Rural Australian adolescents’ perceptions of help seeking barriers and sources of psychological help for mental health problems

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Abstract

The purpose of this study was to investigate the barriers to seeking help and sources of support for mental health problems as they are perceived by Australian rural adolescents. Participants comprised 52 students from Years 9 and 10 recruited from four rural secondary schools. Eight focus groups were conducted. Each focus group was presented with two hypothetical scenarios of an adolescent living in a rural area with a mental disorder, and questions regarding the scenarios were posed in order to create group discussion. Interviews were transcribed and a thematic analysis was applied to the qualitative data. Results revealed a range of perceived barriers to seeking help for mental health problems for rural adolescents which could be considered as unique to rural settings. However, adolescents also expressed positive attitudes to seeking help and identified a range of professional help sources available to young people in rural areas, particularly those which are school-based. These findings contribute to the research area of Australian rural adolescent mental health where studies focusing on adolescents’ perspectives are rare and also suggest a way forward. In particular, the findings of this study support recent moves towards providing school-based mental health services to young people in rural areas.
Introduction

Despite the high prevalence of mental health problems among Australian adolescents, research suggests that they are reluctant to seek professional psychological help (see Sawyer et al. 2000). This under-utilization of mental health services by Australian youth is disturbing as research supports the positive effects of early treatment on long term outcome for mental health problems (e.g. Conus & McGorry 2002; Steinhausen, Rauss-Mason & Serdel 1991; Stephenson 2000).

Several studies in Australia and overseas have investigated barriers to help seeking for adolescents residing in urban locations. Common barriers to seeking help identified in the literature are confidentiality concerns, preferring to manage problems without others’ help, perceptions that no one can help, and a lack of knowledge of where to access potential helpers (Dubow et al. 1990; Lindsey & Kalafat 1998; Sheffield et al. 2004; Timlin-Scalera et al. 2003). Studies examining barriers to seeking help experienced by rural adolescents have focused on barriers to utilizing services for general health concerns (Atkinson et al. 2003; Booth et al. 2004; Elliott & Larson 2004; Quine et al. 2003). However, research suggests that the attitudes towards mental illness that exist in rural Australian communities are likely to further interfere with help-seeking behaviour (Fuller et al. 2000). Specifically, a reluctance to acknowledge mental health problems, social stigma, a culture of self-reliance, and a view that equates mental illness with ‘insanity’ have been identified as the main factors influencing the help seeking behaviour of people in rural and remote Australian communities (see Boyd et al. 2006 for review). A recent qualitative study conducted with a small number of clients
from a child and adolescent mental health service in rural Australia discovered that many of these barriers to help seeking in a rural context also impact on the adolescent’s utilization of mental health services in an on-going way (Aisbett et al. 2006).

Access to mental health services in rural areas is further complicated by the poor accessibility of tertiary services and a lack of qualified staff (Judd et al. 2006). In 1998, the Australian Human Rights and Equal Opportunity Commission identified rural adolescents as facing significant disadvantage in accessing necessary health care and education (Australian Human Rights and Equal Opportunity Commission 1999). Furthermore, young people do not always know what services are available to meet their needs (Tasmanian Department of Health and Human Services 2001). Responding to the mental health needs of young Australians requires “…sensitive, creative and innovative approaches that transcend many existing service boundaries” (National Mental Health Working Group 2004). Recent Australian research suggests that adolescents have a preference for school-based care (Boyd et al. in press). However, while alternative models of health service delivery including school-based services have been recently developed in Australia they are yet to be formally evaluated (Kang et al. 2006).

The present study

Given the lack of available literature on the topic as well as the significance of the issue to mental health service delivery in Australia, the present study aimed to explore the barriers to seeking help for mental health problems as well as potential sources of
help for these problems as they are perceived by rural adolescents. An exploratory
design was implemented – the focus group methodology – was chosen as it is fruitful for
gathering a breadth of information on a given topic.

