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## **Exploring Professional Help-seeking for Mental Disorders**

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## **Abstract**

Only a third of people with mental disorders seek professional help. In this study we aimed to investigate attitudes toward help-seeking among non-help-seekers drawn from a community survey in South London. We conducted qualitative interviews with 24 participants with symptoms of mental disorders. We analysed data using thematic analysis. Participants' reasons for not seeking professional help included: perceiving their problems as normal or unsuitable for professional help; negative expectations of professional help; believing informal strategies were sufficient; fearing being stigmatized for having a mental disorder and help-seeking; self-perceptions of being strong and/or self-reliant. A small number (n=4) had resolved their problems. Participants with unresolved mental disorders (n=20) had more chronic stressors, particularly about finances and family relationships, and greater concerns about professional help and stigma than other participants. Potential targets for interventions to encourage help-seeking could be focused around stigma about help-seeking as well as the self-perception of being strong.

## **Keywords**

depression, health behavior, health care, access to, health care, users' experiences, health information seeking, lay concepts and practices, mental health and illness, research, qualitative, social support, stigma.

Common mental disorders are widespread (Demyttenaere et al., 2004; Kessler et al., 2009; Mathers & Loncar, 2006), but the majority of people with mental disorders do not receive treatment (Alonso et al., 2007; Bebbington, Meltzer, et al., 2000; Kessler et al., 2005; Wang et al., 2007). This suggests there is a large unmet public health need despite there being evidence based interventions available to improve the lives of people with mental disorders (Meltzer et al., 2003). One of the reasons why people do not receive treatment for mental disorders is because they do not seek help (Author et al., 2014). Data from the Adult Psychiatric Morbidity Surveys suggested that two thirds of people with mental disorders had not contacted their physician regarding their problems (Bebbington, Brugha, Meltzer, Jenkins, et al., 2000). Although most people with lifetime mental disorders will eventually seek treatment this is normally years after the onset of their mental disorder (Wang et al., 2005). The time between onset and treatment seeking varies between disorders. For mood disorders it ranges from 6 to 8 years whereas for anxiety disorders the range is between 9 and 23 years (Wang et al., 2005). Rates of help-seeking also vary across different populations and levels of problem severity. Men are less likely than women to consult their General Practitioner (GP) for mental health problems (Bebbington, Meltzer, et al., 2000) and people with more severe symptoms of mental disorder are more likely to seek help (Bebbington, Brugha, Meltzer, Farrell, et al., 2000; Bebbington, Meltzer, et al., 2000). Seeking help for mental disorders does not guarantee treatment. The authors of one study found that only 30% of people with mental health problems who sought help from their GPs were receiving treatment (Bebbington, Brugha, Meltzer, Jenkins, et al., 2000).

Previous research has described various explanations as to why people do not seek professional help. Some people have a low perceived need for treatment (Andrade et al., 2013; Mojtabai et al., 2011). Perceived need has been found to be associated with the severity of the mental disorder: people with mild and medium severity problems are more likely to

have low perceived need than people with high severity problems (Andrade et al., 2013; Mojtabai et al., 2011). A desire to handle the problem alone was the most common explanation given by people who did perceive a need for treatment but did not seek it or dropped out (Mojtabai et al., 2011). Another possible explanation for low rates of help-seeking is that people do not recognise the symptoms of mental disorder and do not know about the most effective treatments. This has been termed low mental health literacy (Jorm, 2000). Connected to this is the finding that people's concepts of mental disorders influence their preferred treatment options: when people in a vignette study regarded a person as experiencing a life crisis, they preferred non-medical interventions (Lauber, Nordt, Falcato, & Rossler, 2001). Findings from the Defeat Depression Campaign surveys also highlighted public views about GPs that might hinder help-seeking. A large proportion of respondents believed that people were embarrassed to consult GPs about depression, that GPs would regard them as unbalanced or neurotic, and that GPs just give pills. However it should be noted that a similar proportion responded that they felt GPs were understanding and sympathetic (Paykel, Hart, & Priest, 1998). Stigma regarding mental health problems can also influence help-seeking (Author et al., 2011a; Schomerus & Angermeyer, 2008). Stigma can be attached both to mental disorders and to help-seeking for mental disorders (Author, 2014; Author, 2011). In addition, self-stigma, or the turning of negative attitudes about mental disorders toward oneself, can also lead to a reluctance to seek professional help (Schomerus & Angermeyer, 2008).

