The measure was developed and is primarily used in samples of undergraduate students (e.g. Garrison, Kahn, Sauer, & Florczak, 2012; Garrison, Khan, Miller, & Sauer, 2014; Kahn, Hucke, Bradley, Glinski, & Malak, 2012; Vogel & Wester, 2003). The DDI has been found to have good psychometric properties, with high internal consistency (Cronbach's alpha of .93), good test-retest reliability (r = .80), and adequate validity (Kahn et al., 2012). In the present study, the DDI was found to have good reliability (Cronbach's alpha of .94).

2.2.8 Experiences with Help-Seeking. Four questions on help-seeking experiences were created for the current study. Participants were asked to report if they had sought professional services for an emotional or mental health problem in the past 12 months (yes or no). If participants had sought help, they were asked who provided the service, the reason for seeking

help, and to give a brief description of their experience. Participants who did seek help were asked to indicate how satisfied they were with the help they received on a 7-point Likert scale from 1 (*very unsatisfied*) to 7 (*very satisfied*), and to indicate how likely they would be to seek help for a similar problem in the future on a 6-point Likert scale from 1 (*not at all likely*) to 6 (*very likely*).

Participants who reported that they had not sought help in the past 12 months were asked if there was a time in the past 12 months that they felt they needed professional help coping with their emotions, or mental health but did not receive it. Those who indicated '*yes*' to needing help in the past year were then asked to endorse potential barriers that may have prevented them from seeking help. Potential barriers were: 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), and other (participants were provided the option to write their response).

2.2.9 Coding of help-seeking questions. Responses to the open-ended questions were coded by conducting a content analysis. First, the principle investigator (PI) read the responses and analysed the responses for content. Based on the content, initial coding schemes were developed (see Table 2, Table 3, and Table 4). The PI then meet with the supervisor to review the initial coding schemes. Revisions to the coding scheme were made based on feedback from the advisor, specifically some codes were combined. The PI then trained two research assistants (RAs) to code the data. RAs and the PI coded the first five participant responses resulting in a

95.2% agreement. Discrepancies in coding were resolved by consensus thus resulting in 100% agreement. The PI coded all of the participant responses. The RAs each coded half of the participant responses resulting in two coders for every response. The inter-rater agreement between the PI and RAs was 100% for service provider, 91.3% for the reasons for seeking help, and 89.7% for the brief description about their help-seeking experience. All coding discrepancies were resolved by consensus among the coders resulting in 100% agreement across codes.

Table 2

Coding Scheme of Mental Health Service Providers (N = 41)

Source
Counsellor/Therapist
Psychologist
Social Worker
Medical Doctor
Psychiatrist
Online Counsellor
Religious Leader

Table 3

Coding Scheme for Reasons for Seeking Mental Health Help

Reason
Depression (e.g., depressed, sad, depressive episodes)
Anxiety (e.g., anxiety, social anxiety disorder, panic attacks)
Management of distress (e.g., help on the next steps to take in order to solve my issue, I wanted advice on the measure measures to take)
Relational conflict (e.g., bad relationship, familial conflict)
Stress/Overwhelmed (e.g., I was dealing with a lot of stress, nothing was working out in my life, many sudden life changes
Trauma (e.g., PTSD, traumatic childhood experiences, sexual assault)
Grief/Loss (e.g., Suffered the loss of a family member)
Eating Disorder
To vent
Borderline Personality Disorder
Suicidal (e.g., I was suicidal, suicidal thoughts)

Table 4

Coding Scheme of Descriptions of Experiences with Professional Help

Code
Helpfulness/Satisfaction (e.g., my experience was mostly rewarding, very helpful; it was a great experience, I found that talking to someone outside of my family and friend group was extremely beneficial)
In session comfort (e.g., understanding and supportive and wanted the best for me, my psychologist's office was a safe space)
New coping strategies/skills (e.g., practical cognitive and behavioural tools I could implement when anxious, learned to cope in a positive way)
Distress reduction (e.g., relieved a lot of stress, functioning at my full capacity again, less anxiety)
Unhelpful/Unsatisfied (e.g., the experience wasn't worth the time and effort, I was very unsatisfied that my GP would not refer me to a psychiatrist)
Medication
Gained Insight (e.g., helped me view events in a different way, opened my eyes about my anxiety and depression)

2.3 Procedure

Following clearance from the institutional Research Ethics Board, students were given access to complete an online survey. Participants were recruited through the undergraduate participant pool. Participants' ages were screened for in the recruitment process. Participants who respond to the screening question "What is your current age?" with 17-25 years were deemed eligible to participate in the current study. Participants then had access to view an online advertisement. Participants were informed that they would receive 1.0 bonus points towards an applicable course of their choosing and that the survey will take approximately one hour to complete. After participants had signed up for the online study they were provided a link to the online survey. Prior to beginning the study, participants were asked to review a Letter of Information and Informed Consent to Participate in Research Form.

After the completion of the online survey, students were provided with contact information for various counselling services offered in the Windsor-Essex community, including the Student Counselling Services at the University of Windsor, in the case that they were currently experiencing psychological distress. All participants were compensated for their participation with course credit using the name they were prompted to provide.

CHAPTER 3

RESULTS

3.1 Missing Data Analysis

Data were collected from a total of $N = 217$ participants. After the data were de-identified, it was examined for missing data. Two-hundred and thirty-six variables were examined for missing data. Items that were presented to only certain participants (e.g. Experiences With Help-Seeking Questionnaire item 5, which was only presented to participants who reported having sought professional help in the past 12 months for their emotional or mental health needs) were not analyzed for missing data. It was observed that 44% of cases ($n = 96$) had at least one missing data point. Cases with more than 5% missing data were removed from the dataset. There were six cases removed with missing data, the remaining was $N = 211$. On average, there was .25% of data missing per case. Little's MCAR (1988) suggested that the data were missing at random when assessed all together, $\chi^2(7523) = 3669.293$, $p = 1.000$.

Because there was minimal missing data and data were missing at random, Expectation Maximization was conducted to impute missing values for all the missing data.

3.2 Statistical Assumptions for Planned Analyses

Sample size. Based on an a priori analysis using G*Power 3.1 (Faul, Erdfelder, Buchner, & Lang, 2009), a suggested total sample size was estimated to detect adequate power for multiple regression analyses ($n = 105$). Input parameters in determining adequate sample size were identified as having a desired statistical power of .8 in detecting a medium effect ($f^2 = .13$; Cohen et al., 2003), and a desired significance level of .05 (two-tailed). Input parameters also specified up to eight predictors. Output parameters of the power analysis outlined were: $\lambda^2 = 13.65$, critical $F^2 = 2.30$, and an ideal total sample size of 105. For multiple regression analyses,

a sample size of at least 15 observations per predictor is recommended (Pituch & Stevens, 2016). The sample size of $N = 211$ was sufficient for planned analyses, which include a maximum of eight predictors.

Absence of influential outliers. For the purpose of regression analyses, Tabachnick and Fidell (2013) suggest that univariate outliers be reduced through windsorizing, and multivariate outliers should be deleted. For the current study, variables of interest were examined by calculating *z*-scores, where values greater than 3.29 were considered potential outliers (Tabachnick & Fidell, 2013). One participant was found to be an outlier on the GHQ variable, one outlier was found on the DERS-Impulse Control variable, and four outliers were found on the Help-Seeking Behaviours-Formal variable. As a result, these data points were addressed by windsorizing, which was used to reduce the influence of these outliers and involved modifying these outlier data point scores on these variables to fit within the normal distribution (i.e., one unit greater than the next most extreme score in the distribution; Tabachnick & Fidell, 2013). The *z*-scores of these variables were subsequently re-calculated for the presence of outliers and found to be within the acceptable range. Standardized DFFITS values were inspected to identify multivariate outliers, this was used because the cut-off value is calculated to accommodate the sample size and number of predictors (Jackson, 2017). No influential observations were observed.

Normality. The normality of variables of interest were assessed for the current study. Across the total sample, the Komologorov-Smirnov test suggested that the distributions of Help-Seeking Intentions –Informal, Help-Seeking Behaviours –Informal, and Temperament –Negative Affectivity were significantly different from a normal distribution. Results suggested that skewness and kurtosis statistics for all variables, except for Help-Seeking Behaviours– Formal,

had an absolute value less than two, which suggests that the data were still normally distributed within acceptable limits (Pituch & Stevens, 2016). It was expected that Help-Seeking Behaviours – Formal would not be normally distributed as it is not a common occurrence among the population to seek formal help for mental health problems (i.e. there is usually significantly more people who do not seek help from a formal source than those who do). Additionally, visual inspections of histograms for variables of interest did not appear reasonably different from a normal distribution.

Absence of multicollinearity. To examine multicollinearity, the Tolerance and VIF statistics were examined. Tolerance statistics for all predictor variables were greater than .10, which suggests an absence of multicollinearity. Tolerance statistics ranged from .38 to .79. VIF statistics for all predictor variables was between 1 to 10, which suggests an absence of multicollinearity. VIF statistics ranged from 1.26 to 2.64.

Homoscedasticity of errors and linearity. To evaluate homoscedasticity of errors and linearity, the standardized predicted values of outcome variables were plotted with the standardized residuals. The data were evenly distributed, with the exception of some mild negative skewness in the distributions for the Help-Seeking Behaviours –Formal. Here, a mild funnel shape was observed. Again, this is expected as formal help-seeking is an uncommon behaviour.

Independence of errors. This assumption was tested using the Durbin-Watson statistic. Values less than 1 or greater than 3 indicate concerns, and values approximating 2 represent the ideal Durbin-Watson statistic (Field, 2009). Regarding the present study data, all of the Durbin-Watson values were within values of 1 to 3, and were approaching the value of 2. This suggests

that the assumption of independence of errors had not been violated and a lack of autocorrelation can be assumed.

3.3 Descriptive Statistics

The means, standard deviations, and observed ranges for all study variables are presented in Table 5.

