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Adolescent opinions on the Asking for Help Program : Assessing participant outcomes

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Adolescent Opinions on the *Asking for Help Program*: Assessing Participant Outcomes

by

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DECLARATION OF CO-AUTHORSHIP

I hereby declare that this thesis incorporates material that is the result of joint research, as follows:

The author was responsible for creating the moderator guides for the focus groups, conducting the focus groups, participant recruitment, and data collection. Dr. Rosanne Menna and Dr. Kathryn Lafreniere created the intervention program of interest, the *Asking for Help Program.* All of the mentioned researchers helped to select the questionnaire battery. This collaboration is covered in chapters one and two of the thesis. In all cases, the key ideas, primary contributions, experimental designs, data analysis, and interpretation were performed by the author, and the contribution of co-authors was primarily through the provision of supervision and the intervention program.

I am aware of the University of Windsor Senate Policy on Authorship and I certify that I have properly acknowledged the contribution of other researchers to my thesis, and have obtained written permission from each of the co-author(s) to include the above material(s) in my thesis.

I certify that, with the above qualification, this thesis, and the research to which it refers, is the product of my own work.

ABSTRACT

This study examined the effectiveness of a school-based intervention, the *Asking for Help Program.* Participants were 50 at-risk adolescents, aged 14 to 19 years old (M = 15.98, SD = 1.30), who completed pre- and post-questionnaires to assess perceived barriers to help seeking, attitudes towards seeking professional help, and actual help seeking. Qualitative data was also collected using focus group interviews. Qualitative findings detected significant gains in participants' perceptions of barriers pertaining to knowledge and social stigmas as well as suggested that participants' attitudes towards seeking help improved. Findings are discussed within the context of participants' perceived and actual change as well as participants' suggestions for how the intervention could be improved.

DEDICATION

To adolescents everywhere: I have faith in *you*.

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Foremost, I would like to thank my supervisor, Dr. Rosanna Menna, for her support, patience and mentorship. Her standards for research taught me invaluable lessons and continue to be something I aspire to. To the rest of my committee members, I am grateful for their constructive feedback and enthusiasm for this research project.

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Finally, I would like to recognize the adolescents who participated in the study. They touched my life with inspiring comments and taught me more about risk and resilience than I could have ever learned from a text book or class. The compassion, bravery, and resilience that they show in their everyday lives is an inspiration. I appreciated their honesty and willingness to share personal experiences – their insights will undoubtedly contribute to improving the *Asking for Help Program*, and thus, touch the lives of other adolescents.

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INTRODUCTION

Adolescence is the period of transition between childhood and adulthood where significant psychological, social, and physical developmental changes take place (Crockett, Petersen, Graber, Schulenberg, & Ebata, 1989). In fact, adolescence has been identified as a period when rates of psychopathology increase and the onset of adult psychological disorders emerge (Offer, Howard, Schonet & Ostrov, 1991). Adolescence is also a time when youth place greater importance on affiliating with their peer group instead of their family, initiating romantic relationships, and striving for greater independence. For these reasons, it is not surprising that many teenagers feel overwhelmed and insecure; however, for students with emotional and behavioural difficulties, adolescence is a time of increased emotional sensitivity, withdrawal, distractibility, and disruptiveness that is likely to interfere with their ability to cope (Horowitz et al., 2003).

Help seeking is an important coping behaviour that involves actively seeking out assistance from formal (e.g., professionals) or informal (e.g., relatives and friends) resources for a problem or concern (Fallon & Bowles, 2001). An adolescent's reaction to stress, such as seeking help and utilizing support systems, has been shown to have a buffering effect on adolescent well-being. In fact, healthy coping strategies are associated with better adjustment outcomes and fewer emotional and behavioural problems (Cauce, Mason, Gonzales, Hiraga, & Liu, 1994; Dubois, Felner, Sherman, & Bull, 1994; Schonert-Reichl & Muller, 1996). The importance of how youth perceive and respond to life stressors is emphasized in Menna and Ruck's review (2004) in which it is cited that adolescent help-seeking has implications for future competence, coping

skills, well-being, and subsequent life choices. Despite this, evidence suggests that very few adolescents seek the appropriate help when experiencing difficulty (Cauce et al., 2002).

It has been estimated that approximately half of adolescents with behavioural or emotional problems do not seek help from mental health services (Ostrov, Offer, and Hartlage, 1984). Dubow, Lovko, and Kausch (1990), who found that nearly two-thirds of junior high school students with distressing problems did not seek help, in spite of experiencing depression and engaging in risky activities such as substance abuse and suicidal behaviour, support such findings. Other research has reported that up to 40% of adolescents with thoughts of self-harm have failed to seek help or talk to anyone (Evans, Hawton, & Rodham, 2004). More concerning are research findings showing that the willingness to seek help significantly decreases as suicidal ideation increases (e.g., Deane, Wilson, & Ciarrochi, 2001).

The present study examined the success of a school-based help seeking intervention program designed to address the needs of adolescents. A goal of the present research was to examine pre- and post-intervention differences in adolescents; specifically, attitudes towards help seeking, actual help seeking, and perceived barriers. Also of interest, was to explore adolescent perceptions of how worthwhile the intervention was and how it was useful.

Organization of Literature Review

First, various unproductive coping strategies will be discussed within the context of cognitive models that can be used to predict who will seek help. Next, differences between adolescent male and female help-seeking will be reviewed to help emphasize the

role gender plays in determining when adolescents seek help and what barriers they face. Further discussion will examine how problems commonly reported by youth are often underestimated by caretakers and rarely understood by service providers. Subsequently, the types of resources available to adolescents and the barriers adolescents face will be addressed. Factors that promote help-seeking behaviour and the effect of the family environment on adolescent help-seeking will also be considered. Finally, research on adolescent help-seeking intervention programs will be reviewed and focus group feedback sessions will be evaluated. Prior to presenting the rationale of the current research, the methodological issues and limitations of past research will be examined.

Help Seeking as a Coping Behaviour

As a result of the stress adolescents experience from significant life changes, many youth are at an increased risk of academic failure, school dropout, depression, delinquent behaviour, and substance abuse (Menna & Ruck, 2004). Laukkanen, Honkalampi, Hintikka, Hintikka, and Lehtonen (2005) suggest that such negative outcomes result when an adolescent's coping style fails to provide him with a sense of continuity and self-coherence. Alternatively, other researchers propose that adolescents become vulnerable to negative influences when they have a poor sense of self and their role (Zimmerman, Copeland, Shope, & Dielamn, 1997).

Research investigating adolescent coping styles suggests that avoidant or passive coping (e.g., denial of problems) significantly contributes to behavioural problems and symptoms of depression (Beutler, Moos, & Lane, 2003; Muris, Schmidt, Lambrichs, Meesters, 2001). In a study of 2,419 high school students where self-reports were used to identify youths' attitudes about coping and help-seeking strategies, researchers found that

maladaptive coping methods reflected dysfunctional attitudes and isolating behaviours such as keeping one's feelings to oneself and disconnecting from social groups (Gould et al., 2004). In fact, Gould et al. reported that one third of students with suicidal ideation reported feeling that people should be able to handle their own problems without outside help. They also found that one fourth to one third of depressed or suicidal adolescents felt that drugs and alcohol were an effective means of stopping depressive symptoms (Gould et al.). This evidence supports the idea that high-risk adolescents may hold attitudes that lead to or sustain maladaptive coping.

The abundance of research on adult help-seeking suggests that social cognitive models can be used to predict how likely one is to seek assistance. For instance, Protection Motivation Theory (PMT) proposes that the tendency to adopt a given behaviour is a function of one's expectancies regarding the consequences and value of the behaviour (Milne, Sheeran & Orbell, 2000). According to PMT, two variables mediate behaviour change. First, 'Threat Appraisal' refers to a process of evaluation where an individual considers how vulnerable he feels to a threat, how serious he believes the threat is to his life, and how much fear the threat evokes. Second, 'Coping Appraisal' refers to an individual considering whether a coping response (e.g., seeking help) will be effective in reducing the threat, how able the individual is to perform the response, and how costly performing the response will be to the individual. When applied to help seeking, PMT suggests that a person is more likely to seek help if a problem is causing significant distress, seeking help is associated with few costs, and it is believed that the problem will improve upon asking for assistance.

The Theory of Planned Behaviour (TPB) can also be applied to predict the likelihood that a person will seek help. This theory posits that a person's attitudes regarding the target behaviour (e.g., help seeking), motivation to comply with social norms, and perceptions of control contribute to the intention to perform the behaviour (Vondras & Madey, 2004). Using this model, a person is most likely to seek assistance if they perceive help seeking favourably (e.g., a sign of autonomy), sense social pressure to seek help (e.g., family suggestions), and believe barriers to receiving help will be overcome with ease.

Importantly, the aforementioned models were developed to predict adult behaviours and suitability for treatment. Only recently have researchers begun to work toward developing a model that could be applied specifically to adolescents. Cauce et al. (2002) suggest that adult models fail to consider variables unique to the adolescent experience. For instance, none of the previously mentioned models directly considers the influence of one's family – which is often the most proximal influence in an adolescent's life. As such, Cauce et al. developed a model specific to adolescent help seeking that the family and adolescent's perception of need are seen as vital to recognizing adolescent problems. In addition to considering youths' attitudes about mental health services, perceived need for help, and problem severity, this model also considers challenges specific to an adolescent's decision to seek help. For instance, Cauce et al. emphasize the adolescent's need for privacy and autonomy as well as their often insecure sense of self-identity. Finally, the model identifies common barriers to seeking help that relate to adolescent services, such as family confusions about which treatment centers are designed for youth and the need for parental consent.

Gender Differences

Adolescent help seeking has been shown to be gender dependent in that females tend to seek help more often than males (Boldero & Fallon, 1995; Dubow et al., 1990; Schonert-Reichl & Muller, 1996). Compared to their male counterparts, females have also been found to recognize the need for mental help more readily, hold more positive attitudes towards mental health professionals, and place greater confidence in service providers (Leong & Zachar, 1999). Male adolescents tend to express their emotions in more external ways (e.g., aggression), and as a result, are often found to be at greater risks for interpersonal conflict and violent outbursts (e.g., Casper, Belanoff, & Offer, 1996).

After investigating help-seeking behaviours among male Caucasian high school students in affluent New England suburbs, Timlin-Scalera, Ponterotto, Blumberg, and Jackson (2003) discovered that social pressures significantly influenced participants' help-seeking behaviours. Males between the ages of 14 to 18 years reported an intense need to maintain a strong masculine image and felt extreme pressure from the competitive culture they were embedded in. For instance, many participants felt obligated to attain the wealth and success their parents had. Male adolescents who identified themselves as gay, a school athlete, or learning disabled reported stressors unique to their experience. Gay males reported distress about finding someone to have an intimate relationship with or to disclose their sexual orientation. Athletes were found to report tremendous pressure to maintain the superior image that they felt their town and school had established. Adolescent participants with learning disabilities reported feeling incompetent, inadequate, and low-self esteem because of their disability. Adolescents

with a learning disability were also found to be absent from school significantly more often than the other participants, described school as futile, and were more prone to engage in drug use. The majority of adolescents were found to use ineffective strategies to manage problems (i.e., denial and avoidance of problems, aggression, and withdrawal from social groups). Further investigation is needed in order to generalize these findings to adolescents from middle and lower socio-economic status as well as to different ethnicities.

O'Brien, Hunt, and Hart (2005) investigated male help-seeking behaviours in a sample diverse in social economic background, occupation, health status, and age. While participants ranged from 15 to 72 years old and all endorsed the view that men should be reluctant to seek help, younger males were most reluctant and seemed more influenced by male stereotypes (e.g., men should be able to handle their problems without the help of others). O'Brien et al. found that the majority of participants justified seeking help to preserve or restore their manhood; for instance, being able to perform sexually or to heal a visible and obviously painful injury.

Together, the literature suggests that adolescent help-seeking behaviours are heavily influenced by the social norms present in one's environment. Cauce et al. (2002) note that contextual influences often result in females feeling free to exhibit concerns and are rewarded for doing so, whereas males are more likely to be rewarded for being tough and independent. Indeed, many studies show significant differences in parental responses towards male and female children. In fact, gender socialization has been reported to occur as soon as infancy (Parke, 1996; Rubin, Provenzaro, & Luria, 1974; Stern & Karraker, 1989). The common findings within such studies are that male infants are

often handled more aggressively, greeted more often with masculine phrases (e.g., "Hello, Tiger" vs. "Hello, Princess"), and are far more likely to be involved in rough-and-tumble play as compared to girls. Additionally, Leaper, Anderson, and Sanders (1998) found that parents were more verbally responsive to girls – using more supportive speech and speaking to them more often. As such, these studies illustrate the predominance of gender roles within our society and how children may be influenced from a very early age. Perhaps, it is a result of these influences that gender differences in help seeking have been found in children as young as 3-years-old (Benenson & Koulnazarian, 2008). Papini, Famer, Clark, Micka, and Barnett (1990) report that social pressures to behave in gender-appropriate ways intensify during adolescence and often result in females revealing problems to others while males conceal problems. Such findings raise questions as to whether society has failed to teach boys effective ways of communicating their problems and that it is okay to show vulnerability.

Additional gender differences have been reported in the help-seeking literature regarding who adolescents turn to for help and the types of problems adolescents find most distressing. However, inconsistencies exist within research concerning to whom adolescent males turn to for help most often. While one researcher reports that males seek help from teachers and peers (Borg, 1998), others show evidence that males seek help primarily from parents and then peers (Hodgson, 1986; Weigel, Devereux, Leigh, & Ballard-Reisch, 1998). Still, others have found that male adolescents seek out help from parents and not peers (Boldero & Fallono, 1995). Results are uniform across studies for female adolescents as it has been consistently reported that female adolescents seek help primarily from friends (Borg, 1998; Weigel et al., 1998). Overall, females appear to seek

help from their friends, mothers, and mental health professionals more often than their male counterparts (Schonert-Reichl & Muller, 1996), but males may confide in parents for personal concerns more than females (Hodgson, Feldman, Corber, & Quinn, 1986).

Boldero and Fallon (1995) suggest that adolescents often judge the suitability of various help-seeking resources based on their expectations of different relationships. For example, while adolescent females tend to prefer peer interactions marked by reciprocity, exclusivity, and understanding, adolescent males tend to prefer interactions based in competition, status, and dominance (Ladd, Price, & Hart, 1990). From such findings, researchers suggest that adolescent females are more likely to express concerns to friends, as compared to adolescent males, as their expectations of friends are more likely to be that of empathy and camaraderie (Clark & Ayers, 1993).

When considering who to seek help from, it seems that adolescent males struggle more often with aversive emotions and beliefs that others will not be able to provide sufficient aid; in contrast, females often hesitate to seek help in fear of judgment or unfavorable opinions of others (Kuhl, Jarkson-Horlick, & Morrissey, 1997). However, once adolescents decide to seek help, research suggests that the type of problem youth experience influences the help resources they choose. Frydenberg and Lewis (1993) found that females are more likely to report problems to do with family, interpersonal relationships, and health problems in comparison to males who are more likely to report educational problems. The implications of this will be discussed in later sections.

Problems of Youth and Service Utilization

Problems that adolescents have identified as important and stressful include school-related issues, such as worrying about grades, college or university applications,

family conflicts, and financial difficulties, health, problems with peers, and romantic relationships (Menna & Ruck, 2004). The most frequently reported problems endorsed by adolescents included: feeling overweight (18%), having trouble with parents (17%), depression (11%), alcohol use (10%), peer pressure (9%), trouble dating (9%), drug use (7%), and suicidal thoughts (6%) (Dubow, Lovko, & Kausch, 1990). A study done just five years later (Culp, Clyman & Culp, 1995) suggests that the prevalence rates of youth-related problems increased significantly: loneliness (66%), school-related problems (64%), depression (54%), not feeling good about oneself (55%), and problems with friends (50%). Importantly, each of these studies used samples of junior high (grades 6 to 8) and high school students (grades 9 to 12) with similar demographic characteristics.

While some may argue that youth in need of help will be recognized by care-givers, research has found that the difficulties experienced by adolescents far exceed what is estimated by parents and teachers. In fact, as levels of reported distress increased in adolescents, parents and teachers were less likely to identify levels of distress accurately (Santor, Kusumakar, Kutcher, & McCurdy, 1999). Further studies show that mental health professionals may also significantly underestimate the severity of an adolescent's problems. One study showed that one half of suicide attempters aged 15 to 24 years had no healthcare contact or aftercare recommendations in the month following their attempt and only one quarter were referred for a psychiatric consultation (Suominen, Isometsa, Martunnen, Ostamo, Lonnqvist, 2004). The same study reported that many 15 to 19 year old male suicide attempters had no treatment contract before or after their attempt despite being diagnosed with a mental disorder.

The second cycle of the Canadian Community Health Survey (CCHS), involved approximately 37,000 people aged 15 years and older findings showed that approximately 25% of people aged 15 to 25 years reported receiving help during the past year compared to approximately 45% of adults between the ages of 25 to 64 and 33% of adults aged 65 and older (Statistics Canada, 2003). Based on this, adolescents appear to forgo help more than other age groups. Despite this, Stanhope, Menna, and Newby-Clark (2003) found that approximately 68% of 451 Canadian adolescents (14 to 19 years old) reported seeking help for problems related to school, family, peers, and significant others. Similarly, Rickwood and Braithwaite (1994) reported comparable results based on a sample of 704 Australian adolescents (16 and 19 years old) when asked if they had sought help for a psychological problem in the past 12 weeks. Fallon and Bowles (2001) also found that 58% (196 participants) of Australian adolescents had sought help for personal problems within the last six months. Importantly, Cauce et al. (2002) note that the variation in the rates of help seeking may be related to characteristics of samples (e.g., ethnicity) and how help seeking is operationalized. For example, the CCHS is designed to represent approximately 98% of the population aged 15 years or older in the ten Canadian provinces opposed to Stanhope et al. who focused on a school-based population.

Together, the literature suggests that adolescence is a period of change when one is particularly vulnerable and likely to experience distress (Santor, Poulin, LeBlanc & Kusumakar, 2007). Given the inexperience of youths, it is particularly important that adolescents seek appropriate help when encountering life stressors to develop effective coping skills. As such, an understanding of adolescent issues and service utilization is

critical to any outreach attempting to address the problem of infrequent adolescent help-seeking.

Help Resources as Dependent on the Type of Problem

Of popular debate in the help-seeking literature are the factors that prompt youth to choose one help resource over another. Boldero and Fallon (1995) suggest that an adolescent's 'preferred helper' may be determined by the perceived effectiveness of the help resource in solving the problem or the nature of the relationship between the adolescent and the help resource (i.e., familiar and trustworthy). However, most researchers suggest that adolescents seek help from more than one help resource and select one resource over others according to the type of problem (Sullivan et al., 2002). For example, adolescents have been found to seek help from friends more often for interpersonal problems and seek help from teachers and health professionals more often for school- and health-related problems respectively (Fallon & Bowles, 1999). It appears that adolescents consider the suitability of various help resources before seeking assistance.

Adolescents seek help from formal and informal resources. Formal resources are doctors, social workers, psychologists, and other professionals. Informal resources of help include friends and family. A prominent finding within the help-seeking literature is that adolescents prefer to seek help from informal resources (Raviv, Sills, Raviv, & Wilansky, 2002).

Formal Help Resources

Consistent with the belief of perceived effectiveness, Wintre, Hicks, McVey, and Fox (1988) found that adolescents justified seeking professional help when they

perceived the expert as being more knowledgeable about their problem than informal resources. For instance, adolescents who perceive their family as being unable to provide appropriate help, due to frequent family conflict, have been shown to be more likely to seek professional help (Menna & Ruck, 2004). Sears (2004) presents similar findings as adolescents living with someone other than their parent, or who chose not to talk to family members about their problems were found to be more likely to seek professional help. Importantly, Sears notes that these findings may reflect the presence of a confounding variable since adolescents with poor family relationships tend to have higher prevalence rates of negative emotional and behavioural adjustment problems.