Understanding the reasons for low rates of treatment for mental disorders can benefit from both quantitative and qualitative methodologies. The use of qualitative approaches enables the identification of novel findings that are not already present in existing literature and can help to reveal the complexity of why people do not seek help. Findings from qualitative studies suggest that one reason for the low rates of help-seeking is that there are

differences between lay and professional concepts of mental disorders. Lay people tend to normalise and externalise the causes of common mental disorders compared to professionals who are more likely to have a medical understanding (Anderson et al., 2006; Biddle, Donovan, Sharp, & Gunnell, 2007; Pescosolido, Gardner, & Lubell, 1998; Pill, Prior, & Wood, 2001). However the authors of qualitative help-seeking studies have sampled population subgroups such as older adults (Author, 2006), male offenders (Howerton et al., 2007), low income mothers (Anderson et al., 2006) or young adults (Biddle et al., 2007) and have included help-seekers or people without mental health problems in their samples.

This study contributes to the current literature by investigating attitudes toward help-seeking in a community, as opposed to a clinical, sample of people with mental disorders, and by focusing specifically on individuals who have not sought professional help. By using qualitative research methods we sought to provide participants with an opportunity to introduce original explanations that would be harder to identify in the context of structured interviews.

## **Methods**

We carried out semistructured interviews with 24 participants who had experienced symptoms of mental disorders for which they had not sought professional help in the past 12 months. Ethical approval for this study was received from the King's College London Psychiatry, Nursing and Midwifery Research Ethics Committee (PNM/10/11-24). The contact details of the potential participants passed on by the South East London Community Survey group were treated in accordance with the Data Protection Act 1998.

### *Participant Recruitment*

We recruited participants from a population who had completed the South East London Community Health Survey (SELCoH), a community survey of psychiatric and physical morbidity including randomly selected households in the South London Boroughs of



Southwark and Lambeth (n=1698) (Author et al., 2011b). We sent an opt out letter to eligible individuals who had consented to be contacted about participating in additional research studies. Two weeks later we telephoned individuals who had not opted out to discuss participation in the study. Our sample was drawn from SELCoH participants whose survey responses suggested they had experienced symptoms of mental disorders for which they had not sought professional help in the 12 months prior to completing the survey. The presence of a mental disorder was indicated by a score of 18 or more on the CIS-R component of the SELCoH study (Lewis, Pelosi, Araya, & Dunn, 1992). The mean CIS-R score was 23 (range: 18 to 35). We assessed use of professional help with the following survey question: “In the past 12 months, have you spoken to a GP or family doctor, a psychological therapist/counsellor or other sources of help on your own behalf, either in person or by telephone about being anxious or depressed or about having a mental, nervous or emotional problem?” In addition, we only invited individuals to participate in the present study if they had not sought help in the time between participating in SELCoH and being contacted by us. The median time between participating in SELCoH and the current study was 16.5 months (range: 6 months to 2 years).

We purposively sampled eligible SELCoH participants on the basis of age, ethnicity and gender in order to achieve a demographically diverse sample and to ensure that our sample included men from Black and minority ethnic groups because this sub-group is under-researched in the area of help-seeking. Table 1 contains information about the characteristics of the participants. We used an iterative procedure of participant selection, interview and data analysis, and ended the recruitment when no new themes emerged and we had determined that the themes were fully tested and refined within a diverse sample. We reached theoretical saturation after we had completed and analysed 24 interviews.

**INSERT TABLE 1 ABOUT HERE**

### *Qualitative Interview Procedure*

We carried out interviews either in participants' homes, a university research office, or a café, according to participant preference. Interviews lasted 1-2 hours and were carried out by the first author. An additional research volunteer accompanied the first author to interviews in participants' homes. We sought informed consent from participants on the telephone before the interview. We talked through the consent form again with participants before the start of the interviews. We derived the interview guide from a review of the research literature about help-seeking for common mental disorders. During the interviews the first author encouraged participants to pursue their own additional topics of interest to explore themes that were not present in existing research. The interviews began with a broad question: "When you completed the SELCoH study, some of the answers you gave suggested that you were either stressed or anxious or feeling down. Can you tell me why you think that was?" This provided a focus for the discussion and allowed participants to describe their experiences in their own words. Additional topics included participants' own attributions for their mental disorders, their coping strategies and their beliefs about different types of mental health treatment interventions.

