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Help-Negation

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Without Abstract

Overview

Help-negation refers to the help-avoidance or withdrawal that has been found in samples of adolescents who are currently experiencing clinical and subclinical levels of suicidal thoughts (e.g., Wilson et al. *2005a*), depressive symptoms (e.g., Wilson et al. *2007*), and symptoms of general psychological distress (e.g., Wilson *2010*). In each study, adolescents with higher symptom levels are also those with lower intentions to seek help from health-care professionals, family, and friends, and higher intentions to seek help from no one. Consistent results have also been found among adults (see Wilson and Deane *2010*, for a review). Although the determinants of help-negation are not yet known and require further research, studies among adolescents have found that, in this population, help-negation for suicidal ideation and symptoms of depression is not fully explained as a function of sex, hopelessness, a lack of prior help-seeking experiences, (Wilson et al. *2005a*), a lack of current desire for help (Wilson et al. *2010*), religious affiliation (Wilson et al. *2005a*), the perception of poor quality prior help-seeking experiences (Wilson et al. *2007*), or symptoms of co-occurring forms of psychological distress (Wilson et al. *2010*). However, having lower levels of hopelessness has strengthened the help-negating effect of suicidal ideation for seeking help from family (Wilson et al. *2005a*). Having higher levels of depressive symptoms also strengthened the effect for seeking help from friends, family, and no one (Wilson and Deane *2010*). Beliefs about mental health treatment and the need to solve one's problems alone have been implicated in the help-negation process, but the specific role of these cognitions and how they might change for

different types of psychological symptoms is still unclear (Wilson 2010; Wilson et al. 2005a, 2010). Research to date suggests that help-negation is a substantial barrier to adolescents seeking and engaging in appropriate help for suicidal ideation, depressive symptoms and symptoms of general psychological distress. Findings of help-negation raise important implications for prevention initiatives and policies, as well as treatment strategies that rely on proactively seeking, accessing and engaging in help. How successful can the initiatives be if a consequence of experiencing psychological distress, even in its very early stages of development, is a tendency to withdraw from specific helping opportunities or to avoid help altogether? In the future, identifying the determinants of help-negation and better understanding the role of affective, social, and cognitive variables in strengthening and maintaining the help-negation process among adolescents should be a research priority. Improving what one knows about help-negation at different developmental stages might make it possible to address help-avoidance early, and consequently, reduce the high prevalence of mental disorders that currently exist among adolescents the world over (Wilson and Deane 2010).

Background

Worldwide, up to 20% of children and adolescents experience a disabling mental disorder that, if left untreated, can cause distress and disability that lasts for decades (Belfer 2008). Approximately 50% of all adult mental health disorders start by age 14 and three quarters start before age 24 (Kessler et al. 2005). These are mostly anxiety disorders, followed by substance-use disorders and mood disorders (Wilson 2010). These disorders also have high levels of comorbidity with other serious mental health problems, such as suicidal ideation (Wilson et al. 2007). Internationally, suicide is the third leading cause of death in the 15–24 year age group (Belfer 2008). These statistics underscore the need for mental health research to identify and better understand factors that are involved in protecting against the disability of mental disorder, and specifically, against the development of acute suicidality.

Accessing appropriate help can successfully reduce the long-term impact of many mental health problems and potentially prevent the development of levels of psychological distress requiring treatment (Rickwood et al. 2007). However, epidemiological studies suggest that, globally, up to three quarters of the adolescents who would likely benefit from mental health care are not seeking or engaging in this type of help for their condition (see Wilson et al. 2010, for a review). As yet, one does not have a definitive reason to explain why adolescents who are experiencing symptoms of psychological distress do not want help. One possibility is that the gap between estimated rates of unmet need and those who engage in appropriate help is partially explained by processes involved in help-negation (Wilson et al. 2011).