As would be predicted based on findings suggesting that help seeking is gender dependent, females are more likely to perceive a need for professional help (Dubow et al., 1990). As well, adolescents who report severe suicidal ideation, poor physical health, or a history of abuse are more likely to recognize a need for professional help, but do not always seek assistance (Saunders, Resnick, Hoberman, & Blum, 1994). Based on research, Saunders et al. described youth who tend to seek professional help as those who have had a medical check-up in the previous year, use informal supports, and have parents who were not married. Theses studies seem to highlight the importance of parent-adolescent relationships as youth living separately from their parents and youth who describe a high level of family conflict are repeatedly shown to seek (or want) professional assistance. Stated another way, adolescents who have fears of being alienated from their family, have concerns about confidentiality, or feel family members are not capable of providing sufficient help tend to seek professional help (Menna &

Ruck, 2004). Based on the aforementioned research, formal help resources appear to be chosen when informal supports are not enough.

Recent studies suggest that adolescents are more likely to seek professional help from school personnel, in particular guidance counselors, than other formal help sources (e.g., Fox & Butler, 2007; Scotto Rosato, 2007). This has become an issue of great concern as frequent adolescent difficulties (i.e., those related to substance abuse and psychological conditions) are currently outside the role and training of school personnel, and thus, may be minimized, overlooked, or handled inappropriately (Farrand, Parker, & Lee, 2007). This highlights the importance of who an adolescent chooses to seek help from as specialized training and resources are often required to effectively manage issues that many at-risk youth experience (e.g., homelessness, drug abuse, gang affiliations, etc).

Informal Help Resources

Many youth are thought to prefer to seek help from informal resources since help can be sought more casually than when seeking help from formal resources (e.g., no need to make an appointment; Raviv et al., 2000). More specifically, Raviv et al. depict friendship as providing a reciprocity that minimizes the visibility of the help-seeking process, and for this reason, may be associated with fewer barriers to help seeking. Moreover, informal resources are often more familiar to the adolescent seeking help and may be more likely to understand their needs in comparison to an unfamiliar professional.

As was mentioned earlier, research investigating patterns of help seeking suggests that adolescents do not seek help from parents and friends for the same problems (Boldero & Fallon, 1995) or with the same frequency (Schonert-Reichl & Muller, 1996). For instance, an adolescent's peer group is more likely to influence choices regarding

clothing, dating relationships, music, and substance use whereas parents are thought to influence choices regarding education, occupation, and long term goals (Sullivan et al., 2002; Windle, Miller-Tutzauer, Barnes, & Welte, 1991). A further distinction can be made between parents since research has shown that adolescents seek help more often from mothers due to availability, support, maternal warmth, acceptance, and understanding (Sullivan et al.).

In addition, research suggests that adolescents' expectations differ for various types of informal help resources. While expectations of nurturance have been found to be important when adolescents decide to seek help from a friend, expectations that the resource will know how to help have been found to be more important when seeking a parent for help (Sullivan et al., 2002). In fact, Sullivan et al. suggest that adolescent help seeking serves the function of obtaining sound advice when parents are consulted, and the function of developing and maintaining relationships when peers are consulted. The implications of this are twofold. First, help seeking appears as not only a means of coping, but also a way to increase camaraderie among peers. Second, parents appear to remain an important and positive resource when adolescents view their parents as being able to help sufficiently.

Few studies have been conducted to assess the adequacy of informal helpers' responses to adolescents who disclose upsetting experiences, such as dating violence. However, one such study showed that while nurturing was the most common response of helpers (i.e., family and high school peers), responses differed depending on the severity of the experience. Specifically, adolescents who told someone about being victimized by severe dating violence were more likely to receive an avoidant response than adolescents

who told someone about a less severe incidence of dating violence (Weisz, Tolman, Callahan, Saunders, & Black, 2006). Further, males were more likely to encounter minimizing responses when disclosing less severe forms of dating violence than females. Notably, help seekers are suspected to have differed in the way they presented their story; that is, girls were found to be more likely to report that they cried while seeking help whereas boys were found to be more likely to report that they had laughed or told their story in a humorous way (Weisz et al.). Based on their findings, the researchers propose that the potential helpers did not feel able or willing to help when presented with very a serious problem and may have avoided talking to the youth seeking help due to gender stereotypes or fears about the abuser's reaction (Weisz et al.). Additionally, Weisz et al. suggest that adolescents may have responded unfavorably to help seekers because of their limited experience with dating violence and potential uncertainty of the definition of abuse and how to access formal supports.

In general, the literature indicates that though adolescents feel more comfortable and familiar with informal help sources, friends and family are often ill equipped and unqualified to provide adequate assistance for complex problems. Further research is needed to assess how readily informal helpers recognize their own limitations and rely on formal, as opposed to informal, supports.

Barriers to Seeking Help

It is believed that an adolescent's expectations of how likely others will be able to help, the reactions others will have, and the anticipated success of the help-seeking process play an important role in determining whether youth seek help (Miller & Read, 1987). As such, adolescents have been reported to engage in cost-benefit analysis when

making the decision to seek help. Wills (1983) showed that youth often feel that the costs associated with seeking help for minor problems outweigh the benefits, but that as symptom severity and distress increase, youth are more likely to seek help – especially from professional resources.

In addition to concerns regarding the usefulness of seeking help, not knowing where to receive help was reported as a major barrier to obtaining professional help (Sheffield, Fiorenza, & Sofronoff, 2004). Even when adolescents are able to identify appropriate help resources, research shows that help may be more available to some youth than to others. For instance, adolescents with internalizing problems (i.e., depression and anxiety) may be less likely to receive help than those with externalizing behaviour problems (i.e., aggression and hyperactivity). Garland and Zigler (1994) suggest that the latter group is more likely to seek out help and that these individuals are more likely to be identified by teachers and caregivers due to disruptive behaviour. Likewise, another study found that adolescents with low socio-economic status reported receiving less emotional support from family, peers, and school personnel than did adolescents with middle socio-economic status (Menna, Ruck, Silverman, & Keating, 2007). These results seem to reflect the fact that parents of lower class families often need to work longer hours, are more likely to be single-parents, and are less likely to be able to afford private services. At this time, it is important to note that the majority of research on help seeking has been limited to adolescents in the middle and upper social classes. Based on this, one must interpret research with caution so as to not generalize the obtained results with adolescents in families of low socio-economic standing.

The gap created when those who need help do not receive it has been conceptualized as the 'service gap' (Kushner & Sher, 1991). While many factors are thought to contribute to the service gap, Nadler (1991, 1997) attributes its emergence to the emotional costs that youths incur when seeking help. For instance, Nadler refers to the relationship between an adolescent's self-esteem and help-seeking behaviour. More specifically, Nadler suggests that adolescent help-seeking often results when youth feel inferior as a result of their problem and see the consequences of seeking help (e.g., being labeled as weak) as being less severe. Notably, the concept of inferiority is often mistaken as being related to mental illness. For instance, nearly half of 57 Grade 8 students confused mental illness with mental retardation, inadequacy, a permanent state of insanity, or something that necessitates hospitalization (Chandra & Minkovitz, 2006).

According to the Vulnerability Hypothesis (Bramel, 1968), people with a positive self-image are less vulnerable to threats to their self-esteem and are less affected by ideas that seeking help is a sign of inadequacy and weakness. As such, Bramel posits that people with a positive self-image will be more likely to seek assistance than those with a lower self-image. In this view, asking for help, when required, may be seen as a sign of autonomy since one must be competent to recognize a need for help and sensible enough to choose an appropriate help resource. On the other hand, the Consistency Hypothesis (Tessker & Schwartz, 1972) proposes that people seek out feedback consistent with their self-image. In this case, people with a positive self-image are thought to be less likely to seek help, as asking for assistance may elicit feelings of inadequacy that are contrary to their self image. Notably, the majority of research on help-seeking attitudes and behaviours supports the Consistency Hypothesis. For instance, youth were less likely to

seek help if they felt that they had contributed to the problem causing distress, felt the problem was unique to their experience, or had feelings of inferiority or dependence (Nadler 1991, 1997).

Raviv et al. (2000) illustrated the presence of the 'threat to self' by comparing adolescents' willingness to seek help for themselves to their willingness to refer another adolescent for help. Their findings revealed that adolescents are more willing to refer others for help than to seek help for themselves, especially for severe problems. The only exception to this finding was when the resource of support was a friend. In agreement with the Consistency Hypothesis, Raviv et al. suggest that feelings of need, inferiority, and incompetence inhibit adolescent help seeking; however, similar problems belonging to other adolescents do not evoke the same feelings of weakness. From this, Raviv et al. introduced the 'person service gap' in an attempt to highlight the discrepancy between adolescents' willingness to seek help and their recognized need for help (willingness to refer another youth in the same situation for help). Using this construct, one is presumably able to measure adolescents' perceived need for help by freeing them from possible threats to their self-image.

Research has also examined how barriers to seeking help change depending on whether adolescents intend to seek assistance for themselves or for a friend (Cigularov, Chen, Thurber, and Stallones, 2008). Questionnaire responses obtained from 854 high school students revealed that youth perceive the most prominent barriers for 'self' to be an inability to discuss problems with adults (e.g., lack of communication skills), self-overconfidence, fear of hospitalization, and lack of closeness to school personnel, whereas youth perceived the most prominent barriers for 'friend' as friendship concerns,

approachability of adults at school, fear of friend's hospitalization, and underestimating a friend's problem. These findings support Raviv et al.'s (2000) results of why adolescents seek help more for others than for themselves; that is, the threat that seeking help poses to an adolescent's ego appears to be significantly greater than the threat of losing a good friend or being misunderstood by adults.

Promoting Factors of Help Seeking

While many factors have been found to deter youth from seeking help, variables such as social support, increased psychological distress, greater adaptive functioning, and fewer perceived barriers have been identified as increasing adolescents' willingness to seek help for mental illness (Sheffield et al., 2004). For instance, resources are sought as symptoms and problem severity increase; thus, distress is believed to motivate adolescents enough to overcome barriers to help seeking (Sheffield et al.). Parent and peer involvement (e.g., statements of concern) have also been found to improve the likelihood that an adolescent will recognize their problem and seek help (e.g., Fröjd, Pelkonen, von der Phalen, & Kaltiala-Heino, 2007). Further, anticipation of positive responses from family, peers, and school staff have been shown to be key factors in determining young adolescents' comfort and willingness to confront mental health problems (Chandra & Minkovitz, 2006).

Adolescents with large social networks appear to seek help more often from informal resources than adolescents with lower levels of social support (Sheffield et al., 2004). However, adolescents' with fewer supports may compensate by connecting with others who have similar interests. For instance, extracurricular activities may enhance one's social network, and thus, increase the number of potential resources (e.g., coaches;

Timlin-Scalera et al., 2003). In addition, researchers have found that adolescents motivated by interests in friendship tend to ask for help more often from their friends and associate feelings of satisfaction with friendship after doing so (Okada, 2007). Adolescents who are unable to form strong social networks are still likely to seek help as the presence of promoting factors increases. The ability to trust others, form good doctor-patient relationships, and having prior positive help-seeking experiences all increase the likelihood that adolescents will seek help (Wilson & Deane, 2001).

Education has also been associated with increases in adolescent help seeking. After involving rural adolescents enrolled in Grade 9 health classes in a unit of instruction on mental health, Heights, Esters, and Ittenbach (1998) found that participants' attitudes about seeking professional help and their conceptions of mental illness improved significantly compared to their peers who were assigned to the control group based on class assignments. The observed effects were maintained when adolescents who attended the instructional unit were assessed 12 weeks later. Chandra and Minkovitz (2006) found evidence to suggest that positive help-seeking experiences (e.g., resolving a problem) with mental health professionals and accurate mental health knowledge positively influences help-seeking attitudes and reduces mental health stigmas of students as young as 12 years old. The former findings suggest that educating adolescents on help-seeking opportunities promotes help seeking in the near and distant future whereas the latter emphasizes the importance of early intervention.

Relationships between Help Seeking and the Family Environment

Research findings suggest that an adolescent's family experience relates to how they cope with stress and handle problems. In particular, Noller (1991) identified family

intimacy, level of family conflict, and parenting style as components for assessing family functioning and how adolescents may be influenced by familial experiences. Noller describes the ideal family environment as one that models effective and positive communication styles as well as provides opportunities to express oneself openly and without fear of harsh criticism. Related to this, Chandra and Minkovitz (2006) found that family conversations about mental health had a significant impact on adolescents' comfort to address mental health concerns. Notably, nearly eighty percent of 57 Grade 8 students reported that their families avoided discussing mental health issues, dismissed the subject, or discouraged youth from talking about their problems outside of the home (Chandra & Minkovitz). A relation between adolescents' perceptions of family functioning and the types of problems adolescents encounter has also been reported. Fallon and Bowles (2001) found that adolescents who reported a problem relating to their family perceived a high level of family conflict and were more likely to describe their parents as domineering. In contrast, adolescents who reported health problems indicated low levels of family conflict and adolescents who reported relationship problems (e.g., with peers) perceived their parents as fair and accepting.

While no direct link has been found between adolescent family environments and help-seeking behaviours, there is evidence to suggest that spending greater amounts of time with one's parents indirectly results in stress reduction and problem avoidance (Fallon & Bowles, 2001). The majority of research attributes these effects to modeling. For instance, patterns of positive communication (e.g., discussing problems calmly and openly) within a family provide a model that adolescents can apply when expressing themselves to others (Menna & Ruck, 2004). Related to this, Cohen, Kasen, Brook, and

Struening (1991) reported that parents can effectively model help seeking behaviours from professional and non-professional resources by consulting with teachers, family, clergy, and mental health professionals for their own concerns. Further, parental attitudes toward their adolescents' need for service have been shown to significantly impact the adolescents' decision to seek help and use available services (Angold et al., 1998).

Despite the positive effect family environments can have on adolescents' help seeking, Jorm and Wright (2007) provide evidence to suggest that the views of young people and their parents conflict with recommended mental health practices. When participants were presented with vignettes describing either depression, depression with alcohol abuse, social phobia, or psychosis, adolescents and their parents judged general (e.g., counseling) and informal sources of help as being more valuable and effective than specialist mental health services (e.g., psychiatrists, psychologists, and specific forms of therapy such as Cognitive Behaviour therapy). The findings indicate that participants selected help resources and interventions based, in part, on the label given to potential resources. Jorm and Wright suggest a need to improve parental knowledge of appropriate treatment in order to positively influence youth and avoid delayed help seeking, use of inappropriate help sources, and poor adherence to clinical referrals and recommendations.

As a whole, the research on familial environments suggests that one's family plays a central role in equipping adolescents with effective tools for self-advocacy and problem solving. It appears that in spending more time with their families, adolescents can learn both adaptive and maladaptive ways to communicate their problems to others, perceive help seeking (e.g., sign of weakness or autonomy), evaluate resources, and form relationships with formal help sources.

Adolescent Help-Seeking Intervention Programs

While many studies have emphasized the importance of providing people with adequate help resources, very few studies have attempted to increase actual help seeking. Santor et al. (2007) present findings that highlight the importance of actively promoting the use of help resources. This study involved implementing an intervention program designed to address known barriers to seeking help for mental health difficulties, such as the need for confidentiality, the difficulty some adolescents have recognizing signs of distress, and the difficulty adolescents experience when trying to identify appropriate help resources. Researchers used a non-randomized controlled design where Grade 8 students (n=388) served as the treatment group and Grades 7 and 9 students (n=399 and n=337, respectively) served as controls. Adolescents assigned to the treatment group attended two in-class workshops designed to help youth identify signs of distress and difficulties related to depression, minimize barriers to seeking help, and take advantage of available resources (e.g., school based teen health center). The workshops took place in October and February of the academic year and provided access to an exclusive website designed to provide information on levels of distress, e-mail contact with mental health professionals, and a bulletin board where health-related questions could be posted confidentially, and answered.

From their efforts, Santor et al. (2007) discovered that adolescents who were experiencing mental health difficulties engaged more often in help seeking and received a greater number of referrals to services after completing the help-seeking intervention program. The observed effect of the intervention was not only found for male and female adolescents but was moderated by the level of distress adolescents reported. In other

words, referrals for services were greatest for adolescents who participated in the intervention program and reported high levels of distress. These findings suggest that there is great value in investing in resources to promote help seeking among adolescents.

The impact that classroom presentations have on help seeking has also been evaluated in high school settings; however, the findings are not as promising as those presented by Santor et al. (2007). For instance, Australian Grade 10 students' intentions to seek help remained low and their perceived barriers to seeking help remained unchanged after listening to health professionals present material designed to encourage help seeking (Deane, Wilson, & Russell, 2007). The researchers suspect that developmental changes related to greater needs for independence and individuation explain the findings. Notably, the literature supports this hypothesis as other researchers have found that younger adolescents have greater needs for support and assistance than older adolescents (e.g., Levpušček, 2006). Older adolescents are more likely to have co-occurring internalizing and externalizing symptoms relative to younger adolescents (Tolan and Henry, 1996). Though the relation between an intervention's effectiveness and an adolescent's age requires further study, the presented findings encourage one to consider whether interventions need to be more intensive (e.g., more sessions) as adolescents mature in order to address more complex problems and greater resistance to seek help. Programs that appeal to younger adolescents may not interest older adolescents.

Findings from Adolescent Focus Groups on Help Seeking

More and more researchers have begun to conduct focus groups as a means of obtaining information on adolescent help seeking, instead of relying primarily on self-

report questionnaires and clinical interviews. While the latter techniques may be more suitable for quantitative analysis, the former offers rich qualitative information that may easily be overlooked when asking youth to express themselves from a limited list of options.

Molock et al. (2007) asked 42 church-going African American adolescents between the ages of 12 and 18 to read a vignette about a suicidal student before participating in 1 of 6 focus groups. Although 76% of the participants had been exposed to a suicidal peer and were able to recognize depression and a risk of suicide, researchers discovered that the majority of the participants were ambivalent to the seriousness of the problem and whether the character needed professional help. In fact, the findings suggest that many of the youth perceived expressions of hopelessness within the vignette as manipulative cries for help and described the character with little empathy (e.g., punk) after learning of his decision to commit suicide (Molock et al.). Based on their responses, many of the adolescents believed that peers with serious thoughts of suicide would not disclose their intentions to others. Though some participants recognized the character's need for help and readily acknowledged that adolescents are ill-equipped to assess the warning signs of suicide or handle the crisis alone, other participants argued that peers were the most appropriate helpers because adults often minimize problems, overact, fail to listen, or give unsolicited advice (Molock et al.). Importantly, very few adolescents selected mental health professionals as helpers and tended to prefer community-based programs within school, church, or community settings if helpers were young adults, empathic listeners, non-judgmental, maintained confidentiality, and seemed comfortable in their role as a help resource. Overall, Molock et al. highlight the difficulty that

adolescents have recognizing problems, assessing problem severity, responding empathically, and selecting appropriate help resources. The fact that adolescents were so resistant to professional help suggests a need for community education and highlights the importance of collaborative relationships between informal and formal help sources.

Wilson and Deane (2001) conducted six student focus groups with adolescents (11 males, 12 females) ranging between 14 and 17 years of age. The goal of the study was to question adolescents directly about the help-seeking behaviours they engaged in, their opinions on how barriers to help seeking could be reduced, their suggestions on effective strategies for raising sensitive issues with youth, and how they felt appropriate adolescent help seeking might be increased.

Adolescents expressed that having strong positive relationships with potential help resources can influence a youth's decisions to seek help (Wilson & Deane, 2001). Adolescents also agreed that believing the chosen resource heard their concern, valued their feelings, accepted them, and treated them with respect significantly influenced their decision to seek help from others and seek help for subsequent problems. In fact, after having positive help-seeking experiences, adolescents reported feeling empowered to express themselves and often sought help from the same person again. Further, Wilson and Deane found adolescents were more likely to seek help if they believed the resource was trustworthy and had experienced a similar problem.

Adolescents also described gaining knowledge about help seeking by observing others and from word of mouth (e.g., what friends recommended or described using themselves). Adolescents saw education as a key feature of promoting help seeking and felt that school-based programs are needed to teach youth the importance of seeking help,

the benefit of turning to appropriate helping resources, the types of problems that are most compatible with different resources, and effective help-seeking strategies (Wilson & Deane, 2001). Despite this, the adolescents felt such education programs would only be effective if youth were engaged by their peers (e.g., student-run programs and peer presentations on personal experiences with help seeking). Most importantly, adolescents believed that school-based programs could reduce the barriers to help seeking.