### *Data Analysis*

We audio-recorded the interviews, transcribed them verbatim and entered them into QSR Nvivo 9 for Windows ([www.qsrinternational.com](http://www.qsrinternational.com)). We used thematic analysis to investigate the data and our approach was a positivist one in which we used an iterative method to check the themes that we identified. We coded and analysed the transcripts in multiple stages as per the process outlined by Braun and Clarke (2006). After repeated reading of the transcripts, the research team (first author, second author, fifth author, sixth author) and two volunteer researchers who had been present at the interviews independently coded the first two interviews. The research team developed a coding framework and the first author and two

volunteer researchers coded the remaining transcripts using this framework. The research team met regularly to refine the coding framework and to reach consensus on the definition and content of the themes. Once this had been achieved, we tested the themes by re-reading the transcripts to check for validity and deviant cases. The second author, fifth author and sixth author investigated the relationship between the emergent themes and the existing literature on help-seeking and constructed a preliminary model to explain non-help-seeking. We checked the relevance and validity of this preliminary model against each participant's interview and we then checked it back against the entire data set. The second author, fifth author and sixth author revised and presented the preliminary model to the rest of the research team as a validity check. During the next stage of the analytic process, the first author merged similar themes, removed extraneous themes and explored the interrelationships between themes through the use of thematic diagrams and matrices (Miles & Huberman, 1994). We used the preliminary model as the basis for the exploration of the interrelationship between the themes.

## **Results**

We present the findings in three sections: explanations for not seeking help (comprising five subthemes), a comparison of themes across participants whose problems appeared to have resolved and those whose problems had not, and finally, a description of the interrelationship between themes.

### *Explanations for Not Seeking Professional Help*

We identified five main themes in relation to participants' explanations for not seeking professional help: problem concept, perceptions of professional help, ways of coping, stigma and self-perception.

#### *Problem Concept*

*Perception of the Cause of the Problem.* All participants believed life stress had precipitated their problems. Participants' reported stressors varied in number, severity and chronicity. Participants did not always distinguish between life problems and mental disorders so there was often an overlap when participants described the triggers and consequences of their problems. Thus, in line with participant narratives and previous research, we do not distinguish between mental disorders and other stressors. Many participants described multiple stressful life events and chronic health, financial, employment, housing and family problems. Some were struggling with the long-term effects of abuse or traumatic incidents and/or felt overwhelmed by the accumulation of problems they were experiencing.

*Perception of the Type of Problem.* Participants distinguished between problems that they felt were or were not appropriate for professional help. Some believed they were experiencing problems of living and not mental disorders (Pill et al., 2001). They felt able to resolve these problems and did not think professional help was suitable.

I don't think depression is a mental illness. I think it's just a way you see life and if you wanna make things seem worser than what they are then you're the one who's gotta think about things differently I think.

Whilst others acknowledged that they had mental disorders, they did not think these were severe enough for professional help. Some individuals believed their problems were permanent and could not be improved. They discussed the contribution of intrinsic factors to their mental distress, whether biological or personality related. "Well I think my brain, my mind, my personality makes me- I dunno. I think in terms of getting worked up I think I get upset or sad or depressed."

*Perceptions of Professional Help*

Participants anticipated a range of obstacles regarding the accessibility of professional help and questioned the appropriateness and/or helpfulness of treatments offered.

What would I have wanted her to offer me? I don't know really a panacea. Which again would be medication wouldn't it really but which is what I didn't want. So maybe that's why I didn't go as well thinking what can anyone offer when you're feeling like that? You want a listening ear and someone to come in and change all the circumstances. Heh heh. Which wasn't going to happen was it?