Table 5

Means, Standard Deviations, and Ranges of Study Variables (N=211)

Scale	*M*	*SD*	Range
Distress Disclosure	33.99	10.12	0 – 60
Symptomology	13.33	6.28	0 – 32
Help-Seeking Intentions –Informal	3.28	1.09	.44 – 5.66
Help-Seeking Intentions – Formal	1.93	1.37	0 – 5.60
Help-Seeking Behaviours – Informal	2.06	1.03	0 – 5.00
Help-Seeking Behaviours – Formal	.56	.86	0 – 3.50
Negative Affect	4.19	.68	2.11 – 6.19
Secure Attachment	3.92	.86	1.25 – 6.00
Preoccupied Attachment	2.95	.67	1.50 – 5.00
Fearful Attachment	2.96	.89	1.00 – 5.00
Dismissing Attachment	3.29	.65	1.60 – 5.00
Help-Seeking Attitudes – Total	84.23	12.66	51 – 115
Help-Seeking Attitudes – Openness	27.13	5.42	13 – 40
Help-Seeking Attitudes – Propensity	28.40	5.30	12 – 39
Help-Seeking Attitudes – Stigma	30.82	6.37	10 – 40
Emotion Regulation – Total	89.95	24.74	37 – 149
Emotion Regulation – Non-Acceptance of Emotional Responses	14.50	6.46	6 – 30
Emotion Regulation – Difficulty Engaging in Goal-Directed Behaviour	15.69	4.76	5 – 25
Emotion Regulation – Impulse Control Difficulties	12.79	4.96	6 – 27
Emotion Regulation – Lack of Emotional Awareness	15.51	4.46	6 – 29
Emotion Regulation – Limited Access to Emotion Regulation Strategies	18.99	7.75	8 – 40
Emotion Regulation – Lack of Emotional Clarity	12.41	4.26	5 – 25

Table 6

Correlations among Study Variables (N=211)

	2	3	4	5	6	7	8	9	10	11	12	13
1. Help-Seeking Behaviours – Formal	.49***	.53***	.20**	.18**	-.08	.09	-.09	.21**	-.04	.02	.11	-.09
2. Help-Seeking Behaviours – Informal		.31***	.57**	-.05	-.34**	-.01	.11	-.10	.19**	-.17*	.05	-.24**
3. Help-Seeking Intentions – Formal			.37**	.03	-.10	.02	.10	-.01	-.05	.01	-.02	-.07
4. Help-Seeking Intentions – Informal				-.24**	-.35**	-.34	.22*	-.29**	.28**	-29**	-.11	-.16*
5. Symptomology					.24**	.50**	-.31**	.64**	-.46**	.41**	.31**	.19**
6. Distress Disclosure						.19**	-.45**	.38**	-.42**	.54**	-.14*	.40**
7. Negative Affectivity							-.17*	.59**	-.43**	.36**	.35**	.01
8. Help-Seeking Intentions								-.44**	.27**	-.33**	-.02	-.21**
9. Emotion Regulation									-.52**	.54**	.31**	.19**
10. Secure Attachment										-.63**	-.16*	-.30**
11. Fearful Attachment											.01	.53**
12. Preoccupied Attachment												-.31**
13. Dismissing Attachment												

Note. $*p < .05$. $**p < .01$. $***p < .001$.

3.4 Preliminary Analyses

Pearson correlational analyses were conducted between the study variables (i.e., Help-Seeking Behaviours –Formal, Help-Seeking Behaviours –Informal, Help-Seeking Intentions – Formal, Help-Seeking Intentions –Formal, Symptomology, Distress Disclosure, Negative Affectivity, Help-Seeking Intentions –IASMHS, Emotion Regulation –Total, Secure Attachment, Fearful Attachment, Preoccupied Attachment, and Dismissing Attachment) and demographic variables (i.e., age, gender, family income, and previous counselling) service to identify potential covariates for further analyses. Correlation analyses revealed that age was significantly correlated Help-Seeking Behaviours –Formal ($r = .14$, $p < .05$), such that older age was associated with more formal help-seeking behaviours. Gender was significantly associated with Negative Affectivity ($r = .18$, $p < .01$), such that being a female was related to having higher levels of negative affectivity. Gender was also significantly positively associated with Help-Seeking Intentions (IASMHS; $r = .23$, $p < .01$), such that being female was related to endorsing higher levels of help-seeking intentions. Family income was significantly correlated with Help-Seeking Behaviours –Formal ($r = -.20$, $p = .01$), such that higher income was associated with more help-seeking behaviours. Previous use of counselling services was significantly correlated with Help-Seeking Behaviours –Formal ($r = .14$, $p = .04$), such that having previously used counselling services was associated with more formal help-seeking behaviours. Previous use of counselling services was significantly correlated with Symptomology ($r = -.28$, $p < .001$), such that having previously used counselling services was associated with more symptoms of mental health distress. Previous use of counselling services was significantly correlated with Negative Affectivity ($r = -.31$, $p < .001$), such that having previously used counselling services was associated with more negative affect. Previous use of

counselling services was significantly correlated with Emotion Regulation –Total (r = -.33, p < .001), such that having previously used counselling services was associated with more emotion dysregulation. Previous use of counselling services was significantly correlated with Preoccupied Attachment (r = -.22, p < .01), such that having previously used counselling services was associated with more preoccupied attachment style. Previous use of counselling services was significantly correlated with Dismissing Attachment (r = -.17, p = .02), such that having previously used counselling services was associated with more dismissing attachment style.

Accordingly, *t*-tests were conducted to further explore the significant relationships among study variables and gender and previous use of counselling services. Age was not further explored because the sample recruitment was controlled to only include young adults (17 to 25 years old). Gender differences for these variables are presented in Table 7. Findings revealed that females endorsed significantly higher levels of negative affectivity than did males. Females also reported significantly greater intentions to seek help as measured by the IASMHS, but not the GHSQ –Modified. Differences among study variables by previous use of counselling services are presented in Table 8. Findings revealed that those who had previously used counselling services reported significantly more formal help-seeking behaviours, more symptoms of mental health distress, more negative affect, more emotion dysregulation, more preoccupied attachment style, and more fearful attachment style. As suggested by Tabachnick and Fidell (2013), to avoid over-controlling the data, demographic variables were only entered as covariates into the primary analyses when correlated with both the outcome and predictor variables.

Table 7

Gender Differences in Study Variables

Variable	Males (n = 25)		Females (n = 186)		
	M	*SD*	*M*	*SD*	*t*(209)
Negative Affectivity	3.85	.56	4.23	.68	-3.41**
Help-Seeking Intentions --Total	76.32	12.93	85.29	12.27	-2.26**

Note. *$p < .05$. **$p < .01$. ***$p < .001$.

Table 8

Previous Counselling Differences in Study Variables

Variable	Yes (n = 91)		No (n = 118)		
	M	*SD*	*M*	*SD*	*t*(209)
Help-Seeking Behaviours –Formal	.71	.90	.45	.85	2.12*
Negative Affectivity	4.43	.70	4.00	.61	4.79***
Symptomology	15.33	6.52	11.77	5.69	4.20***
Emotion Regulation –Total	98.90	25.72	82.68	21.49	4.99***
Preoccupied Attachment	3.12	.70	2.82	.59	3.33**
Fearful Attachment	3.12	.85	2.83	.89	2.40*

Note. *$p < .05$. **$p < .01$. ***$p < .001$.

Pearson Correlation analyses were conducted among the study variables (Table 2). Help-Seeking Behaviours –Formal and symptomology were significantly correlated with Help-Seeking Intentions –Formal such that greater intentions to seek formal help and more symptoms of mental health distress were associated with more formal help-seeking behaviours. Help-Seeking Behaviours –Formal were significantly correlated with Emotion Regulation – Total, such that greater emotion dysregulation was associated with more formal help-seeking behaviours.

Help-Seeking Behaviours –Informal were significantly correlated with Help-Seeking Intentions –Informal indicating that greater intentions to seek help from informal sources was associated with more help-seeking from informal sources. Help-Seeking Behaviours –Informal were significantly correlated with Distress Disclosure, suggesting greater tendency to disclose psychologically distressing information with others was associated with more informal help-seeking behaviours. Help-Seeking Behaviours –Informal were significantly correlated with Secure Attachment Style, such that greater secure attachment in close relationships was associated with more informal help-seeking behaviours. Help-Seeking Behaviours –Informal were significantly correlated with Fearful Attachment Style, such that greater fearful attachment in close relationships was associated with less informal help-seeking behaviours. Help-Seeking Behaviours –Informal were significantly correlated with Dismissing Attachment Style, such that greater dismissing attachment in close relationships was associated with less informal help-seeking behaviours.

While unexpected, the Help-Seeking Intentions –Total variable computed from the IASMHS was not significantly correlated with Help-Seeking Behaviours –Formal and Informal

($p > .05$). Further inspection of the correlations among subscales of the IASMHS revealed that Openness to Help-Seeking was significantly correlated with Help-Seeking Behaviours –Formal ($r = -.18$, $p = .01$), and Propensity to Help-Seeking was significantly correlated with Help-Seeking Behaviours –Informal ($r = .14$, $p < .05$).

3.5 Primary Analyses

Objective 1: Examine the relation between help-seeking intentions and help-seeking behaviors

As anticipated in hypothesis 1, higher levels of help-seeking intentions were significantly related to higher levels of help-seeking behaviours (See Table 2). Both formal and informal help- seeking behaviour were significantly related. In keeping with help-seeking research (e.g., Nagai, 2015), participants reported significantly greater intentions to seek help than help-seeking behaviour within the past four weeks, this was true for both informal help seeking behaviours ($t(211) = 29.12$, $p < .001$) and formal help-seeking behaviour ($t(207) = 9.23$, $p < .001$).

Objective 2: Explore predictors of help-seeking behaviors

A multiple regression analysis was conducted to evaluate predictors of Help-Seeking Behaviours –Formal. Study variables that were found to significantly correlate with Help-Seeking Behaviours –Formal were included in the model (i.e., Help-Seeking Intentions – Formal, Emotion Regulation –Total, Symptomology, and Openness to Help-Seeking), and previous use of counselling services was entered as a covariate. The results of the regression indicated that the model explained 31.3% of the variance (Adjusted $R^2 = .313$), and that the model was a significant predictor of Help-Seeking Behaviours –Formal, $F(5, 200) = 19.67$, $p <$

.001 (see Table 9). Help-Seeking Intentions –Formal was found to be the only significant predictor ($\beta = .51$, $p < .001$) of formal help-seeking behaviour.

To further asses the predictors of Help-Seeking Behaviours –Formal, correlations among the subscales of the DERS and Help-Seeking Behaviours –Formal were evaluated. It was found that Help-Seeking Behaviours –Formal were significantly correlated with Non-Acceptance of Emotional Responses, such that a greater tendency to react to emotional distress negatively or unaccepting was associated with more formal help-seeking behaviours. Help-Seeking Behaviours –Formal were significantly correlated with Lack of Emotional Clarity, such that greater difficulties knowing the emotions one is experiencing was associated with more formal help-seeking behaviours. Help-Seeking Behaviours –Formal were significantly correlated with Impulse Control Difficulties, such that greater difficulties concentrating and completing tasks when experiencing negative emotions was associated with more formal help-seeking behaviours. Help-Seeking Behaviours –Formal were significantly correlated with Limited Access to Emotion Regulation Strategies, such that greater belief that one has little agency in regulating emotions once upset was associated with more formal help-seeking behaviours.