Adolescents also reported that they would be more receptive to advice from resources if the helper seemed natural and sincere. For instance, youth recommended that help resources engage in causal conversation before discussing a youth's problems in-depth so as to make adolescents feel more comfortable (Wilson & Deane, 2001). Further, the adolescents felt they would be more inclined to attend follow-up sessions with professionals if they received a reminder call and were asked whether they felt that the treatment was working. The latter is of particular importance, as Wilson and Deane highlight that the efficacy of previous help seeking experiences significantly impacts subsequent decisions to seek help.

Using a similar research design, Ballon, Kirst, and Smith (2004) investigated factors related to adolescents' attitudes and motivation to seek help with the intentions of making recommendations as to how youth may be better matched to treatment options. Unlike the previously mentioned study, Ballon et al. (2004) conducted four focus groups with participants aged 14 to 21 years olds (17 males, 7 females) who endorsed using drugs or alcohol in a way that resulted in negative consequences. These adolescents may have been in treatment prior to the focus group but could not have dropped out of treatment and were recruited from a variety of resources – including group homes,

treatment programs, and shelters. Content analysis of focus group transcripts revealed that the adolescents expected to encounter a variety of barriers when seeking help for substance abuse problems but were unable to recognize how many barriers could be overcome (Ballon et al.).

Unlike results obtained from self-report questionnaires and clinical interviews, the adolescents described barriers relating to a lack of self-motivation and shame (Ballon et al., 2004) as opposed to feeling that help seeking was a sign of weakness. In line with the comments made by the adolescents in Wilson and Deane's (2001) study, adolescents with substance abuse problems reported that they had failed to seek help because they felt their parents would not understand or accept their problem and may not be supportive or trustworthy enough to help (Ballon et al.). Similarly, Ballon et al. suggest that youth avoided seeking help in fear that parents would bombard them with questions, such as why they were using drugs, and what was upsetting them.

Adolescents with substance abuse problems also identified poor doctor-patient relationships as an important barrier to seeking help. Many adolescents expressed feeling dissatisfied with doctors and staff at treatment facilities. In particular, the adolescents felt medical professionals were uncaring, impersonal, and spoke using too many technical terms (Ballon et al., 2004). While not expressed by all adolescents, Ballon et al. report that educational factors influence adolescent help seeking. For instance, a number of adolescents believed that educating adolescents on the risks associated with substance abuse could result in more youth recognizing their need for help and the possible health benefits of seeking treatment.

Importantly, Ballon et al. (2004) emphasize that whether the barriers identified by youth exist or not, the fact that youth perceive barriers suggests a need to address their concerns. To this end, adolescents suggested educating youth on existing services, improving doctor-patient relationships by encouraging medical staff to demonstrate compassionate, non-judgmental attitudes, and expanding the diversity of treatment services available (Ballon et al.). Especially valuable are adolescent suggestions to increase family involvement in treatment practices, develop channels for peer support, and work towards ensuring that an adolescent's first treatment contact remains supportive.

Taken together, the results obtained from Santor et al. (2007) and adolescent focus groups speak to the need for the *Asking for Help Program* (Menna & Lafreniere, 2007). This eight week school-based intervention program was designed to positively impact adolescents' well-being, future success, and coping skills by targeting help seeking. Specifically, the *Asking for Help Program* offers adolescents the opportunity to increase their awareness of psychosocial and physical symptoms, develop skills to appraise problems, identify resources, and critically examine reasons why failing to seek help can have negative impacts on one's well-being and future success (Menna & Lafreniere). The *Asking for Help Program* also addresses adolescent requests for education on how to ask for help. For example, adolescents are taught effective strategies to seek assistance, evaluate the help that is provided, generate alternative solutions, and implement their chosen course of action (Menna & Lafreniere). Further, this program emphasizes the importance of understanding one's emotions and is designed to help adolescents gain the skills needed to manage their emotions (e.g., feelings of shame)

more productively (Menna & Lafreniere). Upon completion of the *Asking for Help Program,* adolescents are expected to be able to recognize their own need for help as well as others' need for help and possess the skills necessary to seek appropriate resources in either case.

Methodological Issues and Limitations of Past Research

Until recently, adolescent help-seeking has been relatively neglected in comparison to the enormity of the literature on adult help-seeking. It is perhaps for this reason that many adult health services have been feebly modified to serve adolescent populations (Cauce et al., 2002). To date, the bulk of the literature on adolescent help seeking has focused primarily on clinical populations, such as youth identified with depression, substance abuse problems, eating disorders, and self-harm (e.g., Evans et al., 2004). Unfortunately, data gathered from such groups cannot be generalized to the average adolescent and those adolescents who are at-risk of developing problems. For this reason, non-clinical populations should be investigated in order to develop successful primary and secondary intervention programs. Moreover, to this researcher's knowledge, adolescent focus groups have not been conducted following the completion of an intervention program. This suggests that adolescents have limited opportunities to report on their perspective of available treatments and their perceptions on how they improved as a result of intervention. Further, no intervention strategies currently in use have been developed based on available adolescent feedback (e.g., focus groups with youth identified as at-risk or typically developing). As such, it seems unlikely that existing programs fully address the needs of youth. The consequences of this may be twofold. First, adolescents may be reluctant to seek treatment or participate in intervention

programs that they perceive to be inadequate. Second, adolescents who take advantage of existing services may drop-out or decide not to seek professional help in the future if programs fail to meet their needs.

A further limitation of past research is that some studies on adolescent help seeking have examined adolescents' intentions to seek help rather than actual help seeking. This oversight can be seen as leading to problems of construct validity and reliability. Finally, researchers who have used content analysis to examine focus group transcripts have reported significant limitations as a result of their chosen recording methods. In particular, it is difficult to credit any participant as having said a recorded phrase due to poor sound quality and voice recognition. This may compromise the interpretation of the results.

Justification and Rationale of Current Study

The present study attempted to address several limitations from past research. The primary purpose of the current research was to evaluate the effectiveness of the *Asking for Help Program* (Menna & Lafreniere, 2007), a school-based intervention program, from the perspective of participating youth. Importantly, the *Asking for Help Program* was developed based on the first author's clinical experience, adolescent opinions, and the help-seeking literature. This intervention was designed to increase adolescent actual help seeking by reducing identified barriers and fits well with the school curriculum as educators now place a great emphasis on empowering students and encouraging them to become self advocates. The effectiveness of the *Asking for Help Program* was evaluated using both qualitative and quantitative means as well as treatment and control groups.

Focus groups are now a well-established interview technique in social science research for obtaining qualitative data and were conducted in the present research to assess adolescent satisfaction levels with the *Asking for Help Program.* This means of inquiry was chosen as it allowed adolescents to respond freely to a series of open-ended questions and provided an effective forum for generating adolescent views and insights on help seeking. Notably, adolescents possess the cognitive ability and maturity to examine the meaning of abstract concepts, analyze their thinking, and generate solutions using effective problem-solving strategies for real-life problems (Horowitz et al., 2003). Further, given that the adolescents had the opportunity to become familiar with one another during the program, focus groups were believed to provide the adolescents with a more comfortable interview environment than if interviewers questioned them alone (Horowitz et al.). For these reasons, focus groups were thought to provide an appropriate context for conducting a needs assessment and exploring insights that may improve the *Asking for Help Program* for future youth.

The current research also extended previous methodology by including measures to assess actual help seeking, participants' perceptions of stressful problems. Pre- and post-test quantitative data were collected in order to compare participants' actual amount of change.

Research Question

How effective is the *Asking for Help Program* at improving attitudes on help seeking, increasing actual help seeking, and reducing barriers to seeking help from the perspective of adolescent participants?

Hypotheses

The following hypotheses relating to adolescents' perceptions are primarily exploratory due to the nature of focus group data. However, directional hypotheses are used when considering adolescents who are most likely to benefit from the *Asking for Help Program.*

Hypothesis 1. It was predicted that the majority of adolescents, on post-evaluation, would show significant (α=0.05) positive changes in their attitudes towards seeking professional help, would engage in help seeking more frequently, and would show evidence to suggest that barriers relating to help seeking were reduced.

Hypothesis 2. Level of perceived stress was predicted to moderate the relation between participating in the *Asking for Help Program* and treatment outcome. More specifically, adolescents who indicated greater stress levels were predicted to benefit significantly (α=0.05) more than adolescents with mild stress levels.

H*ypothesis 3.* All adolescents were expected to report improved attitudes towards professional help resources and fewer perceived barriers in the focus groups. It was also predicted that all of the adolescents would see themselves as being more informed on the benefits of seeking help and more competent in choosing appropriate helping resources.

METHOD

Participant Recruitment

This study is part of a larger research project designed to evaluate the effectiveness of a school-based intervention, the *Asking for Help Program*, developed by Drs. Rosanne Menna and Kathryn Lafreniere. As such, participants in the current study were obtained through the *Asking for Help Program.* Three Catholic secondary schools agreed to participate in this research based on students' demonstrated need. The schools are located throughout the city of Windsor, Ontario and represent a population diverse in socioeconomic backgrounds and educational goals.

Permission was sought from the University of Windsor Ethics Research Board, the Windsor-Essex Catholic District School Board, and the principals of the participating schools. After obtaining permission to conduct the study, school personnel were asked to identify at-risk youth. Two of the participating schools offered *Essential English, Discovering the Workplace, and Co-operative Education*; these classes were known to attract at-risk youth because of their content (e.g., hands-on experience) and structure (e.g., less formal and more accommodating). Teachers of these classes consented to classroom presentations on the study. Students enrolled in each class were given packages containing information about the study as well as parental and participant consent forms. Adolescents were asked to give back the completed package to their classroom teacher if they were interested in participating. Students were informed that they did not need to participate in the proposed research and that their choice would not influence their school grades.

The remaining school had a Student Success Teacher who was involved with peer-mediation groups and individual counseling. Potential youth were approached by the Student Success Teacher with a package containing information about the study as well as parental and participant consent forms. Only the names of youth who expressed interest in participating in the study were made known to the researcher.

Participants

The participants were 55 adolescents between the ages of 14 and 19 ($M = 15.98$, $SD = 1.30$) who were identified as at-risk by school personnel and enrolled in secondary school. To be considered at-risk, youth must have demonstrated difficulties dealing with stress, coping with problems (e.g., issues pertaining to family or school) or had been identified as at-risk for school failure. Youth with treatment histories for psychiatric disorders or problems with the law were excluded from the study to eliminate potential confounding variables.

Approximately equal numbers of females ($n = 27$; $M = 16.00$ years, $SD = 1.27$ years) and males ($n = 28$; $M = 16.04$ years, $SD = 1.29$ years) participated in the study. No medical problems were reported by 80% of the participants. The medical conditions reported were ulcers, migraines, and kidney failure. Five participants were diagnosed with ADHD and one participant was diagnosed with co-morbid depression and anxiety and, according to parental report, was taking medications and attending counseling to manage the symptoms. At the time of the study, 27.3 % of the participants were receiving professional help. The majority of the participants were Caucasian and living with both of their parents. Six of the participants had emancipated minor status and were living independently. Demographic information is presented in Table 1.

The overall attrition rate for the study was 12.72%. One adolescent from the treatment group and 3 adolescents from the control group failed to complete the *Asking for Program.*

Table 1.

Socio-Demographic Characteristics of Participants

Demographics	*N*	%
Ethnicity[a]		
Caucasian	29	52.7
Multi-racial	8	14.5
African Canadian	7	12.7
Native Canadian	4	7.3
Bi-racial	3	5.5
Arabic-Canadian	1	1.8
Lebanese-Canadian	1	1.8
Currently Receiving Professional Help[a]		
School Counsellor	5	9.1
Social Worker	4	7.3
Multiple Professionals	4	5.5
Psychologist	1	1.8
Anger Management Group	1	1.8
Parental Marital Status[a]		
Married	22	40
Divorced	14	25.5
Separated	14	25.5
Living Together	4	7.3
Remarried	1	1.8
Parents'/Guardians' Occupation[b]		
Business and Professional	18	22.5
Sales and service	34	42.5
Trades, transport, and machine operators	14	17.5
Processing, manufacturing, and utilities	14	17.5

Note. Occupations were classified according to the 2006 Canadian Census. Due to missing data, not all of the participants are represented.
[a]n = 55, [b]n = 40

Measures

The *Teen Background Questionnaire* was designed to provide demographic information such as one's date of birth, gender, grade, ethnicity, and parental marital status, education and employment status (see Appendix A).

The *Adolescent Life Change Event Scale* (ALCES; Yeaworth, McNamee, & Pozehl, 1992; Yeaworth, York, Hussey, Ingle, & Goodwin, 1980) consists of 37 items designed to represent life-changing events in adolescence (see Appendix B), and thus, can be used as a measure of cumulative life stress. The ALCES was used to examine whether participants' stress levels remained constant or altered throughout the study.

The ALCES required the participants to indicate whether any of 31 listed life-change events happened to them in the past year and provided adolescents two blank items, which they were able to use to describe any other events they had experienced within the same timeframe. The wording of two items was changed ("hassling" to "fighting", "flunking" to "failing") to ensure that descriptions were more meaningful to the adolescents. As suggested by Yeaworth et al. (1980), life-changing events such as "starting menstrual periods" and "starting to date" were changed to read "problems with menstrual periods" and "problems with dating". In addition, "death of a parent" was broken down into "death of father" and "death of mother" to ensure that the measure reflected higher stress levels which are likely to occur when both parents die in a short period of time (Yeaworth et al., 1980). Finally, "having problems with...acne, overweight, underweight, too tall, too short" was divided into separate items to ensure that the information obtained from this measure was more meaningful (Yeaworth et al., 1980). High scores on the ALCES represent high levels of stress.

The ALCES has been shown to have acceptable reliability (Spearman from r = .93 to r= .98) and validity (Yeaworth et al., 1980). Relationships between the ALCES and various adolescent stressors, both physiological (e.g., hypertension) and psychological (e.g., suicidality) have also been reported. For this study, Cronbach's alphas ranged from 0.82 to 0.90.

The *Attitudes toward Seeking Professional Psychological Help Scale (ATSPPH; Fischer & Turner, 1970)* was originally a 29-item questionnaire which consisted of four subscales: Factor 1 – Recognition of Personal Need for Professional Help; Factor II – Tolerance of Stigma Associated with Psychological Help; Factor III - Interpersonal Openness; and Factor IV – Confidence in Mental Health Professional. Mackenzie, Knox, Gekoski, and Macaulay (2004) attempted to revise the ATSPPH in order to better understand the nature of attitudes toward seeking mental health services and the relationship between attitudes and service use. The process of adaptation involved replacing the original 4-point rating scale with a 5-point scale (0 = strongly disagree, 4 = strongly agree) and changing the wording to include gender-neutral pronouns, a variety of mental health professionals (e.g., changing "psychologists" to "professionals"), and mental health problems (e.g., changing "emotional difficulties" to "psychological problems"). In addition, 12 items were added to assess perceptions about how family and friends would react to professional help and to assess perceived control over the barriers associated with seeking help (Mackenzie et al.).

The aforementioned changes resulted in a 41-item questionnaire that was later reduced to 24 items based on findings from factor analyses which supported 3 indices: psychological openness, help seeking propensity, and indifference to stigma. Since the

24-item measure had not been used within the literature at the time of the current study and had been standardized using a college sample, the 41 item questionnaire (refer to Appendix C) was used with the intension of conducting a factor analysis upon data collection. Unfortunately, the sample size of this study was too small to be conducive to factor analysis; thus, the total score of the mentioned 24 items was used to assess general attitudes towards seeking professional help. Notably, scores on this measure reflect the degree of how negative one's attitudes are about seeking professional help. For this reason, high scores indicate extremely negative attitudes toward seeking professional psychological help and low scores indicate positive attitudes; this is rather counter-intuitive. For this sample, the Cronbach's alpha coefficients ranged from 0.81 to 0.85.

The *Actual Help Seeking Questionnaire* (Rickwood & Braithwaite, 1994) enables one to identify the resources adolescents have sought advice or help from within the past two weeks as well as the type of problem that led them to ask for assistance. Adolescents were required to indicate whether they sought help from any of nine listed resources and were able to describe problems they failed to seek help for. Four of the nine resources represent informal helpers, four represent formal helpers, and one allowed the adolescents to enter a help resources not include on the questionnaire. Participants are also asked to describe the problem that they presented to each help resource. This measure was developed using a sample of 715 (404 females, 311 males) Australian adolescents in secondary school between the age of 16 and 19 years old. For the mentioned study Rickwood and Braithwaite found alphas that ranged from 0.68 to 0.85. For this sample, the Cronbach's alpha coefficients ranged from 0.61 to 0.67 for formal help and from 0.44 to 0.67 for informal help. Four participants indicated seeking help from a resource not

listed on the questionnaire; however, the researcher was able to include these responses within the formal and informal categories. The moderate alpha ratings may be accounted for by the lack of variance within the participants' help seeking responses. For instance, 15 of 54 (27.77%) participants who completed the AHSQ at Time 1 indicated seeking help from one help source within a two week period. Analyses were conducted using total subscale scores for formal and informal help (see Appendix D). .

The *Barriers to Adolescent Help Seeking* (*BASH;* Kuhl, Jarkon-Horlick, Morrissey, 1997*)* was designed to identify the factors that most strongly inhibit adolescents from seeking help from therapists. Items were developed to reflect high face validity based on documented barrier categories within the literature. The categories include: affordability, alienation, confidentiality, family as sufficient to help, knowledge of resources, locus of control, peers as sufficient, perceptions of therapist, self-awareness/self-perception, self-sufficiency, stigma, time availability, and usefulness of therapy. Content and criterion-related validity was determined to be acceptable by 4 independent adolescent clinicians. Further, the BASH was found to have a split-half reliability of 0.82 and a Cronbach's alpha of 0.91. A test-retest reliability of 0.91 was found after a two-week period (Kuhl et al.).

For the purpose of the present study, a revised version of the BASH (BASH-R; refer to Appendix E) was created to examine multiple factors that inhibit help-seeking behaviours, as opposed to barriers related solely to therapists. The BASH-R includes 18 of the original 37 items representing various reasons why youth might not seek professional help for a stressful or psychological problem. Items were selected to represent 12 of the 13 barrier categories proposed by Kuhl et al. (1997), thus, the chosen

items were similar in content to items that were omitted in an effort to reduce the length of the questionnaire. The chosen items were modified to omit specific references to therapists; for example, "If I had a problem and told a therapist, he would not keep it a secret" was changed to "If I got professional help for my problem, my problem wouldn't be kept a secret." For each of the 18 items, adolescents are asked to choose a response ranging from (1) strongly disagree to (5) strongly agree. Analyses were conducted using participants' total BASH-R score. Higher scores indicate higher belief-based barriers to professional psychological help seeking. For this sample, Cronbach's alphas for the total score ranged from Cronbach's α from 0.72 to 0.79.

Semi-Structured Interview Questions. Two semi-structured interview schedules were designed based on the purpose of the study, previously conducted focus groups (e.g., Wilson & Deane, 2001), and available focus group references (e.g., Morgan, Krueger, & King, 1998). Question content was also guided by the goals of the *Asking for Help Program* and the researcher's hypotheses. Focus group questions were first designed for adolescents involved in the intervention as the effectiveness of the *Asking for Help Program* was central to the study. The questions concentrated on asking the participants whether they felt that the intervention changed their definition of help seeking or their feelings about seeking help. Further, the questions allowed the participants to indicate their preferred help source, comment on the barriers to adolescent help seeking, and make suggestions for how they would change the intervention program to better suit their needs. A draft of the moderator's guide was reviewed by several undergraduate and graduate students as well as the researcher's supervisor to ensure questions were clear, used meaningful language, and best addressed the research

questions (refer to Appendix F). The final interview schedule designed for intervention groups was then used to create a modified version to present to control groups. Questions for each type of focus group differed only slightly. More specifically, questions were re-written to include definitions of terms that the control group may not have been familiar with (e.g., barriers) and to exclude references to the *Asking for Help Program* (refer to Appendix G). As such, the control group was asked general questions about their definition of help seeking, feelings about seeking help, preferred help sources, perceived barriers to seeking help, and opinions on what a help-seeking intervention should involve in order to cater to the needs of adolescents.

