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The impact of previous experience of depression and previous help seeking behaviour upon intentions to seek help for varying severity levels of depression in the future

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Abstract

Help seeking behaviour can be seen as a decision-making process that follows the stages of symptom appraisal, attitudes towards help seeking and translating intentions into behaviour. If people can be encouraged to seek help early on when they experience depression, this can prevent the escalation of difficulties. The aim of the present study was to understand the process of help seeking for depression, with a focus on how severity of symptoms, past experiences with depression and past help seeking for depression might influence future decision-making. Online social networks were utilised to generate a sample of 202 participants (M=33.5 years, SD=9.80) of which 61% were female. Participants completed the hospital anxiety and depression scale, a brief state measure of anxiety and depression, to control for their current levels of distress. Participants were then presented with three short vignettes describing a person experiencing depression of different severity levels (mild, moderate, and severe). These vignettes were created for this study, and had been piloted. Participants were asked to rate either their actual help seeking behaviour if they had experienced that severity of depression in the past, or their intentions to seek help if they had not experienced that severity of depression in the past. Help seeking routes included both formal and informal sources of help. Two-way repeated measures analysis of variance (ANOVA) showed that the more severe the symptoms of depression the higher the reported help seeking behaviour and intention for both formal and informal help. Intention to seek informal help as well as help seeking behaviour from informal sources was higher than from formal sources of help for mild and moderate symptoms of depression. For severe symptoms of depression, both formal and informal help seeking and help seeking intentions were at similar levels. Multivariate analysis of covariance (MANCOVA) indicated that intention to seek help for more severe symptoms of depression in the future was not related to past experience of depression of different severity levels, whereas past help seeking behaviour was correlated with increased intention to seek help for more severe symptoms of depression. The theoretical implications of the study, as well as the implication for practice are discussed and recommendations for future research are offered.

Table of Contents

List of Tables

List of Figures

Chapter I: Introduction

It is important that the field of counselling psychology focuses not only on delivering psychological interventions for clients, but also on understanding more about potential clients of counselling services, to better facilitate help seeking when someone experiences distress. In order to reach out and serve clients best, we need to understand how people make sense of their world, process information, make plans, and, ultimately, act (Vogel, Wester, Larson, & Wade, 2006). Understanding the different ways in which individuals cope with their difficulties, either by actively trying to address or resolve the problem or by avoiding doing so, could help counselling psychologists encourage people in distress to use services. Thus, a particularly salient question that deserves empirical examination is: What factors are most influential in the decision to seek professional help?

Consequently, the purpose of this study is to examine past help seeking behaviour as well as intentions to seek help for depression in an adult sample of both men and women. Specifically, this project aims to examine how severity of depression symptoms, past experience of depression, and past help seeking behaviour, might affect intention to seek help in the future for different severity levels of depression.

Help seeking is defined as a communication process with others, focusing on a specific physical or psychological problem that creates enough distress for the individual that they need to take action to manage it, for example by seeking treatment or solutions to their problem from external sources (Gourash, 1978). Help seeking behaviour is not a simple act that depends on the individual's motivation. Instead it has been described as a decision-making process involving a series of steps and decisions from individuals in order to manage their difficulties (Moller-Leimkuhler, 2002; Suchman, 1965; Vogel et al., 2006). Within this conceptualisation of help seeking, there are two types of help that can be sought. Formal help seeking refers to requests for help from professional sources, such as doctors, psychologists, social workers, and schoolteachers. Informal help seeking refers to seeking help from family-based (i.e., parents, siblings, relatives), and peer group-based sources (i.e., friends, partners, colleagues) (Grinstein-Weiss, Fishman & Eisikovits, 2005).

Research has shown that a measure of intentions to perform a given behaviour is a good predictor that an individual will engage in that behaviour in the future (Albarracin, Johnson, Fishbein, & Muellerleile, 2001; Armitage, 2007; Bagozzi, 1981; Hagger, Chatzisarantis, & Biddle, 2002; Sheeran, 2002; Sheeran & Abraham, 2003). This is particularly the case for health related behaviours. For instance, empirical research has shown that intentions to perform a particular health behaviour were able to account for 22% of the variation in smoking cessation attempts (Armitage, 2007), 26% of the variation in physical activity frequency (Hagger et al., 2002) and 30-32% in blood donation behaviours (Bagozzi, 1981).

Similarly, past behaviour (that is, whether, and how often, an individual has previously engaged in the target behaviour) is also a good predictor of engaging in that behaviour again in the future (Borland, Owen, Hill, & Schofield, 1991; Chen & Mak, 2008; Dadfar & Friedlander, 1982; Hagger, Chatzisarantis, Biddle, & Orbell, 2001; Norman, Conner, & Bell, 1999; Van Der Rijt & Westerik, 2004). Conner and Armitage (1998), in a review of the theory of planned behaviour, concluded that past behaviour is likely to account for approximately 13% of the variance in actual behaviour.

Thus, the more an individual reports that they intend to do something (such as seek professional support for their problem) and the number of times they have already done so in the past, the more likely they are to follow through with their intentions and act upon them. Nevertheless, despite the moderate predictive utility of intentions and past behaviour upon future behaviour, there remains a substantial 'intention-behaviour gap' such that not everyone who reports an intention to do something will act upon that intention (Sheeran, 2002; Sheeran & Abraham, 2003; Sheeran, Orbell, & Trafimow, 1999; Sutton, 1998). This has generated a large body of research investigating the potential contribution of other factors to explain behaviour, either by acting independently or in interaction with intentions, to increase the likelihood that intentions will be translated into actual behaviour.