A number of participants had sought and/or received professional help for mental disorders in the past with mixed results. Participants were also often in frequent contact with health care professionals for physical health problems, and some had mentioned their mental disorders in these consultations without seeking or receiving treatment. Some participants anticipated finding the act of help-seeking unpleasant. They believed that their GPs were too busy to discuss mental health issues and would be indifferent or disdainful of their difficulties (Cape & McCulloch, 1999). Many participants expected their GPs to offer them medication which they thought might be a temporary fix which could lead to side effects and dependency. Participants also expressed concerns that talking therapy involved uncomfortable self-disclosure. However some participants were being encouraged by friends and family to seek professional help. Despite their concerns, many participants also expressed positive attitudes or talked about previous positive experiences. "But maybe I should [seek professional help]. Possibly I should because I know talking about things does help just sort it through in my own mind."

### *Ways of Coping*

Participants employed a variety of informal coping strategies to manage their stressors and mental disorders, a finding which supports previous studies (Jorm, Griffiths, Christensen,

Parslow, & Rogers, 2004). Participants coped with their problems by problem solving, making life changes, information seeking, using alternative remedies, using drugs and alcohol, pursuing hobbies and self-improvement activities, and exercising. Some participants from minority ethnic groups found praying and religious practice helpful for managing their mental disorders although they also raised concerns that an inability to cope would be perceived by members of their religious community as a lack of faith.

### *Social Network*

Participants' social networks were the most commonly mentioned sources of help and support (Angermeyer, Matschinger, & Riedel-Heller, 1999). "I've talked to my mum when I got really down . . . and she was like depression is the worst, it's addictive, you need to stay active."

Some participants only felt able to talk to their immediate family as they feared other people would gossip about them if they disclosed mental disorders. Black African participants were more likely than participants from other ethnic groups to express these concerns. Others did not share their problems with family members because they wanted to protect them from worry, or they believed that self-disclosure would undermine their position of authority within the family. Overall, concerns about seeking help from their social network were more commonly expressed by participants who identified themselves as members of Black and minority ethnic groups.

You can't discuss these things with my wife and my children. Because for them everything's got to be fine. No matter how I feel or how I deal with it. Your father's always the one, even my Dad now, he's always the one that gives you stability doesn't he? When things go wrong you turn to your father and mother don't you cause they're the rock built upon you-they're the rock that launched you into the world so to say. So I'm their rock.

## *Stigma*

*Stigmatising Attitudes About Help-seeking.* Participants expressed concern more frequently about the stigma of help-seeking than of having a mental disorder. Some participants believed help-seeking was a sign of weakness, a failure to cope with their problems, a lack of faith or self-indulgence. “Whereas if I don’t ask for help in my eyes I ain’t admitting to her I’ve got a problem. ‘Cause you see I don’t think I’ve got a problem, I think I’m dealing with it.”

*Stigma of Having a Mental Disorder.* Some participants were put off help-seeking because they felt stigmatised by being identified as having a mental disorder. They were worried about being stigmatised by their employers, work colleagues or health care professionals (Barney, Griffiths, Jorm, & Christensen, 2006). “Because people are thinking oh she’s- well she needs to see a professional. Or she needs to take medication. People feel very anxious about that.”

## *Self-perception*

*Being the Strong One.* Some participants referred to being responsible for others as part of their explanation for not seeking help. They wished to see themselves as resilient, capable or believed they needed to be strong within their family or among their work colleagues, often to conform to cultural expectations. Some participants felt they had no choice but to be strong for the sake of others in their lives that were going through difficulties.

When me Dad passed away I wasn't allowed to grieve. ‘Cause I'd to be strong for me Mum. ‘Cause me brother's- I’ve got a brother who- who is a complete and utter waster of space . . . it was always me being there to help them out the best that I could.

*Self-sufficient.* Some participants preferred not to share personal information with family or friends as they wanted and felt able to manage on their own.

No we're not really like a close-knit family. We got brought up to just get on with whatever ourselves, doing it ourselves is easier that's the way we got brought up. I don't rely on anybody, I just do it.

#### *Cross-comparison of the Resolved and Unresolved groups*

*Perceived Improvement Since SELCoH Interview.* After giving their accounts of their problems at the time of the original SELCoH interview, participants were asked how they felt at the time of the current study. Only four participants felt their problems had resolved. Some participants in the unresolved group reported improvements since their SELCoH interview but others considered themselves to be no better. Although there were some thematic differences between the resolved and unresolved groups, the differences within the unresolved group were largely a matter of degree. The unresolved group was comprised of a diverse group of participants whose problems varied in terms of complexity and chronicity and who expressed different levels of willingness to seek help. For example, those with more complex problems often faced greater obstacles, more stigma and reported less willingness to seek help. Table 2 shows the distribution of themes for the two groups.