Procedures

Pre-Testing

The adolescents who expressed interest in the study were required to provide informed consent, and return the parental consent forms before completing the measures. Testing took place during class time at the students' respective schools. Since two of the three schools invited entire classes of students to participate in the study, and the majority of these students enrolled in the study, teachers were asked to leave the classroom while students completed questionnaires. The remaining school provided an empty classroom that students were called to in order to complete the questionnaires. Before asking participants to complete questionnaires, researchers reminded participants of their right to leave items blank or to withdrawal from the study at any time without penalty. Students randomly received one of three questionnaire packages; the packages only differed in the order that the questionnaires were presented.

Due to the prevalence of reading difficulties (n = 21), students with the same questionnaire version sat near each other in order to hear the questions read aloud by a research assistant. This was done to ensure that students with reading difficulties were not singled out. Those who felt comfortable reading the questionnaires were encouraged to work at their own pace. Notably, the research assistants stood at an appropriate distance from the participants to ensure each participant's privacy. A minority of students (n = 8) waived their right to privacy while completing the questionnaire package due to learning disabilities; in these cases, more intensive individual help was provided by a research assistant. After filling out the questionnaires, participants were randomly assigned to the intervention program or to a waitlist (i.e., control group). Before leaving the testing room, participants were given contact numbers (e.g., Children's Help Line; see Appendix H) and the opportunity to ask the researcher assistants questions related to concerns they had about their responses or the study.

Since the majority of classes approached about the study consented to participate at two of the three schools, the *Asking for Help Program* had to accommodate specific time slots; as such, the program was offered once a week for a two hour session or twice a week for two one hour sessions. This allowed students to complete the intervention within 4 weeks (a total of 8 hours). Graduate students enrolled in Clinical Psychology at the University of Windsor were trained to facilitate the intervention and attempts were made to pair facilitators appropriately so as to ensure that less experienced facilitators worked with more experienced ones. Facilitators' clinical experience prior to the intervention ranged from no prior experience working with adolescents to having completed clinical internships with children and adolescents. All facilitators were

required to attend a workshop, where they were trained on the *Asking for Help Program,* and weekly supervision meetings with Dr. Rosanne Menna to review the content of the intervention, assess adherence, and discuss concerns. For the purpose of this study, the intervention was offered to 5 treatment groups and 4 control groups. Each group had no more than 9 participants and no less than 5 ($M = 5.89$, $SD = 1.36$); however, attendance varied each week ($M = 6.5$, $SD = 1.70$). Table 2 presents each intervention group's size, age, and attendance. The average attendance for the intervention was adequate for both the treatment group ($M = 6.93$, $SD = 1.17$) and the control group ($M = 7.29$, $SD = 0.85$).

Table 2.

Intervention Groups: Size, Age, Gender, and Attendance

Group	N	Gender (females, males)	Age (*M*, *SD*)	Attendance (*M*, *SD*)
Treatment				
1	6	(1, 5)	(15.67, 0.52)	(7.33, 0.82)
2	5	(4, 1)	(14.80, 0.84)	(7.40, 0.89)
3	9	(6, 3)	(16.56, 0.53)	(6.89, 1.36)
4	7	(0, 7)	(16.71, 0.76)	(6.57, 1.51)
5	6	(4, 2)	(15.00, 0.89)	(6.67, 1.03)
Control				
1	5	(2, 3)	(14.00, 0.00)	(7.60, 0.89)
2	6	(2, 4)	(17.83, 0.75)	(6.00, 2.35)
3	4	(4, 0)	(17.20, 0.45)	(6.80, 2.17)
4	4	(2, 2)	(15.60, 0.55)	(5.60, 2.70)

Note. Participants who dropped out of the intervention were not included in this table.

Post-Testing

Once the intervention groups completed the *Asking for Help Program* in their respective schools, the treatment and control groups completed the questionnaire package previously discussed for a second time. In addition, all adolescent participants were invited to take part in an in-school focus group on help seeking. Due to poor school attendance and attrition, only 26 of the 34 (76%) adolescents assigned to the treatment group and 19 of the 21 (90%) participants assigned to the control group engaged in a focus group. A total of 9 one-hour focus groups took place so as to ensure that students were placed with the same students that they would be or had completed the *Asking for Help Program* with (see Table 3). This design ensured that participants who participated in the *Asking for Help Program* were asked questions specific to the effectiveness of the intervention program while also ensuring that participants assigned to the control group were asked more general questions on help seeking.

The researcher facilitated each of the 9 focus groups. Each focus group had no more than 7 participants and no less than 4 ($M = 5.00$, $SD = 1.00$). Conversations were documented using a sensitive digital recording device, the Olympus DS-30 Digital Stereo Conference Recorder, which enabled the researcher to differentiate, which participant said which statement(s) upon playback. A trained transcriber took notes during the focus group in order to collect behavioural information. The transcriber also wrote down the beginning of each of the participants' utterances to supplement the voice recognition software. Importantly, the transcriber indicated the speaker of each utterance by using code names that the participants created for themselves and displayed on name tags.

Table 3.

Focus Groups: Size, Gender, Age, and Attendance

Group	N	Gender (females, males)	Age (*M*, *SD*)	Attendance (*M*, *SD*)
Treatment				
1	6	(1, 5)	(15.67, 0.52)	(7.33, 0.82)
2	5	(4, 1)	(14.80, 0.84)	(7.40, 0.89)
3	7	(5, 2)	(16.57, 0.54)	(6.57, 1.40)
4	4	(0, 4)	(16.60, 0.89)	(7.20, 1.10)
5	4	(2, 2)	(14.50, 0.58)	(6.75, 0.50)
Control				
1	5	(2, 3)	(14.00, 0.00)	(7.60, 0.89)
2	6	(2, 4)	(17.83, 0.75)	(6.00, 2.35)
3	4	(4, 0)	(17.25, 0.50)	(6.50, 2.38)
4	4	(3, 1)	(15.50, 0.58)	(5.50, 3.11)

Note. All of the adolescents who participated in a focus group were included in this table. Subsequent sections will provide additional information on participants (n=1) who had to be excluded from context analysis.

The researcher began facilitating each focus group by welcoming the group. The purpose of the discussion was explained once again and the participants were informed of their right to withdraw from the study and participate in discussions based on their comfort level. Confidentiality was then discussed and documented, such that each participant signed a contract indicating that they would not disclose other participants' personal information or reveal the identity of anyone in the focus group to outside people. Once the ground rules were explained and permission was obtained to audio tape the session, the recorder was turned on and the researcher posed the first question. Participants were asked a total of 8 questions during the focus group. For the purpose of the present study, the researcher opted for a medium level of moderation, and thus, used probes to gain additional information, clarify responses, or invite other participants to comment. A detailed moderating script for the two types of focus groups can be found in Appendices F and G.

Upon completing the focus group, participants assigned to the control group began the intervention program and were asked to complete the questionnaire package for a third and final time within two weeks of finishing the *Asking for Help Program.*

Anonymity and Confidentiality

In order to assure the anonymity and confidentiality of adolescent participants, consent forms have been kept separately from completed questionnaires. In addition, identifying information on testing material was removed or hidden with a black marker. Code numbers were used on questionnaires and consent forms to ensure that the appropriate follow-up could be done if participants indicated any signs of risk (e.g., suicidal ideation); however, none of the participants indicated such risk. Finally,

adolescents were told not to say their own name or the names of other adolescents during the course of the focus group (code names were to be used instead). The latter was to ensure that adolescents remained anonymous on audio recordings.

Focus Group Coding

Focus group interviews were analyzed and interpreted using content analysis. The accuracy of the findings from content analysis was validated using Cohen's Kappa as a measure of inter-rater reliability between the primary investigator and an external rater. To do this, a web application for calculating Cohen's unweighted kappa value, VassarStats, was used. For the purpose of this study, Kappa > .70 was considered an acceptable degree of inter-rater reliability.

The transcripts were first transcribed verbatim by the researcher using the participants' chosen code names. The researcher and an independent auditor, with experience in qualitative research methodology, then read a randomly selected transcript and independently created thematic categories for the purpose of content analysis. The two parties met to compare and discuss the thematic categories until a consensus was reached as to the number and names of the categories; this resulted in a final coding scheme with seven categories (see Table 4). The parties then independently applied the final coding scheme to three randomly selected transcripts of the original nine transcripts (33%). The parties met for a second time upon applying the codes to the first of these three transcripts to assess the similarity of coding and to resolve discrepancies. At this time, the parties had agreed on 97% of the cases ($\kappa = 0.96$), suggesting that a highly acceptable degree of reliability had been achieved. After the raters completed coding the remaining two transcripts, the parties were determined to have agreed on 93% of the total

number of cases ($\kappa = 0.92$); once again, this indicated that a highly acceptable degree of reliability had been achieved and allowed the researcher to code the remaining six transcripts without having to consult the auditor.

Table 4.

Final Coding Scheme and Descriptions of each Theme

Theme	Description
Independence	The statement indicated how participants' views about independence influence their decision about whether or not to seek help.
Lessons learned and perceived changes	Participants shared what they learned during the intervention program and/or what changes they noticed in themselves since beginning the intervention.
Stigma	Participants referred to societal views or misconceptions related to those that seek help.
Barriers to seeking help	Participants stated things that prevent them from seeking help. Each statement included in this code was assigned a secondary code for the purpose of understanding which barriers were reported: (1) knowledge, (2) trust, (3) perceptions of help resources' ability to help (4) fear of judgement, (5) past experience, (6) maladaptive coping skills, (7) other.
Formal and informal help seeking	Participants provided definitions of help seeking, gave examples of problems that they would seek help from formal and/or informal sources, and shared their personal experiences with help resources.
Suggestions to improve the intervention	Participants shared ideas for how the *Asking for Help Program* could be improved to better suit their needs.
Recommending the intervention	Participants indicated whether or not they would recommend a friend to the *Asking for Help Program* and shared the reasoning behind their response.

RESULTS

Since the current study involved collecting both qualitative and quantitative data, a mixed method approach was used to analyze the results. This form of analysis allowed the researcher to corroborate findings from different sources of data and acquire a more comprehensive understanding of the effectiveness of the *Asking for Help Program.* This approach offered the advantage of using one method's strength to compensate for the other method's weakness (Creswell, 2003). As such, quantitative and qualitative data were weighted equally and compared to assess whether the analyses supported each other.

Data Screening

Prior to conducting statistical analyses, the data were screened for outliers and the distribution of all the variables was examined for skewness and kurtosis; all of the values fell within an acceptable range except the AHSQ (kurtosis = 10.17) at Time 1 of the study and the AHSQ (kurtosis = 5.97) and the ATSPPH (kurtosis = 3.43) at Time 2 of the study. To ensure normality was achieved, one participant's AHSQ score at Time 1 and one participant's AHSQ score at Time 2 were discarded as their total scores indicated a positive response bias. Outliers were considered to be data two standard deviations from the mean. To address the distribution of the ATSPPH at Time 2, 4 outliers were replaced with the highest value plus one, as suggested by Fields (2005). Standardized residual plots were examined to check for linearity; the data satisfied this condition as the values on the graphs appeared in a random, evenly dispersed array around zero.

Planned Analyses

Means, standard deviations, and ranges were calculated for all the variables. Independent t-tests were performed to ensure that the treatment and control groups did not significantly differ in age or questionnaire responses at the outset of the study. Similarly, the gender of the participants assigned to the treatment and control groups was compared using chi square analyses. Dependent t-tests were also performed to ensure that the control group's responses at Time 1 did not significantly differ from their responses at Time 2. Repeated-measures analysis of variance (ANOVA) tests were conducted to compare the treatment group to the control group at each time point in the study. A multiple linear regression was conducted to determine whether participants' stress moderated the relation between participating in the intervention program and treatment outcome. Focus group responses were analyzed using content analysis.

Preliminary Analyses

The means, standard deviations, and the minimum and maximum values for all of the variables were calculated for the treatment and control groups (Table 5). There were 14 male and 16 female participants who completed post-testing measures in the treatment group whereas there were 9 male and 9 female participants in the control group completed post-testing measures. In order to determine whether there was a significant association between participants' group assignment and their gender, the number of females and males in each group was compared using chi square analysis. No significant difference was found, $\chi^2(1)=.881, p > .05$. An independent t-test was performed to determine whether there was an association between participants' group assignment and age; no significant differences were found, $t\,(53) = -1.01, p > .05$.

Table 5.

Pre-Testing: Means, Standard Deviations, and Minimum and Maximum Values for Study Variables

Variables	*N*	*M*	*SD*	Minimum	Maximum
Age					
Treatment	33	15.88	1.02	14.00	18.00
Control	17	16.06	1.71	14.00	19.00
ALCES					
Treatment	24	8.38	5.17	1.00	22.00
Control	16	7.81	6.64	0.00	21.00
BASH-R					
Treatment	32	54.16	6.94	39.00	73.00
Control	20	49.85	10.12	26.00	65.00
ATSPPH					
Treatment	31	78.77	15.58	38.00	114.00
Control	17	81.53	22.22	47.00	134.00
AHSQ					
Treatment	34	1.32	1.25	0.00	4.00
Control	20	1.45	1.50	0.00	4.00

Note. N values differ due to missing data.

Pre-test Analyses

Independent t-tests were conducted to determine whether participants who were assigned to the treatment group had scores that significantly differed from participants who were assigned to the control group at pre-testing (see Table 5). The difference between participants' reported stressful events within the last year, $t(38) = .301, p > .05$, attitudes toward seeking professional help, $t(46) = -.503, p > .05$, barriers to adolescent help seeking, $t(50) = 1.055, p > .05$, and actual help seeking, $t(52) = -1.224, p > .05$, did not significantly differ based on their group assignment.

Research Question 1. Do adolescents show significant (α=0.05) positive changes in their attitudes toward seeking professional help, reported help-seeking behaviour, and show evidence to suggest that barriers relating to help seeking are reduced after participating in the *Asking for Help Program?*

To test the hypothesis that the majority of adolescents would show significant positive changes in their attitudes toward seeking professional help and would show evidence to suggest that barriers relating to help seeking were reduced on post-evaluation, a repeated-measures ANOVA was conducted for two of the criterion variables (i.e., BASH-R and ATSPPH). This type of analysis was chosen as it controls for individual differences in participants' responses over time. For each of the repeated- measures ANOVAs, participants' total score on the questionnaire was entered as a within subject variable with multiple levels (i.e., Time 1 and Time 2). Group assignment was entered as the between subject variable. One participant assigned to the treatment group was eliminated from the analyses because the participant attended fewer than 4 sessions of the *Asking for Help Program.* As Table 6 illustrates, the results indicated that the groups'

attitudes toward seeking professional help, $F(1,40) = 1.73$, $p > .05$, and perceived barriers to help seeking, $F(1,44) = 0.02$, $p > .05$ did not significantly differ.

A repeated-measures multivariate analysis of variance (MANOVA) was used to assess whether the participants' actual help seeking increased. The informal and formal help subscales were entered as the within subject variables within multiple time points; group assignment was entered as the between-subject variable. One participant was eliminated from the analysis due to poor attendance. No significant main effect was found between the treatment and the control groups, $F(1,51) = 27.55$, $p > .05$. Univariate ANOVAs, revealed a significant effect for time for the control group. Compared to the treatment group, the control group sought more help at post-testing, $F(1,51) = 5.47$, $p < .05$ (see Table 7).

Table 6.

Repeated-Measures ANOVA: Pre- and Post-Intervention Scores for Attitudes toward Help and Perceived Barriers

ATSPPH	*N*	*M*	*SD*	*F*	*p*
Time 1					
Treatment	30	78.73	15.84	1.73	0.20
Control	17	81.53	22.22		
Time 2					
Treatment	28	80.71	13.34		
Control	19	77.53	14.9		
BASH-R					
Time 1					
Treatment	31	52.23	7.03	0.02	0.96
Control	20	49.85	10.11		
Time 2					
Treatment	27	51.19	7.36		
Control	21	49.52	10.86		

Table 7.

Repeated-Measures MANOVA: Pre- and Post-Intervention Scores for Actual Help Seeking

Subscale	Group	*N*	*M*	*SD*	*F*
Informal					5.47*
Time 1					
	Treatment	33	0.97	0.98	
	Control	20	1.30	1.22	
Time 2					
	Treatment	33	0.66	1.02	
	Control	20	0.95	0.99	
Formal					0.31
Time 1					
	Treatment	33	0.30	0.58	
	Control	20	0.55	1.05	
Time 2					
	Treatment	33	0.18	0.73	
	Control	20	0.45	0.69	

Note. * denotes statistical significance at $p < 0.05$. Time 2 represents the treatment group's post-testing results. The control group began the intervention after completing the questionnaires at Time 2.

Dependent t-tests were conducted to assess whether the control group's initial responses significantly differed from their responses at Time 2 of the study, before they participated in the intervention program (see Table 5). The results revealed that the control group's reported stressful life events, $t(13) = -1.059, p > .05, r = .28$, attitudes toward seeking professional help, $t(15) = 1.135, p > .05, r = .28$, barriers to adolescent help seeking, $t(19) = 1.314, p > .05, r = .29$, and actual help seeking, $t(19) = .265, p > .05, r = .06$, did not significantly differ from Time 1 to Time 2. This suggested that the control group did not improve on the measured variables while they waited to participate in the *Asking for Help Program.*

Dependent t-tests, comparing Time 2 and Time 3 data, were conducted to assess whether the control group reported significant gains after having completed the *Asking for Help Program* (see Table 8). Participants were eliminated from the analyses if they attended fewer than four sessions of the *Asking for Help Program;* this cut-off eliminated four participants from the control group. The results indicated no significant differences in the control group's attitudes toward seeking professional help, $t(14) = -.72, p > .05$, or perceived barriers to help seeking, $t(14) = -1.73, p > .05$. The results also indicated no significant differences in the control group's informal, $t(17) = -1.76, p > .05$, and formal, $t(17) = -1.37, p > .05$, help seeking.

Table 8.

Dependent T-Tests for the Control Group Pre- to Post-intervention for Barriers, Attitudes toward Help Seeking, and Actual Help Seeking

Variables	*N*	*M*	*SD*	*t*
BASH-R				
Time 2	17	48	10.97	-1.73
Time 3	15	54.4	9.75	
ATSPPH				
Time 2	15	79.6	14.52	-.72
Time 3	14	81.43	14.68	
AHSQ: Informal				
Time 2	18	0.61	1.03	-1.76
Time 3	18	0.89	0.96	
AHSQ: Formal				
Time 2	18	0.89	0.96	-1.37
Time 3	18	0.33	0.14	

Note: No significant differences were found

Research Question 2. Does stress moderate the relationship between participating in the *Asking for Help Program* and treatment outcome?

To test the hypothesis that adolescents who indicated greater stress levels would benefit significantly (α=0.05) more than adolescents who indicated mild stress levels, a multiple linear regression analysis was conducted. In the first block of the analysis, the dichotomous treatment variable (i.e., treatment or waitlist) and stress variable were entered as predictors; one of the outcome measures was entered as the dependent variable (i.e., total scores on the ATSHP, BASH-R, or AHSQ). The interaction term was entered in the second block of the analysis. Adolescents assigned to the treatment group, who attended fewer than four sessions of the *Asking for Help Program,* were excluded from the analyses (see Table 9).

The first model, $F(2,33) = 4.65, p < .05$, and the second model, $F(2,32) = 3.20, p < .05$, were significant when the AHSQ informal subscale was entered as the dependent variable. The first model, $F(2,33) = 18.37, p < .001$), and the second model, $F(2,32) = 14.40, p < .001$), were also significant when the AHSQ formal subscale was entered as the dependent variable. However, only the first steps of these analyses were significant; thus, the results did not support a moderating effect as the change in R^2 was not significant when the interaction term was added. The results revealed that both steps of the analysis were insignificant when perceived barriers or attitudes towards professional help seeking were entered as the dependent variable (refer to Table 10). Thus, the results suggest that stress did not moderate the relation between participating in the intervention and treatment outcomes.

Table 9.