Help-negation was first described in the literature as the unique pattern shown by acutely suicidal clients who have “reached a state of utter hopelessness concerning treatment, [to] soundlessly abandon, politely terminate, or angrily reject treatment” (Clark and Fawcett 1992:40). As the research area has developed, help-negation has been represented behaviorally as refusal or avoidance of available help prior to treatment, and during treatment, as disengagement and withdrawal from the treatment process (Rudd et al. 1995). In both contexts, help-negation can be measured as the inverse relationship between levels of psychological distress symptoms and positive

help-seeking intentions (i.e., the planning and action component of the individual's decision to seek help), and the positive relationship between levels of psychological distress symptoms and intentions to seek help from no one (Wilson and Deane 2010). In most help-negation studies, intentions have been used as the dependent help-seeking measure because intentions proximate actual help-seeking behavior and provide an efficient method for measuring the effect (Wilson et al. 2010). Thus, a specific measure of help-negation is the inverse correlation between different types of psychological distress symptoms (e.g., suicidal ideation and depressive symptoms) and help-seeking intentions.

Help-negation in adolescence has been examined mostly in high-school student samples. Samples have ranged in size from 269 to 1,700 participants and have ranged in age from 12 to 18 years (Wilson et al. 2005a, 2007, 2010). Adolescents in each sample have reported levels of psychological distress symptoms that have ranged from subclinical to clinically relevant, but in each study, the majority of adolescents reported that their symptom levels were low. These studies have assessed a range of forms of psychological distress including suicidal ideation, depressive symptoms, and symptoms of general psychological distress. They have also assessed intentions to seek help for different problems (e.g., suicidal thoughts, personal and emotional problems, physical health concerns) and for different help-sources (e.g., friends, family, mental health professionals, physical health professionals, no one). Across studies, aspects of psychological distress have been related negatively to help-seeking intentions for specific sources and positively to intentions to seek no help from anyone (Wilson 2010; Wilson et al. 2005a, 2007, 2010).

Across studies, the inverse correlation between suicidal ideation and intentions to seek help for suicidal thoughts has ranged from $r = -0.13$ for a family doctor to $r = -0.25$ for a mental health professional (e.g., school counselor), $r = -0.33$ for friends, and $r = -0.47$ for parents (Wilson et al. 2005a, 2010). The inverse correlation between suicidal ideation and intentions to seek help from a family doctor for non-suicidal problems has ranged from $r = -0.12$ for an emotional problem to $r = -0.20$ for a physical health problem (Wilson et al. 2010). The inverse correlation between symptoms of depression and intentions to seek help for a personal–emotional problem has ranged from $r = -0.13$ for a family doctor to $r = -0.31$ for parents (Wilson et al. 2007). And the inverse correlation between symptoms of general psychological distress and intentions to seek help from a family doctor has ranged from $r = -0.17$ for a physical health problem to $r = -0.24$ for suicidal thinking (Wilson et al. 2010). Across studies, positive correlations have also been found between suicidal ideation and intentions to seek help from no one for suicidal thoughts, $r = 0.30$ (Wilson et al. 2005a), and between depressive symptoms, symptoms of general psychological distress, and intentions to seek help from no one for a personal–emotional problem, $r = 0.13$ to $r = 0.34$ (Wilson 2010; Wilson et al. 2007).

Together, these results suggest that adolescents with the highest levels of suicidal ideation and depressive symptoms are often those with the lowest intentions to seek help from friends, parents, and other family members for their condition (e.g., Wilson et al. 2005a, 2007). Adolescents with the highest levels of suicidal ideation are often those with the lowest intentions to seek help from a mental health professional for their suicidal thoughts (Wilson et al. 2005a). And, adolescents with the highest levels of suicidal ideation and symptoms of general psychological distress are often those with the lowest intentions to seek help from a family doctor, who can provide both

mental health care for their suicidal thoughts and medical care for physical health concerns (Wilson et al. 2010). These results also provide evidence that adolescents with the highest levels of suicidal ideation (Wilson et al. 2005a), depressive symptoms (Wilson et al. 2007) and symptoms of general psychological distress are often those with the highest intentions to *not seek help from anyone*.

Suicidal ideation refers to people's thoughts and ideas about death, suicide, and serious self-injurious behaviors. It is both a proxy measure for suicide and an independent estimate of risk for suicide completion (Wilson et al. 2010). Importantly, these studies suggest that the help-negating effect of suicidal ideation impedes adolescents' help-seeking for a broad range of health concerns that include symptoms of psychological distress as well as signs and symptoms of physical health problems. Adolescents who are at the highest risk for suicide completion are also those who are most likely to withdraw from proactively seeking help for their physical and mental health problems, and to avoid help altogether (Wilson et al. 2005a, 2010).