People in distress do not always seek help when they experience a problem: this failure to act is called help seeking delay. In patient care, help seeking delay, or help seeking gap, refers to the period between an individual's first awareness of a sign or symptom of illness, and their initial professional consultation (Bish, Ramirez, Burgess, & Hunter, 2005). Research has shown that a help seeking gap exists for different health conditions, including life-threatening or serious conditions such as

breast cancer (Bish et al., 2005; Facione, 1993; Montazeri, Ebrahimi, Mehrdad, Ansari, & Sajadian, 2003), acute coronary syndrome and stroke (Moser et al., 2006), urinary incontinence (Koch, 2006), irritable bowel syndrome and nonulcer dyspepsia (Koloski, Talley, & Boyce, 2001) and infertility (White, McQuillan, & Greil, 2006). There is a similar pattern for emotional difficulties, and only a minority of distressed individuals seek professional help for their emotional or psychological distress (Biddle, Gunnell, Sharp, & Donovan, 2004; Brown et al., 2011; Dew, Bromet, Schulberg, Parkinson, & Curtis, 1991; Gourash, 1978; Kessler et al., 1994; Oliver, Pearson, Coe, & Gunell, 2005; Roness, Mykletun, & Dahl, 2005; Tijhuis, Peters, & Foets, 1990). In an Australian study, Andrews, Issakidis and Carter (2001) reported that less than one third of individuals who would be likely to benefit from psychological treatment actually obtained such services. In this study, the help seeking rate for depression was 60%. In a Canadian study just over 28% of participants (n=1964) who met criteria for a DSM-III diagnosis in the previous year saw any health care professional (Bland, Newman, & Orn, 1997). Similarly in the UK, help seeking for mental health difficulties is low. In a questionnaire survey conducted with 3004 young adults aged 16–24 years, only 22% of men and 35% of women reported seeking any help for suspected mental health difficulties as measured by the 12-item general health questionnaire (Biddle et al., 2004). A similar questionnaire survey found that only 28% of people with extremely high scores had sought help from their general practitioner but most (78%) had sought some form of help (Oliver et al., 2005).

It is apparent that whilst some people do seek help for psychological and emotional issues, there are often many others who do not, despite the fact that their problems could be helped or reduced by seeking help. A clearer understanding of the reasons behind decisions to seek professional help (and decisions to avoid doing so) would allow the profession of counselling psychology to reach out to those who need services with messages tailored to more specifically address these reasons. The present study will focus on help seeking for depression, which is one of the most common psychological difficulties (Kessler et al., 1994; Kringlen, Torgersen, & Cramer, 2001), affecting 10% of the population in Britain at any one time (Singleton, Bumpstead, O'Brien, Lee, & Meltzer, 2001).

Help seeking for depression specifically is low. It has been reported that over half of the people with depression do not seek professional help (Andrews, Hall,

Teesson, & Henderson, 1999; Bland et al., 1997; Henderson, Pollard, Jacobi, & Merkel, 1992; Roy-Byrne, Stang, Wittchen, Ustun, Walters, & Kessler, 2000) and people are more reluctant to seek help for it from mental health professionals (Andrews et al., 1999; Burns, Eichenberger, Eich, Ajdacic-Gross, Angst, Rossler, 2003; Jorm, Medway, Christensen, Korten, Jacomb, Rodgers, 2000). Moreover, the delays to seek help for depression are usually long. For instance, Thompson, Issakidis and Hunt (2008) reported that only 28% of people attending a specialist anxiety clinic with a primary anxiety or mood disorder reported to have sought help within one year of onset. The average length of the delay to seek help was 8.2 years.

In general, the literature indicates that individuals who are young, white, educated and middle-class seek informal as well as formal help more often than do people from minority groups, and people who are older, less educated and working class (Bish et al., 2005; Facione, 1993; Gourash, 1978; Leaf, Bruce, Tischler, & Holzer, 1987; Montazeri et al., 2003; Smith, Pope, & Botha, 2005; Tijhuis et al., 1990; Wang et al., 2005). Many studies also report higher levels of health care utilisation among women compared to men (Angst et al., 2002; Bertakis, Azari, Helms, Callahan, & Robbins, 2000; Galdas, Cheater, & Marshall, 2005; Hawton, 2000; Koopmans & Lamers, 2007; Moller-Leimkuhler, 2002; Moller-Leimkuhler, 2003; O'Brien, Hunt, & Hart, 2005).

Several other factors have been examined in relation to their impact upon formal help seeking for mental health issues. There is evidence that individuals prefer to try to manage problems on their own or to first seek help from their informal networks (Rickwood & Braithwaite, 1994), that people are more likely to seek counselling when they perceive their problems to be severe (Cramer, 1999; Komiya, Good, & Sherrod, 2000) and when they have more social support (Fosu, 1995; Goodman, Sewell, & Jampol, 1984; Horwitz, 1977; Owens, Lambert, Donovan, & Lloyd, 2005; Rickwood & Braithwaite, 1994; Rüdell, Bhui, & Priebe, 2008). Moreover, other factors have been implicated in the health seeking gap for mental health issues, including fear of treatment (Kushner & Sher, 1989; 1991), anticipated cost of seeking help (Vogel & Wester, 2003), a desire to avoid discussing distressing information and experiencing painful feelings (Cepeda-Benito & Short, 1998; Kelly & Achter, 1995; Komiya et al., 2000; Vogel & Wester, 2003) and stigma and shame or embarrassment about mental health and about help seeking for mental health difficulties (Fosu, 1995; Fuller, Edwards, Procter, & Moss, 2000; Jorm, 2000;

Komiya et al., 2000; Pederson & Vogel, 2007; Takeuchi, Leaf & Kuo, 1988; Vogel & Wade, 2009). Some authors have also argued that distressed individuals might be more likely to seek help for emotional problems from their lay support network, rather than from professionals, because emotional problems are connected more with weakness and stigma (Fuller et al., 2000; Pederson & Vogel, 2007; Vogel & Wade, 2009).

Our previous experiences shape our beliefs and the way we view new experiences and in this way also affect our future behaviour (Markus, 1977; Odgen, 2004; Weinman & Petrie, 1977). Thus, past experience with a particular emotional difficulty is also likely to have an effect upon an individual's intention to act in a certain way and seek help in the future. An individual's past help seeking behaviour also appears to be related to behaving in a similar way in the future should the need to seek help arise again (Chen & Mak, 2008; Friedman & West, 1987; Halgin, Weaver, Edell, & Spencer, 1987; Robbins & Greenley, 1983; Schomerus, Matschinger, & Angermeyer, 2009a; Sherwood, Salkovskis, & Rimes, 2007). Moreover, an individual's sense of self-efficacy has also been included in different models trying to understand health behaviours, such as the social cognitive theory (Bandura, 1986), the protection motivation theory (Rogers, 1983) and the theory of planned behaviour (Ajzen, 1991).

The present study has three aims. The primary aim is to quantitatively examine whether having experienced symptoms of depression and help seeking behaviour for those symptoms in the past affects an individual's intention to seek both informal and formal help for more severe symptoms of depression in the future. Additionally, the study examines how the severity of the symptoms of depression might affect both actual help seeking behaviour for these symptoms, and intention to seek informal and formal help for these symptoms in the future. Specifically, four main research questions are explored:

(1) What is the relationship between the severity of imagined or past symptoms of depression and the ratings of future intention to seek help or past help seeking behaviour, respectively?