Multiple Linear Regression: Barriers, Actual Help Seeking, and Attitudes toward Help Seeking at Time 2

Variables at Time 2	*N*	*M*	*SD*
BASH-R	48	49.35	9.83
Stress	48	0.38	5.33
Interaction Term	48	0.06	2.99
ATSPPH	47	79.42	13.92
Stress	47	0.32	5.25
Interaction Term	47	0.01	2.96
AHSQ: informal	49	0.76	0.99
Stress	49	0.37	5.34
Interaction Term	49	0.12	2.78
AHSQ: formal	49	0.28	0.56
Stress	49	0.37	5.34
Interaction Term	49	0.12	2.78

Note. Stress variable was centered for the purpose of performing these analyses.

Table 10.

Multiple Linear Regression: Perceived Barriers, Stress, and Help Seeking

Time 2	B	SE B	β	R^2	ΔR^2
[a] BASH-R					
Step 1					
Group Assignment	3.52	3.65	0.18		
Stress	0.31	0.34	0.17	0.02	0.02
Step 2					
Group Assignment	3.97	3.48	0.20		
Stress	0.75	0.39	0.41		
Interaction Term	-1.40	0.69	-0.43	0.11	0.09
[b] ASHQ: informal					
Step 1					
Group Assignment	-0.13	0.28	-0.07		
Stress	0.07	0.03	0.46	0.22	0.22*
Step 2					
Group Assignment	-0.13	0.28	-0.07		
Stress	0.09	0.03	0.53		
Interaction Term	-0.04	0.06	-0.12	0.23	0.01
[b] ASHQ: formal					
Step 1					
Group Assignment	-0.40	-0.40	-0.36		
Stress	0.07	0.07	0.63	0.53	0.53*
Step 2					
Group Assignment	-0.40	0.13	-0.36		
Stress	0.08	0.01	0.77		
Interaction Term	-0.05	0.03	-0.26	0.57	0.05
[c] ATSPPH					
Step 1					
Group Assignment	1.85	5.14	0.07		
Stress	-0.07	0.46	-0.03	0.02	0.02
Step 2					
Group Assignment	1.80	5.24	0.07		
Stress	-0.13	0.57	-0.05		
Interaction Term	0.16	1.02	0.04	0.02	0.00

*Note. * denotes significance at $p < 0.05$*

Research Question 3. Do adolescents report improved attitudes about seeking help and perceived barriers pertaining to seeking help after completing the *Asking for Help Program*?

Of the 50 participants in the study, 45 attended a focus group. Of these 45 participants, 26 had been assigned to the treatment group and 19 had been assigned to the control group; however, one participant was eliminated from the content analyses because they decided to stop attending the *Asking for Help Program* after the second session. The adolescents assigned to the treatment group, who attended a focus group, had a good rate of attendance ($M = 7.04$, $SD = 1.02$). There were a total of 12 female and 14 male participants in the focus groups for the treatment group ($M = 15.74$ years, $SD = 1.06$) and a total of 11 female and 8 male participants in the focus groups for the control group ($M = 16.21$ years, $SD = 1.67$)

Themes

The following themes regarding adolescents' attitudes about seeking help and perceived barriers pertaining to seeking help were elicited from the focus group discussions. Participant opinions are organized according to group assignment and age when different perspectives emerged and could be appropriately summarized using these categories.

Perceived barriers to adolescents help seeking

Table 11 illustrates the percentage of participants in the treatment and control groups who endorsed each of the following themes.

Table 11.

Barriers: Percentage of Participants Who Endorsed each Theme

Theme	Treatment % (n)	Control % (n)
Knowledge	76 (19)	63 (12)
Trust	52 (13)	53 (10)
Stigma	40 (10)	68 (14)
Judgement	20 (5)	16 (2)
Maladaptive Coping	16 (4)	21 (4)
Previous Experience	4 (1)	5 (1)
Overcoming Barriers	88 (22)	89 (17)*

Note. Treatment Group N = 25; Control Group N = 19
*58% of the adolescents in the control group suggested ineffective strategies for overcoming barriers to help seeking (e.g., not caring what other people think).

Knowledge

Treatment Group. 19 of the 25 (76%) participants indicated that adolescents are often misinformed about formal help resources. In fact, nearly all of the participants assigned to this group (88%) failed to realize that they had participated in a therapeutic program with trained facilitators because the *Asking for Help Program* did not fit their idea of professional help. The following statements were taken from two different adolescents:

> *I would recommend this program to my friends, but I would never recommend a professional kinda of help. Our leaders were cool. They laughed when we told jokes and they were easy to talk to – you'd never get that with a professional.*

> *I got a lot of different perspectives in this group and I got the female perspective from our group leader. When you go to professionals they give you the same advice no matter what your problem is.*

Four participants, who had sought formal help in the past, explained that many adolescents erroneously believe that professionals are cold hearted or mean. The participants who had experience with professionals indicated that adolescents' views of mental health workers would change if they were given the opportunity to work with a professional.

> *If more people knew that professionals are nice people, they would ask for help more. I was forced to see my social worker at first, but now I really like my time with her. She makes me smile and I can talk about whatever I want. I thought she was going to be so mean and that I would hate her, but I look forward to seeing her now.*

The participants also explained that many youth do not know where to seek help or are unable to recognize problems within their own lives. The following quotes were taken from two different adolescents:

I think that most problems that we have don't really need professional help because they're not that bad. On the other hand, if everyone around you is having a similar problem it's hard to see it as a problem – it becomes normal. I don't think people in high school know what a 'major problem' would be!

I don't think teenagers know that they can get help for little problems...like, if they need a lunch because they forgot theirs or if they want to know how to write an application for a job. Those things are all problems, but people just think of the big problems, like parents getting divorced or getting kicked out of the house...

Participants also expressed the belief that adolescents who acknowledge personal problems often underestimate how many of their peers are dealing with the very same problem. The following dialog took place between two participants (P):

P1: I'm not saying that we're all messed up or anything, but I bet that if we told each other more about our problems we'd all have something to say about it. We've all experienced the same types of things, but no one talks about it.

P2: My friend had to tell me to ask for help. I have problems in every class and I think that everyone else is getting it, so I must to stupid. I got my teacher to help me after my friend said, "Just go ask, (a student's name) can't get it either. You're not the only one!"

With regards to the Grade 11 and 12 participants who were members of the treatment group, many seemed to minimize what they had learned from the *Asking for Help Program.* It is still unclear as to why the adolescents would have done this in a group of their peers whom they had completed the program with; however, it may be that it is 'uncool' to learn about help seeking. Notably, this occurred in mixed gender groups as well as all-male groups. The following conversation took place between the facilitator (F) and a participant.

F: Do you feel differently about seeking help now that you've completed the program?

P: No not really. Nothing was new to me.

F: Okay, so you didn't learn anything, because you already knew the information?

P: Yeah. I knew it... Well.....okay I did learn some things... I learned who to go to for the scenario, where to go, how I can say things, and that I need to be more open about the problems I have. I still knew most of it though.

Control Group. Twelve of the 19 (63%) participants admitted to being unsure of who to go to for help and being unaware of the services that different professionals can offer to adolescents. For instance, some participants believed that all mental health professionals engage clients in traditional methods of psychoanalyses and set rigid standards for how clients are to participate in therapy.

I would never go to a professional...what we're doing here is a lot more comfortable. This is a lot more comfortable than laying in a bed with this guy sitting there saying, "Tell me about yourself." I would recommend that a friend do this with someone like you (looking at focus group moderator), but not professional help.

The participants stated that their uncertainty about the client-professional relationship and how a professional might react to their problem has prevented them from seeking help. This is what two adolescents had to say:

I wanted to seek help from a professional one time, but I didn't know what would happen. So, I didn't ask for help.

I just don't know what to expect from a professional – like, what would happen if I went to them? What would they do? If I knew I might go.

Despite having no experience with professionals, 12 of the 19 (63%) participants in the control group described adolescents who use formal help resources, such as shelters and residential treatment programs, unfavourably. However other participants who had first-hand experience with such resources and were quick to correct their peers' misconceptions. The following conversation took place between two adolescents:

P1: (A teacher) told me to go to (a shelter) one time, but I didn't want to. I know some of those girls (in the shelter) and it would not be good because they're all gangsta' and tough. I just look like a little white girl that's not going to do anything.

P2: I was there and I went to (a drug rehabilitation program) the girls that I was with...they're not bad. The girls at the shelter were younger girls, like school aged kids in grades six through eight. They were so annoying, but not gangster.

Similar to the treatment groups' comments, the control group was frequently unable to label situations in their lives as problematic or needing help. The following dialog took place between two participants and the facilitator.

P1: Our problems don't need professional help.

F: Some of you have mentioned personal problems, like fighting with your parents, dealing with your parents' divorce, and getting a failing grade. Are these the types of problems you're talking about?

P1: Yeah, stuff like that.

P2: I fought with my parents a lot, but then they kicked me out and I live with my boyfriend now.

P1: Yeah, that will probably happen to me soon too.

Trust and Potential Resources

Treatment Group. Thirteen of the 25 (52%) adolescents who participated in a focus group after completing the intervention described feeling that their family and friends were unable to provide adequate assistance or had rejected them when they asked for help. Specifically, adolescents stated that no one cared about their problems enough to help them or made efforts to understand and listen to their concerns. Four of the adolescents shared the following comments:

I wouldn't go to my dad because he'd probably just look at me, say he doesn't care, and walk away. Yeah, he doesn't really care what happens. He just says, "What do you want me to do?" He just completely ignores anything I have to say. And when I do have something important to say, he's like, "You were talking?"

Sure you have friends, but some of them ... they've broken your trust.

I don't have a lot of people that I would talk to.

Some of my family just don't care!

The participants also shared experiences where family members had broken their trust by retelling the adolescents' personal problems to several relatives. The following dialog took place between 5 participants:

P1: My family tells each other about my problems all the time.

P2: So does mine.

P3: They don't realize that you want them to help and then they think that they have to go and tell everybody else.

P4: Yeah, then it's a big issue.

P5: Yeah, the rest of the family is asking you if (the information) is true, so everyone is involved.

Control Group. Ten of the 19 (53%) participants assigned to the control group indicated not seeking help because they were unable to trust someone or felt rejected by their preferred helper. The following statements were shared by two adolescents:

Sometimes I ask for help and they say "No, go away!"

I've learned to talk to people that can't talk back – babies, animals, anything that can't repeat that I say. I don't get any help, but I don't need to worry about everyone finding out my problems and I get things off my chest.

Though some of the adolescents indicated that they could trust people in their lives with personal matters, participants indicated that informal help sources, especially

parents, often attempt to get them to disclose more information than they want to. As a result, the participants indicated refraining from seeking help.

> *I can't go to my mom 'cause when I go to her about one problem she just keeps asking me and asking me and (the conversation) will move to so many other things...it's annoying!*

Stigma

Treatment Group. Ten of the 25 (40%) adolescents admitted that their self-perceptions had been affected in the past by comments their peers made when they asked for help.

> *Basically, if people go for help from the guidance counsellor they think that other kids will find out and they'll get laughed at and called a weirdo. So they get scared of being made fun of and don't ask for help. It's happened to me – you think there's something wrong with you or that you're a baby compared to other people because you need help.*

In particular, males seemed to worry that other male peers would disapprove of their decision to seek help. Eight of the 15 (53%) male participants in the treatment group described a process of marginalization where males eventually fail to seek help because asking for help is perceived to be demasculinizing and prevents one from bonding with other males. Notably, these eight males were between 16 and 18 years old. Two male participants shared their experiences of asking for help:

> *Guys told me, "You're not a man! You can't deal with it!" I deal with my own problems now 'cause I can't stand that sh**.*

> *When I need help I go to one of my girl friends. I guess it's because I wonder if another guy will think I can't handle my own problems, like I'm a kid or something. Guys deal with things differently than girls I think. The girls I talk to I can trust - if they tell everyone then you're gonna get it from the guys later.*

Notably, one female participant suggested that males often lose the respect of their peers after seeking help. The following includes a comment that the female participant made in response to a male participant's comment:

Male: Guys told me, "You're not a man! You can't deal with it!"

Female: Yeah, they don't respect you after. If a guy needs help he's gonna lose his friends' respect if he asks for it.

All of the males believed that it is more socially acceptable for males to seek help when discussions related to personal problems and help seeking take during recreational sports or activities that are typically associated with males as opposed to females. The following was taken from a conversation with the facilitator and 3 male participants:

P1: I'd rather talk about (my problems) while we're all doing something.

F: Why do you think that is?

P1: I guess doing something else distracts us. The focus isn't on problems or getting help, it's just asking friends a question. The focus is on what you're doing...basketball or something.

P1: Play poker!

P2: Basketball or soccer...something active and outside with a ball.

F: Hmm, I wonder how we would talk about help seeking while playing those kinds of games.

P2: We could talk while we were shooting hoops if we had to.

P3: I agree. You feel more comfortable when you can talk about this stuff during a game. People are more likely to think that you're a suck if you just walk up to them as say "What should I do?"

Control Group. 14 of the 19 (68%) participants referred to the social stigma attached to help-seeking behaviours. Specifically, participants explained that help

seeking is often interpreted by adolescents as being indicative of weakness, disability, or low intelligence. The following quotes were taken from two different participants:

> *You start to feel bad about going 'cause you think something is wrong with you. Seeking help means that something could be wrong.*

> *Someone is embarrassed about asking for help because it makes them seem weak like they can't do anything for themselves or that they're too stupid to figure it out.*

The conversation below transpired between participants:

> *P1: Yeah, I would ask for help if I need it.*

> *P2: I wouldn't! But, I would be proud of you or whatever 'cause you know you have something wrong with you and are getting help.*

> *P1: I'm not saying that I need a shrink or anything!*

The negative characteristics associated with seeking help were described as barriers because many of the adolescents did not want to be perceived as inferior.

> *We think that if other people were to find out (that we sought help) people would think they're better than us. Other people probably think, "Oh that kid, he's obviously messed up because he's going to get help."*

Similar to the treatment group, all of the males assigned to the control group indicated feeling more comfortable discussing personal problems while engaged in physical activity and suggested that the intervention program include having adolescents play sports. In fact, when given the opportunity to provide suggestions to improve the *Asking for Help Program*, 4 of the 8 (50%) males made jokes related to gambling and alcohol. These 4 males were part of the same group and were between 17 and 19 years old.

> *P1: (The intervention) would have been better if we got to play sports instead of sitting down. I like being active when I (talk about problems and help seeking).*

P2: Yah, that would have helped.

F: Do you think that you could talk while playing sports?

P3: I do it all the time. I talk about a lot of stuff with friends while we're playing video games or sports or whatever.

P4: You wouldn't talk about anything (to do with help seeking while playing sports) -hahaha! Bring out the girls and the cigars!

P1, P2, P3, P4: (laughter and high fives)

Judgment.

Treatment Group. 5 of the 25 (20%) adolescents admitted that fears that other people would judge them have often prevented them from seeking help. For instance, one participant shared:

I don't know. I probably don't get help because it's just one of those things where I'm afraid of going to someone else because I'm afraid of what they will think of me.

Other participants indicated being irritated by questions peers ask them about their help seeking. Specifically, female participants suggested that their friends judge them based on who they chose to seek help from. The following was taken from a conversation between four female participants:

P1: Yeah, people ask you questions like, "why are you going there?" and stuff like that. And what's wrong with going to the people that I go to? They're just as good as anyone else – if not better, because I feel comfortable with them.

P2: People make fun of you and tease you. They make you feel embarrassed without saying anything bad.

P3: It's peer pressure.

P4: It's judgment. People judge ya.

Control Group. Though some (3 of the 19, 16%) participants stated that they had friends who were unlikely to think negatively of them for seeking help, 5 of the 19 (26%) participants expressed skepticism and believed that their peers would judge them for seeking help. This is one conversation that occurred between two of the participants:

> *P1: They are my friends and they are not going to make fun of me – they will probably help me.*
>
> *P2: Yeah right!*
>
> *P1: I'm serious.*
>
> *P2: Everyone's not like that. You're lucky.*

Other participants shared personal experiences where their peers had misjudged them as being dishonest or unpopular for seeking help. The following was taken from two different adolescents:

> *I'm really close with the school principal and everyone says, "oh you're ratting people out" and I tell them "no, I'm not, like you don't know my situation. Shut up! Go away!" People assume the worst of people – that's what high school is all about.*
>
> *I've talked with (teacher's name) about some of the things that bother me, but other people start saying that you talk to teachers because you had no one else in your life you can talk to or they ask you if you have a crush on the teacher. It's stupid!*

Maladaptive Coping Skills.

Treatment Group. 4 of the 25 (16%) participants shared the belief that adolescents often fail to care about their emotions and ignore their problems as a way of coping with the things that worry or bother them. As a result, the participants admitted that they often deny they have a problem or convince themselves that the problem is too small to worry

about. As a result, they claimed not to seek help. The following was shared by two of the participants:

> *No one cares about feelings. Thoughts and feelings...I don't care. Most of the time, I ignore my problems.*
>
> *Well, if I get a bad grade on a test I figure it's only one test and not worth the worry. I don't ask for help because it's no big deal if it's just one test. If I failed a class I'd have to realize that I had a problem and need to do something.*

Control Group. 4 of the 19 (21%) participants admitted that they fail to seek help because they solve their problems, if only temporarily, using unhealthy coping strategies. In some cases the participants described their own maladaptive coping behaviours. Here is what 4 participants shared:

> *Some people actually deal with their problems by self-inflicting pain.*
>
> *We have anger management problems. I have a very bad anger problem and it gets to the point where I get so mad that I don't think...I have a mental thing. I don't remember anything until after the situation – like when (someone I know) was jumped, I guess I just started punching. I guess it's not the best way to handle things, but (those people) haven't bothered me since.*
>
> *I turned to drugs for something to do I guess, but I'm clean now. I lost a lot of weight and my personality changed. My family was having problems then.*
>
> *To overcome my family's judgment of me, I moved out of the house. That's how I dealt with it I got out.*

Previous Experience

Although the majority of participants implied that their help seeking experiences have influenced, and in most cases reduced, the likelihood that they would seek professional help, a very small minority of participants (n = 2) explicitly stated how negative experiences with formal help sources have prevented them from seeking help. Despite the small number, the message that the adolescents conveyed was clear – all

experiences with professionals influence an adolescent's willingness to seek help and their perception of other formal help sources.

Treatment Group. One participant explained that their opinion of mental health professionals was re-formed after a negative experience with a psychologist. According to the participant, s/he had a positive attitude towards professional help sources until s/he felt that the professional had not given their best effort.

> *I had to go to a psychologist one time. He had a cheesy smile and nod ...I could already see dollar signs rising in his eyes...When they talk to you, they're like, "So, do you blame your father?" Yes, I blame my father for a few things but not everything. Then they say, "Do you blame your mother?" No, she's a saint. "Do you blame your brother?" I don't have a brother. He is the kind of person I'm suppose to get help from?*

Control Group. Within the control group, one participant expressed that she is now unable to seek help due to a situation involving a formal resource outside of the mental health profession. The following was taken from the participant's description of the negative experience:

> *(Something scary happened in my home) and when I came to school the next day my teacher was treating me differently and I didn't know why ...I didn't tell anybody about what had happened. Then she said, "oh, well the (professional) that (your family dealt with was) my husband." My whole class found out and all my other teachers, and I felt so embarrassed going into class...Now, I don't go to people to tell them things so that they can help me. I just like talk to (young kids or animals) who can't say anything back.*

Other

Treatment Group. Adolescents' also described perceived barriers to seeking help as relating to the cost of professional help, the inconvenience of finding transportation, being overconfident in one's ability to manage problems, and peer pressure. However, these themes were only expressed by one participant; the other participants nodded their heads in agreement, but did not expand on the discussion. Based on such responses, the

researcher inferred that these themes were not as important to the adolescents as the themes described in detail above. The following was taken from three participants:

> *I went to counselling once and it was all good...my dad was really happy until they gave him the bill. So, if you don't have that kinda money for an hour session, it holds you back.*

> *I think that when you're our age, when you're a teenager, we think that we're better than a lot of people. We think we're above everything - going to ask for help takes your confidence away.*

> *Some people peer pressure you not to ask for help 'cause they're afraid that you'll get them into trouble. Like if you do something illegal with someone else and you want help, but they don't.*

Suggestions for Overcoming Barriers to Seeking Help

Treatment Group. In general, the participants struggled to think of ways that adolescents could overcome barriers to seeking help. Problem severity (14 of the 25, 56%), increased stress levels (23 of the 25, 92%), and positive experiences (5 of the 25, 20%) were mentioned as things that motivate youth to seek help. The following quotes were taken from 2 different adolescents on separate occasions:

> *Stress would make me get help. A lot of stress would definitely make me get help.*

> *You have to go through a couple of good help seeking experiences, like, where you actually get something out of it. So, I guess you need to ask for help before you can start to overcome anything.*

Further, 7 of the 25 (28%) adolescents shared that they overcame barriers to seeking help because their family and friends had forced them to seek help. Each of these adolescents expressed gratitude towards those who encouraged them to seek help and described their experience as positively influencing their views of formal help sources. Here is what one participant shared:

I was forced 'cause (my mom) thought that I had problems and got me help. I'm still seeing a social worker. It's helped me a lot, so I'm really glad my mom forced me.