#### **INSERT TABLE 2 ABOUT HERE**

*Resolved Group.* Participants in the resolved group tended to be younger, female and to have more financial and social resources. They had experienced acute stress related to life events which involved unemployment, a relationship breakdown, marriage and unconsolidated debts.



I was worried about things you know. I wasn't worried about getting married 'cause I was happy with my partner but I was worried about the day going okay and selling the flat . . . it felt like sort of having another job on top of my regular job which is full time, which is quite- can be quite stressful anyway.

They saw their difficulties as life problems, which they felt they could manage through targeted problem solving strategies, often involving their social network.

I would say talking to friends and family. I've got quite a strong family network as you can see hence I'm now living with my mum and dad but I'm very close to my parents and I've also got a lot of friends.

They were willing to seek professional help if necessary and they did not hold stigmatising attitudes. Their self-perception did not seem to conflict with professional help-seeking and they regarded themselves as problem solvers or as part of an effective social support network.

*Unresolved Group.* The unresolved group included older participants than the resolved group, and comprised more men than women. Their problems were multiple, medium to long term, consisting of stressful life events coupled with chronic strains, some of which persisted from childhood or adolescence. They had experienced stress related to life events such as birth, death, divorce, starting university, unemployment and acute health problems. In addition these participants had experienced chronic physical and mental disorders, family relationship difficulties, family members' physical and mental disorders, financial and housing problems. The most common sources of stress for these participants were their finances and their families. They had fewer personal and social resources than the resolved participants and they varied in terms of how confident they were that they could

manage their problems. Some felt that their problems were severe and difficult to manage whereas others normalised their difficulties and saw them as manageable.

I can find my own ways of sorting or thinking through a problem. Because a lot of it possibly is just common sense. I think I've got enough of that. So I feel in some ways that I don't need a counsellor for those reasons.

Participants expressed mixed views about the effectiveness of professional help. Some participants were positive about the possibilities of professional help but others were concerned that external life problems could not be addressed by health care professionals, and that psychological problems were intrinsic and could only be managed by the participants themselves.

Cause I think are they gonna help me? What can they actually do? They can't change what happened. They're not gonna change what happened to me. They're not gonna I think change- wipe my memory again for me that I'm never gonna remember it again. So what is the point?

Some of the participants whose problems had improved (but not resolved) since SELCoH regarded their problems as manageable and maintained that they did not interfere too much with their day to day life, despite the fact that they continued to experience mental health difficulties and ongoing stressors.

Well you know I'm coping with it anyway and I think I've coped with that quite well. Well not quite well but four- it's been four years now so I think I'm coping. I'm still functioning. I'm still working and things.

Some of these participants felt they were ‘spinning plates’ and were afraid that they would not be able to cope.

It’s really really difficult to cope sometimes but you just have to. You just have to cope. There’s no not coping about it. You’ve just got to deal with it. It’s hard and there’s times you feel you can’t deal with it.

Participants in the unresolved group tended to discuss stigma as an obstacle to professional help-seeking more than the resolved group.

Just being a man or a woman just trying, there’s some things at time you just want to show the next person that you are coping. Which I think is not good you know you are just, want to show that you’re managing with it – that you can cope with your problems. And that’s what it is.

Stigma also affected participants’ possibilities for informal coping strategies as they anticipated negative reactions from employers, work colleagues or members of their social network. “I have heard if you have depression on your medical records and employers find out about it, you know, they are less likely to employ you.”

He doesn’t know what is happening in my house I don’t know what is happening in his house. I don’t say my problem to anybody. I only say my problem to God. You know the friend will go and tell a friend, the friend will go and tell another friend.

Participants with severe and chronic problems more often expressed reservations about talking to family members because of wanting to protect them from worry or to maintain their status within the family. Some described themselves as self-sufficient and preferred not to share personal information with other people as they felt able to manage on their own.

I didn't feel the need – like I didn't have any urges to explain to the doctors what was happening. One, I'm quite a private person anyway when it comes to just talking in generally. This is different. This [interview] is like for research purposes but when it comes to personal, I don't put myself out there anyways.