(2) Is there a relationship between the type of help (formal or informal) people use or intend to use if they were to experience depression in the future, and the severity of the symptoms of depression?

(3) Does the severity of previous experiences of depression affect participants' intentions to seek help if they were to experience a more severe episode of depression in the future?

(4) What is the relationship between past help seeking behaviour and participants' future intention to seek help if they were to experience more severe difficulties in the future?

The directional hypotheses that examine these aims are described in Section 2.6 (page 50). The study also seeks to contribute to the extant research on help seeking by employing an alternative means of studying help seeking behaviour, the vignette methodology. Finally, it is hoped that these findings can be used to inform the practice of counselling psychology by helping clinicians identify factors that affect help seeking behaviour and in this way find ways to increase access to services and facilitate clients' help seeking as early as possible.

1.1. Preamble to the chapters

The present research project quantitatively investigates help seeking behaviour for depression, and the relationship between past experiences of depression, previous help seeking for depression, and future intentions to seek help for depression, using the vignette methodology.

Chapter II includes a review of the literature on help seeking and defines and explores the process of help seeking. Factors that have been shown to impact upon help seeking decisions are presented, together with relevant research conducted in the field. The specific factors that are of most relevance to the hypotheses of this study are examined, leading to the research questions and predictions of the current research project. The methodology is discussed in Chapter III, describing participants and recruitment, data collection and instruments, the development of the vignette methodology, and ethical considerations. Chapter IV presents the results of the statistical analysis of the data, and Chapter V discusses the implications of the main findings of the research for the profession and practice of counselling psychology, the limitations of the study, and recommendations for future research. A conclusion is presented in Chapter VI and is followed by a reflective account of the process of conducting the research in Chapter VII.

Chapter II: Literature Review

The review of the literature starts by defining and exploring help seeking and the process individuals follow to seek help. The relationship between the severity of difficulties and an individual's intention to seek help, as well as their actual help seeking behaviour, are explored. Next, the way in which previous experience might influence a person's intention to seek help in the future is discussed, as well as the relationship between past behaviour, intentions, and future behaviour. Finally, the aims and hypotheses of the study are described.

2.1 The process of help seeking

The process of help seeking provides the critical link between the onset of problems and receiving help, and does not necessarily end with the involvement of professionals (Angermeyer, Matschinger, & Riedel-Heller, 1999). Help seeking is an interpersonal process and represents the succession of contacts where distressed individuals make efforts to receive help from people around them, whether this includes health professionals or not. This is a cognitive as well as a behavioural process (Hartnoll, 1992) and the research suggests that help seeking pathways are not random but are structured processes. The point at which some form of help is sought represents a stage in this structured process of help seeking, and will be the result of a complex interplay of internal and external factors that combine to influence an individual's decision at the time (Jordon & Oei, 1989).

The present study adopts an information-processing framework (Moller-Leimkuhler, 2002; Vogel et al., 2006) to explore individuals' help seeking intentions, and their actual help seeking behaviour, for depression. The information-processing model of taking decisions advanced by Vogel et al. (2006) describes a series of four cognitive and affective steps in which an individual interprets their world and chooses to make a specific decision. Specifically, individuals (a) encode and interpret internal and external cues, (b) generate and evaluate behavioural options, (c) decide on and enact a selected response, and (d) respond to personal and peer evaluations of the selected behaviour. Within the information processing framework, therefore, help seeking is a structured process that is also conceptualised in stages, each of which is a decision-making point (Carrol & Johnson, 1990; Moller-Leimkuhler, 2002; Suchman, 1965; Vogel et al., 2006). These stages include recognising and defining a

physical or psychological phenomenon as a problem, deciding whether to seek help, and deciding from whom to receive help.

Help seeking delay refers to the period between an individual's first awareness of symptoms and medical consultation and diagnosis and, according to Psycho-physiological Comparison Theory (PCT), delay can occur at any of the stages of this decision-making process (Andersen, Cacioppo, & Roberts, 1995; Cacioppo, Andersen, Turnquist, & Tasinary, 1989; Nooijer, Lechner, & Vries, 2001). The PCT considers a model of help seeking delay for cancer from two different perspectives. First, help seeking delay is viewed as a result of the attributions individuals make when relating their symptoms to their prior expectations and knowledge about physiological or bodily processes. According to Andersen and colleagues, symptom appraisal occurs through comparison of the present symptoms to situational events (e.g., tiredness may be attributed to working long hours) and of known health difficulties (e.g., tiredness might be due to having the flu). The second perspective considered by PCT is how delay to seek help can happen in one of the different stages of decision-making. The model of delay presented by Andersen et al. conceives delay comprised of a series of stages, each governed by a conceptually distinct set of decisional and appraisal processes. Delay that happens at the first stage of symptom interpretation is called appraisal delay, delay that occurs between the realisation of the problem and deciding on a form of help is called illness delay, followed by behavioural delay which represents the time between when the decision is taken and help is actually sought. The final stage in this model is scheduling and treatment delay, which is the delay to first receive medical attention and begin treatment.

According to Carrol and Johnson (1990), the process of decision-making begins with the realisation that there is a decision to be made, and help seeking decisions are based both on the perception of distress and on the individual's belief in being able to cope (or not) with the distress (Vogel et al., 2006). Specifically, an individual initially detects symptoms and appraises their seriousness by recognising and interpreting internal and external cues. Internal cues might include the individual noticing symptoms of depression such as difficulty sleeping and loss of pleasure. External cues might include feedback from others about changes in the individual's mood and behaviour. Delay at this point is appraisal delay, which Andersen et al. (1995) found to account for the majority (i.e., at least 60%) of the total help seeking

delay in women newly diagnosed with cancer. The quantitative findings are supported by qualitative research with some studies reporting that people may have difficulty making appropriate decisions about whether to seek professional help because they are not able to accurately recognise or understand what their symptoms mean (MacInees, 2006; Smith et al., 2005). For instance, Davies, Sieber and Hunt (1994) reported that younger people were better able to observe and interpret symptoms of depression, such as low motivation and lack of concentration, than older individuals. In this study older adults did not regularly use or think in psychological terms, meaning they used different labels for these symptoms than did the younger group. This mislabelling of symptoms may result in a failure to identify depressive symptoms as noteworthy or distinct and delay moving to the next stage in the help seeking process and seek help. As a result, when symptoms do occur older adults may fail to recognise them as being psychologically meaningful and subsequently do not process them as being important to remember.