Method

Participants

Participants comprised 52 students from Years 9 and 10, recruited from four rural
Victorian secondary schools. Rurality was determined based on the Accessibility/
Remoteness Index for Australia (ARIA) score for each school (Department of Health and
Aged Care, 2001). ARIA assesses remoteness on a scale of 0 to 12 according to the
accessibility to four categories of urban centres that have a minimum population of
5000, as measured by the road distance. Schools’ ARIA scores ranged from 3.69 to
5.13. All four schools were located in areas classified as moderately accessible
according to ARIA (Department of Health and Aged Care 2001). This ARIA category
reflects significantly restricted accessibility to services, goods, and social interaction for
residents.

Design and Procedure

According to Krueger and Casey (2000), the purpose of focus groups is to gain an
understanding of participants’ thoughts and feelings about the topic being discussed.
Focus groups allow for the collection of data in a social context, which allows people to express and compare their opinions to the views of other group members (Krueger & Casey 2000). Ideally, focus groups should comprise 6 to 8 participants who share characteristics relevant to the topic discussion. Research utilizing the focus group method involves conducting a series of groups on the same topic using pre-determined questions, whilst allowing the flexibility to address emerging themes (Krueger & Casey 2000).

Students who returned their consent forms with parental permission participated in the study. Eight focus groups were conducted in total with up to eight students in each group. Four groups were held with Year 9 students and another four focus groups were conducted with Year 10 students. Focus groups ran for approximately 20 minutes and all focus groups took place at the students’ school. Focus group discussions were moderated by the first author and captured in MP3 format using a digital recording device. Before commencement of focus groups, students were given light refreshments. This provided an opportunity to establish rapport with the participants prior to engaging them in group discussion.

Focus group instruments and question guide

Five hypothetical scenarios involving a young person living in a rural area with a mental health problem were used as the basis for discussion. These hypothetical scenarios represented common mental health problems experienced by adolescents, i.e., depression and anxiety disorders, disruptive behaviour disorders, substance use
disorders, eating disorders, and first episode psychosis. Scenarios were developed by the first author in accordance with DSM-IV-TR criteria and reviewed by the other authors who are members of the Rural Adolescent Mental Health Group at the University of Ballarat.

Two of the hypothetical scenarios were presented to each group. Each focus group for both the Year 9 and Year 10 students was assigned a group number, ranging from one to four. For each group a scenario duo was allocated (see Table 1). This ensured that all five scenarios were presented at least twice.

Key semi-structured questions were used to explore the help-seeking behaviour and perceived barriers to seeking help in relation to the hypothetical scenarios. Students were prompted to expand on their responses as appropriate.

Data analysis

All data were de-identified and transcribed verbatim according to qualitative data transcription guidelines described by McLellan, Macqueen, and Neidig (2003). A thematic analysis of the transcripts was subsequently carried out (see Flick 2002). First,
short case studies were written for each focus group summarizing participant characteristics and central topics discussed. Then, open and selective coding were performed on the transcript from the first focus group. Open coding involves organizing segments of the transcript into key categories. Selective coding extends open coding by identifying specific thematic domains and categories within the main categories to create a thematic structure. Subsequent focus group transcripts were analysed based on this thematic structure using a constant comparative method (Strauss & Corbin 1990). The constant comparative method involves the process of comparing emerging themes across transcripts to construct subcategories of superordinate themes. As additional or contradictory evidence was obtained from each focus group, the thematic structure was revised. Strategies employed to enhance the rigour of the thematic analysis included seeking rival explanations, peer debriefing, and taking a team approach to reflexivity (Patton, 2002; Barry, Britten, Barber, Bradley, & Stevenson 1999).

Results

The themes that emerged from qualitative analysis of the transcribed focus group data fell into two broad categories. The first broad theme comprised various barriers to seeking help in the context of rural communities for adolescents who experience a mental health problem. The second broad theme was adolescents’ ideas and attitudes to seeking psychological help from a variety of community sources.
Thematic descriptions are provided below with selected quotations from focus group participants.

1) Barriers to Seeking Help for Mental Health Problems in Rural Communities

A perceived lack of specialist local services and the consequent need to travel to gain access to appropriate help were seen by participants as significant obstacles to the scenario characters receiving help. As stated by one participant “… the lack of options of where to go to get help might prevent her”. Transportation difficulties as a potential barrier to help-seeking were noted by another student: “he might have to find someone to drive him to Horsham, or Naracoorte or wherever”. Students seemed to acknowledge the limited availability of professional helpers in their town to be a negative aspect of living in a rural area. For instance, one student commented “you know you need to sort of have the resources and stuff, which we lack’.