A hierarchical multiple regression analysis was performed to evaluate predictors of Help-Seeking Behaviours –Formal. Study variables that were found to significantly correlate with Help-Seeking Behaviours –Formal were included in the model including the subscales of the DERS (i.e., Help-Seeking Intentions –Formal, Symptomology, Openness to Help-Seeking, Non-Acceptance of Emotional Responses, Lack of Emotional Clarity, Impulse Control Difficulties, and Limited Access to Emotion Regulation Strategies), and previous use of counselling services was entered as a covariate. The results of the regression indicated that the model explained 32.2% of the variance (Adjusted $R^2 = .322$), and that the model was a

significant predictor of Help-Seeking Behaviours –Formal, $F(7, 197) = 13.14$, $p < .001$ (see Table 10). Help-Seeking Intentions –Formal and Impulse Control Difficulties were found to be significant predictors of formal help- seeking behaviour ($\beta = .50$, $p < .001$, and $\beta = .04$, $p = .03$).

Table 9

Summary of Multiple Regression Analysis for Help-Seeking Behaviours –Formal

Variables	*B*	*SE B*	β	*F*	Adjusted R^2
				19.67	.313
Step 1					
Previous Counselling	-.09	.11	-.05		
Step 2					
Help-Seeking Intentions –Formal	.33	.04	.51**		
Emotion Regulation –Total	.01	.01	.12		
Symptomology	.01	.01	.05		
Openness to Help-Seeking	-.02	.01	-.09		

Note: B = unstandardized regression coefficient, SE B = standard error of regression coefficient, β = standardized regression coefficient; * $p < .05$, ** $p < .01$

Table 10

Summary of Multiple Regression Analysis for Help-Seeking Behaviours –Formal

Variables	*B*	*SE B*	β	*F*	Adjusted R^2
				13.14	.322
Step 1					
Previous Counselling	-.06	.11	-.03		
Step 2					
Help-Seeking Intentions –Formal	.32	.04	.50**		
Symptomology	.01	.01	.09		
Openness to Help-Seeking	-.02	.01	-.10		
Emotion Regulation –Non-Acceptance of Emotional Responses	-.01	.01	-.07		
Emotion Regulation –Impulse Control Difficulties	.04	.02	.20*		
Emotion Regulation –Limited Access to Emotion Regulation Strategies	.00	.01	-.01		
Emotion Regulation –Lack of Emotional Clarity	.01	.02	.03		

Note: B = unstandardized regression coefficient, SE B = standard error of regression coefficient, β = standardized regression coefficient; * $p < .05$, ** $p < .01$

A hierarchical multiple regression analysis was conducted to evaluate predictors of Help-Seeking Behaviours –Informal. Study variables that were found to significantly correlate with Help-Seeking Behaviours –Informal were included in the model (i.e., Help-Seeking Intentions –Informal, Distress Disclosure, Propensity to Help-Seeking, Secure Attachment, Fearful Attachment, and Dismissing Attachment). The regression was run using the Enter method, with Distress Disclosure in the first step as it has been hypothesized to act as a control variable, and all other predictor variables in the second step. The results of the regression indicated that the model explained 35.7% of the variance (Adjusted $R^2 = .357$), and that the model was a significant predictor of Help-Seeking Behaviours –Informal, $F(6, 204) = 20.43$, $p < .001$ (see Table 11). Significant predictors were Distress Disclosure ($\beta = -.02$, $p = .01$), Help-Seeking Intentions –Informal ($\beta = .50$, $p < .001$), Fearful Attachment ($\beta = -.27$, $p = .01$), and Dismissing Attachment ($\beta = .21$, $p = .03$).

Table 11

Summary of Multiple Regression Analysis for Help-Seeking Behaviours –Informal

Variables	*B*	*SE B*	β	*F*	Adjusted R^2
				20.43	.357
Step 1					
Distress Disclosure	-.02	.01	-.18*		
Step 2					
Help-Seeking Intentions –Informal	.50	.06	.53**		
Propensity to Help-Seeking	-.01	.01	-.04		
Secure Attachment	.05	.09	.04		
Fearful Attachment	.21	.10	.18*		
Dismissing Attachment	-.27	.11	-.17*		

Note: *B* = unstandardized regression coefficient, *SE B* = standard error of regression coefficient, β = standardized regression coefficient; * $p < .05$, ** $p < .01$

Help-Seeking Behaviours by Attachment Style. Attachment styles were significantly correlated with a number of the variables hypothesized to predict Help-Seeking Behaviours. Additionally, as previously discussed, attachment style can have an effect on an individual's help-seeking process. Therefore, additional analyses were performed to evaluate differences among help-seeking behaviour by attachment style as measured by the Relationships Questionnaire (RQ).

Secure Attachment Style. Using only data from participants who indicated on the RQ that Secure Attachment style best described them, Pearson correlations were conducted to assess predictors of Help-Seeking Behaviours. Help-Seeking Behaviours –Formal was significantly correlated with Openness to Help-Seeking measured by the IASMHS (r = -.28, p =.01), Help-Seeking Intentions –Formal (r = .49, p < .001) and Symptomology (r = .33, p = .01). Furthermore, in assessing the subscales of the DERS, Help-Seeking Behaviours –Formal was significantly correlated with Non-Acceptance of Emotional Responses (r = .27, p = .02), Impulse Control Difficulties (r = 33, p = .01), Lack of Emotional Awareness (r = .26, p = .02), Limited Access to Emotion Regulation Strategies (r = .29, p = .01)and Lack of Emotional Clarity variable (r = .31, p = .01).

Help-Seeking Behaviours –Informal was significantly correlated with Help-Seeking Intentions –Informal (r = .47, p < .001), such that greater intentions to seek help from informal sources was associated with more informal help-seeking behaviours. Because this was the only variable significantly related to Help-Seeking Behaviours –Informal, a regression analysis was not evaluated.

A multiple regression analysis was carried out to evaluate predictors of Help-Seeking Behaviours –Formal for secure attachment style. Study variables that were found to significantly correlate with Help-Seeking Behaviours –Formal were included in the model (i.e., Help-Seeking Intentions –Formal, Openness to Help-Seeking, Symptomology, Non-Acceptance of Emotional Responses, Lack of Emotional Clarity, Impulse Control Difficulties, Lack of Emotional Awareness and Limited Access to Emotion Regulation Strategies), with previous use of counselling services entered as a covariate. The results of the regression indicated that the model explained 32.8% of the variance (Adjusted $R^2 = .328$), and that the model was a significant predictor of Help-Seeking Behaviours –Formal, $F(9, 65) = 5.00$, $p < .001$ (see Table 12). Help-Seeking Intentions –Formal was found to be the only significant predictor ($\beta = .45$, $p < .001$) of formal help-seeking.

Table 12

Summary of Multiple Regression Analysis for Help-Seeking Behaviours –Formal for Secure Attachment Style (N = 74)

Variables	*B*	*SE B*	β	*F*	Adjusted R^2
				5.00	.328
Step 1					
Previous Counselling	-.10	.20	-.06		
Step 2					
Help-Seeking Intentions –Formal	.30	.06	.45**		
Symptomology	.03	.02	.16		
Non-Acceptance of Emotional Responses	.01	.03	.02		
Impulse Control Difficulties	.06	.03	.26		
Lack of Emotional Awareness	.04	.02	.19		
Lack of Emotional Clarity	.01	.04	.05		
Limited Access to Emotion Regulation Strategies	-.02	.03	-.13		
Openness to Help-Seeking	-.01	.02	-.04		

Note: B = unstandardized regression coefficient, SE B = standard error of regression coefficient, β = standardized regression coefficient; * $p < .05$, ** $p < .01$

Fearful Attachment Style. Using only data from participants who indicated that Fearful Attachment style best described them, Pearson correlations were evaluated to assess predictors of Help-Seeking Behaviours. Help-Seeking Behaviours –Formal was significantly correlated with Help-Seeking Intentions –Formal ($r = .53$, $p < .001$), Symptomology ($r = 24$, $p = .03$), and Negative Affectivity ($r = .22$, $p < .05$). Help-Seeking Behaviours –Formal was significantly correlated with Impulse Control Difficulties ($r = .24$, $p = .03$), and Limited Access to Emotion Regulation Strategies ($r = .26$, $p = .02$,

Help-Seeking Behaviours –Informal was significantly correlated with Help-Seeking Intentions –Informal ($r = .51$, $p < .001$), Distress Disclosure ($r = -.23$, $p = .04$), and Openness to Help-Seeking ($r = -.22$, $p < .05$).

A multiple regression analysis was carried out to evaluate predictors of Help-Seeking Behaviours –Formal for fearful attachment style. Study variables that were found to significantly correlate with Help-Seeking Behaviours –Formal were included in the model (i.e., Help-Seeking Intentions –Formal, Symptomology, Impulse Control Difficulties, Limited Access to Emotion Regulation Strategies, and Negative Affectivity). The regression was run using the Enter method, with Negative Affectivity and Previous Counselling in the first step as they were hypothesized to act as control variables, and all other predictor variables in the second step. The results of the regression indicated that the model explained 34.1% of the variance (Adjusted $R^2 = .337$), and that the model was a significant predictor of Help-Seeking Behaviours –Formal, $F(6, 75) = 7.85$, $p < .001$ (see Table 13). Help-Seeking Intentions – Formal was found to be the only significant predictors ($\beta = .54$, $p < .001$) for formal help-seeking behaviour.

A multiple regression analysis was performed to assess predictors of Help-Seeking Behaviours –Informal for fearful attachment style. Study variables that were found to significantly correlate with Help-Seeking Behaviours –Informal were included in the model (i.e., Distress Disclosure, Help-Seeking Intentions –Informal, and Openness to Help-Seeking). The regression was run using the Enter method, with Distress Disclosure in the first step as it was hypothesized to act as a control variable, and all other predictor variables in the second step. The results of the regression indicated that the model explained 34.8% of the variance (Adjusted $R^2 = .348$), and that the model was a significant predictor of Help-Seeking Behaviours –Informal, $F(3, 79) = 15.59$, $p < .001$ (see Table 14). All variables in the model were significant predictors of Help-Seeking Behaviours –Informal, specifically Distress Disclosure ($\beta = -.22$, $p = .03$). Help-Seeking Intentions --Informal ($\beta = .49$, $p < .001$), and Openness to Help-Seeking ($\beta = -.32$, $p = .001$).