In another study examining the role of appraisals in help seeking behaviour, Cameron, Leventhal and Leventhal (1993) observed that the presence of a new symptom by itself was often not enough to prompt an individual to recognise a problem, and that in order to seek help the person had to interpret the symptom as severe enough. For example people who sought help reported more pain and explained their symptoms as indicating a specific disease, perceived more increase in the severity of their symptoms and more disruption to their daily activities than matched controls that did not seek help. How an individual interprets and appraises their symptoms can also be influenced by the beliefs they hold about health and illness, the knowledge and ideas they have about what their symptoms mean and what it means to be healthy or not (Ogden, 2004). For example if an individual considers that symptoms such as inability to sleep, lack of pleasure and tiredness indicate there is a problem, they might react differently than if they view them as part of normal experience. The beliefs about health and illness that an individual holds, and their interpretation of the meaning or severity of the symptoms they experience play an important role in the appraisal of the situation and therefore in deciding whether to seek help or not.

Help seeking can also be influenced by the beliefs individuals hold about their own ability to cope with the distress (Cameron et al., 1993; Vogel et al., 2006) and their self-efficacy, which is concerned with people's beliefs in their capabilities

to perform a specific action required to attain a desired outcome (Luszczynska & Schwarzer, 2005). According to protection motivation theory (PMT; Rogers, 1983) both threat and coping appraisals are important in predicting health behaviour. Coping appraisals involve the process of assessing the alternative behaviours that might reduce the threat. This process is based on the individual's expectation that carrying out a specific behaviour can remove the threat (response efficacy) and a belief in one's capability to successfully perform the recommended behaviour (self-efficacy). Coping appraisals, and especially self-efficacy, have been found to be strong predictors of intention and behaviour (Luszczynska & Schwarzer, 2005).

Once a symptom is interpreted as needing attention, the next step in the help seeking process involves deciding if and where to go for help, by considering behavioural options, based on the individual's goals. Specifically, people make initial efforts to overcome their difficulty by choosing a way of responding (or coping). Individuals might use "approach" coping, such as taking medication or seeking help from family, friends, or professionals. They might also use "avoidance" coping, for example denying that the problem exists (Hagger & Orbell, 2003; Leventhal, Meyer, & Nerenz, 1980; Leventhal, Nerenz, & Steele, 1984). The individual makes initial coping efforts (Kovacs, 2007) in an attempt to return to his or her previous situation and might decide to self-treat whilst postponing seeking formal help. Delay to seek help at this stage is called illness delay. Illness delay is affected not only by an individual's beliefs on their ability to cope with the distress and their coping style, but also by the severity of their distress.

For psychological or emotional difficulties such as depression, whether someone will decide to do something to resolve the problem or not will depend on how severe the symptoms they experience are (Biddle et al., 2004; Bland et al., 1997; Dew et al., 1991; McCracken et al., 2006; Oliver et al., 2005; Oppenheimer, Sheehan, & Taylor, 1988; Rickwood & Braithwaite, 1994) and on their self-efficacy beliefs, that is, the individual's sense of being able to change his or her situation. Specifically in the case of depression individuals might feel hopeless and unable to view their situation as changeable or themselves as capable of changing it, and therefore might not seek appropriate help.

If the difficulties persist, the next move in the decision making process is to seek appropriate professional help, although there may be some delay between the decision to seek help, and the act of seeking help itself (behavioural delay). Several

factors can contribute to delay following realisation of the problem. For a difficulty such as depression, these factors can include the stigma and shame of having mental health problems, or that others might consider the person to be responsible for the problem (Fosu, 1995; Fuller et al., 2000; Jorm, 2000; Komiya et al., 2000; Pederson & Vogel, 2007; Takeuchi et al., 1988; Vogel & Wade, 2009). Seeking formal help is only the last stage of the help seeking pathway and only one of the possible behavioural responses to be considered (Carrol & Johnson, 1990). Once an individual has recognised their symptoms and appraised their seriousness they still have a number of available choices before and beyond seeking professional consultation (Rogers, Entwistle, & Pencheon, 1998). Frequently some sort of self-care (i.e., informal care, religious or alternative medical solutions) precedes professional treatment seeking. Self-care and the use of other sources of help might cause additional delays in seeking professional help.

Doing nothing about symptoms may be unwise neglect, but it may also be a positive, appropriate, and logical first response to a difficulty (Rogers et al., 1998). For instance, the difficulty might not last long enough to warrant seeking help and allowing some time for the problem to be resolved might on many occasions be enough. A subsequent decision to act in order to address the symptoms can be precipitated by several factors, including the actions or advice of others, a change in the assessment of risk or the situation, or where the containment of the problem is no longer possible, due to the severity of symptoms (Biddle et al., 2004; Bland et al., 1997; Dew et al., 1991; McCracken et al., 2006; Oliver et al., 2005; Oppenheimer et al., 1988; Rickwood & Braithwaite, 1994). Another option that individuals might select is self-care, with or without medication. This can include a wide range of practices such as taking over-the-counter medication, dietary changes, taking homemade, homeopathic or naturopathic remedies, increasing physical activity, resting or taking a holiday, and reducing activities such as alcohol or substance use (Morin, LeBlanc, Daley, Gregoire, & Merette, 2006).

The use of social support has also been recognised as an important factor influencing an individual's decision to seek help (Birkel & Reppucci, 1983; Freidson, 1970; Gourash, 1978; Horwitz, 1977; McKinlay, 1973; Neighbors, 1985; Unger & Powell, 1980). Thus, whilst informal sources of help such as talking to ones friends and family, colleagues or using internet resources can be the first step in the help seeking process, these might either encourage or discourage help seeking from

professionals. Friends and family might have negative attitudes towards seeking help that might discourage someone from taking further action. Internet groups of other sufferers might disseminate anecdotal evidence about misdiagnoses from their own doctors, and alternative views about treating a problem.

The initial definition and response to both psychological and physical difficulties often takes place in the community (Horwitz, 1977). There is empirical evidence and a general consensus in the literature that informal or lay support networks come first in the help seeking pathway, as they are identified by individuals as more helpful than formal sources of help (Hernan, Philpot, Edmonds, & Reddy, 2010) and might or might not be followed by formal sources of help according to how successful they are in alleviating the problem (Neighbors & Jackson, 1984). Neighbors and Jackson (1984) suggest that the majority of individuals prefer to use informal help only or informal help in combination with professional help when they have to deal with life stressors, emphasising that the extent and nature of available social networks will influence the quantity and quality of advice and informal support. Distressed individuals might then seek help from formal sources of help such as doctors, psychiatrists, psychologists, counsellors, social workers, and other private or public sector agencies and people.