Recurring themes across all groups were the exclusionary social practices and fear of social stigma that participants believed would affect the character’s decision to seek help. The substance abuse disorder was the only scenario for which exclusionary social practices were not identified. Bullying was discussed specifically in relation to the anorexia nervosa and depression scenarios, whilst social exclusion was mentioned in relation to the schizophrenia, depression and conduct disorder scenarios. Participants’ responses indicated an expectation that their rural communities would react to the characters in the scenarios by teasing, ignoring and actively excluding the individual from community life. Statements from participants providing examples of these
practices were “… yeah, people finding out and then making fun of her”, “… they get shunned by everyone, no one talks to them”, and “… like the whole school would talk about oh something’s wrong with her, you know, something’s wrong with her.”

A lack of anonymity in rural towns was consistently discussed as a likely barrier to help seeking across school groups and scenarios. Students’ responses suggested that living in a rural town means residents’ lives are clearly visible to the community, making it difficult to behave differently without this being quickly noticed by others. For example, the following comment was made by a participant: “I reckon it’d get noticed quicker in [Town 2] compared to like a bigger town if you were like that, because everybody, like everybody knows everybody”. Gossip was perceived to be a negative consequence of living in a rural town with a mental health problem for all of the other scenarios. For example, one participant said “but no matter what, because you’re in a small town it’s gonna be talked about anyway”. General consensus among focus group participants was that because ‘everyone knows everyone else’ in a rural town, once abnormal behaviour is observed and the individual is identified as having a mental health problem this may also become known throughout the community. One participant stated “Ah well being a small town you get a reputation and it’s pretty much stuck with ya…there’s no getting out of it,” while another participant mentioned “…and like cos here everyone’s friends and like everyone notices, like you can’t go, like you can’t put your head down on a table and like sit like this… and not be noticed.”

Various types of stigma emerged as potential barriers to help seeking across the schizophrenia, anorexia nervosa, depression, and conduct disorder scenarios. No
themes involving stigma were identified for the substance abuse disorder scenario. In general, students indicated that people in their rural towns would typically label an individual as crazy if they were identified as having a mental health problem. An illustration of public stigma was the comment made by a participant “they’ll think he’s crazy”. In addition, participants’ own stigmatizing attitudes to the characters in the scenarios were evident for the scenarios involving schizophrenia and conduct disorder. Statements from students such as “he’s a psycho” and “he’s a bit of a nutter” as well as “yeah, probably send him to a crazy house” are examples of the stigmatizing attitudes expressed by some participants. Another form of stigma that was mentioned for the schizophrenia and conduct disorder scenarios was self-stigma, in which the character was perceived to possibly stigmatize him or herself for having a mental health problem. For instance, one student explained “simple fact that he would think himself that it might be a bit different, you know, a bit weird…you know what I mean”.

Also evident across focus groups was the perception that seeking help for mental health problems was a sign of weakness. Some students’ responses suggested that they would rather suffer from a mental health problem than seek help and risk being perceived by others as weak. A response from one student “… and then if they see her going to the counsellor well then they’ll think oh yeah, she’s not as strong as she sort of looks” demonstrates this culture of self-reliance as a potential barrier to seeking help. This reluctance to seek help and preference to handle problems without outside assistance was mentioned only for the depression and conduct disorder scenarios.
2) Sources of psychological help for rural adolescents

Professionals connected to the school setting were identified as potential sources of help across all groups. One student commented: “Yeah, school’s really the only thing”. The perception of school counsellors and nurses was particularly positive. For example, students stated: “A lot of help would come like, through [the school counsellor]”… “[the school counsellor] is fairly helpful” …“The school nurse, good old [school nurse].”

Teachers were perceived as helpful depending on the nature of the problem presented in the scenario. Participants believed that it is possible to confide in teachers with personal difficulties, but in the case of conduct or substance abuse problems that the teacher would judge the young person negatively. For instance, one participant asked “Would you want to go to the teachers after all those problems at school?” Other participants commented “…but none of the teachers cos they would, they hate him” and “If the teachers have something against him then they might not wanna get someone to help him.”