Even more concerning, these studies suggest that processes of help-negation exist not only for suicidal ideation, but also for depressive symptoms and more broadly, for general psychological distress symptoms that occur very early in the development of mental health problems (Wilson 2010; Wilson et al. 2010). Social withdrawal is commonly recognized as a symptom of major depressive disorder for children and adolescents. Help-negation research suggests that adolescents who are at the highest risk for developing a major depressive episode are also those who are most likely to withdraw from proactively seeking help from family and friends, and avoid seeking help for their condition (Wilson et al. 2005a). Similarly, the results suggest that adolescents with higher levels of general psychological distress symptoms, and consequently, those who are at the highest risk for developing symptoms of a specific mental disorder (e.g., depression and anxiety), are also those who are most likely to withdraw from proactively seeking help from a family doctor for mental and physical health concerns (Wilson et al. 2010). These at risk adolescents are also those who are most likely to avoid help from a specialist mental health service (Wilson 2010).

Together, the help-negation studies in adolescent samples suggest that even when symptom levels are low, suicidal ideation, symptoms of depression, and symptoms of general psychological distress can promote help-negation for different help-sources, for mental and physical health problems. Importantly, these studies suggest that help-negation during adolescence starts early in the development of common mental disorders. Help-avoidance reduces the opportunity to prevent symptoms worsening and increases the risk that mild symptoms will develop into a more persistent mental health problem. Consequently, these studies suggest that help-negation is a substantial barrier to adolescents seeking and receiving help early for different types of psychological and physical health problems (Wilson et al. 2011).

Explaining Help-Negation for Suicidal Ideation Among Adolescents

As the help-negation research area has developed, several studies have examined whether different variables can explain the effect for suicidal ideation (see Wilson et al. 2011, for a review). Among adolescents, being female, feeling hopeless, lacking previous help-seeking experiences, having no current desire for help, and having

weak religious affiliation has been related to higher levels of suicidal ideation and lower help-seeking intentions (Wilson et al. *2005a*, *2010*). Symptoms of depression and general psychological distress have also been related positively to suicidal ideation (Wilson et al. *2005a*, *2010*). Yet, among adolescents, the help-negating effect of suicidal ideation was not fully explained as a function of any of these variables (Wilson et al. *2005a*, *2010*). Beliefs about the need for mental health treatment and the need to solve one's problems alone, as well as the meaning of different symptom-types have been implicated in the development of help-negation, but the specific role of these cognitions and how they might change for different types of psychological symptoms is unclear (Wilson *2010*; Wilson et al. *2005a*, *2010*).

Although hopelessness and depressive symptoms could not fully explain the help-negation effect, they did strengthen help-negation for suicidal ideation. Among adolescents, lower levels of hopelessness strengthened the effect for seeking help from family (Wilson et al. *2005a*). Higher levels of depressive symptoms also strengthened the effect for seeking help from friends, family, and no one (Wilson and Deane *2010*). The results suggest that as levels of hopelessness decrease and levels of depressive symptoms increase, so does the magnitude of the inverse relationship between suicidal ideation and help-seeking intentions. The reasons for these seemingly dialectic results are currently unknown (Wilson et al. *2005a*; Wilson and Deane *2010*). The presence of depressive symptoms might exacerbate suicidal ideation, which, in turn, produces a cumulative distress effect that contributes to help-avoidance. The hopelessness finding is more difficult to explain. It could be expected that higher levels of hopelessness would have a cumulative distress effect that impacts help-negation. However, it was lower levels of hopelessness that strengthened the help-negation effect. Perhaps, more hopeful adolescents perceive they have less need for help and this, in turn, reduces their intentions to seek help as their levels of suicidal ideation increase. They might believe they can resolve their low levels of suicidal ideation on their own. At present, such explanations are speculative, but it is clear that different symptom clusters have different effects on help-negation. Further research is needed to replicate and extend these findings.