Once an individual has decided to seek professional help, and contacts a professional for help, further delays can occur before they actually receive that help. Scheduling delay refers to the time between when an individual first contacts a professional for help, and when they actually receive that help and can be the result of waiting lists to see a particular medical specialist (particularly within the NHS), or because the patient is unable to make time in their diary (Nooijer et al., 2001). Treatment delay refers to the time between the moment when a person first receives medical attention and the beginning of the treatment they require (Andersen et al., 1995; Cacioppo et al., 1989). This delay is predominantly due to the availability of medical specialists or facilities, such as scheduling a necessary surgical procedure (Nooijer et al., 2001).

It has been suggested that individuals evaluate the outcomes of their behaviour using personal and peer evaluation (Cameron et al., 1993; Vogel et al., 2006) and this evaluation might lead to new decisions about what to do next. One of the purposes of the present study is to examine how an individual's previous experience with depression, and their previous help seeking behaviour for it, might

influence their future intention to seek help for depression, as these previous experiences can be used to evaluate the outcome of future help seeking.

Help seeking is a complex problem solving process during which individuals must evaluate the options they have regarding where to go for help. Traditional problem solving models have three stages: interpretation (making sense of the problem), coping (dealing with the problem in order to regain a state of equilibrium), and appraisal (assessing how successful the coping stage has been) (Ogden, 2004). These stages continue until the coping strategies are deemed to be successful and a state of equilibrium has been attained (Ogden, 2004). According to Leventhal's self-regulatory model (Leventhal et al., 1980; Leventhal et al., 1984) individuals deal with illness in the same way they deal with other problems. This process is self-regulatory because the three components of the model relate in a way as to maintain the previous situation. Similarly Hirst and colleagues (1999) suggest that patients' help seeking pathways to mental health care might be better summarised in terms of one or more circular sequential cycles (distress–appraisal–action) where initial appraisals involving the self, significant others and other lay consultants may precede medical consultations. In this model, the help seeking pathway ends when the distress or problem has been alleviated.

The process of help seeking is described in Figure 1 and has been created taking into consideration the different factors proposed by the research to be involved in the decision-making process of help seeking. The following sections of this chapter outline several key factors of interest to the present study that might influence help seeking behaviour for depression: evaluations of symptom severity; previous experience with depression; and previous experience of seeking help.

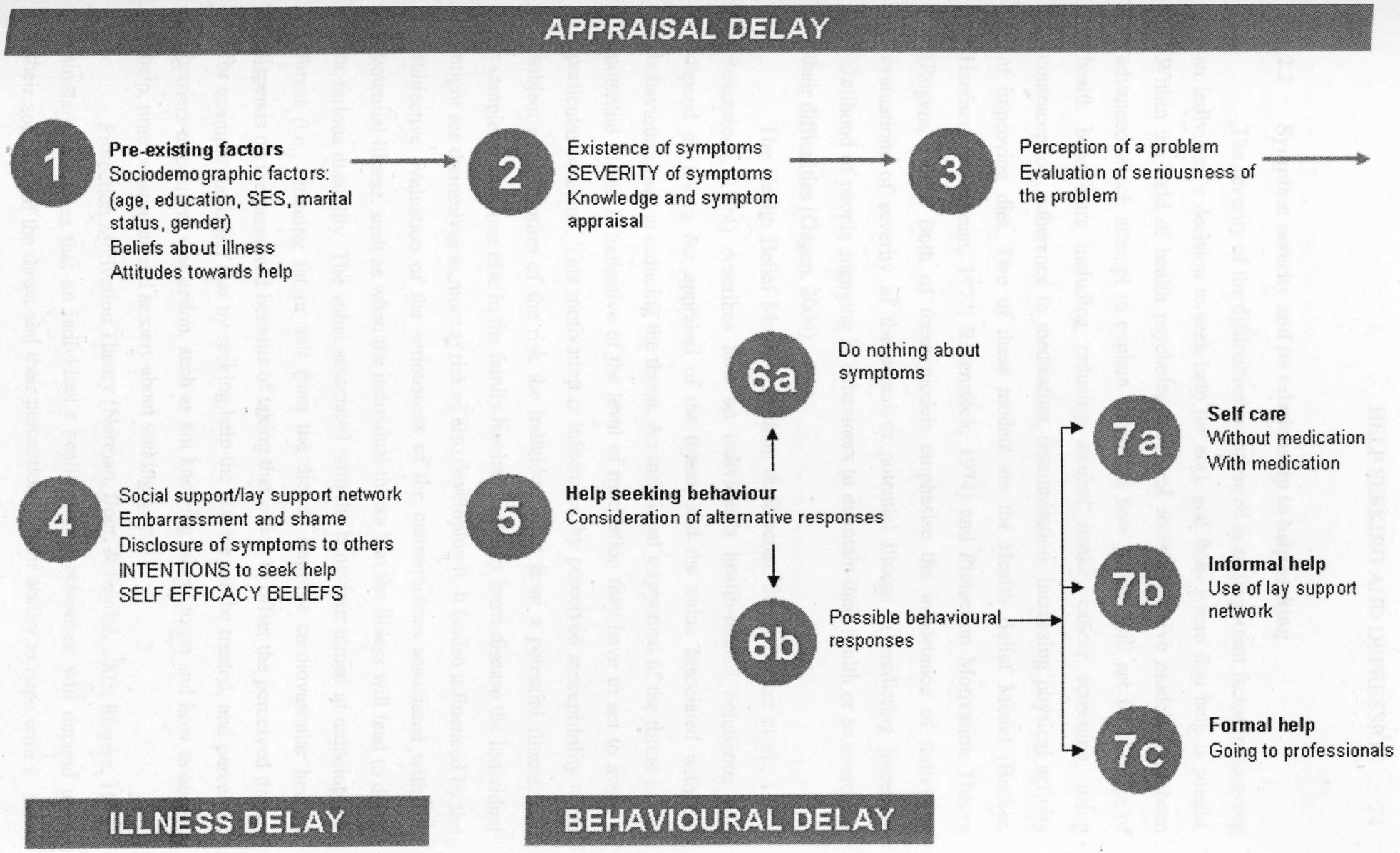

Figure 1. The process of help seeking and help seeking delay

2.2 Symptom severity and its relationship to help seeking

The severity of the difficulties experienced is an important factor influencing an individual's decision to seek help (or not), and from where that help is sought. Within the field of health psychology, several social-cognitive models have been advanced which attempt to explain or predict how people will act for a range of health behaviours including reducing alcohol intake, cancer screening, using contraception, adherence to medication, immunisation, increasing physical activity or improving diet. Two of these models are the Health Belief Model (Becker, Haefner, & Maiman, 1977; Rosenstock, 1974) and Protection Motivation Theory (Rogers, 1983). Both of these models emphasise the importance of individual evaluations of severity of the actual or potential illness in predicting increased likelihood of people engaging in behaviours to maintain their health or to overcome their difficulties (Odgen, 2004).