Medical and health professionals were commonly discussed as possible sources of help. Positive attitudes towards this group of helpers were consistently expressed with the exception of general practitioners (GPs), who were viewed both positively and negatively by participants at two of the four schools. For instance, some participants stated: “The first thing she probably wouldn’t want to do, is start like, taking pills and things like that…like from a doctor prescribing her pills and stuff”, and “… she might not
trust the doctors in [the town]”. A range of allied health professionals were identified as potential sources of help by participants depending on the scenario. For instance, participants identified dietitians, rehabilitation workers, and community health nurses as potential sources of help for young people with eating disorders or substance use problems.

Informal sources of help for adolescents with mental health problems were also identified by focus group participants. Friends and parents were consistently mentioned as prospective sources of help. Both positive and negative attitudes were expressed regarding the helpfulness of parents and friends. For example: “You trust your friends and you tell your friends everything”, “… the friends are the people that she’d most likely open up to, I think”, “maybe he needs to talk to his mum and dad”, and “I don’t think she would go to her parents about this, or like family.” In the case of anorexia nervosa, parents were viewed as helpful when they actively intervened to get the character help. One participant stated: “Yeah, the parents will, if they’re good parents, they will turn around and say right something is wrong with you whether you think so or not, you know…and that’s a good thing, this is, it’s not one of those parents forcing it’s one of those parents doing what they have to do to keep their child alive.”

**Discussion**

The numerous barriers to seeking help for mental health problems identified by this group of rural adolescents can be considered specific to rural environments. These
findings extend the existing literature where studies focusing on rural adolescent perceptions are rare.

In the present study, focus group participants identified logistical problems such as a lack of transport, and a consequent need to travel to receive appropriate help due to a lack of local services, as a major barrier to the characters seeking help for adolescents with a mental health problem in their community. Exclusionary social practices and stigma were also identified by adolescents in this study as barriers to help seeking for a mental health problem. These findings are consistent with similar results from a study of adult users of psychiatric care in the Scottish Highlands (Parr et al. 2004) and a study which sampled the opinions of mental health workers in rural Australia (Fuller et al. 2000). In the present study, self-stigma was also thought to possibly prevent the characters from seeking help in some scenarios. Students’ own stigmatizing attitudes to the characters were also apparent during many of the focus group discussions. Very few studies have considered the role of self-stigma in adolescent help seeking for mental health problems in rural settings. However, Aisbett et al.’s (2006) also discovered that self-stigma was a considerable barrier to the utilization of mental health services by the rural adolescents who were interviewed.

Social visibility is a consequence of living in a rural area is a phenomenon which has been identified and discussed in social geographic research (see Parr & Philo 2003). In the present study this phenomenon was identified by participants as potentially having a negative impact on rural young people seeking help for mental health problems. In rural environments, the visibility of people’s lives is higher than in urban areas meaning rural
youth are likely to experience less privacy in their lives than urban youth. This phenomenon acts as a help seeking barrier in a combination with other factors including a lack of anonymity in rural settings and fear of social stigma or community gossip. For instance, participants in Aisbett et al.’s (2006) study indicated that on being seen entering a mental health service a client may subsequently be the subject of community gossip and in turn experience stigma and social exclusion (see Aisbett et al., 2006). Findings from the present study also suggest that rural young people live in a culture that values individuals taking care of themselves and that this may result in external help being resented or avoided. This finding is also consistent with Aisbett et al.’s (2006) study of clients of child and adolescent mental health services in rural Australia.

Despite the numerous barriers to seeking help for mental health problems that were identified by participants in this study, the young people who took part also identified several sources of community support. It was encouraging to discover that the adolescent participants in this study had such positive attitudes towards many professional sources of help, although attitudes to seeking help from GPs were mixed. Contrary to previous findings (e.g., Dubow et al. 1990; Lindsey & Kalafat 1998; Timlin-Scalera et al. 2003) adolescents in this study possessed good knowledge about the nature and availability of professional help in their respective towns.