Table 13

Summary of Multiple Regression Analysis for Help-Seeking Behaviours –Formal for Fearful Attachment Style (N = 81)

Variables	*B*	*SE B*	β	*F*	Adjusted R^2
				7.85	.337
Step 1					
Previous Counselling	-.11	.16	-.07		
Negative Affectivity	-.06	.14	-.05		
Step 2					
Help-Seeking Intentions –Formal	.32	.06	.54**		
Symptomology	.02	.02	.15		
Impulse Control Difficulties	.02	.02	.10		
Limited Access to Emotion Regulation Strategies	.01	.02	.13		

Note: B = unstandardized regression coefficient, SE B = standard error of regression coefficient, β = standardized regression coefficient; * $p < .05$, ** $p < .01$

Table 14

Summary of Multiple Regression Analysis for Help-Seeking Behaviours –Informal for Fearful Attachment Style (N = 82)

Variables	*B*	*SE B*	β	*F*	Adjusted R^2
				15.59	.348
Step 1					
Distress Disclosure	-.02	.01	-.22*		
Step 2					
Help-Seeking Intentions –Informal	.48	.09	.50**		
Openness to Help-Seeking	-.06	.02	-.32**		

Note: B = unstandardized regression coefficient, SE B = standard error of regression coefficient, β = standardized regression coefficient; * $p < .05$, ** $p < .01$

Preoccupied Attachment Style. Using only data from participants who indicated that Preoccupied Attachment style best described them, Pearson correlations were evaluated to assess predictors of Help-Seeking Behaviours. Help-Seeking Behaviours –Formal was significantly correlated with Help-Seeking Intentions –Formal ($r = .52$, $p < .01$). Help-Seeking Behaviours –Informal was significantly correlated with Help-Seeking Intentions –Informal ($r = .69$, $p < .001$). Because no other variables were significantly related to Help-Seeking Behaviours, regression analyses were not evaluated.

Dismissing Attachment Style. Using only data from participants who indicated that Dismissing Attachment style best described them, Pearson correlations were evaluated to assess predictors of Help-Seeking Behaviours. Help-Seeking Behaviours –Formal was significantly correlated with Distress Disclosure ($r = -.40$, $p = .04$), and Help-Seeking Intentions –Formal ($r = .68$, $p < .001$).Help-Seeking Behaviours –Informal was significantly correlated with Distress Disclosure ($r = -.45$, $p = .02$), Help-Seeking Intentions –Informal ($r = .66$, $p < .001$ and Lack of Access to Emotion Regulation Strategies ($r = -.49$, $p = .01$).

A multiple regression analysis was carried out to evaluate predictors of Help-Seeking Behaviours –Formal for dismissing attached individuals. Study variables that were found to significantly correlate with Help-Seeking Behaviours –Formal were included in the model (i.e., Distress Disclosure and Help-Seeking Intentions –Formal). The regression was run using the Enter method, with Distress Disclosure in the first step as it was hypothesized to act as a control variable, and the other predictor variable in the second step. The results of the regression indicated that the model explained 44.9% of the variance (Adjusted $R^2 = .449$), and that the model was a significant predictor of Help-Seeking Behaviours –Formal, $F(2, 22) =$

10.77, $p = .001$ (see Table 15). Help-Seeking Intentions –Formal was found to be the only significant predictor ($\beta = .61$, $p = .001$).

A multiple regression analysis was carried out to evaluate predictors of Help-Seeking Behaviours –Informal for dismissing attached individuals. Study variables that were found to significantly correlate with Help-Seeking Behaviours –Informal were included in the model (i.e., Distress Disclosure, Help-Seeking Intentions –Informal, and Lack of Access to Emotion Regulation Strategies). The regression was run using the Enter method, with Distress Disclosure in the first step as it was hypothesized to act as a control variable, and all other predictor variables in the second step. The results of the regression indicated that the model explained 42.1% of the variance (Adjusted $R^2 = .421$), and that the model was a significant predictor of Help-Seeking Behaviours –Informal, $F(3, 23) = 7.29$, $p = .001$ (see Table 16). Help-Seeking Intentions –Informal was found to be the only significant predictor ($\beta = .50$, $p = .02$).

Table 15

Summary of Multiple Regression Analysis for Help-Seeking Behaviours –Formal for Dismissing Attachment Style (N = 24)

Variables	*B*	*SE B*	β	*F*	Adjusted R^2
				10.77	.449
Step 1					
Distress Disclosure	-.02	.01	-.20		
Step 2					
Help-Seeking Intentions –Formal	.37	.10	.61**		

Note: B = unstandardized regression coefficient, SE B = standard error of regression coefficient, β = standardized regression coefficient; * $p < .05$, ** $p < .01$

Table 16

Summary of Multiple Regression Analysis for Help-Seeking Behaviours –Informal for Dismissing Attachment Style (N = 26)

Variables	*B*	*SE B*	β	*F*	Adjusted R^2
				7.29	.421
Step 1					
Distress Disclosure	-.03	.02	-.24		
Step 2					
Help-Seeking Intentions –Informal	.53	.22	.50*		
Limited Access to Emotion Regulation Strategies	-.02	.03	-.10		

Note: B = unstandardized regression coefficient, SE B = standard error of regression coefficient, β = standardized regression coefficient; * $p < .05$, ** $p < .01$

Objective 3: Explore participants' help-seeking experiences

Approximately 19 (n = 41) percent of participants responded that they had sought professional help for an emotional or mental health problem in the past 12 months. Reported sources included Counsellor/Therapist, Psychologist, Social Worker, Medical Doctor, Psychiatrist, and Religious Leader. Frequencies of responses can be found in Table 17.

Reported reasons for seeking help and associated frequencies can be found in Table 18. Reasons included: Depression (e.g.., depressed, sad, depressive episodes); Feeling Anxious (e.g., anxiety, social anxiety disorder, panic attacks); Management of distress (e.g., help on the next steps to take in order to solve my issue, I wanted advice on the measures to take); Relational conflict (e.g., bad relationship, familial conflict); Feeling Stress/Overwhelmed (e.g., I was dealing with a lot of stress, nothing was working out in my life, many sudden life changes; Trauma (e.g., PTSD, traumatic childhood experiences, sexual assault); Grief/Loss; Eating Disorder; To vent; Borderline Personality Disorder; and Suicidal thoughts (e.g., I was suicidal, suicidal thoughts).

Table 17

Frequencies of Mental Health Service Providers (N = 41)

Source	Frequency (Percent)
Counsellor/Therapist	14 (34.1)
Psychologist	10 (24.4)
Social Worker	9 (22.0)
Medical Doctor	9 (22.0)
Psychiatrist	5 (12.2)
Online Counsellor	2 (4.9)
Religious Leader	1 (2.4)

Note: Participants reporting multiple providers were coded multiple times.

Reported descriptions of experiences with help-seeking and associated frequencies can be found in Table 19. Descriptions included: Helpfulness/Satisfaction (e.g., my experience was mostly rewarding, very helpful, I found that talking to someone outside of my family and friend group was extremely beneficial); In session comfort (e.g., understanding and supportive and wanted the best for me, my psychologist's office was a safe space); New coping strategies/skills (e.g., practical cognitive and behavioural tools I could implement when anxious, learned to cope in a positive way); Distress reduction (e.g., relieved a lot of stress, functioning at my full capacity again, less anxiety); Unhelpful/Dissatisfied (e.g., the experience wasn't worth the time and effort, I was very unsatisfied that my GP would not refer me to a psychiatrist); Medication; and Gained Insight (e.g., helped me view events in a different way, opened my eyes about my anxiety and depression).

Additionally, participants provided quantitative data regarding their satisfaction with the help sought ($M = 5.44$, $SD = 1.64$, range = 1 – 7), and how likely they would be to seek professional help again for a similar problem ($M = 4.73$, $SD = 1.69$, range = 1 – 6). Satisfaction and future help-seeking were statistically significantly correlated ($r = .69$, $p < .001$), such that greater satisfaction with previous help was associated with higher intentions to seek help for a similar problem in the future.

Sixty participants (27.6%) reported that they had not sought professional help in the past 12 months and that they felt they should have at some point. Participants identified a number of barriers ($M = 4.32$, $SD = 2.11$, range = 1 – 11) that may have prevented them from seeking the help they needed. (see Table 20). The total number of barriers to help-seeking reported was analysed using Pearson correlations to evaluate the relationships between barriers reported and

attachment style. Total barriers to help-seeking reported was significantly correlated with Secure Attachment (r = -.26, p < .05), such that more secure attachment was associated with fewer reported barriers to help-seeking. Total barriers to help-seeking was significantly correlated with Preoccupied Attachment (r = .26, p < .05), such that more preoccupied attachment was associated with greater barriers to help-seeking. Fearful and Dismissing Attachment were not significantly correlated with barriers to help-seeking.

Table 18

Frequencies of Reasons for Seeking Mental Health Help

Reason	Frequency	Percent
Depression (e.g., depressed, sad, depressive episodes)	15	36.6
Feeling anxious (e.g., anxiety, social anxiety disorder, panic attacks)	14	34.1
Management of distress (e.g., help on the next steps to take in order to solve my issue, I wanted advice on the measures to take)	13	31.7
Relational conflict (e.g., bad relationship, familial conflict)	8	19.5
Feeling stress/overwhelmed (e.g., I was dealing with a lot of stress, nothing was working out in my life, many sudden life changes)	5	12.2
Trauma (e.g., PTSD, traumatic childhood experiences, sexual assault)	3	7.3
Grief/Loss (e.g., Suffered the loss of a family member)	3	7.3
Eating Disorder	2	4.9
To vent	2	4.9
Borderline Personality Disorder	2	4.9
Suicidal (e.g., I was suicidal, suicidal thoughts)	2	4.9

Note: Participants reporting multiple reasons were coded multiple times.

Table 19

Frequencies of Descriptions of Experiences with Professional Help

Description	Frequency	Percent
Helpfulness/Satisfaction (e.g., my experience was mostly rewarding, very helpful, I found that talking to someone outside of my family and friend group was extremely beneficial)	18	43.9
In session comfort (e.g., understanding and supportive and wanted the best for me, my psychologist's office was a safe space)	14	34.1
New coping strategies/skills (e.g., practical cognitive and behavioural tools I could implement when anxious, learned to cope in a positive way)	7	17.1
Distress reduction (e.g., relieved a lot of stress, functioning at my full capacity again, less anxiety)	6	14.6
Unhelpful/Dissatisfied (e.g., the experience wasn't worth the time and effort, I was very unsatisfied that my GP would not refer me to a psychiatrist)	5	12.2
Medication	4	9.8
Gained Insight (e.g., helped me view events in a different way, opened my eyes about my anxiety and depression)	2	4.9

Note: Participants reporting multiple responses were coded multiple times.