Control Group. Similar to the treatment group, the control group expressed that high levels of stress and overwhelming problems would motivate them to seek help (17 of the 19 adolescents; 89%). In particular, the participants described a cost-benefit analysis where help seeking is determined to be worthwhile when one is able to gain significant relief from the problem. The following is a quote from one of the participants:

The more stressed out I feel the more likely I am to ask for help. Sometimes I just feel like it's too big for me to deal with anymore and I think of the relief I'll feel once I tell someone and they help me.

11 of the 19 (58%) participants assigned to the control group suggested the barriers to seeking help could easily be overcome by applying strategies that have proven effective for them in other areas of life. For instance, the participants explained that adolescents could seek help more often if they stop caring about what other people think of them, ignore negative comments made by peers, and improve their self-confidence. When asked, some of these same participants admitted to trying to implement these strategies and had not noticed an improvement in their ability to ask for help.

Courage and self-confidence. If you were going to take a test, you'd do something like that. You need self-confidence in order to give yourself the courage to pass the test or ask for help. I talk to myself all of the time before I go to take a test – I'm boosting my confidence.

Basically, just don't care what other people think.

Attitudes Towards Help Seeking

Help Seeking: Definitions and Attitudes

Treatment Group. 20 of the 25 (80%) adolescents assigned to the treatment group indicated that they viewed help seeking as a positive thing. Adolescents who participated in the *Asking for Help Program* were often able to list the advantages and disadvantages of seeking help before expressing whether they believed help seeking to be a positive or a negative behaviour.

> *It takes up too much time and it's just boring sometimes. People talk for too long when you ask them for help, they take too long to make a decision, and they don't always help you, but you find new ways to solve your problems and get to open up about stuff.*

Participants in the treatment group often included why people seek help, what they might gain from seeking help, and what the process of seeking help looks like in their definition of help seeking. The dialog below was taken from a conversation between three participants:

> *P1: Help seeking is a process of opening up to someone about your problems.*
>
> *P2: It's about finding resources and where you can go for help because not all of the resources will be a good match for you.*
>
> *P3: It's finding out what your problem is in the first place – what's the main source?*
>
> *P2: It's solving your problem by finding new ways to look at things and handle them.*

Control Group. 11 of the 19 (58%) participants assigned to control group endorsed positive views on help seeking. This finding may have been lower than the reported percentage for the treatment group because the control group tended to view help seeking as being related primarily to professional helpers and not family or friends. Relative to

the treatment group, the control group also differed in their ability to support their opinions and define help seeking. For example, the control group provided vague reasons to support their opinion (e.g., "*I don't know, it's positive if it helps you")* and often defined help seeking by repeating the phrase in a sentence: *"Help seeking is when you seek help. I think it's pretty self-explanatory."*

Formal and Informal Resources

Treatment group. All of the adolescents in the treatment group claimed to seek help significantly more often from family and close friends than from professionals. Overall, the participants indicated a preference for informal resources because they believed these sources to be more trustworthy, approachable, and familiar with who they are as individuals. The following was taken from a conversation between three participants:

> *P1: I keep (my concerns) in the family because I figure my family is easier to talk to.*
>
> *P2: I agree, you can be more open with them*
>
> *P3: For sure! You're around them more often and they've known you for your entire life.*

The comments below include statements made by three adolescents on separate occasions:

> *I choose my sisters for more personal matters because they are more experienced with who I am.*
>
> *I chose (friends and family) because they are trustworthy.*
>
> *I think we go to (family and friends) because they trust us too. If they have a problem or if they need to tell anyone anything or talk to anybody, they can come to us.*

The adolescents also indicated a preference for informal help sources that encourage adolescents to make their own decisions. One participant stated:

> *My mom gives me different roads to choose from, not that I have to choose what she says. She lets me decide what option to pick – if it doesn't work, I can keep going back for more advice.*

Five of the 25 (20%) of the participants admitted to having sought professional help after being forced to do so by their parents and 22 of the 25 (88%) indicated seeking help from school personnel on a regular basis. In fact, one participant shared that s/he feels comfortable speaking to teachers, vice principals, and principals in order to ensure her/his learning needs were met:

> *Last year my teacher let me use a calculator and write my tests in the Resource room. The math teacher that I have now called me lazy and wouldn't let me write my tests in the room or use a calculator, so I've been failing math. It wasn't fair, so I went to the vice principal and got my math teacher in trouble...when that didn't fix the problem I went to the principal...the principal promised me that I will not get a grade lower than 51% in the class if I do my best. School is a place where I feel comfortable telling people how they can help. Plus, I really need math to go to college for the job I want.*

Control Group. All of the adolescents in the control group also reported seeking help significantly more often from family and close friends than from professionals. In addition to indicating that trust and familiarity were important, the control group expressed a preference for informal helpers that confide in them, thus, creating a reciprocal relationship that professionals could not provide.

> *I think we go to (family and friends) because they trust us too. If they have a problem or if they need to tell anyone anything or talk to anybody, they can come to us.*

The control group also highlighted the importance of being spoken to as an equal, as opposed to a child or an inferior party. One participant shared that she felt like her guidance counsellor's friend when she sought help:

> *Our guidance counsellor talks to us like we're not just students – we're like friends. We're all at the same level I guess.*

Seven of the 19 (36%) adolescents who participated in a focus group admitted to having sought professional help after being forced to do so by their parents. Notably, 16 of the 19 (84%) adolescents stated that they seek help from school personnel and guidance counsellors; however, many of these students did not consider school personnel to be professional help sources. In general, the participants described professional help as something that is needed in extreme or desperate situations, such as having thoughts of suicide.

> *An example of a major problem would not be getting pregnant or your parents separating – I can handle that. If I was having thoughts of suicide that would be a major problem, but that would be the only time that I would get professional help – if I ever thought of killing myself. And, that would be never so I would never get professional help.*

Although 4 of the 25 (21%) adolescents felt professionals could provide them with an unbiased opinion, the majority of the participants expressed feeling uncomfortable seeking professional help, felt that professionals would not be able to relate to their experience, or that professionals were not truly interested in helping them.

> *I just think it's weird that you're going to go to this person you don't even know. You've just met them and you're going to tell them all of your problems? Why? You don't even know them!*
>
> *It's kinda better to go to someone you don't even know 'cause they don't really know you and can give you a fair opinion.*

I have my views about professionals. I don't know, I see it as they're just there to do their job – make money. They're just there to get paid.

I want people who have first hand experience with what we've gone through (referring to the group), not people who just go to university and think they know everything...how you live on the streets or how this and that feel. People can't possibly know unless they've gone through it. That just really bugs me!

Lessons Learned and Perceived Changes

Treatment Group. 16 of the 25 (64%) adolescents who completed the *Asking for Help Program* before participating in a focus group indicated that they were more willing to ask for help and felt more comfortable sharing their problems with other people because of their experiences in the intervention program. The quotes below were taken from two participants who provided detailed accounts of how the intervention helped them:

I really wasn't comfortable telling anyone anything about my problems before. Now I can say more stuff to my mom and I have different ways to talk to my dad. I'm not sure what made me more comfortable and I can't tell you what I learned, but it was helpful somehow.

Before the program there wasn't as many options, I didn't think, to get help from. There wasn't as many places to go for help, but now I realise that there are a lot of places that you can go and there are a lot of people that you can talk to. I know that it's a lot easier for professionals to help because they are qualified and can (solve problems) easier than I can alone – they see it every day.

Specifically, the adolescents indicated that they learned different ways of seeking help, and starting conversations with their parents as well as how to choose more appropriate help sources.

I learned different ways and different people to ask for help from. It's just the way that you ask that I found really helpful and knowing who to ask for different scenarios.

Of the 16 participants who indicated that they would be more willing to seek informal help, three also shared that they would not hesitate to seek professional help after completing the intervention because the group facilitators had demystified the process and resources associated with formal help. For example, one of the participants stated:

> *It's just not something that I knew about before – I didn't even think about it. Now that I know a lot about the help that I can get, I would go if I needed it. I wouldn't think about it, I would just go.*

23 of the 25 (92%) adolescents who completed the intervention program felt that hearing about their peers' problems and beliefs was extremely helpful. In particular, the participants acknowledged that group discussions helped to normalize their problems, reduced their feelings of embarrassment, and provided a sense of validation.

> *I learned that there are more people in this group who will listen to you than I thought. I didn't know most of you (referring to the group) have the same issues that I do. I learned to respect others because we had these rules we went over – to listen to what other people have to say. We had to follow the rules and it helped me get along with everyone better.*

Four participants also indicated that the intervention program provided them with the opportunity to practice talking about their problems and build larger support networks. Two participants' comments related to these issues are shown below:

> *I talk to people more than I used to. I used to never talk about my problems until this group, but now I do. I learned to give people a chance and I don't get as frustrated over my problems...I've gotten them off my chest.*

> *I feel like I definitely have more people to go to because I made friends in this group. I'd be willing to help you guys (looking at the group) if you asked me.*

Control Group. Four of the 19 (21%) participants assigned to the control group expressed that the focus group by itself made them realize that it may benefit them to consider asking for help more often and helped them to connect with other adolescents.

> *I always try to deal with problems myself... Well I mean, it is working for me, but I could start asking people for help.*

One adolescent expressed the belief that his extended family thought poorly of him and admitted to feeling supported by his peers after hearing of another participant's similar experience and how he dealt with it. This was the first time that the adolescent had ever shared personal concerns with his peers.

Independence

Discussions about being independent were generated in each of the focus groups based on questions related to how the participants felt about asking others for help. In general, the participants described the concept of being independent as a choice that one makes as opposed to a barrier to seeking help; however, adolescents' attitudes towards seeking help differed based on how important independence was to them.

Treatment Group. All of the participants enrolled in Grades 9 or 10 within the treatment group (n = 10) expressed positive attitudes towards seeking help in cases when they had attempted to solve the problem themselves and were unsuccessful or had encountered a problem that was too overwhelming for them to deal with alone. This is what one participant said:

> *It just depends on the problem. If it is a minor problem you probably don't need help anyways, you can probably figure it out by yourself. If it's a major problem, then yeah, it's good to ask someone for help.*

In contrast, eight of the 15 (53%) participants enrolled in Grades 11 and 12 within the treatment group expressed a strong need to solve their own problems. The participants claimed that they have refused to seek help despite needing assistance because they believe they already have the knowledge that help sources can provide. The remaining half of the Grades 11 and 12 students did not comment when the topic of independence was discussed.

> *They basically tell you what you already know about yourself and how to deal with your problems. It's basically the same thing as if you were to go to yourself. The exact same thing.*

Despite their attitudes towards seeking help for themselves, all of the participants in the treatment group expressed the belief that their peers should seek help if they need it and often fail to seek help in order to maintain an image within their peer group. The following quotes were taken from two different adolescents:

> *No, he just thinks that he's hard core. Don't try to be all cool, (another participant's name). I don't know, he's kinda being an idiot for saying he wouldn't ask for help.*

> *If you need help, you should get it. If I need it, I ask, but I don't need it.*

Control Group. Similar to the treatment group, the majority of the participants enrolled in Grades 9 or 10 within the control group (8 of 9 participants; 89%) expressed positive attitudes towards seeking help in cases when they had attempted to solve the problem themselves and were unsuccessful or had encountered a problem that was too overwhelming for them to deal with alone. One participant explained her approach to help seeking as:

> *I try to figure it out myself first, but nobody knows everything. There's no possible way that you can know everything; you're going to need some guidance.*

In contrast, four of the 10 (40%) participants enrolled in Grades 11 or 12 and one participant enrolled in Grade 9 or 10 within the control group shared that their life experiences had forced them to develop negative attitudes towards help seeking and had taught them to rely on very few people. Two examples of participants' comments can be found below:

> *Our situations have forced us to grow up at a very young age...we're more mature than a lot of Grade 12 students because you see things that other people our age don't and have to worry about much more - we have money problems and live on our own.*

> *My dad is an alcoholic so I can't live with him and my mom is very dependent on other people...she would choose her boyfriends over her kids any day. Me and my boyfriend broke up two weeks ago and I had nowhere to go. My mom tells me, "I already told you, you can't stay here!" I grown up being forced to be independent. Now, I don't like people helping me...I feel guilty I guess.*

Although the aforementioned Grade 9 and 10 participants within the control group expressed the importance of their peers seeking help, when needed, five of the 10 participants enrolled in Grades 11 or 12 and one participant enrolled in Grade 9 or 10 emphasized the need for personal privacy. Specifically, the older adolescents appeared more likely to discourage friends from sharing personal information or asking them for help. The older participants explained that this is often due to their own experiences and their desire to focus on their own problems, as opposed to becoming involved in those belonging to others. The following statement was taken for a conversation between the facilitator and a participant; at the end of the conversation, the participant acknowledges that her option, at least in part, is influenced by her inability to help others:

> *F: Would it be okay if a friend came to you and asked for help?*

> *P: Yeah. But, some situations...they shouldn't. Like some situations they just shouldn't tell their friends.*

F: Can you think of an example?

P: A big family issue you should keep in the family. You shouldn't go around telling everyone.

F: What do you tell your friends if they come to you with a problem like that?

P: "Why did you tell me that? You should keep that stuff to yourself." Because you know what? People ask you for your opinion on things and they stand there and wait for you to say something when you don't know what to say...except, "keep it to yourself."

Additional Insights

Treatment Group. Adolescents who completed the intervention program all indicated that their attitude towards attending the *Asking for Help Program*, though positive, could have improved if they were able to contribute to decisions pertaining to what would be discussed in the group, how the material would be presented, and the activities used to teach information. For example, 22 of the 25 (88%) adolescents assigned to the treatment group felt that the role playing activities were ineffective and often resulted in off-task behaviour. The following is a conversation between three participants:

P1: The role playing was lame. You couldn't put yourself in that position. It's not real.

P2: I just don't like being the center of attention.

P3: We should have talked about more group problems instead of just acting out problems that have nothing to do with us. Most of the time when we did role playing activities we just kinda messed around.

In contrast, 14 of the 25 (56%) adolescents expressed finding relaxation exercises very helpful and suggested that this become a larger focus of the program. The following quote summarizes many of the participants' comments regarding this matter:

I think (the intervention program) should have been more stress relieving. You know? I liked the breathing activities and they showed us other stress relieving things too, but we should have done more. We did them only one or two times.

10 of the 25 (40%) participants also suggested that facilitators encourage adolescents to share their personal stories and problems instead of discussing randomly selected issues; however, 18 of the 25 (69%) adolescents admitted that they would not feel comfortable sharing personal information with the group. Along these lines, 7 of the 25 (28%) participants stated that they would have liked to have scheduled time within each session to ask facilitators for guidance on personal problems. The following is a quote from one of the participants:

I want to talk more and ask the leaders questions about my problems instead of them just asking questions and expecting us to come up with any possible answer we can find.

Six of the 25 (24%) adolescents believed that the *Asking for Help Program* was too short in duration. One participants' comment related to this topic quite well:

The (intervention program) felt like once we got it started it was already over. You get the discussion going and then an hour is over and you've only scratched the surface. It would have been better if the groups were longer and for more weeks.

Regarding the method of presentation, 24 of the 26 (92%) participants in the treatment group believed that some of the information would have been better received if it were presented using clips from movies and television shows rather than scenarios that were read aloud. This was one participant's insight:

I think that videos would be a lot better. Just little clips from movies or TV, instead of acting them out. Even public service announcements or something like that.

Finally, 21 of the 26 (80%) adolescents assigned to the treatment group expressed a need for more active forms of participation. Males tended to suggest sporting activities

that allowed for conversation during play whereas both males and females suggested board games. The following comments were shared by two separate participants:

> *There's too much talking, not enough action!*
>
> *You should make a help-seeking game. You would go around the board and if you land on someone's problem then you have to solve it or act something out.*

DISCUSSION

The study evaluated the effectiveness of the *Asking for Help Program* from the perspective of participating youth. This was the first time the *Asking for Help Program* was offered. Adolescents who attended the program were compared to a waitlist-control group. After post-treatment assessment, the wait-list control group received the *Asking for Help Program.* The findings from this study partially supported the hypothesized changes.

Actual Help Seeking

The hypothesis that the *Asking for Help Program* would increase actual help seeking for formal and informal resources was not supported. Quantitative analyses revealed that participants' actual help seeking was not significantly different after the intervention. A significant change was found for adolescents in the control group; these teens sought more help from informal (e.g., family and friends) resources while waiting for the intervention relative to the treatment group. The focus group responses suggest that the participants' help seeking did not increase after the intervention because previous help resources (e.g., family members) often continued to be viewed as untrustworthy or uncaring. Further, participants remained skeptical about professionals' ability to help and relate to adolescent problems. As such, participants' reported seeking limited help and preferred to seek help from informal resources before and after the intervention.

Focus group responses for those adolescents who completed the program suggested that many of the participants felt that they could not seek help from their family and friends due to a lack of trust or negative experiences (e.g., past rejection); this highlights the importance of the facilitators in the *Asking for Help Program.* Evaluations

of mentoring programs have shown the effects that mentors who demonstrate empathy and positive regard can have on youth. Reported outcomes include improved academic achievement, a stronger sense of self-worth and social acceptance, improved relationships with parents, increased self-esteem, and decreased drug and alcohol use (Public/Private Ventures, 2008). These benefits are thought to emerge when role models are able to have a steady, reliable, and constructive presence in the lives of youth (Public/Private Ventures, 2002). Though the *Asking for Help Program* was relatively short-term, focus group responses suggest that the intervention facilitated high-quality and closer peer relationships, as well as provided a supportive relationships with facilitators. Notably, several participants intended to keep in contact with their group members despite the program's termination and felt that they could seek help from these peers. It seems possible that such positive social experiences would cultivate feelings associated with self-acceptance and a sense of empowerment that may inspire youth to view themselves as capable individuals. Consistent with this, the focus group responses indicated that participants perceived themselves as being more equipped to handle their problems and more willing and comfortable to seek help as a result of the intervention. Specifically, the adolescents reported benefiting greatly from activities that provided practice, enhanced social networks, and focused on skills training (e.g., initiating conversations with adults for the purpose of seeking help). Thus, relative to the participants waiting to participate in the intervention, adolescents in the control group may have been less compelled to seek help due to the resources and improved skill sets that the intervention offered.

Given that the participants completed post-testing questionnaires within two weeks of completing the intervention program, it is possible that not enough time had elapsed to detect improvements in actual help seeking. For example, adolescents would be unlikely to seek help if distressing problems were improved or resolved during the *Asking for Help Program*. As such, it seems that the effectiveness of the intervention could be more accurately assessed if post-testing took place three months after the program's completion; thus, allowing time for adolescents to encounter problems and apply the learned material.