A strong theme of the focus groups was the particularly positive attitudes adolescents had to seeking school-based help from school counsellors and nurses. A recent study conducted by Boyd et al. (in press) with adolescents who had experience of seeking help for mental health problems in a rural context also found that the
participants held positive attitudes towards school-based helpers. Taken together, these findings suggest that recent efforts towards implementing and evaluating school-based health services have considerable merit (see Kang et al. 2006), particularly when school-based health care is known to increase the number of mental health consultations, especially by males (Kang et al. 2006).

Highly consistent with past research, adolescents expressed a preference for informal sources of support, especially their peers (see Sullivan et al. 2002). However, they also stressed the important role that parents have to play in mediating help seeking for adolescents, particularly those who have little insight into their difficulties. This suggests that further exploration of parent-mediated pathways to help seeking for rural adolescents is warranted.

Methodological considerations

Due to the exploratory, qualitative nature of this research generalizations to the wider population cannot be inferred. These findings require verification using a larger community sample before any such generalizations can be made.

Despite the homogeneity of focus group participants generally being considered a strength of the method, it is possible that a similar group composition has limitations, especially when the group is comprised of youth. For example, participants in the focus groups may have modified their responses to reflect perceived normal opinions by their
peers. This subtle peer group pressure might have prevented alternative viewpoints from being expressed. Similarly, it is possible that the facilitator of the focus groups did not establish sufficient rapport with the participants in order to gain a depth of understanding of the participants’ views and opinions. The focus groups ran for about twenty minutes. Although time was taken before the formal commencement of the groups to meet with participants and establish rapport with them, it is quite possible that the participants presented only the views and opinions that they believed were acceptable to the facilitator.

Although participants were all from rural areas as indicated by ARIA scores for the school suburbs, the degree of rurality for all groups was only moderate. It is possible that students from towns rated by ARIA as having a higher level of rurality may have identified different or additional information. Similarly, although attempts were made to balance the gender composition of the groups, there was an over-representation of female participants in most of the groups, which may have influenced the findings. For instance, male participants may have restricted or modified their contributions to the group discussion as they were in the minority.

A final limitation to be noted was that the present study investigated rural young people’s perceptions of help seeking and barriers to seeking help based on their responses to hypothetical scenarios. Thus, results of this study may not give insight into the actual help-seeking behaviours of these adolescents should they develop mental health problems in the future.
Conclusion

This study aimed to explore the perceived barriers to seeking help for different types of mental health problems for adolescents living in rural areas. Key perceived barriers identified included logistical problems, exclusionary social practices, stigma, social visibility and a culture of self-reliance. Adolescents also expressed their attitudes to a range of potential sources of psychological help. Positive attitudes towards school-based helpers and informal sources of support were strongly expressed. Mixed attitudes to GPs were noted. These attitudes appeared to be related to difficulties with adolescents trusting GPs. This particular finding is worthy of further exploration.

The implications of these findings relate back to the study’s main aims. First, it is important for policy makers to recognize and acknowledge that the rural context provides additional barriers to help seeking for adolescents with mental health problems that are above and beyond those which may be encountered by urban youth with similar difficulties. Specific programs that will assist rural adolescent in overcoming barriers to seeking professional psychological help are needed. Second, the sources of help that rural adolescents prefer – i.e., school-based helpers and informal sources – are those that are under-resourced and under-qualified to provide mental health treatment. Given that the barriers to seeking help for rural adolescents are substantial, effort needs to be directed towards increasing the availability of school-based mental health services as well as strengthening informal sources of support to assist rural adolescents with mental health problems to overcome help seeking barriers.
References


Table 1

Focus Groups by Year Level, Scenario Group, School, Gender and Total Number of Participants

<table>
<thead>
<tr>
<th>Scenario Group</th>
<th>Year 9</th>
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<td>School</td>
<td>Males</td>
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<tr>
<td>Total N</td>
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<td>17</td>
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*a* where Group 1 comprised Scenarios 1 and 2, Group 2 comprised Scenarios 3 and 4, Group 3 comprised Scenarios 2 and 3 and Group 4 comprised Scenarios 4 and 5.