Table 20

Frequencies of Barriers to Seeking Help for an Emotional or Mental Health Problem (N = 60)

Barrier	*N*	Percent
Didn't get around to it	39	63.3
I was too busy	34	56.7
I like to handle things on my own	30	50
I didn't know where to go	29	48.3
Other responsibilities got in the way	27	45
Cost/money	22	36.7
I felt the help would be inadequate or unhelpful	22	36.7
Other people might have found out	13	21.7
Help was not available at the time I needed it	9	15
Transportation problems	9	15
I know very little about mental health (e.g., signs of problems)	7	11.7
I do not trust professionals	4	6.7
Services were not available in my area	4	6.7
Waiting times were too long	3	5
Language barrier	0	0
Other	7	11.7

Note: Participants reporting multiple responses were scored multiple times.

CHAPTER 4

DISCUSSION

The overall purpose of the current study was to further understand the connection between young adults' help seeking behaviours and the predictive value of help-seeking intentions, attachment style, and emotion regulation. More specifically, it was of interest to examine the relations between these constructs in the context of a single model. Although researchers have explored the relations between predictors of help-seeking intentions in young adults (Karreman & Vingerhoets, 2012; Romanson, 2018; O'Connor et al., 2014; Gulliver et al., 2010), only a few studies have focused on predictors of both formal and informal help-seeking behaviour. In addition, the present study has meaningfully extended the help seeking literature by providing insight into help seeking behaviour as a continuous variable.

A further goal of this study was to explore the young adults' experiences with seeking help from professionals and reported barriers to seeking help.

4.1 Summary of Findings

4.1.1 Distinguishing between help-seeking intentions and behaviours. Consistent with the hypothesis, the current study has replicated previous findings regarding the discrepancies between help-seeking intentions and help-seeking behaviours (Nagai, 2015; Romanson, 2018). The results indicate that help-seeking intentions are only moderately associated with help-seeking behaviours, further emphasizing the importance that help-seeking intentions should not be substituted for the assessment of help-seeking behaviours. The current study also helped to confirm that predictors of help-seeking intentions were also associated with help-seeking behaviours in response to directions suggested by Nagai (2015).

4.1.2 Predictors of Formal Help-Seeking Behaviours. As expected, results indicated that greater intentions to seek help from formal sources predicted more help-seeking behaviours from formal sources. Additionally, results indicated that greater impulse control difficulties predicted more help-seeking behaviours from formal sources. However, other variables that were included in the model (i.e., Symptomology, Openness to Help-Seeking, Non-Acceptance of Emotional Responses, Limited Access to Emotion Regulation Strategies, and Lack of Emotional Clarity) were not significant predictors of help-seeking behaviours from formal sources. One of the key factors of the HBM in relation to illness behaviour, or mental health help-seeking include health motivations that are brought on by symptomology (Kirscht, 1974). In the present study, symptomology may be related to help-seeking behaviours by way of help-seeking intentions.

These findings significantly contribute to the existing literature by measuring both formal and informal help-seeking behaviours as a continuous variable. This allows research to examine the degree to which specific factors contribute to behaviours. For instance, findings from the present study indicate that an increase in Help-Seeking Intentions –Formal by one standard deviation (i.e., 1.37), will increase Help-Seeking Behaviours –Formal by approximately half a standard deviation (i.e., .43). On average, by increasing an individual's intention to seek help from professionals from moderately unlikely to slightly unlikely, would increase Help-Seeking Behaviours –Formal from less than once to once in the past four weeks. This means that increasing individuals' intentions to seek formal help by a small amount may make the difference between them not seeking help at all to beginning to engage in formal help-seeking. This also emphasizes that individuals do not need to have relatively high intentions to seek help in order to begin to engage in help-seeking behaviours.

4.1.3 Predictors of Informal Help-Seeking Behaviours. As expected, results indicated that greater intentions to seek help from informal sources predicted more help-seeking behaviours from informal sources. One of the key factors of the HBM in relation to illness behaviour, or mental health help-seeking include the benefits or value of help-seeking actions (Kirscht, 1974). Here, intentions to seek-help from informal sources may be valued based on how helpful they believe the help will be. These findings contribute to the existing literature by measuring help-seeking behaviours as a continuous variable. For instance, the findings form the present study indicate that an increase in Help-Seeking Intentions –Informal by one standard deviation (i.e., 1.09), Help-Seeking Behaviours –Formal will increase by approximately half a standard deviation (i.e., .55). Therefore, on average, by increasing an individual's intention to seek help from neither likely nor unlikely to slightly likely, Help-Seeking Behaviours –informal would increase from less than twice to between two to five times in the past four weeks. This means that increasing individuals' intentions to seek formal help by a small amount may make the difference in the amount of help they seek from others close to them.

A greater tendency to disclose psychologically distressing information predicted more informal help-seeking. This finding confirms previous findings that those who feel more comfortable self-disclosing emotions were more likely to disclose their emotional distress with sources available to them (Vogel & Wester, 2003). Individuals who endorsed more of a fearful attachment style were more likely to engage in informal help-seeking behaviours. This finding is consistent with the literature that fearful anxious attachment would predict help-seeking behaviours when in distress (Vogel & Wei, 2015). Specifically, these individuals are more likely to have negative views of themselves contributing to greater distress. In addition,

individuals with fearful attachment style avoid developing close relationships with others in order to avoid rejection (driven by a perception of the self as unworthy), despite wanting close relationships. Greater dismissing attachment predicted less informal help-seeking. This finding is consistent with the literature that dismissing attachment would predict less help-seeking behaviours (Vogel & Wei, 2015). Specifically, these individuals are more likely to have negative views of themselves, value the maintenance of independence and invulnerability, and therefore often deny their personal distress (Bartholomew & Horowitz, 1991; Vogel & Wei, 2015). Attachment style was a significant predictor of help-seeking behaviours but only for informal sources. This may be because attachment style is a measurement of an individual's internal working model of close relationships (Bowlby, 1991), which are reflected in the informal (e,g., parent, sibling, best friend, partner) but not formal help sources.

4.1.4 ***Predictors of Help-Seeking Behaviours by Attachment Style.*** To further explore the role of attachment style in help-seeking behaviour separate analyses were conducted for secure, fearful and dismissing attachment styles. The findings of these analyses revealed that for both formal and informal help-seeking behaviours; help-seeking intentions was a significant predictor of help-seeking behaviour. This was the finding for formal help-seeking behaviours of individuals with secure, fearful, and dismissing attachment styles, and for informal help-seeking behaviours of individuals with dismissing attachment style. These finding highlight that across attachment styles that intentions to seek-help remained the most important predictor. For fearful attachment style, intentions to seek help, distress disclosure and openness to help-seeking predicted informal help-seeking behaviour. This finding confirms previous findings that those who feel more comfortable self-disclosing emotions were more likely disclose their emotional distress with sources available to them (Vogel & Wester, 2003). This may be more

salient for individuals with fearful attachment because they tend to be fearful of trusting and depending on others (Bartholomew & Horowitz, 1991). Therefore, those who are fearfully attached may avoid close relationships, however once in distress, their tendency and openness to disclose emotional distress with others becomes predictive of whether these individuals seek help from informal sources or not.

4.1.5 Experiences with professional help-seeking. Approximately 19% of the sample of young adults sought help from a formal source in the past 12 months, which is relatively high in contrast to previous research (Smetanin et al., 2011). Specifically, these young people reported seeking help from counsellors/therapists, psychologists, social workers, medical doctors, psychiatrists, online counsellors, and religious leaders.

In evaluating the reasons participants reported seeking help, experiencing symptoms of internalizing behaviours was primarily reported. Specifically, depression (21.7 %), anxiety (20.3 %) were the most prevalent areas of concern reported., Other reasons for seeking help from a professional were feeling overwhelmed or stressed (12.2%) and dealing with relational conflicts (19.5%). Almost one third of participants reported that one of the reasons they sought help was to manage their distress. Approximately 5 percent of the participants reported seeking help from a professional so they could vent. These reported reasons for help-seeking compliment the current study's findings. Specifically, reported depression, anxiety, and life stressors that prompted individuals to seek help aligns with the finding that higher levels of reported symptomology were associated with more help-seeking behaviours.

In evaluating the brief descriptions that participants reported seeking help, efficacy of the help sought was a common theme. The questions posed to participants was open-ended and thus the findings from the present study are thought to represent the most salient sentiments

about participants' help-seeking experiences. Specifically, just under half of the participants (43.9%) reported themes of helpfulness or satisfaction with the help sought, while 12.2% reported that their experiences were unhelpful or unsatisfying. Over one third of participants reported feeling comfortable while seeking help. Other themes that were identified from the participants' responses can be conceptualized as different aspects of help-seeking outcomes. Specifically, developing new coping strategies or skills (17.1%), distress reduction (14.6%), receiving medication (9.8%), and gained insight into their mental health problems (4.9%) were reported outcomes of seeking help for their emotional or behavioural problems from professionals.

Reported barriers to seeking help endorsed by those who reported they felt they should have sought help for an emotional or mental health problem but did not in the past 12 months was consistent with previous literature on the barriers to help seeking for young adults (Wilson & Deane, 2012). Barriers regarding the individual's lack of availability was the most prevalently endorsed (i.e., didn't get around to it, I was too busy, other responsibilities got in the way). This may be reflective of time restricted lifestyle of being an undergraduate student; however, future research should further explore the perception of availability and time requirements of help-seeking among undergraduate students. Logistical barriers were also a common and expected barrier to seeking help (i.e., cost/money, transportation problems). An unexpected and prevalent barrier to help-seeking was that participants reported not knowing where to go (48.3 %), that help was not available at the time it was needed (15 %), and that services were not available in my area (6.77 %). This was unexpected because the participants were all students at a university, enrolled in a psychology course, with free on-campus mental health services located central to campus, which are indicated in all of their course syllabi. This

indicates that further efforts are needed to inform university students of the mental health resources available to them. Another barrier to help seeking that was reported to be prevalent in the current study was that the help would be inadequate or unhelpful (36.7 %). Personal barriers to help-seeking included preference to handle things on their own (50 %), worry that others would find out (21.7 %), little knowledge on the signs of mental health problems (11.7 %), and not trusting professionals (6.7 %) were other barriers reported as expected in the literature (Wilson & Deane, 2012).