A number of participants emphasized the theme of needing to be strong and self-sufficient. All participants who were fathers identified themselves in the role of protector and provider, but female participants also talked around this theme.

I'm their stability. I'm the one that they have to look at when things are falling down, you know. Well you know especially with my culture . . . you know the man's the the brick work, the foundations. You know your wife is important, your family is important but without that foundation there no it's ehm it's meaningless because you're just building a house on sand so to say, eventually it's going to sink.

### *Interrelationship Between the Themes*

Participants' perceptions of the cause and nature of their problems were related to their sociocultural context and the norms for what constitutes problems of daily living, tolerable levels of distress and problems worthy of attention from health professionals. Influential sources of information about mental disorders and treatments included members of their social network, books, the internet and television. Beliefs about the possible consequences of acknowledging a mental disorder and seeking help were strongly influenced by the threat of stigma, fear of discrimination or of seeing themselves as weak or self-indulgent. Many participants described their self-perception and their role in their family and workplace in terms of the reliance placed on them by others which they felt could be threatened if they

sought professional help. Whilst this emphasis on personal strength and resilience might not in itself prevent help-seeking, the belief that help-seeking is a sign of weakness reinforced the imperative to cope with their difficulties alone. These participants would therefore need to be convinced that the benefits of seeking help would outweigh the potential threat to their self-perception. Participants' beliefs about the efficacy of professional help were also influenced by information from their social network, their own previous experiences and general ideas, such as the belief that strangers could not help with their personal problems. These concerns led participants to cope with their problems without formal support.

## **Discussion**

We set out to understand the low levels of professional help-seeking by exploring the experiences and beliefs of members of the public with diagnosable mental disorders for which they had not sought professional help for 12 months or more.

The results demonstrate that help-seeking is influenced by interrelated beliefs, personal history and social influences. Participants' problems were on a continuum of complexity and chronicity and they expressed a range of attitudes regarding their willingness to seek formal help. At one end of the spectrum was a small group of four people who reported that their problems had now resolved. Although a smaller proportion, this is in line with the findings of the UK Adult Psychiatric Morbidity Survey of 2000 which demonstrated that an average of 50% of participants with common mental disorders had recovered at the 18 month follow-up stage (Lewis, 2003). The resolved group's problems were either less severe, less complex or less chronic than the unresolved group, and they seemed to have more personal and social resources. They made no mention of stigma in recounting their preferences for dealing with mental disorders. These participants also expressed more positive attitudes toward professional help, and a willingness to seek help if needed.

The majority of participants continued to suffer ongoing problems with fewer personal and social resources to support them. They expressed multiple concerns about seeking professional help and many had low intentions to do so. The difference between those participants who described some improvement in their mental health and those whose problems remained unresolved was that their personal and social stressors seemed to be more chronic with the most common sources of stress being their finances and problems within their family relationships.

The tendency of participants to regard their mental disorders as directly related to stressful life events and problems of living is consistent with previous research on lay concepts of mental health (Pill et al., 2001). Many participants felt that addressing their life stresses would improve their mental health. Participants' help-seeking behaviour also seemed to be influenced by the experiences and perceptions of their friends and family. The influence of the social network on help-seeking was demonstrated by Pescosolido and colleagues who found that a person's social network influenced their pathway into mental health services (Pescosolido et al., 1998). Moreover, Pescosolido's Network Episode Model suggests that we should consider the social network alongside the individual and environmental context as important factor and complex interaction which contribute to recognition, response and outcomes of mental health problems (Pescosolido, 2013). Many participants' friends and families were also experiencing difficult and chronic life events, opening up the possibility that this resulted in participants normalising their own problems. Our findings suggest that normalisation can delay or prevent help-seeking when people perceive common mental disorders not to be serious or to be outside the realm of psychiatric professionals (Biddle et al., 2007; Prior, Wood, Lewis, & Pill, 2003).

Previous research has highlighted the differences between lay and professional concepts of what problems are suitable for professional help (Angermeyer et al., 1999; Biddle

et al., 2007; Pescosolido et al., 1998). Our findings suggests that these differences are more complex than the question of whether a person believes they have a mental disorder or not: some of our participants identified themselves as having mental disorders yet did not seek professional help. However, many participants were also determined to minimize their own mental health difficulties to avoid the stigma of help-seeking, and maintain their own self-concept. The perceived risks, personal costs and the uncertain benefits of help-seeking, might explain why our participants were not willing to seek professional help.