Barriers to Help Seeking

The hypothesis that the *Asking for Help Program* would reduce barriers was partially supported. Quantitative results suggested that adolescents' perceived barriers towards seeking help did not change over the course of the intervention. However, qualitative analyses provided additional insights which indicated that the treatment and control groups reported similar barriers, but perceived many of the barriers differently. For example, a large proportion of the control group associated help seeking with weakness, inferiority, and disability. In contrast, the treatment group did not believe that help seeking indicated that a person was weak or disabled; instead, adolescents who participated in the intervention indicated being better able to understand how stigmas associated with seeking help have negatively affected their behaviour and self-perception. Males assigned to the treatment group attributed their concerns that male peers would see them as 'less of a man' if they asked for help to social stigmas. Further, these males admitted to modifying their behaviour, such as seeking help from female peers, as a way to avoid experiences associated with social marginalization. Overall, it seems that the

treatment group was able to identify how social stigmas affect their behaviour and self-perception whereas the control group simply confirmed the existence of social stigmas and, unintentionally, demonstrated the powerful influence that they have on adolescents' (e.g., help negation and experiences of inferiority) and adolescents' perceptions of those who seek help.

The most frequently reported barrier by participants was knowledge; that is, both the treatment and control groups shared the belief that adolescents are often unable to recognize problems as requiring help or are unable to select appropriate resources because they are misinformed or uninformed about professional resources. However, a larger portion of the treatment group endorsed knowledge (e.g., information about where to get help, who to ask for help, and how to evaluate help resources) as a barrier to help seeking. Overall, the treatment group tended to acknowledge adolescents' lack of knowledge about formal resources and the prevalence of erroneous beliefs related to professional resources, such as the belief that formal resources are "cold hearted or mean." As such, it appears that the treatment group became more aware of their lack of knowledge about barriers as a result of the *Asking for Help Program.* In fact, most of the information that the treatment group suggested adolescents need to know can be found in the *Asking for Help Program* facilitator's manual. Unlike the treatment group, the control group indirectly endorsed knowledge as a barrier to help seeking; that is, conversations among the participants demonstrated the control group's inability to recognize problems and provide accurate information on formal help resources. Thus, the intervention appears to have been successful in teaching participants to identify barriers and how barriers affect their own willingness to seek help.

In general, all of the participants struggled to think of ways to overcome barriers to seeking help; however, the control group was more likely to suggest unrealistic ways of surmounting the barriers. For instance, participants assigned to the control group implied that it would be easy for adolescents to seek help if they stop caring about what other people think about them. This suggestion implies that barriers, such as social stigma and judgment, should be easily overcome; yet, the literature indicates that this is rarely the case. Notably, despite having found the suggested strategies to be unhelpful and unsuccessful, the control group indicated that such strategies could work for other adolescents. As a result, it seems that the intervention helped the treatment group assess previous, and perhaps unrealistic, ideas about how they could overcome barriers and allowed them to realize that doing so is often hard to achieve. It seems reasonable to conclude that being better able to evaluate the difficulty of surmounting barriers to seeking help would more adequately prepare one to seek help. This may help to explain the increase in help-seeking behaviour upon post-testing.

The treatment group had difficulty identifying how barriers to help seeking could be overcome, but they shared that they had learned how to select more appropriate resources and learned more about what formal help sources can provide. Hence, qualitative findings suggest that the intervention not only enabled adolescents to identify how barriers to resources affect their self-perception and subsequent behaviour, but taught them information that is likely to reduce the most reported barrier – knowledge. Accurate recognition and labeling of mental health disorders by young people has been found to be associated with improved help seeking and treatment preferences, suggesting

the adolescents are less likely to deal with mental health problems on their own and more likely to consult a professional (Wright, Jorm, Harris, & McGorry, 2007).

In summary, the results from the content analysis appear to be inconsistent with the quantitative findings relating to the Barriers to Adolescent Help Seeking Questionnaire and Attitudes Towards Seeking Psychological Professional Help. This might be explained by comparing the barriers listed on the BASH-R and the barriers identified by the adolescents during the focus groups. The focus group responses revealed that not all of the adolescents' perceived barriers were adequately represented on the measure. For instance, participants' gain in knowledge was not captured by the quantitative measure because none of the 18 items were designed to assess knowledge as a barrier. Further, the number of items designed to assess the barriers that the adolescents identified in the focus groups may have been insufficient to detect significant changes in participants' perception. For this reason, it seems that quantitative findings may have underestimated the effectiveness of the intervention in certain aspects.

Barriers can best be understood as a complex web of interactions. Unfortunately, one often needs to surmount more than one barrier before significant changes can be observed in their behaviour (i.e., seeking help from formal and informal help sources without hesitation). Based on participant responses in the focus groups, Figure 1 demonstrates how the mentioned barriers can feed to strengthen one another and reduce the likelihood that an adolescent would seek help (see Figure 1).

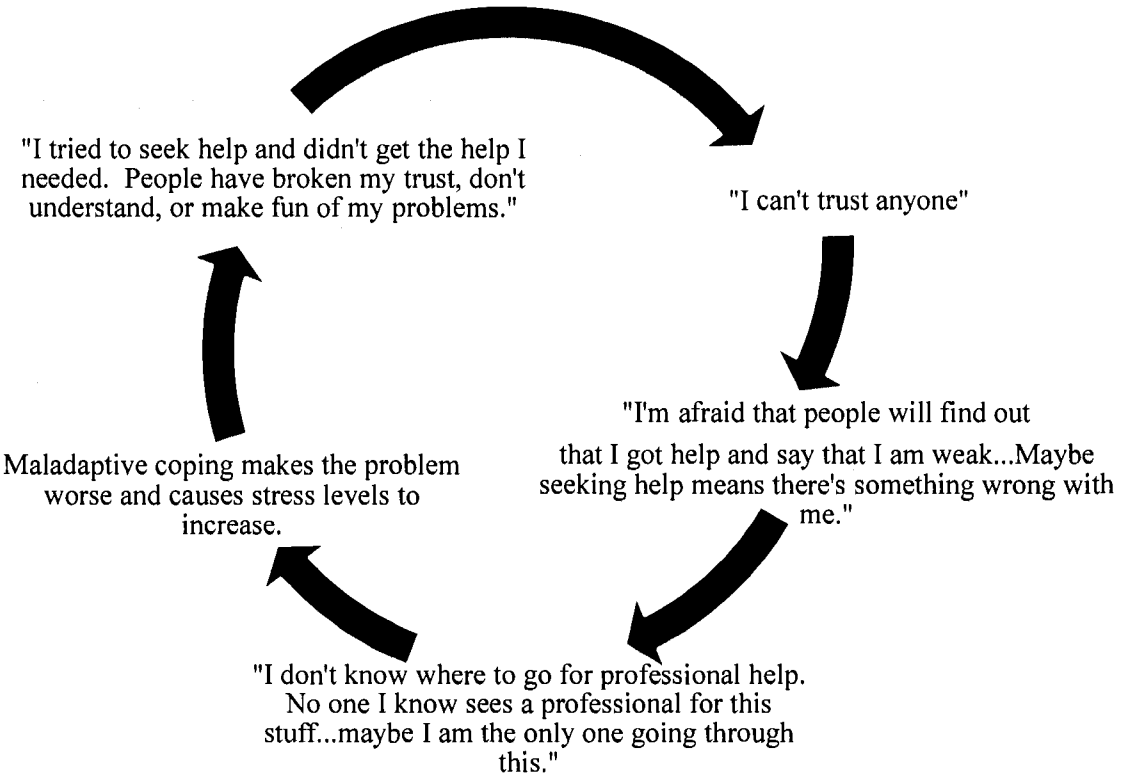

Figure 1.

One example of how barriers interact to reduce help-seeking behaviours.

The fact that participants perceived the mentioned barriers suggests a need to address their concerns; however, the present findings also encourage one to consider how accurately perceptions reflect reality. Although 54% of the adolescents who participated in a focus group admitted to having fears that other people would judge or stigmatize them for seeking help, 77% of the participants assigned to the treatment group and 58% of the participants assigned to the control group reported positive attitudes towards seeking formal and informal help seeking. This suggests that adolescents believe other people will see them as weak if they seek help when, in fact, the majority of participants reported positive views of help seeking.

Attitudes towards Help Seeking

The hypothesis that the *Asking for Help Program* would improve adolescents' attitudes toward seeking help was partially supported. No significant differences were found between adolescents who attended the intervention and those in the waitlist-control group on a quantitative measure of attitudes towards help seeking (i.e., ATSPPH). However, qualitative findings indicated that the *Asking for Help Program* positively influenced adolescents' attitudes towards seeking help and, in the minority of cases, encouraged youth to seek professional help for personal problems. When asked, adolescents attributed the positive attitude change to experiences within the group, such as hearing about their peers' problems, sharing personal information and developing a peer support network which they believed would sustain itself after the intervention. For the purpose of this study, the Attitudes towards Seeking Professional Psychological Help questionnaire examined help seeking attitudes related to formal resources, and thus, cannot be seen as a true reflection of general attitudes towards seeking help. Taken

together, quantitative and qualitative findings indicate that participants' attitudes towards seeking professional psychological help were relatively unaffected; however, participants' responses in the focus groups suggest that their attitudes towards seeking informal help improved greatly.

Focus group responses from adolescents who were in the treatment group indicated that they continued to seek help from informal resources more than formal ones. The adolescents attributed this to their view of family and friends – people who are more familiar, comfortable, convenient, and able to reciprocate by providing information about themselves or their problems. Some participants also reported the belief that formal resources would lack first-hand experience with the adolescent's reported problem(s), such as living in poverty and being alienated from one's family. Adolescents in the waitlist-control group also reported thinking that professionals engage in out-dated, rigid practices that would pressure one to disclose personal information and would impose course of action. Such a narrow-minded view of formal help resources prevented the majority of the control group from recognizing school personnel, whom they had successfully sought help from in the past, as formal resources. The treatment group appeared to have a more accurate view of formal help sources; however, they often seemed unable to identify the *Asking for Help Program* as a formal source of help. In fact, participants often indicated that they would recommend a friend to the *Asking for Help Program*, but would not recommend professional help. Taken together, the findings suggest that the intervention helped dispelled the treatment groups' misconceptions about formal resources, but may have been unable to present the benefits of formal help as outweighing the costs (e.g., social stigma, cost, etc.).

Molock et al. (2007), provide some insight as to why adolescents would be willing to recommend the intervention program to a friend, but would refrain from recommending formal resources. The results of the pilot study suggest that adolescents prefer community-based resources within schools, recreation centers and other familiar places, especially when such resources are provided by young adult helpers (e.g., graduate students as opposed to middle-aged professionals). Similarly, Wilson and Deane (2001) found that adolescents believed that school-based interventions could reduce the barriers to seeking help if presentations were given by their peers and were primarily 'student-run.' These findings indicate that adolescents may initially perceive younger resources as being able to provide a more collaborative relationship and view older resources as more likely to generate a power imbalance. This preference is consistent with adolescents' desire to be independent and suggests that adolescents may not realize the value of working with an experienced professional. Alternatively, the results may highlight the importance of professionals' knowledge and familiarity with youth culture. That is, younger professionals and those who frequently work with adolescents may be more familiar with youth culture, and thus, better able to relate to adolescents and engage them in conversation. The clinical implications of the aforementioned findings are threefold. First, in order to establish better working relationships with adolescents, professional training efforts should emphasize the importance of becoming familiar with adolescent culture. Second, professionals may attract more adolescents by marketing their services through word-of-mouth (e.g., significant community leaders who youth respect and enjoy), presenting themselves more informally (e.g., semi-casual clothing), and including adolescent-appropriate displays in

office settings (e.g., popular magazines, quiet playing music, small snacks, brain-teaser puzzles, and framed comics). Lastly, professionals may benefit from re-conceptualizing the notion of formal and informal resources; it is possible that these terms may be better applied to a helper's approach and interpersonal style when working with adolescents, as opposed to differentiating those with specialized training and those without. Undoubtedly, formal and informal practices have value when working with adolescents and may be combined to enhance rapport and therapeutic success.

Stress as a Moderator of Treatment Outcome

The results from regression analyses revealed that stress does not moderate the relationship between participating in the *Asking for Help Program* and the change in one's attitudes towards professional resources, behaviours, or perceived barriers. Despite the present findings, stress may play a significant role in moderating, and perhaps mediating, the relationship between intervention efforts and treatment outcome. As was previously mentioned, the BASH-R and ATSPPH are unlikely to have captured adolescents' attitudes towards seeking informal help and did not include all of the barriers that the participants reported. As such, it seems that the collected data reflects only a small portion of the larger picture. In fact, recent research (Gifford, 2005) suggests that results vary depending on the type of stress being measured, for example, life-event stress compared to chronic stress. The former is defined as objective occurrences that change the usual activities of most people (Dohrenwend et al., 1978) and include stressors listed on the ALCES. Alternatively, the latter is defined as stressful life circumstances that recur or persist (Pearlin, 1989) and include enduring problems, such as interpersonal difficulties and economic hardships (Pearlin, 1983; 1989). Given the

sample's reported life histories (Emancipated Minor status) and familial conflict, the study may have benefited from including a measure designed to capture stress and the duration of exposure to the stressor. For instance, being asked to leave one's family home is not a discrete occurrence; indeed it is a chronic stressor that begins with family disputes, persists during the adolescent's adjustment to independent living, and affects the adolescent's future well-being and life choices. Thus, the cumulative advantages and disadvantages that one experiences may influence an adolescent's motivation to seek help and their treatment outcome more than one or more stressful life events (Gifford, 2005). In fact, it may be the case that life events merely intensify the on-going day-to-day stress that some of the participants in this study reported experiencing. For example, the reading difficulties that the sample experienced represent one of many possible persistent educational stressors that youth with poor academic performance are likely to experience.

Future Research

Further evaluation of the *Asking for Help Program* is needed and is likely to benefit from the application of quantitative subscales as a means of determining whether specific aspects (e.g., barriers related to knowledge) can be influenced without influencing larger constructs (e.g., perceived barriers). Research should also assess both stressful life events and chronic stressors, including negative relationships with family members, difficulties with peers, and persistent academic problems. Moreover, particular stressful-life events and the level of stress experienced as a result of a life-event may be important to control for when considering moderating variables. This study would likely have benefited from a more general measure of help-seeking behaviour; that is, one designed to assess help seeking over a longer period of time (i.e., 3 months).

As a research community, investigators are encouraged to begin to create new measures and improve those in circulation. Current measures often fail to capture the complex and unique experience of adolescence and, for this reason, compels researchers to compliment quantitative data with qualitative study. This study may have benefited from additional qualitative data, such as conducting focus groups with the facilitators of the intervention for the purpose of assessing their perceptions of the program effectiveness and it's component parts.

Finally, involving more adolescents in research would improve the statistical power and generalizability of future studies. A larger sample size would be more appropriate for multi-level modeling, and thus, would allow researchers to account for group influence, facilitator differences, variations within the intervention schedule and adherence to the manual.

Concluding Remarks

This study provided more complete information than previous studies because the study sought to assess previously examined variables, which do not lend themselves to precise measurement techniques, using quantitative and qualitative analyses. The focus groups in the study provided rich information that would have otherwise been missed by quantitative data. The qualitative study allowed the researcher to assess the effectiveness of the *Asking for Help Program* more accurately and did not rely on participants' reading abilities. The examination of the qualitative findings suggested that the participants were more likely to recognize how barriers and attitudes affect their help-seeking practices and may be more likely to ask for help from informal sources to overcome such obstacles. Further, the participants may be more willing to seek help from formal resources based

on their new found understanding of what professionals can offer that family and friends cannot.

While research has shown evidence that middle school students can improve their ability to identify signs of distress and minimize barriers to seeking help after attending only two workshops and being provided with electronic resources (Santor et al., 2007); high school students pose additional challenges related to their growing need for independence and emerging symptoms of psychopathology. Overall, adolescent interventions, especially those designed for at-risk youth, need to be more intensive and flexible. Though manual-based programs lend themselves to research and evidence-based practice, program providers should consider engaging adolescents by allowing them to modify the program in subtle ways so as to best suit their needs. Based on the present study, adolescents recommend increased use of electronic media, frequent participant-lead discussions, and more active, less classroom-like environments. Ultimately, adolescents involved in the current study seemed willing to share their personal experiences and concerns.

The results of the current study suggest that it is critical to address adolescents' misconceptions about formal resources and prevalence rates as part of mental health education. To do this, it is essential the informal and formal resources work collaboratively. Ideally, the combination of educational, professional, and familial support will provide adolescents with the tools to challenge misconceptions, overcome barriers, and improve their attitudes towards seeking help so as to increase their sense of well-being and potential for future success. For instance, it may be of great benefit to add discussions about how adolescents can overcome the mentioned barriers to academic

curriculums. Mental health providers must also acknowledge the stigmatizing attitudes that adolescents have towards professional resources and should make efforts to address these perspectives with clients before beginning treatment. Finally, because positive support can prevent further or more severe problems, it is important that intervention efforts begin to reach participants' family and friends.

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APPENDIX A

Teen Background Information Questionnaire

1. When is your birthday?
   Please give the month, day, and year of your birth (e.g., June 3, 1993).

   My birthday is _____.

2. What gender are you?
   - ☐ Male
   - ☐ Female

3. How old are you in years? (example: I am 14 years old.)
   I am _____ years old.

4. What race or ethnicity do you *most* identify with?
   - ☐ East Asian
   - ☐ South Asian
   - ☐ Caucasian
   - ☐ African Canadian
   - ☐ Caribbean
   - ☐ Hispanic
   - ☐ Native Canadian
   - ☐ Biracial - Please Specify _____
   - ☐ Multi-racial - Please Specify _____
   - ☐ Other - Specify _____

5. How many brothers and sisters to do you have? (Please indicate how many of each, if you are an only child put 0 for each)

   I have __ older brother(s), __ older sister(s), __ younger brother(s) and __ younger sisters.

6. Are your parents _____?
   - ☐ Married
   - ☐ Divorced
   - ☐ Separated
   - ☐ Living together
   - ☐ Remarried
   - ☐ None of the above (Please Specify: _____)

7. Which parents/guardians do you live with? (Check all that apply)
   - ☐ Mother
   - ☐ Father
   - ☐ Step-father
   - ☐ Step-mother
   - ☐ Other (Please Specify: _____)

8. What is your mother's education level?
   - ☐ Less than 7 years
   - ☐ Junior high school (Grade 9)
   - ☐ Some high school (Grade 10 or 11)
   - ☐ Graduated from high school or equivalent high school diploma
   - ☐ Some college or university (at least one year)
   - ☐ Graduated from college or university
   - ☐ Graduate/professional school (e.g., Master's, Ph.D.)
   - ☐ Other _____

9. What is your father's education level?
   - ☐ Less than 7 years
   - ☐ Junior high school (Grade 9)
   - ☐ Some high school (Grade 10 or 11)
   - ☐ Graduated from high school or equivalent high school diploma
   - ☐ Some college or university (at least one year)
   - ☐ Graduated from college or university
   - ☐ Graduate/professional school (e.g., Master's, Ph.D.)
   - ☐ Other _____

10. Is your mother currently employed?
    ☐ Yes ☐ No
    What is/was your mother's occupation? _____

11. Is your father currently employed?
    ☐ Yes ☐ No
    What is/was your father's occupation? _____

12. Do you have any medical conditions? ☐ Yes ☐ No If yes, please list them.

_____

_____

_____

_____

13. Are you receiving any professional help or counselling services? If yes, describe these services and who (e.g., school counsellor, social worker, psychologist) provides them.

_____
_____
_____
_____

14. Are you on any prescription medications? ☐ Yes ☐ No If yes, please list them.

_____
_____
_____
_____

APPENDIX B

Adolescent Life Change Event Scale

(Yeaworth, McNamee, & Pozehl, 1992)

Please indicate which of the following stressful life events have happened to you **within the last year**. If you have experienced the item, circle **Yes**. If you have not experienced the item, circle **NO.** For any other stressful events you have experienced within the last year, that are not already included in this list, please describe them on item 32 and 33.