4.2 Implications of Findings

The result of the first objective emphasizes that help-seeking intentions are not equivalent to help-seeking behaviours. Therefore, future research should continue to measure help-seeking with behaviours. Additionally, clinicians should not interpret young people's intentions to seek-help when they are not distressed as indicative that they would seek help when distressed. While intentions were consistently found to be a significant predictor of help-seeking behaviours from both formal and informal sources, the relationship was not strong enough to equate the two variables.

The results of the second study objective indicated that individuals' intentions to seek help from particular sources was the best predictor of help-seeking behaviours with those same sources. Therefore, public health and on-campus mental health initiatives should focus on how to approach specific sources for help. Results indicated that individuals do not need to have high intentions to seek help to begin to engage in help-seeking behaviours. Therefore, public health and on-campus mental health initiatives should focus on targeting individuals who may have very low intentions to seek help, and make attempts to increase their intentions if only by a small amount.

The results of the third study objective indicated that public health initiatives are needed to promote mental health literacy in young adults. Specifically, it would be beneficial for these efforts to help educate young adults to notice the signs of mental health problems, and when to seek help. It would also be beneficial for these efforts to educate young adults about the differences among mental health services and providers. This was evident based on the reported barriers to help-seeking. Participants in the current study reported barriers to help-seeking that can be addressed by public health and on-campus mental health initiatives. These initiatives should aim to highlight the resources that are available to students on and off-campus, to potentially reduce the barrier to help-seeking of not knowing where to seek services. Information of these resources can be more prominent on university websites, and although they have been previously included in course syllabi at the university the current study took place, course instructors should be encouraged to emphasize the resources.

4.3 Limitation and Future Research Directions

There were several limitations of the present study, and in addition areas of focus for future directions in research are identified and discussed. The generalizability of the study findings may be limited to young people. In particular, the sample was comprised of young adults aged 17 to 25 years of age, who were living in a midsized urban city in Southwestern Ontario, and were enrolled in an undergraduate university program. These results should be understood as reflecting the help-seeking behaviours and intentions of a particular sample of emerging adults and may not generalize to individuals of other life situations or age groups.

In order to address the potentially limited generalizability of the current results to other young adults, future research should focus on better understanding help-seeking in a more diverse sample. In particular, it may be informative to explore help-seeking behaviours in

young adults who are not enrolled in post-secondary education. That is, individuals who are enrolled in post-secondary education have access to on-campus mental health services that are readily available to them. Yet, most of the empirical literature on help-seeking during emerging adulthood has been conducted on samples of university students (O'Connor et al., 2014). Future research would benefit from understanding the experiences of a community sample of young adults who do not have readily accessible mental health services.

The present study was limited by its lack of diverse sample. In particular, participants were predominantly Caucasian, and only approximately one tenth of the sample were males. Previous research has demonstrated that well-being and mental health help-seeking are influenced by ethnicity and culture (Smith & Silva, 2011; Yeh, Hunter, Madan-Bahel, Chiang & Arora, 2004); therefore, the results of the present study may not generalize to individuals of diverse racial or cultural backgrounds. While gender differences were not found to be significant within the study sample, gender differences have repeatedly shown to influence experiences with emotion regulation, and help-seeking behaviours (Nam et al., 2010; Leong & Zachar, 1999; Yeh, 2002; Komiya et al., 2000); therefore, the extremely small sample of male participants may not have been representative of the population. Future studies on help-seeking, should consider the impact of race, culture, and gender when recruiting samples and interpreting findings.

This study was limited by a general lack of diversity in reported attachment style. A majority of participants reported that secure and fearful attachment styles best described them, and relatively few reported that preoccupied and dismissing attachment styles best described them. The current study assessed predictors of help seeking, splitting the data by reported attachment style. Sample sizes of preoccupied and dismissing attachment styles were small and

future research would be more robust using a larger number of participants with these attachment styles. An alternative way to assess the data of the current study, would be to calculate attachment on the two orthogonal axes theorized by Bartholomew and Horowitz (1991): model of the self, and model of others.

This study was also limited by its exclusive use of cross-sectional data. The data were collected at only one point in time, and as a result, causal relationships among the study variables and help-seeking behaviours could not be conclusively determined. Therefore, future research endeavours should make efforts to incorporate longitudinal methodology by collecting data over multiple time point to enable the evaluation of causal relationships involved in help-seeking processes. Additionally, as discussed, the variables in the current study may be interacting with each other as part of a process that leads to help-seeking intentions which was then found to significantly predict help-seeking behaviours. Future research should aim to use Structural Equation Modeling to better understand the multilevel process that young adults undergo in the help-seeking process.

4.4 Conclusion

The current study sought to better understand help-seeking behaviour among young adults. Findings indicate that the best predictor of help-seeking behaviour was help-seeking intentions. Predictors of more formal help-seeking behaviours included difficulties with impulse control and self-disclosure of distress to others. Attachment style predicted help-seeking behaviours but only for informal sources. Findings also shed light on young adults' help-seeking experiences with formal sources and barriers in seeking professional mental health services.

REFERENCES

Ainsworth, M. D. S. (1973). The development of infant-mother attachment. In B. Caldwell, and H. Ricciuti (Eds.), *Review of child development research* (pp. 1-94). Chicago, IL: University of Chicago Press.

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the Strange Situation.* Hillsdale, NJ: Lawrence Erlbaum.

Bäackström, M., & Holmes, B. (2001). Measuring adult attachment: A construct validation of two self–report instruments. *Scandinavian Journal of Psychology, 42*(1), 79-86.

Bandura, A. (1997). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review, 84,* 191-215. doi: 10.1037/0033-295X.84.2.191

Bartholomew, K. & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology, 61*, 226-244.

Becker, M. H. (1974). The health belief model and sick role behavior. *The Health Belief Model and Personal Health Behavior* (pp. 82-92). Thorofare, New Jersey: C.B. Black.

Bergeron, E., Poirier, L.R., Fournier, L., Roberge, P., & Barrette, G. (2005). Determinants of service use among young Canadians with mental disorders. *Canadian Journal of Psychiatry, 50*, 629-636.

Biddle, L., Gunnell, D., Sharp, D., & Donovan, J. L. (2004). Factors influencing help seeking in mentally distressed young adults: A cross-sectional survey. *British Journal of General Practice, 54*, 248-253.

Boak, A., Hamilton, H. A., Adlaf, E. M., Beitchman, J. H., Wolfe, D., & Mann, R. E. (2014). The mental health and well-being of Ontario students, 1991– 2013: Detailed OSDUHS

findings (CAMH Research Document Series No. 38). Toronto, ON: Centre for Addiction and Mental Health.

Bowlby, J. (1969,1991). *Attachment and loss: Vol. 1*. London, England: Penguin.

Bridges, Lisa J., Denham, Susanne A., & Ganiban, Jody M. (2004). Definitional Issues in Emotion Regulation Research. *Child Development, 75*(2), 340-345. doi: 10.1111/j.1467-8624.2004.00675.x

Buckholdt, K. E., Parra, G. R., & Jobe-Shields, L. (2009). Emotion regulation as a mediator of the relation between emotion socialization and deliberate self-harm. *American Journal of Orthopsychiatry*, *79*, 482-490. doi:10.1037/a0016735

Campos, J. J., Frankel, C. B., & Camras, L. (2004). On the nature of emotion regulation. *Child Development*, *75*, 377-394. doi:10.1111/j.1467-8624.2004.00681.x

Cassidy, J. (2008). The nature of the child's ties. In J. Cassidy, & P. Shaver (Eds.), Handbook of attachment: Theory, research, and clinical applications (2nd ed.) (pp. 3-22). New York, NY: The Guilford Press.

Cheng, H. L., McDermott, R. C., & Lopez, F. G. (2015). Mental health, self-stigma, and help-seeking intentions among emerging adults: An attachment perspective. *The Counseling Psychologist, 43*, 463-487.

Cisler, J. M., Olatunji, B. O., Feldner, M. T., & Forsyth, J. P. (2010). Emotion regulation and the anxiety disorders: An integrative review. *Journal of Psychopathology and Behavioral Assessment*, *32*, 68-82. doi:10.1007/s10862-009-9161-1

Cohen, J., Cohen, P., West, S. G., & Aiken, L. S. (2003). *Applied multiple regression/ correlation analysis for the behavioral sciences, 3rd ed*. Lawrence Erlbaum: Mahwah, NJ.

Cole, P., Martin, S., & Dennis, T. (2004). Emotion regulation as a scientific construct: Methodological challenges and directions for child development research. *Child Development, 75*, 317-333.

Coulton, C. J., & Frost, A. K. (1982). Use of social and health services by the elderly. *Journal of Health and Social Behavior, 23,* 330-339.

Croll, J., Neumark-Sztainer, D., Story, M., & Ireland, M. (2002). Prevalence and risk and protective factors related to disordered eating behaviors among adolescents: relationship to gender and ethnicity. *Journal of Adolescent Health*, *31*, 166-175. doi:10.1016/S1054-139X(02)00368-3

Czyz, E., Horwitz, A., Eisenberg, D., Kramer, A., & King, C. (2013). Self-reported Barriers to Professional Help Seeking Among College Students at Elevated Risk for Suicide. *Journal of American College Health, 61*(7), 398-406.

Deane, F. P., Wilson, C. J., & Ciarrochi, J. (2001) Suicidal ideation and help-negation: Not just hopelessness or prior help. *Journal of Clinical Psychology, 57,* 901-914.

Derryberry, D., Rothbart, M. K., Derryberry, D., & Rothbart, M. K. (1988). Arousal, affect, and attention as components of temperament. *Journal of Personality and Social Psychology, 55*(6), 958-966. doi:10.1037/0022-3514.55.6.958

Diaz-Granados, N., Georgiades, K., & Boyle, M. (2010). Regional and Individual Influences on Use of Mental Health Services in Canada. *Canadian Journal of Psychiatry, 55*(1), 9-20.

Dinges, N. G., & Cherry, D. (1995). Symptom expression and the use of mental health services among American ethnic minorities. In J. F. Aponte, R. Y. Rivers & J. Wohls (Eds.), *Psychological interventions and cultural diversity* (pp. 40-56). Needham Heights, MA: Allyn & Bacon.

Dubow, E. F., Lovko, K. R., & Kausch, D. F. (1990). Demographic differences in adolescents' health concerns and perceptions of helping agents. *Journal of Clinical and Consulting Psychology*, 19, 44–54.