Participants described a mismatch between their preferred solutions and what they thought professional help would offer them (Anderson et al., 2006; Jorm et al., 1997; Pill et al., 2001). For some, previous frustrating or combative interactions with health care professionals, or previous unhelpful mental health help-seeking and treatment experiences had led them to regard professional services with a suspicion that put them off professional help-seeking. However, participants in the resolved group had had more positive previous experiences of professional help and were also more positive about seeking help in the future.

Our participants reported a variety of different ways of coping with mental disorders, which is consistent with Jorm (Jorm et al., 2004) and relates to the theoretical work by Lazarus and Folkman on understanding the different ways in which people try to manage their own problems (Lazarus & Folkman, 1984). Although participants' social networks were viewed as important sources of support for dealing with their mental disorders, some concerns were also expressed. Black and minority ethnic participants expressed more reservations than White British participants about using their social network for support as they felt they might be stigmatized. This study also found that Black African participants were more likely than others to be concerned about friends talking about them (Cinnirella & Loewenthal, 1999; Author et al., 2013). Some Black and minority ethnic participants used religious practice and prayer to help them cope although some also feared their problems

would be viewed by members of their religious community as evidence for a lack of faith (Cinnirella & Loewenthal, 1999; Author, 2006).

Stigma had a strong influence on help-seeking, particularly self-stigma among participants who had not recovered. These findings support previous work where personal stigmatising attitudes were related to a less severe appraisal of mental disorders and lower perceived need for help among depressed community participants (Schomerus & Angermeyer, 2008). Self-stigma, however is complex and is also shaped by one's social context and the attitudes and beliefs of others (Author et al., 2012a; Author et al., 2012b). Social context could therefore have restricted the potential for both formal as well as informal help-seeking through social networks because of anticipated stigma from one's family, friends and work colleagues (Author et al., 2012b).

Some participants expressed a need to appear strong for the sake of others, whether in the family or at work. They also expressed a sense of pride and accomplishment in their ability to do so. However, this appeared to hinder help-seeking and to delay treatment when participants saw help-seeking as a threat to their self-perception. The influence of self-perception has received relatively little attention in the help-seeking literature. However, some research studies have highlighted the interplay between self-perception and help-seeking including a study by Edge and Rogers (2005) which found that the self-identity of 'Strong-Black-Women' contributed to Black Caribbean women's rejection of depression as an illness and their beliefs that they could cope with their problems without professional help. Addis and Malik (2003) suggest that men's help-seeking is influenced by masculine gender norms. Additionally, Gask and colleagues refer to the importance of 'candidacy' and 'identity' in their review about access to mental health care (Gask et al., 2012). They point out that Coyle (1999) has highlighted that people's dissatisfaction with health services might be related to perceived threats to their identity.



The findings of this study demonstrate that people are not ‘help-seekers’ or ‘non-help-seekers’: many participants described previous treatment episodes, were considering professional help and/or were help-seeking for physical health problems. As Pescosolido and colleagues (1998) point out treatment pathways are dynamic, are influenced by sociocultural processes, and consist of multiple strategies and entry points.

### *Strengths and Limitations*

As far as we are aware no other qualitative studies have been conducted solely with non-help-seekers with current mental disorders. A major strength is that the SELCoH study database provided an opportunity to identify members of the public not currently engaged with services and explore the beliefs and attitudes of a group of people who would have otherwise been difficult to recruit.

Although we used a validated assessment of mental disorders to determine eligibility at initial recruitment, participants’ assessment of their problems was necessarily subjective. The median time between the initial SELCoH study and the interview for the current study was 16 months, which could have affected the amount of improvement and perceptions of professional help. It might be that some participants who reported ongoing problems would have resolved their problems had the interviews taken place after a longer period of time. The generalisability of our findings to other parts of England might be limited as the participants were drawn from an inner city area of South East London with greater access to services compared with other areas.