Measures

Help-negation has been measured in several ways. Firstly, it has been measured as the difference in the frequency of help-seeking behaviors between groups with different levels of psychological distress. Secondly, it has been measured as the frequency of those who withdraw from treatment compared to those who do not. For example, in one of the first empirical studies of help-negation, Rudd et al. (*1995*) measured the help-negating effect of suicidal ideation as the number of suicidal clients who withdrew prematurely from treatment, but who also shared similar symptoms, personality characteristics, and levels of psychological distress to a group who stayed in treatment. Thirdly, help-negation has been measured as the difference in the frequency of help-seeking intentions between groups with different levels of self-reported psychological distress symptoms (e.g., Wilson et al. in press a). And fourthly, as noted earlier, help-negation has been measured most commonly as an inverse correlation between self-reported symptoms of psychological distress and intentions to seek help from a range of sources, including *would not seek help from anyone* (e.g., Wilson et al. *2005a*, *2007*, *2010*). Most help-negation studies have measured symptoms of psychological distress with standardized self-report clinical or

epidemiological measures and help-seeking intentions with the General Help-Seeking Questionnaire (GHSQ) (Wilson et al. *2005b*).

The GHSQ (Wilson et al. *2005a*) measures participants' intentions by asking them to rate the likelihood that they would seek help for different problem-types from a variety of specific help-sources. The measure uses a matrix format that can be modified according to purpose and need. Within this format, help-sources and problem-types can be modified to meet sample characteristics and study requirements. In adolescent' studies, help-sources have been selected in consultation with school welfare personnel and have included sources from the following list: boyfriend/girlfriend, friend, parent, relative, mental health professional (e.g., school counselor, counselor, psychologist, psychiatrist), telephone help line, doctor/GP, teacher (year level coordinator, classroom teacher, home class teacher, Dean of Students, support staff), Pastor/Priest, and youth worker, and *would not seek help from anyone*. In each study, the following problem prompt has been used: "If you were having [*problem-type*], how likely is it that you would seek help from the following people?" Problem-types have included: "suicidal thoughts" (Wilson et al. *2005a*, *2010*), "a personal–emotional problem" (Wilson *2010*; Wilson et al. *2005a*, *2007*), "an emotional problem such as feeling depressed or stressed out" (Wilson et al. *2010*), and "a physical health concern" (Wilson et al. *2010*). In each study, participants have rated their help-seeking intentions for each help-source on a 7-point scale (1 = "Extremely unlikely," 7 = "Extremely likely"). In all studies, higher scores indicate higher help-seeking intentions.

Measurement Issues

In some help-negation studies, the frequency of help-seeking behavior has been measured retrospectively, introducing the possibility of recall bias. But, most help-negation studies have relied on cross-sectional data that has been collected at one time-point, which does not allow for unequivocal causal conclusions. Moreover, it is not known whether these results have been influenced by shared sources of method variance in the self-report data or biases in reporting (e.g., minimizing problems and levels of suicidal ideation).

Most help-negation studies among adolescents have used school-based samples. This means the extent to which specific results generalize to samples from rural or remote locations or to adolescents who are not at school is unknown. In addition, adolescents with minimal levels of suicidal ideation and other psychological distress symptoms have been over-represented in most studies. It is unknown whether results from the school-based samples will generalize to adolescents with moderate or severe symptom levels who are identified in other ways (e.g., at risk groups such as unemployed adolescents or adolescents who drop out of high school). Further research is needed to replicate existing results in larger samples of moderately to severely psychologically distressed adolescents. Recruiting larger representative samples might be achieved by using a combination of cross-sectional and targeted sampling (Wilson et al. *2010*).

A large number of help-negation studies have used the GHSQ, and, thus, have measured adolescents' intentions by asking them about problems that might be experienced hypothetically. It is still unclear whether adolescents are actually able to identify with the problem they are asked about when making their ratings. Subsequent studies might address this issue by supplementing the GHSQ with methods that use

problem vignettes, which provide further elaboration of problem details. A vignette version of the GHSQ is now available with preliminary results suggesting that the new measure has good reliability and validity, and is easy to use in clinical and research contexts (Wilson et al. in press a).

Ultimately, there is a need for prospective epidemiological studies to more clearly define the causal relationships between different forms of psychological distress and subsequent help-seeking cognitions and behaviors. In the meantime, less expensive cross-sectional studies, which have stronger correlational designs than used in existing studies, are needed to identify modifiable variables with promise for explaining the help-negation process. In future studies, the directions of relationships between variables might be examined by using longitudinal, cross-lagged, multi-wave designs. Future studies might be improved by obtaining behavioral data to support self-report ratings, from adolescents who are recruited from a wide range of contexts. Future studies would also benefit by the guidance of a person-centered model, which is framed by a person-in-context model and which accounts for both the actual and perceived availability of support that exists across the developmental course of an individual's life (Wilson and Deane *2010*).