1	Death of Father	**Yes No**
2	Death of Mother	**Yes No**
3	A brother or sister dying	**Yes No**
4	A close friend dying	**Yes No**
5	Parents getting divorced or separated	**Yes No**
6	Failing one or more subjects in school	**Yes No**
7	Being arrested by the police	**Yes No**
8	Failing a grade in school	**Yes No**
9	Family member (other than yourself) having trouble with alcohol	**Yes No**
10	Getting into drugs or alcohol	**Yes No**
11	Losing a favorite pet	**Yes No**
12	Parent or relative in your family (other than yourself) getting very sick	**Yes No**
13	Losing a job	**Yes No**
14	Breaking up with a close girlfriend/boyfriend	**Yes No**
15	Quitting school	**Yes No**
16	Close girlfriend getting pregnant	**Yes No**
17	Parent losing a job	**Yes No**
18	Getting badly hurt or sick	**Yes No**
19	Fighting with parents	**Yes No**
20	Trouble with teacher or principal	**Yes No**
21	Having problems with being overweight	**Yes No**
22	Having problems with being underweight	**Yes No**
23	Having problems with your height (being too tall or too short)	**Yes No**
24	Starting a new school	**Yes No**
25	Moving to a new home	**Yes No**
26	Change in physical appearance (e.g., glasses, braces)	**Yes No**
27	Fighting with brother or sister	**Yes No**
28	Problems with menstrual periods (girls only)	**Yes No**
29	Having someone new move in with your family (e.g., grandparent, adopted child)	**Yes No**
30	Starting a job	**Yes No**
31	Mother getting pregnant	**Yes No**
32	Problems with dating	**Yes No**
33	Making new friends	**Yes No**
34	Brother or sister getting married	**Yes No**
35		
36		

APPENDIX C

Attitudes Toward Seeking Professional Psychological Help

For each item indicate whether you:

Disagree (0)
Somewhat disagree (1)
Undecided (2)
Somewhat agree (3)
Agree (4)

1. Although there are clinics for people with psychological problems, I would not have much faith in them.	**0**	**1**	**2**	**3**	**4**
2. I am quite certain that my immediate family members would support me if I were to seek professional help for psychological problems.	**0**	**1**	**2**	**3**	**4**
3. If good friends asked my advice about a psychological problem, I might recommend that they see a professional.	**0**	**1**	**2**	**3**	**4**
4. I would feel uneasy going to a professional because of what some people would think.	**0**	**1**	**2**	**3**	**4**
5. People with strong characters can get over psychological problems by themselves and would have little need for professional help.	**0**	**1**	**2**	**3**	**4**
6. If I needed professional help it would be difficult to overcome my own reservations about getting it.	**0**	**1**	**2**	**3**	**4**
7. There have been times when I have felt completely lost and would have welcomed professional advice for a psychological problem.	**0**	**1**	**2**	**3**	**4**

8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.	**0**	**1**	**2**	**3**	**4**
9. I would be uncomfortable seeking professional help for psychological problems because people might find out about it.	**0**	**1**	**2**	**3**	**4**
10. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.	**0**	**1**	**2**	**3**	**4**
11. I would rather live with certain psychological problems than go through the ordeal of getting professional treatment.	**0**	**1**	**2**	**3**	**4**
12. Psychological problems, like many things, tend to work out by themselves.	**0**	**1**	**2**	**3**	**4**
13. 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.	**0**	**1**	**2**	**3**	**4**
14. There are certain problems which should not be discussed outside of one's immediate family.	**0**	**1**	**2**	**3**	**4**
15. A person with a serious psychological problem would probably feel most secure in a good mental hospital.	**0**	**1**	**2**	**3**	**4**
16. My close friends would approve if I were to seek professional help for psychological problems.	**0**	**1**	**2**	**3**	**4**

17. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.	**0**	**1**	**2**	**3**	**4**
18. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns	**0**	**1**	**2**	**3**	**4**
19. If I were experiencing psychological problems I might not seek professional help for financial reasons.	**0**	**1**	**2**	**3**	**4**
20. Having been diagnosed with a mental disorder is a blot on a person's life.	**0**	**1**	**2**	**3**	**4**
21. I would rather be advised by a close friend than by a professional for psychological problems.	**0**	**1**	**2**	**3**	**4**
22. Important people in my life would think less of me if they were to find out that I was experiencing psychological problems.	**0**	**1**	**2**	**3**	**4**
23. People with psychological problems are not likely to solve them alone; they are likely to solve them with professional help.	**0**	**1**	**2**	**3**	**4**
24. I resent a person - professionally trained or not - who wants to know about my personal difficulties.	**0**	**1**	**2**	**3**	**4**
25. It would be relatively easy for me to find the time to see a professional for psychological problems.	**0**	**1**	**2**	**3**	**4**
26. I would want to get professional help if I were worried or upset for a long period of time.	**0**	**1**	**2**	**3**	**4**

27. The idea of talking with a professional strikes me as a poor way to get rid of psychological problems.	**0**	**1**	**2**	**3**	**4**
28. Mental illness carries a burden of shame.	**0**	**1**	**2**	**3**	**4**
29. I would be embarrassed if my neighbour saw me going into the office of a professional who deals with psychological problems.	**0**	**1**	**2**	**3**	**4**
30. There are experiences in my life I would not discuss with anyone.	**0**	**1**	**2**	**3**	**4**
31. It is probably best not to know *everything* about oneself.	**0**	**1**	**2**	**3**	**4**
32. If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy.	**0**	**1**	**2**	**3**	**4**
33. There are factors beyond my control that might prevent me from seeing a professional if I needed help with psychological problems.	**0**	**1**	**2**	**3**	**4**
34. There is something admirable in the attitude of people who are willing to cope with their conflicts and fears *without* resorting to professional help.	**0**	**1**	**2**	**3**	**4**
35. At some future time I might want to have psychological counseling.	**0**	**1**	**2**	**3**	**4**
36. People should work out their own problems; getting professional help should be a last resort.	**0**	**1**	**2**	**3**	**4**

37. I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems.	**0**	**1**	**2**	**3**	**4**
38. Had I received treatment for psychological problems, I would not feel that it ought to be "covered up".	**0**	**1**	**2**	**3**	**4**
39. If I thought I needed professional help, I would get it no matter who knew about it.	**0**	**1**	**2**	**3**	**4**
40. If I were to experience psychological problems I could get professional help if I wanted to.	**0**	**1**	**2**	**3**	**4**
41. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen.	**0**	**1**	**2**	**3**	**4**

APPENDIX D

Actual Help FSeeking Questionnaire

Below is a list of people who you might seek help or advice from if you were experiencing a personal or emotional problem. Check any of these people who you have gone to advice or help in the **PAST MONTH** for a personal or emotional problem and briefly describe the type of problem you went to them about. Please circle a number from 1 to 5 to indicate how helpful the assistance you received was.

	Describe the Problem	Not at all Helpful	Somewhat Helpful	Helpful	Very Helpful	Extremely Helpful
☐ **Partner** e.g., partner, boyfriend, or girlfriend	_____ _____ _____	**1**	**2**	**3**	**4**	**5**
☐ **Friend** (not related to you)	_____ _____ _____	**1**	**2**	**3**	**4**	**5**
☐ **Parent**	_____ _____ _____	**1**	**2**	**3**	**4**	**5**

	Describe the Problem	Not at all Helpful	Somewhat Helpful	Helpful	Very Helpful	Extremely Helpful
☐ **Other relative/family member**	_____ _____ _____	**1**	**2**	**3**	**4**	**5**
☐ **Mental health professional** e.g., school counselor, psychologist	_____ _____ _____	**1**	**2**	**3**	**4**	**5**
☐ **Phone help line** e.g., Lifeline, Kids Help Line	_____ _____ _____	**1**	**2**	**3**	**4**	**5**
☐ **Family doctor**	_____ _____ _____	**1**	**2**	**3**	**4**	**5**

	Describe the Problem	Not at all Helpful	Somewhat Helpful	Helpful	Very Helpful	Extremely Helpful
☐ **Teacher** e.g., guidance counselor, classroom or homeroom teacher	_____ _____ _____	**1**	**2**	**3**	**4**	**5**
☐ **Someone not listed above** Please describe who this was: _____	_____ _____ _____	**1**	**2**	**3**	**4**	**5**
☐ **I have not sought help from anyone for my problem**	_____ _____ _____	**1**	**2**	**3**	**4**	**5**

APPENDIX E

Barrier to Adolescent Seeking Help – Revised (BASH-R)

The following questions talk about reasons why youth might not seek professional help (from a psychologist, psychiatrist, social worker, counselor) for stressful or psychological problems. Read each statement carefully and choose the response that is *most* like your feelings about that statement.

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
If I had a problem I would solve it myself.					
Even if I wanted to, I wouldn't have time to get professional help.					
If I got professional help for a problem, my problem would not be kept secret.					
If I got professional help, I may have to do or say something that I don't want to.					
I'd never want my family to know I was getting professional help.					
Adults really can't understand the problems that kids have.					
Even if I had a problem, I'd be too embarrassed to get professional help for it.					
I could not afford to get professional help even if I wanted to.					
No matter what I do it will not change the problems I have.					
If I got professional help, I might find out I was crazy.					
I think I should work out my own problems.					
If I had a problem, my friends could help me more than professional help.					
If I had a problem, my family could help me more than professional help.					
From what I know, professional help is helpful for most people.					
I cannot imagine having a problem so serious that I would need professional help.					
If I ever got professional help, my family would hear about it.					
The idea of getting professional help is pretty scary to me.					
I'd never want my friends to know I was getting professional help.					

APPENDIX F

Moderator's Guide: Intervention Group

(Modified with permission from Wilson, C.J., & Deane, F.P.)

Introduction

Hi everyone, thank-you for coming to this focus group. Each of you has been invited to take part today because your point of view is very important to me and other people interested in designing programs that promote adolescent help-seeking behaviours.

The purpose of this discussion is to find out about your opinions and experiences about seeking help for personal or emotional problems as well as your experiences with the *Asking for Help Program.* In a few minutes, I will ask you some questions about help-seeking. There are no wrong answers, I just want to hear what you think and feel. I want to know your opinions. I will not tell our teachers, parents, or classmates how you answered any of my questions, but to ensure that everyone's privacy is respected it's important that you agree not to discuss what is said here today as well. It is important that everyone feel free to express their view, so I need your agreement that you will keep the things we share with each other today confidential. Does anyone have any questions? If you agree to keep what is discussed today confidential please raise your hand. *(Pause).* Even though I trust you all to keep our agreement, I cannot promise you that everyone in our group will do this so if you feel uncomfortable we can discuss this further. If you don't think you can feel comfortable with this or cannot commit to our agreement you are free to leave before we begin.

During our time together you may notice this recorder. I've brought it with me today so that I have a reminder of everything we discuss. Again, what you said is extremely important to me. Even though I will not be sharing this tape with anyone outside of my research study, I will be typing out our conversation when I go back to listen to our discussion. Because of this, I'd like us all to use code names so that no one will be able to identify you from listening to the tape. I've written my code name on my name tag and I'd like you to do the same with a code name that you create for yourself. Your code name should not be a nickname that you've had in the past, your last name, or your middle name. Try to make up a name that no one could identify you with. For the rest of today we'll be referring to each other by our code names if we need to call on one another. Does anyone have any questions about this?

Allow time to create code name tags and comment on adolescent creativity.

There are a few guidelines I need to follow during our discussion today so that I hear all of what you have to say. First, you don't have to speak in any particular order, but please be sure not to speak when anyone else is talking. Also, when you're speaking, please don't feel that you have to talk directly to me. You may want to talk to each other at times rather than me - just be sure that everyone can hear what you are saying.

There are a number of us here today and it is really important to me that I get to hear everyone's point of view. Some of you may agree with what someone else is saying, or you may disagree with them. It is important that you let me know when you agree or disagree with each other. To be fair, please word what you have to say without raising your voice or using "put-downs" such as name calling. Finally, because we have a limited time together, I may need to stop you and redirect our discussion if we're getting off track. Okay let's begin!

Questions

**Only use probes when appropriate and needed*

1. What does help seeking mean to you now that you've participated in the *Asking for Help Program*?

   Probes:
   Have you started thinking differently about people you know that seek help/don't seek help?
   Has made it easier to ask for help?

2. Has the *Asking for Help Program* changed the way you feel about seeking help?

   Probes:
   How do you feel when you recognize a problem?
   Have you gone to anyone for help since the program began? What was your experience like?

3. Who do you go to when you seek help?

   Probes:
   Would you have chosen that person before the *Asking for Help Program*?
   How do you ask these people for help?
   How did you find out about them?
   Do you go to friends? Family? Doctors?

4. Why do you choose those people?

   Probes:
   Why? How do they respond that makes you choose them?
   Are they helpful? How?
   What are some of the problems that these people can help you deal with?

5. What do you feel prevents youth from seeking help?

   Probes:
   Can you tell us your reasons for feeling that way?
   Have you been prevented from seeking help because of that?
   What are some reasons for not seeking help at home/school?
   What are some reasons for not seeking help from doctors and psychologists?

6. What are some ways you think the barriers that we just discussed can be overcome?

   Probes:
   You mentioned _____ as a barrier. What could be done about that to increase the likelihood that you would seek help?
   Can you explain your reasons for suggesting that?
   What are other ways of breaking down barriers?
   What is the best way doctors/adults can discuss problems with adolescents?

7. I want you to think about your experience in the *Asking for Help Program* and how you participated each week. Now I want you to think about what was most helpful to you about *Asking for Help* and what was least helpful. We're gong to break up into smaller groups now (establish groups of two or three). I've given each group a set of cards. On each card I've written something to do with the *Asking for Help Program*; for example, some cards name different activities you did and others mention things about the facilitators and the other students – their attitude during the group, the way they presented information, and more. I want you to put the cards in order to reflect what you found most to least helpful. In other words, put the activities that you liked the best and found most helpful at the top of your list. If you remember something that is not on a card please write your thought down on one of the blank cards and add it to your ranking.

   Probes:
   Did everyone in your group agree to the same order or did you have to compromise?
   What made you decide to put _____ before _____ after speaking to your group about it?
   Are there some cards that your group still disagrees on? What does everyone else think?

8. How do you feel the program could be improved for future groups of teenagers like you?

   Probes:
   What if the teenager's problem is drug use?
   What if the person is having thoughts or feelings about harming themselves or taking their own life?
   What do you think could keep adolescents coming to the program?

9. Would you recommend the *Asking for Help Program* to a friend?

   Probes:
   Why?
   Would you recommend a certain type of person over other people?

Wrap-Up

Unfortunately, we are almost out of time. Let me try and repeat the main points your gave in your responses...What would you like to add to my summary?

There were several topics that we touched on and that we were not able to complete discussing. I regret that we were unable to spend more time today with each other. I want to thank you again for sharing your thoughts and coming to participate in this focus group. I really enjoyed talking with your. Your responses have really helped me understand youth help-seeking behaviour better. I hope your ideas will be able to improve the programs available for youths and that you will be able to take advantage of them.

I need to remind you that the audiotape will be written out. In the written copy you will be referred to as your code name even if someone used your real name by accident during our discussion. This will make sure that you remind anonymous. I also need to remind everyone that our discussion was confidential. Are there any questions?

Finally, if our discussion raised some issues for you, I am staying here for a while so you can talk with me about it if you need to. I also have a list of resources that I would like you all to take a copy of incase you or your friend need someone to talk to about a problem in the future. Again, talk you for your participation.

APPENDIX G

Moderator's Guide: Waitlist Group
(Modified with permission from Wilson, C.J., & Deane, F.P.)

Introduction

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The purpose of this discussion is to find out about your opinions and experiences about seeking help for personal or emotional problems as well as your experiences when you've asked for help in the past. In a few minutes, I will ask you some questions about help-seeking. There are no wrong answers, I just want to hear what you think and feel. I want to know your opinions. I will not tell our teachers, parents, or classmates how you answered any of my questions, but to ensure that everyone's privacy is respected it's important that you agree not to discuss what is said here today as well. It is important that everyone feel free to express their view, so I need your agreement that you will keep the things we share with each other today confidential. Does anyone have any questions? If you agree to keep what is discussed today confidential please raise your hand. *(Pause).* Even though I trust you all to keep our agreement, I cannot promise you that everyone in our group will do this so if you feel uncomfortable we can discuss this further. If you don't think you can feel comfortable with this or cannot commit to our agreement you are free to leave before we begin.

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Questions

**Only use probes when appropriate and needed*

10. What does help seeking mean to you?

    Probes:
    Is it a positive or a negative thing?
    If I said, "I'm going to seek help" what would you think I meant?
    What do you think about people you know that seek help/don't seek help?

11. How do you feel about seeking help?

    Probes:
    How do you feel when you recognize a problem?
    Have you gone to anyone for help in the past? What was your experience like?

12. Who do you go to when you seek help?

    Probes:
    How do you ask these people for help?
    How did you find out about them?
    Do you go to friends? Family? Doctors?

13. Why do you choose those people?

    Probes:
    Why? How do they respond that makes you choose them?
    Are they helpful? How?
    What are some of the problems that these people can help you deal with?

14. What do you feel prevents youth from seeking help?

    Probes:
    Can you tell us your reasons for feeling that way?
    Have you been prevented from seeking help because of that?
    What are some reasons for not seeking help at home/school?
    What are some reasons for not seeking help from doctors and psychologists?

15. What are some ways you think the barriers that we just discussed can be overcome?

    Probes:
    You mentioned _____ as a barrier. What could be done about that to increase the likelihood that you would seek help?
    Can you explain your reasons for suggesting that?
    What are other ways of breaking down barriers?
    What is the best way doctors/adults can discuss problems with adolescents?

16. I want you to think imagine yourself in a program meant to encourage you to seek help and show you the benefits of doing so. Now I want you to think about the kinds of things that would be involved in this program that you would find most and least helpful. We're gong to break up into smaller groups now (establish groups of two or three). I've given each group a set of cards. On each card I've written something to do with our imaginary program; for example, some cards name different activities you may do and others mention things about the people who run the group or about the other group members – their attitude during the group, the way they presented information, and more. I want you to put the cards in order to reflect what you think you would find most to least helpful. In other words, put the activities that you would like to see as part of your ideal program at the top of your list. If you have an idea that is not on the cards please add it on one of the blank cards and add it to your ranking.

    Probes:
    Did everyone in your group agree to the same order or did you have to compromise?
    What made you decide to put _____ before _____ after speaking to your group about it?
    Are there some cards that your group still disagrees on? What does everyone else think?

17. Do you have any ideas about how program providers could keep teenagers like yourself become interested in a program on help seeking?

    Probes:
    What if the teenager's problem is drug use?
    What if the person is having thoughts or feelings about harming themselves or taking their own life?
    What do you think could keep adolescents coming to the program?

18. Would you recommend a program aimed to increase adolescent help-seeking behaviours to a friend?

    Probes:
    Why?
    Would you recommend a certain type of person over other people?

Wrap-Up

Unfortunately, we are almost out of time. Let me try and repeat the main points your gave in your responses...What would you like to add to my summary?

There were several topics that we touched on and that we were not able to complete discussing. I regret that we were unable to spend more time today with each other. I want to thank you again for sharing your thoughts and coming to participate in this focus group. I really enjoyed talking with your. Your responses have really helped me understand youth help-seeking behaviour better. I hope your ideas will be able to improve the programs available for youths and that you will be able to take advantage of them.

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APPENDIX H

Community Resource List

The following is a list of some services within the community relevant for adolescents.

Information and referral services:
Mental Health Service Information Ontario (MHSIO)
Website: mhsio.on.ca
Phone: 1-8666-531-2600
No fee, confidential, anonymous and 24 hours

Information Windsor
Website: www.informationwindsor.com/
Phone: 519-973-4636
No fee, confidential, Windsor-Essex Community Information Database

Helplink Access Services
Phone: 519-257-5437
No free, Referral information

Youth Helpline:
Kids Help Phone
Website: http://www.kidshelpphone.ca
Phone: 1-800-668-6868
No fee, confidential, and 24 hours

Community Mental Health Services:
Teen Health Centre (THC)
Website: www.teenhealthcentre.ca
Phone: 519-253-8481
Address: 1585 Ouellette Ave., Windsor ON N8X 1K5
Satellite Offices in Amherstberg, Belle River, Essex, Kingsville, and Leamington. Contact central office for details.
No fee (with OHIP), confidential, provides referral information, counselling, medical care, etc.

Children Health Care Network
Phone: 519-948-3961
Address: 7717 Wyandotte St E, Windsor, ON N8S 1S6
No fee, confidential, assessment, diagnosis, and treatment

Windsor Regional Children's Centre (RCC)
Phone: 519-257-5215
Address: Huot Building, 3901 Connaught St., Windsor, ON N9C 4H4
No fee, confidential, crisis walk-in services, counseling

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