### *Service Implications*

We believe it is important not to assume that seeking professional help is the best option for everyone experiencing psychological distress. The findings from this study suggest that people who do not seek professional help vary in their need for further assistance and that it is therefore important to target help-seeking interventions toward people whose problems are

not resolving. Identifying the particular concerns of people who are least likely to be able to resolve their problems without professional help could better focus the targeting of interventions. This could be done in different ways. For example, Vogel Wester, Larson, and Wade (2006) suggest addressing men's low uptake of mental health services by marketing mental health services as educational and consultational professional coaching. Another way may be to reframe therapy as something that requires personal strength to undergo, as this could be important for engaging those who identify themselves as needing to appear to be strong (Addis & Mahalik, 2003). Targeting people with chronic physical problems through physical health services they already use might be another way. Finally, raising the profile, range and effectiveness of mental health services, particularly self-referral services, might be helpful to those who do not see their problems as medical. The Improving Access to Psychological Therapies programme (IAPT) in England has set out to address some of the problems highlighted above. IAPT's stepped care approach includes a period of watchful waiting which seeks to avoid unnecessary medical interventions. The IAPT self-referral route may also help to address inequitable access to professional help for mental health disorders, particularly for Black African and Black Caribbean people (Author and colleagues, 2013).

#### *Further Research*

Investigating the characteristics and coping methods used by people whose problems had resolved might be a fruitful endeavour. Similarly, understanding more about those who do not recover and also express a reluctance to seek help merits further work. One possibility might be to follow-up these participants to assess if any improvement does occur. Another possibility is to examine how flexible and open to change their attitudes to help-seeking might be.

An important and unexplored area of work that has emerged from this study is that of self-perception and how this might affect help-seeking. Further research exploring how

stigma is interrelated with one's self perception and social network and can restrict people's help-seeking choices would be useful.

This study has confirmed some previous findings but has also resulted in new findings about improvement without professional help. It has also shown the importance of self-perception in restricting help-seeking.

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**Table 1. Participant Characteristics (n=24)**

	Resolved group  <i>n</i>	Unresolved group  <i>n</i>	Total  <i>n</i>
<b>Age, years</b>			
16-24	1	4	5
25-34	3	3	6
35-44	-	3	3
45-54	-	4	4
55+	-	6	6
<b>Gender</b>			
Men	-	11	11
Women	4	9	13
<b>Ethnic group</b>			
Asian	-	2	2
Black African	-	6	6
Black Caribbean	1	2	3
White British	2	8	10
White Other	1	2	3
<b>Relationship status</b>			
Married and living with husband/wife	1	8	9
Married and separated from husband/wife	-	1	1
Single, never married	2	8	10

Single, living with partner	1	1	2
Divorced	-	1	1
Widowed	-	1	1
<b>Employment status</b>			
Full time work	2	6	8
Part time work	-	4	4
Looking after the home with children <16	-	3	3
Retired	-	3	3
Student	1	1	2
Unemployed	1	2	3
Permanent sick/disabled	-	1	1
<b>Primary diagnosis</b>			
Mild depressive episode	2	5	7
Severe depressive episode	-	1	1
Moderate depressive disorder	-	7	7
Generalised anxiety disorder	2	1	3
Mixed anxiety and depressive disorder	-	2	2
Non-specified neurotic disorder	-	3	3
Specific phobia	-	1	1
<b>CIS-R score (mean)</b>	22.25	23.45	23.25

**Table 2. Analytic Themes Split by Problem Status**

	<b>Resolved group</b>	<b>Unresolved group</b>
<b>Problem</b>	Short duration	Short, medium and long term problems
<b>concept</b>	Single stressor	Acute stressors plus chronic problems
	Life problem	Multiple stressors
	Manageable problem	Low to high severity
		Manageable and unmanageable problems
<b>Professional help</b>	Positive expectations of the effectiveness of professional help	Low, ambivalent and high expectations of efficacy
	Previous positive experiences	Previous unhelpful experiences
		Perceived difficulties in obtaining professional help
<b>Ways of coping</b>	Targeted problem solving strategies	Range of informal coping strategies
	Use of social network	Use of social network but some concerns
<b>Stigma</b>	No stigmatising attitudes	Expression of stigmatising attitudes about help-seeking and having a mental disorder
		Concerns about experiencing stigma
<b>Self-perception</b>	Not in conflict with seeking professional help	Strong person
	Problem-solver	Self-sufficient