The Health Belief Model (Abraham & Sheeran, 2005; Becker et al., 1977; Rosenstock, 1974) describes how an individual's health-related behaviour will depend on his or her appraisal of the threat, and the value associated with the behaviour aimed at reducing the threat. An individual's appraisal of the threat of the potential illness is indicative of the level of motivation they have to act to avoid a particular outcome. This motivation is influenced by perceived susceptibility – the subjective perception of the risk the individual is at from a potential illness. For example, if someone else in the family has had coronary heart disease the individual might see themselves as more at risk of also developing it. It is also influenced by the subjective evaluation of the seriousness of the consequences associated with the potential illness, such as when the individual thinks that the illness will lead to death or serious disability. The value associated with the behaviour aimed at reducing the threat (i.e., reducing fat or salt from the diet to improve cardiovascular health) depends on the perceived benefits of taking that action to offset the perceived threat, for example the belief that by seeking help the disease can be treated, and perceived barriers to perform that action, such as not knowing where to go and how to access help, time constraints and anxiety about seeking help.

Protection Motivation Theory (Norman, Boer, & Seydel, 2005; Rogers, 1983) similarly proposes that an individual's health-related behaviour will depend upon their appraisal of the threat and their perception of their ability to cope with it. Like

the Health Belief Model, the appraisal of the threat depends on the individuals' perceptions of the severity of, and the individual's vulnerability to, the threat. Furthermore greater levels of fear resulting from this appraisal of the threat will increase an individual's motivation to engage in protective behaviour. The individual's appraisals of his or her ability to cope with the threat depend on the available responses to the threat (e.g., taking medication, seeking professional help), the belief in the efficacy of the behaviour aimed at reducing the threat, and the individual's sense of self-efficacy – their belief that they are able to take steps to respond to the threat.

These theoretical models both implicate threat appraisal as an important factor in whether an individual will take steps to address health issues, and describe how threat appraisal will be influenced by an individual's sense of vulnerability to a threat and estimates of the seriousness, or severity, of a potential illness (Conner & Norman, 2005; Odgen, 2004). This is also supported by a large body of empirical research, and the severity of the difficulties and anxiety about the potential serious nature of the problem have consistently been found to be strongly associated with help seeking for physical problems.

A large study of illness perceptions and the use of primary health care in patients was conducted in Denmark (n=1785), with the use of patients' and physicians' questionnaires, and information relating to the patients' primary care use three years before and two years after the baseline measure (Frostholm et al., 2005). The results showed that perceiving the health problem to be highly symptomatic and believing that it would have long-lasting and serious consequences were key predictors of primary health care use. For physical problems, emotional distress reactions to the current health problem and anxiety and depression were also associated with higher use. Similarly, the perceived severity of the difficulties was also identified as an important factor for seeking help for physical problems in reviews of the published literature. Koloski et al. (2001) reviewed 44 publications that used quantitative methodologies such as surveys and reviewing medical notes to identify predictors of health care seeking for irritable bowel syndrome and nonulcer dyspepsia. Koch (2006) identified five studies that investigated help seeking behaviours of women with urinary incontinence, and White et al. (2006) reviewed the literature on treatment seeking for infertility. In most of the studies reviewed by these papers, severity of symptoms was identified as a factor contributing to seeking

help for these conditions, and individuals who sought help perceived their symptoms and condition as more serious than individuals who did not seek help.

Whilst quantitative designs have highlighted the role of perceived severity and distress in leading a person to seek help, the extant qualitative research also shows that the misattribution and under-recognition of symptoms (i.e., when symptoms are not appraised as threatening enough to seek help) can also be a significant cause of delays in help seeking for different conditions (MacInees, 2006; Smith et al., 2005). Qualitative methodologies have explored participants' experiences of delaying help seeking following noticing symptoms of physical health problems. For instance, MacInees (2006) studied illness perceptions in 10 women, three months after a myocardial infarction, using semi-structured interviews and thematic analysis. A key theme which emerged was that women gave the severity of the symptoms as one of the main reasons for seeking help whereas the belief that the symptoms were benign was one of the reasons women delayed to seek help. To provide insight into patients' experiences of recognising symptoms of cancer and seeking help Smith et al. (2005) conducted a qualitative synthesis of international research evidence by identifying relevant qualitative studies, and using meta-ethnography to identify the common themes across the studies. A key theme to emerge from the synthesis of the studies reviewed, was how the gap between the patients first noticing symptoms and seeking medical assessment (the appraisal delay) contributed to an overall delay in seeking help. The authors interpreted this as being due to the way the symptoms were initially appraised, drawing upon the lived experience of participants who described their reasons for delaying seeking treatment for cancer as either not perceiving the symptoms as serious, or not attributing the symptoms to cancer. According to this review, the way the symptoms were appraised by the individuals was not threatening enough to trigger an emotional response that would lead to seeking help.

Qualitative research is important because it investigates the point of view of participants and their lived experience of the phenomenon of interest, and can thus illuminate potential new areas of exploration for quantitative research. Nevertheless, despite the advantages offered by a qualitative approach, these findings should be interpreted with caution, particularly in terms of their generalisability to larger samples, other physical health problems, and particularly to psychological problems, such as depression, due to the necessarily small sample sizes adopted. Moreover,

qualitative findings always rely on the researcher's own interpretation of the participants' meanings.

The literature on help seeking for physical health issues has demonstrated that both the actual and the perceived severity of the difficulties associated with a problem will motivate an individual to seek help and change their situation because of the interference of these difficulties upon his or her functioning (Leventhal et al., 1980; Leventhal et al., 1984). Alternatively, a failure to recognise or under-appraise symptom severity can lead to a delay in help seeking (MacInees, 2006; Smith et al., 2005). Moreover, it has been hypothesised that the severity of the symptoms allows a person to seek help without the fear of being viewed as a "time-waster" (Smith et al., 2005).