Additional Gaps in Knowledge

Even with the limitations raised by these measurement issues, the replication of findings across adolescent studies suggests one can be confident that help-negation occurs for suicidal ideation and depressive symptoms, and there are good indications that help-negation occurs for symptoms of general psychological distress. The pattern of help-negation for formal and informal help-sources also appears to differ by symptom-type. What one does not know is whether help-negation relates to other symptoms of psychological distress, such as anxiety, in adolescent samples. Although epidemiological research suggests that anxiety symptoms promote help-avoidance among adolescents, clinical research suggests that anxiety symptoms promote help-seeking in those who are acutely anxious and depressed (see Wilson and Deane *2010*). The circumstances within which anxiety might lead to the approach or avoidance of help are not well understood. Depending on the nature and severity of symptoms, as well as other contextual and developmental issues, anxiety might be related to both help-avoidance and help-seeking.

Variables that explain, strengthen, or predict help-negation for different symptom-types are largely unknown. A promising direction for further research is to examine the commonalities that currently exist across help-negation results. There may be common processes occurring that promote help-avoidance when adolescents experience different forms of psychological distress. For example, the constricted cognitive–affective state that is associated primarily with suicidal ideation, but also other forms of psychological distress (e.g., depressive symptoms), may play a role in help-negation for symptoms that commonly co-occur. Applying new problem solution strategies requires both the ability to recognize that strategies which have worked in the past aren't sufficient to solve the current problem, as well as the ability to consider a broader range of problem solutions than have been used in the past. Cognitive constriction might interfere with these abilities. Adolescent's primary means of recognizing that a problem exists usually includes attitudinal, affective, behavioral and/or physiological cues (Wilson et al. *2010*). While it might seem reasonable to

expect that higher levels of suicidal ideation and other symptom-types would assist adolescents to recognize their psychological distress and need for help, so far, help-negation results do not support this hypothesis. For suicidal ideation, depressive symptoms, and symptoms of general psychological distress, higher distress levels do not appear to increase capacity for problem recognition. It is possible that there are common processes for these symptom-types that interfere with problem identification and the cognitive help-seeking process (Wilson et al. in press b).

The decision to seek help for symptoms of psychological distress is at the nexus of the adolescent's personal experience of their distress and their interpersonal expression of this experience. Consequently, the adolescent's cognitive, affective, and behavioral responses to their symptoms of psychological distress are implicated in explaining help-negation (Wilson and Deane *2010*). This highlights an important gap in knowledge. Although explanatory models that focus on the individual's cognitive help-seeking processes have been developed, few pay any attention to the influence of the individual's affective state or their cognitive response to, or within, their affective state. Yet, being unaware of one's emotions and cognitive difficulties can correlate with the experience of psychological distress and, commonly co-occur, and together, result in poor performance on cognitive tasks that can involve problem recognition and decision making (Wilson et al. in press b). Across cognitive help-seeking models, problem recognition, deciding to seek help, and selecting a help provider are recognized as the three broad stages that lead to accessing help. Across models, beliefs about seeking help (attitudinal, self-efficacy, normative, risk-related), and help-seeking intentions are common elements. And, across models it is generally agreed that the cognitive help-seeking process is influenced by individual, interpersonal, and sociocultural context variables that promote or impede help-seeking success (see Wilson and Deane *2010*). Future research needs to clarify whether different forms of emotional and cognitive unawareness have a role in explaining help-negation for different symptom-types. This should be considered in conjunction with cognitive variables, such as mental health literacy and beliefs about the need for treatment versus autonomy, and context variables, such as personality style and apathy (Wilson et al. *2011*; Wilson et al. *2007*).