Faul, F., Erdfelder, E., Buchner, A., & Lang, A.-G. (2009). Statistical power analyses using G*Power 3.1: Tests for correlation and regression analyses. *Behavior Research Methods*, *41*, 1149-1160.

Feeney, J. A. (2008). Adult romantic attachment: Developments in the study of couple relationships. In J. Cassidy, & P. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications (2nd ed.)* (pp. 456-481). New York, NY: The Guilford Press.

Feeney, J. A., Noller, P., & Hanrahan, M. (1994). Assessing adult attachment: developments in the conceptualization of security and insecurity. In: Sperling MB, Berman WH, editors. *Attachment in adults: theory, assessment, and treatment* (pp. 128–52. New York, NY: Guilford Press.

Fischer, E. H., & Turner, J. L. (1970). Orientations to seeking professional help: Development and research utility of an attitude scale. *Journal of Consulting and Clinical Psychology,* 35,79-90.

Fortuna, K., Roisman, G,I. (2008). Insecurity, stress, and symptoms of psychopathology: contrasting results from self-reports versus interviews of adult attachment. *Attachment & Human Development, 10*, 11–28.

Fox, H. C., Axelrod, S. R., Paliwal, P., Sleeper, J., & Sinha, R. (2007). Difficulties in emotion regulation and impulse control during cocaine abstinence. *Drug and Alcohol Dependence*, *89*, 298-301. doi:10.1016/j.drugalcdep.2006.12.026

Garrison, A., Kahn, J., Miller, S., & Sauer, E. (2014). Emotional avoidance and rumination as mediators of the relation between adult attachment and emotional disclosure. *Personality and Individual Differences, 70*, 239-245.

Garrison, A., Kahn, J., Sauer, E., & Florczak, M. (2012). Disentangling the effects of depression symptoms and adult attachment on emotional disclosure. *Journal of Counseling Psychology, 59*, 230-239.

Gelaye, B., Tadesse, M. G., Lohsoonthorn, V., Lertmeharit, S., Pensuksan, W. C., Sanchez, S. E., et al. (2015). Psychometric properties and factor structure of the General Health Questionnaire as a screening tool for anxiety and depressive symptoms in a multi-national study of young adults. *Journal of Affective Disorders, 187*, 197-202.

Gillath, O., Bunge, S., Shaver, P., Wendelken, C., & Mikulincer, M. (2005). Attachment-style differences in the ability to suppress negative thoughts: Exploring the neural correlates. *NeuroImage, 28*(4), 835-47. doi: 10.1016/j.neuroimage.2005.06.048

Giromini, L., Ales, F., de Campora, G., Zennaro, A., & Pignolo, C. (2017). *Journal of Psychopathology Behavioral Assessment,* 39(4), 705-714. https://doi-org.ledproxy2.uwindsor.ca/10.1007/s10862-017-9611-0

Goldberg, D. P., Williams, P., & University of London. (1991). *A user's guide to the General Health Questionnaire*. NFER-NELSON.

Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the difficulties in emotion regulation scale. *Journal of Psychopathology and Behavioral Assessment, 26,* 41-54. doi:0882-2689/04/0300-0041/0

Gratz, K. L., & Roemer, L. (2008). The relationship between emotion dysregulation and deliberate self-harm among female undergraduate students at an urban commuter university. *Cognitive Behaviour Therapy*, *37*, 14-25. doi:10.1080/16506070701819524

Gratz, K., & Tull, L. (2010). The Relationship Between Emotion Dysregulation and Deliberate Self-Harm Among Inpatients with Substance Use Disorders. *Cognitive Therapy and Research, 34*(6), 544-553. doi: 10.1007/s10608-009-9268-4

Gratz, K. L., Rosenthal, M. Z., Tull, M. T., Lejuez, C. W., & Gunderson, J. G. (2006). An experimental investigation of emotion dysregulation in borderline personality disorder. *Journal of Abnormal Psychology*, *115*, 850-855. doi:10.1037/0021- 843X.115.4.850

Griffin, D. W., & Bartholomew, K. (1994a). Models of the self and other: Fundamental dimensions underlying measures of adult attachment. *Journal of Personality and Social Psychology, 67*(3), 430-445. http://dx.doi.org/10.1037/0022-3514.67.3.430

Griffin, D. W., & Bartholomew, K. (1994b). The metaphysics of measurement: The case of adult attachment. In K. Bartholomew & D. Perlman (Eds.), *Advances in personal relationships, Vol. 5. Attachment processes in adulthood* (pp. 17-52). London, England: Jessica Kingsley Publishers.

Gross, J. J. (1999). Emotion regulation: Past, present, future. *Cognition and Emotion*, *13*(5), 551-573. doi:10.1080/026999399379186

Gross, J. (2007). *Handbook of emotion regulation*. New York ; London: Guilford Press.

Gross, J. J., & John, O. P. (2003). Individual differences in two emotion regulation processes: Implications for affect, relationships, and well-being. *Journal of Personality and Social Psychology*, *85*, 348-362. doi:10.1037/0022-3514.85.2.348

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

Han, S., & Pistole, M. C. (2014). College student binge eating: Insecure attachment and emotion regulation. *Journal of College Student Development, 55*, 16-92.

Harrington, R., Rutter, M., & Fombonne, E. (1996). Developmental pathways in depression: Multiple meaning, antecedents, and endpoints. *Development and Psychopathology, 8,* 601-616.

Henshaw, E., & Freedman-Doan, C. (2009). Conceptualizing Mental Health Care Utilization Using the Health Belief Model. *Clinical Psychology: Science and Practice,16*(4), 420-439. doi: 10.1111/j.1468-2850.2009.01181.x

Hyland, P., Boduszek, D., Dhingra, K., Shevlin, M., Maguire, R., & Moreley, K. (2015). A Test of the Inventory of Attitudes toward Seeking Mental Health Services. Brit is *Journal of Guidance and Counselling*, *43*(4). ISSN 03069885

Jackson, D. (2017). *Multiple regression analysis outliers* [class handout]. Retrieved from Department of Psychology, University of Windsor, Windsor, ON.

Jonas, B., Brody, S., Roper, D., & Narrow, M. (2003). Prevalence of mood disorders in a national sample of young American adults. *Social Psychiatry and Psychiatric Epidemiology,38*(11), 618-624.

Kahn, J. H., & Hessling, R. M. (2001). Measuring the tendency to conceal versus disclose psychological distress. *Journal of Social and Clinical Psychology, 20*(1), 41-65. https://doi.org/10.1521/jscp.20.1.41.22254

Kapeleris, A., & Paivio, S. (2011). Identity and Emotional Competence as Mediators of the Relation between Childhood Psychological Maltreatment and Adult Love Relationships. *Journal of Aggression, Maltreatment & Trauma, 20*(6), 617-635.

Karreman, A., & Vingerhoets, J. J. M. (2012). Attachment and well-being: The mediating role of emotion regulation and resilience. *Personality and Individual Differences, 53*(7), 821-826, DOI: 10.1016/j.paid.2012.06.014

Kessler, R. C., Brown, R. L., & Broman, C. L. (1981). Sex differences in psychiatric help-seeking: Evidence from four large-scale surveys. *Journal of Health and Social Behavior, 22*, 49-64. doi: 10.2307/2136367.

Khan, J., Hucke, B., Bradley, A., Glinski, A., & Malak, B. (2012). The Distress Disclosure Index: A research review and multitrait-multimethod examination. *Journal of Counseling Psychology, 59*, 134-149.

Kirscht, J. P. (1974). The health belief model and sick illness behavior. *The Health Belief Model and Personal Health Behavior* (pp. 60-81). Thorofare, New Jersey: C.B. Black.

Kline, R. (2011). *Principles and practice of structural equation modeling* (3rd ed.). New York, NY: Guilford Press.

Komiya, Noboru, Good, Glenn E., & Sherrod, Nancy B. (2000). Emotional Openness as a Predictor of College Students' Attitudes toward Seeking Psychological Help. *Journal of Counseling Psychology, 47*(1), 138-43.

Koole, S. (2009). The psychology of emotion regulation: An integrative review. *Cognition & Emotion, 23*(1), 4-41. doi: 10.1080/02699930802619031

Kuhl, J., Jarkon-Horlick, L., & Morrissey, R. F. (1997). Measuring barriers to help- seeking behaviour in adolescents. *Journal of Youth and Adolescence*, *26*(6), 637– 650. http://doi.org/10.1023/A:1022367807715

Kun, B., & Demetrovics, Z. (2010). Emotional intelligence and addictions: A systematic review. *Substance Use and Misuse*, *45*, 1131-1160. doi:10.3109/10826080903567855

Lane, J. M., & Addis, M. E. (2005). Male gender role conflict and patterns of help seeking in Costa Rica and the United States. *Psychology of Men & Masculinity*, 6(3), 155. http://dx.doi.org/10.1037/1524-9220.6.3.155.

Leong, F., & Zachar, P. (1999). Gender and opinions about mental illness as predictors of attitudes toward seeking professional psychological help. *British Journal of Guidance & Counselling, 27*(1), 123-132.

MacDonald, K., Berlow, R., & Thomas, M. (2013). Attachment, affective temperament, and: A study of their relationships in psychiatric outpatients. *Journal of Affective Disorders, 151*(3), 932-941.

Mackenzie, C., Knox, V., Gekoski, W., & Macaulay, H. (2004). An Adaptation and Extension of the Attitudes Toward Seeking Professional Psychological Help Scale 1. *Journal of Applied Social Psychology, 34*(11), 2410-2433, doi: 10.1111/j.1559-1816.2004.tb01984.x

Menna, R., & Ruck, M. D. (2004). Adolescent help seeking behaviour: How can we encourage it? *Guidance & Counseling*, *19*, 176-183.

Mikulincer, M., & Florian, V. (1997). Are emotional and instrumental supportive interactions beneficial in times of stress? The impact of attachment style. *Anxiety, Stress & Coping, 10*(2), 109-127. doi: 10.1080/10615809708249297

Mikulincer, M., Shaver, P. R., & Pereg, D. (2003). Attachment theory and affect regulation: The dynamics, development, and cognitive consequences of attachment-related strategies. *Motivation and Emotion, 27*, 77-102.

Mikulincer, M., & Shaver, P. R. (2007). *Attachment in adulthood: Structure, dynamics, and change*. New York: Guilford Press.

Montazeri, A., Harirchi, A. M., Shariati, M., Garmaroudi, G., Ebadi, M., & Fateh, A. (2003) The 12-item General Health Questionnaire (GHQ-12): Translation and validation study of the Iranian version. *Health and Quality of Life Outcomes, 1*, 1-10.