A similar picture arises for mental health difficulties and emotional distress, including depression (Dew et al., 1991; McCracken et al., 2006), where greater actual severity of the symptoms are associated with more formal help seeking, and low severity of the symptoms can contribute to help seeking delay (Biddle et al., 2004; Bland et al., 1997; Dew et al., 1991; McCracken et al., 2006; Oliver et al., 2005; Oppenheimer et al., 1988; Rickwood & Braithwaite, 1994; Robbins & Greenley, 1983). Studies that have examined help seeking in the context of counselling services have provided evidence that when people perceive their distress to be severe their attitudes to seeking help are more positive (Komiya et al., 2000), they have higher intentions to seek help (Vogel & Wei, 2005) and, consequently, they are more likely to seek counselling (Cramer, 1999). This reiterates the role of attitudes upon shaping intentions, and in turn, intention upon directing behaviour.

Several UK studies highlight the importance of symptom severity on help seeking for psychological difficulties. In a study of 150 drug misusers who had sought help from drug treatment agencies in London (Oppenheimer et al., 1988), a combination of open-ended questions and self-report instruments found that drug misusers waited until they were unable to manage their lives before seeking help. This is often the pattern in help seeking for addiction. Likewise, in a postal questionnaire survey of over ten thousand participants registered with a GP in Somerset, Oliver et al. (2005) examined the variables that were likely to predict both lay and professional help seeking. Participants were asked if they would seek help if their health was suffering as a result of "stress or strain" and also completed the General Health Questionnaire (GHQ-12). The findings showed that participants'

score on the General Health Questionnaire (GHQ-12) was strongly positively correlated with help seeking, such that the higher a person scored on the GHQ-12, the more likely it was that they would seek help for stress of strain (which in this study was used as a euphemism for emotional or psychological difficulties). Whilst the study attempted to avoid the stigma associated with "mental health" difficulties by using euphemistic terms for psychological difficulties, this also means that it is not clear to what mental health difficulties the participants were responding (e.g., stress, depression, anxiety etc.), and thus generalisations can not be made to help seeking for any one particular emotional difficulty, such as depression. Moreover, participants were only asked if they had sought help in the previous few weeks and this study therefore provides no data on how previous help seeking experiences might have influenced current or future help seeking. In another cross-sectional postal questionnaire study conducted in the UK, Biddle et al. (2004) investigated the help seeking behaviours of 1276 mentally distressed young adults (16-24 years). The self-report questionnaire assessed probable mental disorder (using the GHQ-12), suicidal thoughts, and help seeking behaviours (i.e., going to a professional such as a doctor, or seeking help from informal networks such as friends and family). In this study the strongest predictor of help seeking was a higher score on the general health questionnaire and recent experience of suicidal thoughts.

The association between severity of difficulties and seeking help has been found in international studies as well. To examine determinants of seeking help from professionals for mental or emotional problems, Bland et al. (1997) conducted interviews using the Diagnostic Interview Schedule on almost two thousand Canadians at two different times, an average of 2.8 years apart, and also assessed their help seeking behaviour. Of the 570 participants who met the criteria for a DMS-III diagnosis, including generalised anxiety disorder and post-traumatic stress disorder, one of the best predictors of seeking help from professionals was severity of the difficulties and co-morbidity, with 43% of participants with more than one diagnosis seeking help compared to 20% of participants with one diagnosis. Similarly, Rickwood and Braithwaite (1994) examined formal and informal help seeking in response to emotional problems in a sample of 715 final year high school students in Australia, using a set of questionnaires including the GHQ-12. Regression analyses showed that level of psychological distress was the only significant predictor of professional consultation. Furthermore, university students

who rated their problems as restrictive to their activities and threatening to their emotional stability were much more likely to self-refer to the university psychiatric service than those who perceived their problems as less severe, and were more likely to do so if their problems prevented them from doing things they would have liked to do (Robbins & Greenley, 1983).

In terms of help seeking specifically for depression, McCracken et al. (2006) examined the use of services in a sample of over 400 adults aged 18-65 years with depressive or adjustment disorders in five European countries. The findings of this study supported prior findings, reporting that the severity of depression, perceived health status, and social functioning were significant predictors of use of services. Dew et al. (1991) examined rates of mental health service utilisation among depressed white-collar professionals in the USA. Data were initially collected from 1870 participants using a diagnostic interview, providing a final sample of 186 participants who met criteria for major depression during the previous year. A range of factors were examined for their ability to distinguish between participants who sought professional help and participants who did not seek help, as well as between participants who sought different types of help. The results showed that those individuals who consulted mental health specialists were more clinically impaired and had poorer work performance and fewer psychosocial assets (i.e., they were less likely to be married and use available social resources when depressed) than both those who consulted non-mental health professionals *and* those who sought no help.

The extant research on help seeking for psychological problems has primarily focused on the connection between symptom severity and actual help seeking behaviour (i.e., for past or current experiences). Fewer studies have examined the relationship between severity of the symptoms and an individual's intention to seek help in the future, if there is need, although those that have do provide evidence for a relationship between symptom severity and intentions for future help seeking. For example, Vogel and Wei (2005) found that current distress positively contributed to college students' intention to seek counselling. In this study intention to seek counselling was measured by a self-report questionnaire asking participants to rate the likelihood of seeking counselling for a list of problems, using a 1-4 scale. Furthermore in a sample of Chinese-American parents of elementary-school children, intentions to seek help increased when parents perceived their child's

behaviour problem, as depicted in a hypothetical vignette, to be more severe (Lau & Takeuchi, 2001).

There is also some empirical evidence that attitudes towards help seeking are more positive the more severe the current symptoms of distress. For instance, using self-report questionnaires, Komiya et al. (2000), examined predictors of attitudes toward seeking psychological help in a sample of 311 college students in the USA. Regression analysis showed that lower psychological symptom severity was a unique predictor of reluctance to seek psychological services. Conversely, when symptoms were severe, individuals were more open to seeking help.

One likely explanation for the observed relationship between the severity of mental health problems and help seeking is that the more a problem interferes with an individual's functioning, the more their motivation to solve the problem and return to their previous state of functioning increases (Leventhal et al., 1980; Leventhal et al., 1984). Examining this possible explanation using a large sample of 1792 participants diagnosed with mood, anxiety, or substance abuse disorders, Mojtabai and colleagues (2002) found that impairment in role functioning or suicidality were strong predictors of perceived need to seek help from professionals. Similarly, Thompson, Hunt, and Issakidis (2004) examined the barriers to initial help seeking and factors that facilitate help seeking for anxiety and depression by retrospectively taking help seeking history from 233 patients at a specialist anxiety clinic, all of whom had delayed seeking professional treatment for at least one month. Whilst the most frequent endorsed reason for delaying to seek help was lack of knowledge about mental illness or available treatment, the primary prompt to seek help was increasing illness severity or disability. In a study that qualitatively examined help seeking in 63 women with past or current bulimic behaviours or binge eating disorder, Spoor et al. (2007) noted that increased symptom severity, psychological distress, interference with life roles, and health problems were amongst the prompts to seek help. Oppenheimer et al. (1988) also found that drug misusers sought help when they were no longer able to manage their life.