There are also gaps in knowledge about what specific help-negation results might mean, particularly the results related to seeking help from family and friends. Parents are particularly important for younger adolescents because they facilitate access to professional help sources. While the capacity for self-referral develops over adolescence into young adulthood, as independence and autonomy from parents develops, parents continue to play a significant role in the help-seeking process, particularly until young people are financially independent. As young people progress through adolescence, the role of friends is also prominent in help-seeking pathways. For young adults, intimate relationships become an important source of support, particularly for males (Rickwood et al. *2007*). Therefore, indications that the help-negation process extends to family and friends for suicidal ideation and depressive symptoms are particularly concerning. It means that suicidal and depressed adolescents, who are most in need of professional help, may not receive professional care because they simultaneously reject help from the people they are often closest to. Friends and family are often those who are most likely to recognize an adolescent's need for help. Family in particular can be critical to helping adolescents to access professional sources of help, such as the family doctor (Wilson et al. *2010*). Consequently, adolescents who are at risk for suicide and depression might not

receive the support they need to facilitate access to appropriate mental health services (Wilson et al. 2011).

Another reason to explain why adolescents negate help from family and friends might be that they believe these sources can't help (Wilson and Deane 2010). Past help-seeking experiences that are not perceived as helpful by the adolescent might contribute to future help avoidance (Wilson et al. 2007). Such help-avoidance would likely be exacerbated in families and friendships that are experiencing dysfunction (Wilson and Deane 2010). It is also possible that suicidal or depressed adolescents might strive to maintain an appearance of strength, believing that to tell family or friends about their distress might "let their friends or family down." Adolescents have described their concern about unduly worrying their friends and family if they talk about a distressing problem, and particularly if that problem relates to suicide. For friends and family, this suggests that the help-negating effect of suicidal ideation might be underpinned by a fear that telling one's friends and family about suicidal thoughts would place too great a burden on these loved ones (Wilson and Deane 2010). Finally, another reason might be that adolescents who are experiencing suicidal ideation or symptoms of depression, even at subclinical levels, might avoid help because they predict negative consequences (e.g., stigma, rejection, hospitalization) if they tell their friends or family about their problem (Wilson et al. 2005a). The extent to which each of these hypotheses can explain the help-negation effect requires further research.

Implications

Although help-negation research is still in its early stages, results from existing studies suggest that help-seeking promotion programs would do well to consider the role of parents and friends, as well as other informal gatekeepers in accessing appropriate help. Informal gatekeepers include the support people in an adolescent's community who are not trained mental health professionals (such as coaches and teachers). These individuals can facilitate pathways to professional mental health care. Promotion programs should teach skills to adolescents and their gatekeepers, which involve practicing the specific steps involved in seeking help. By rehearsing the steps involved in help-seeking when adolescents are not distressed, it might be possible to improve their use of these steps when they are distressed and in need of good advice (Wilson et al. 2011). Adolescents might also benefit from education about help-negation for different symptom-types to both increase their awareness and possibly, to inoculate them against the avoidance process. This would be particularly important prior to the onset of psychological distress or more acute suicidal states that might strengthen help-negation (Wilson et al. 2005a).

At a policy level, existing research reinforces the need for Governments to fund suicide and depression prevention strategies that focus on reducing barriers to help-seeking, paying particular attention to the help-negation process, and the ways this effect might differ for different indicators of mental health problems and different help-sources. There is also a need for Governments to fund longitudinal epidemiological research that maps help-seeking pathways for different types of psychiatric symptoms, together with the impact of comorbidity between these symptoms, across cultures and countries (Wilson and Deane 2010). Such research might make it possible to address help-negation early, and consequently, reduce the

high prevalence of mental disorders that currently exist among young people the world over (Belfer 2008).

Conclusions

To date, help-negation research provides evidence that, even at subclinical levels, suicidal ideation, depressive symptoms, and symptoms of general psychological distress impede the cognitive help-seeking process during adolescence. Although the identification of the specific variables that account for these results is a task for future research, existing help-negation research highlights the importance of improving understanding of why adolescents become reluctant to seek help as their levels of psychological distress symptoms increase. Future research needs to examine the impact of psychological distress on each component and stage of the cognitive help-seeking process (i.e., beliefs, intentions, problem recognition, deciding to seek help, and selecting a help provider). Future research also needs to identify the determinants of help-negation for different symptom-types. In the meantime, mental health promotion strategies should continue to focus on promoting appropriate help-seeking, as well as to alert adolescents and their families, friends, and mental health care clinicians about the tendency to avoid or withdraw from help even when psychological symptoms are just emerging. By raising awareness, it might be possible to prevent help-negation occurring more strongly in the presence of increased levels of psychological distress.

Cross-References

Help-Seeking

Mental Health Stigma

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