Nagai, S. (2015). Predictors of help-seeking behavior: Distinction between help-seeking intentions and help-seeking behavior. *Japanese Psychological Research,57*(4), 313-322.

Nam, S. K., Chu, H. J., Lee, M. K., Lee, J. H., Kim, N., & Lee, S. M. (2010). A meta-analysis if gender differences in attitudes toward seeking professional psychological help. *Journal of American College Health,* 59, 110–116.

Nykvist, K., Kjellberg, A., & Bildt, C. (2002). Causal explanations for common somatic symptoms among women and men. *International Journal of Behavioral Medicine, 9,* 285-300.

O'Connor, P., Martin, B., Weeks, C., & Ong, L. (2014). Factors that influence young people's mental health help-seeking behaviour: A study based on the Health Belief Model. *Journal of Advanced Nursing, 70*(11), 2577-2587.

Ognibene, T., & Collins, N. (1998). Adult attachment styles, perceived social support and coping strategies. *Journal of Social and Personal Relationships, 15*(3), 323-345. doi:10.1177/0265407598153002

Oldehinkel, A. J., Hartman, C. A., de Winter, A. F., Veenstra, R., & Ormel, J. (2004). Temperament profiles associated with internalizing and externalizing problems in preadolescence. Development and Psychopathology, 16(2), 421- 440. doi: 10.1017/S0954579404044591

Pituch, K. A. & Stevens, J. P. (2016). Applied Multivariate Statistics for the Social Sciences, 6th Ed. New York: Routledge.

Portzky, M., Wagnild, G., De Bacquer, D., & Audenaert, K. (2010). Psychometric evaluation of the Dutch Resilience Scale RS–nl on 3265 healthy participants: A confirmation of the association between age and resilience found with the Swedish version. *Scandinavian Journal of Caring Sciences, 24*, 86–92.

Preacher, K. J., & Coffman, D. L. (2006, May). *Computing power and minimum sample size for RMSEA* [Computer software]. Available from http://quantpsy.org/.

Ravitz, Maunder, Hunter, Sthankiya, & Lancee. (2010). Adult attachment measures: A 25-year review. *Journal of Psychosomatic Research, 69*(4), 419-432. doi: 10.1016/j.jpsychores.2009.08.006

Rey, J. J., Abad, F. J., Barrada, J. R., Garrido, L. E., & Ponsoda, V. (2014). The impact of ambiguous response categories on the factor structure of the GHQ-12. *Psychological Assessment, 26*, 1021-1030.

Rickwood, D., & Braithwaite, V. (1994). Social-psychological factors affecting help-seeking for emotional problems. *Social Science & Medicine, 39*(4), 563-572. https://doi.org/10.1016/0277-9536(94)90099-X

Rickwood, D., Deane, F., & Wilson, C. (2007). When and how do young people seek professional help for mental health problems? *The Medical Journal of Australia,187*(7 Suppl), S35-9.

Rickwood, D. J., Deane, F. P., Wilson, C. J., & Ciarrochi, J. V. (2005). Young people's help-seeking for mental health problems. *Australian e-Journal for the Advancement of Mental Health, 4*, 1-34.

Rickwood, D., Van Dyke, N., & Telford, N. (2015). Innovation in youth mental health services in Australia: Common characteristics across the first headspace centres. *Early Intervention in Psychiatry, 9*(1), 29-37. doi: 10.1111/eip.12071

Romanson, E., (2018). *Online Help Seeking in Emerging Adults: The Role of Attachment Style, Emotion Regulation, and Distress Disclosure,* ProQuest Dissertations and Theses.

Rosenstock, I. M. (1974a). Historical origins of the health belief model. *The Health Belief Model and Personal Health Behavior* (pp. 1-26). Thorofare, New Jersey: C.B. Black.

Rosenstock, I. M. (1974b). The health belief model and preventative health behavior. *The Health Belief Model and Personal Health Behavior* (pp. 27-59). Thorofare, New Jersey: C.B. Black.

Rosenstock, I., Strecher, V., & Becker, M. (1988). Social Learning Theory and the Health Belief Model. *Health Education & Behavior, 15*(2), 175-183. doi: 10.1177/109019818801500203

Rothbart, M. (2007). Temperament, Development, and Personality. *Current Directions in Psychological Science, 16*(4), 207-212.

Rothbart, M. K., Ahadi, S. A., Evans, D. E., (2000). Temperament and personality: Origins and outcomes. *Journal of Personality and Social Psychology, 78*(1), 122-135. doi:10.1037/0022-3514.78.1.122

Schafer, E., & Bartholomew, K. (1994). Reliability and stability of adult attachment patterns. *Personal Relationships, 1*, 23-43.

Smetanin, P., Stiff, D., Briante, C., Adair, C., Ahmad, S. & Khan, M. (2011). *The life and economic impact of major mental illnesses in Canada: 2011 to 2041*. RiskAnalytica, on behalf of the Mental Health Commission of Canada.

Smith, T. (2009). If We Build It, Will They Come? The Health Belief Model and Mental Health Care Utilization. *Clinical Psychology: Science and Practice, 16*(4), 445-448. doi: 10.1111/j.1468-2850.2009.01183.x

Smith, T., & Silva, L. (2011). Ethnic Identity and Personal Well-Being of People of Color: A Meta-Analysis. *Journal of Counseling Psychology, 58*(1), 42-60.

Tabachnick, B. G., & Fidell, L. S. (2013). *Using multivariate statistics* (6th ed.). Upper Saddle River, NJ: Pearson.

Tull, M. T., Stipelman, B. A., Salters-Pedneault, K., & Gratz, K. L. (2009). An examination of recent non-clinical panic attacks, panic disorder, anxiety sensitivity, and emotion regulation difficulties in the prediction of generalized anxiety disorder in an analogue sample. *Journal of Anxiety Disorders*, *23*, 275- 282. doi:10.1016/j.janxdis.2008.08.002

Vogel, D. L., & Wester, S. R. (2003). To seek help or not to seek help: The risks of self-disclosure. *Journal of Counseling Psychology, 50*, 351-361.

Tomkins, S.S. (1984). Affect theory. In P. Ekman (Ed .), Emotion in the human face (2nd ed.), (pp. 353-395). New York : Cambridge University Press.

Weinfield, N. S., Sroufe, L. A., Egeland, B., & Carlson, E. (2008). Individual differences in infant-caregiver attachment: Conceptual and empirical aspects of security. In J. Cassidy, & P. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications (2nd ed.)* (pp. 78-101). New York, NY: The Guilford Press.

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

Whiteside, U., Chen, E., Neighbors, C., Hunter, D., Lo, T., & Larimer, M. (2007). Difficulties regulating emotions: Do binge eaters have fewer strategies to modulate and tolerate negative affect? *Eating Behaviors*, *8*, 162-169. doi:10.1016/j.eatbeh.2006.04.001

Wilson, C. J., & Deane, F. P. (2001). Adolescent opinions about reducing help-seeking barriers and increasing appropriate help engagement. *Journal of Educational and Psychological Consultation, 12,* 345-364

Wilson, C. J., & Deane, F. P. (2012). Brief Report: Need for Autonomy and Other Perceived Barriers Relating to Adolescents' Intentions to Seek Professional Mental Health Care. *Journal of Adolescence, 35*(1), 233-237. doi: 10.1016/j.adolescence.2010.06.011

Wilson, C. J., Deane, F. P., Ciarrochi, J., & Rickwood, D. (2005). Measuring help seeking intentions: Properties of the General Help-Seeking Questionnaire. *Canadian Journal of Counselling, 39*, 15-28.

Wilson, C., Deane, F., Ciarrochi, J., & Rickwood, D. (2007). Measuring Help-Seeking Intentions: Properties of the General Help Seeking Questionnaire. *Canadian Journal of*

Counselling and Psychotherapy / Revue canadienne de counseling et de psychothérapie, 39(1). Retrieved from http://cjc-rcc.ucalgary.ca/cjc/index.php/rcc/article/view/265/588

World Health Organization. (1999). *WHO Welzijnsindex*. <http://www.cure4you.dk/354/WHO-5_%20Dutch.pdf>

Yeh, C. (2002). Taiwanese Students' Gender, Age, Interdependent and Independent Self-Construal, and Collective Self-Esteem as Predictors of Professional Psychological Help-Seeking Attitudes. *Cultural Diversity & Ethnic Minority Psychology, 8*(1), 19-29.

Yeh, C., Hunter, C., Madan-Bahel, A., Chiang, L., & Arora, A. (2004). Indigenous and Interdependent Perspectives of Healing: Implications for Counseling and Research. *Journal of Counseling & Development, 82*(4), 410-419.

APPENDIX A

Background Information Questionnaire

1. What is your age?_____

2. What year were you born?_____

3. What is your gender?

    - Male
    - Female
    - Transgender
    - Genderqueer
    - None of these speak to who I am
        - Please specify:_____

4. Which ethnic category best describes you?
   (Please choose one response that best captures your ethnicity)

    - Aboriginal (North American Indian, Metis, or Inuit)
    - Arab (e.g. Lebanese, Palestinian, Egyptian, Iraqi, etc.)
    - African
    - Caribbean
    - Caucasian
    - Chinese
    - Filipino
    - Korean
    - Latin American
    - South Asian (e.g. East Indian, Pakistani, Sri Lankan, etc.)
    - Southeast Asian (e.g. Vietnamese, Cambodian, Malaysian, etc.)
    - Mixed/Biracial (please specify):_____
    - Other (please specify):_____

5. What year are you in your current program?
    - 1
    - 2
    - 3
    - 4
    - 5+

6. What is your relationship status?
    - Single
    - In a relationship but not living together
    - In a relationship and living together

- Married
- Separated
- Divorced
- Other, please specify:_____

7. Growing up, what was your gross family 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

8. In what setting did you grow up?
    - Urban (i.e. city)
    - Suburban (i.e. town)
    - Rural (i.e. country)

9. Are you currently receiving any counselling services?
    - Yes
    - No

    If yes, who currently provides the services? (check all that apply)
    - On campus counsellor
    - Social worker
    - Psychologist
    - Psychiatrist
    - Medical doctor
    - Other, please specify:_____

10. Have you ever received any previous counselling services?
    - Yes
    - No

    If yes, who provided the services? (check all that apply)
    - School counsellor
    - On campus counsellor
    - Social worker
    - Psychologist
    - Psychiatrist
    - Medical doctor
    - Other, please specify:_____

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