It therefore seems that the more a difficulty interferes with an individual's functioning the easier it is for them to recognise the problem and attempt to solve it. It is possible however that for depression specifically the more depressed someone is the more difficult they might find it to seek help. This is due to the fact that depressed individuals tend to have negative thoughts (Beck, 1964) which might

negatively affect their motivation to seek help. Self-related cognitions are a major ingredient in the motivation process and individuals with low self-efficacy have pessimistic thoughts about their likely accomplishments and personal development (Luszczynska & Schwarzer, 2005). This in turn might affect motivation to seek help and subsequent behaviour as self-efficacy beliefs affect the amount of effort to change the behaviour and the persistence to continue trying, despite setbacks that may undermine motivation (Bandura, 1977). In this case individuals might employ systematic cognitive biases to minimise the threatening nature of health information either by avoiding relevant information or by downplaying the seriousness of the information they receive or its accuracy (Weinman & Petrie, 1997). The more severe the symptoms however, the more difficult it might be to ignore and therefore individuals will be less likely to use these biases or disregard their symptoms.

Findings have also shown that an assessment of severity might affect not only whether an individual seeks help, but also from where or whom they seek it. In a cross-sectional national survey in Germany (n=1564), Angermeyer et al. (1999) investigated attitudes towards help seeking for depression and schizophrenia, using structured interviews with vignettes depicting a person either suffering from depression or schizophrenia. They reported that different attitudes towards different sources of help were noticeable depending on the disorder. Specifically, the role of the lay support system in the help seeking process was most prominent, followed by mental health professionals (psychiatrists and psychologists), general care providers and self-help groups. Advice in favour of the lay support system was stronger for depression than schizophrenia, whilst mental health professionals were chosen first in the case of schizophrenia. The authors suggested that differences in the evaluation of the seriousness of the disorder resulted in advice to consult helpers either more familiar or more distant to the person in need. Overall, however, the more unwell someone is, the more likely it is that they will consult professionals, regardless of their support network. According to Angermeyer et al. public opinion for depression clearly favours the lay support system, advocating the involvement of the family physician if the former resource is exhausted. The authors also noted that the fact that the majority of depressed individuals do not seek professional help highlights the magnitude of distress that is being supported by lay support systems. Neighbors (1985) also reported low usage of the mental health sector in response to mental health problems. Of the 1322 black participants who reported having experienced a

personal problem that had caused them a significant amount of distress, over half had sought no professional help at all, others had utilised the traditional health care sector (i.e., doctors and hospitals) or relied upon their religious ministers and pastors. Therefore, when the use of informal help is taken into account the percentage of respondents who did not receive any help was significantly lower.

Some authors have suggested that social support is protective because it contributes to lower distress, therefore less intention to seek formal help and, as a result, less help seeking behaviour. Testing this proposition using path analysis, Cramer (1999) re-examined the results of two previous studies that had investigated the predictive utility of several variables (i.e., personal distress, attitudes toward counselling, social support, and self-concealment) towards help seeking for psychological problems in undergraduates. Cramer's results showed that lower levels of social support negatively contributed to the experience of distress (i.e., participants with less social support experienced greater distress), and higher levels of distress in turn positively contributed to help seeking behaviour through counselling. This finding was also supported by Vogel and Wei (2005) who studied the mediating roles of perceived social support and psychological distress on the relationship between adult attachment and help seeking intentions in a questionnaire study with 355 college students in the USA. From their structural equation analysis, the authors reported that lower levels of social support negatively contributed to the participants' experience of distress, and distress in turn positively contributed to the participants' intention to seek counselling.

It therefore seems that when the difficulties of a psychological problem are not severe individuals are more likely to turn to their lay support network for help, whereas when difficulties become severe and start to interfere with functioning, they are more likely to approach professionals for help. Individuals with lower (actual or perceived) levels of social support are also more likely to seek help from professional services, possibly because their sources of informal or lay help are smaller.

The role of informal or lay support has also been implicated in predicting individuals' subsequent use of formal help seeking channels. For example, Rudell, Bhui, and Priebe (2008) recruited 268 participants from four GP practice registers and 14 community groups in East London, 117 of whom had a common mental disorder. The authors reported that primary care service use was strongly correlated

with lay and community help seeking. Thus, those people who had previously sought alternative help such as talking to family about distress and utilising traditional help were more likely to then use the formal help through their primary care service. Likewise, the concerns of mother, peers or teachers were among the best predictors of recent help seeking for depression in a sample of over two thousand adolescents in Finland (Frojd, Mauri, Mirjami, von der Pahlen, & Kaltiala-Heino, 2007). McCracken et al. (2006) have also reported that the number of people in an individual's life who are able to provide support has been positively associated with greater health service use for depression.

The above findings suggest that as symptoms of depression become more severe, participants' attitudes towards help seeking will be more positive and their actual help seeking behaviour will increase. What these findings also suggest is that the less severe the difficulty the more people will use their lay support network, whereas when the difficulties become more severe they will seek help more from formal sources. Whilst people who have less social support are more likely to turn first to formal sources of help, the initial use of lay and social channels of support has also been shown to predict later use of professional services for psychological distress. Thus, when the use of all potential sources of help is taken into consideration, the percentage of people who do not receive any help whatsoever for their distress decreases. A similar pattern is predicted for both help seeking intention as well as how that intention translates into actual help seeking behaviour, as a problem becomes more severe.

Severity of the difficulties associated with depression is only one of the factors that can influence an individual's intention to seek help as well as their actual help seeking behaviour. Previous experience of a difficulty and previous help seeking behaviour are also potentially important factors in the decision to seek help for that problem in the future. These factors will be discussed in the following sections.

2.3 The role of past experience upon future intention to seek help

This section describes the theoretical and empirical implications of how previous experience of a difficulty, such as depression, can affect an individual's intentions to seek help for that difficulty in the future. Given that past experience

shapes our beliefs (Markus, 1977), previous experience with depression might affect someone's intention to seek help in the future if faced with a similar difficulty.

According to information processing models, individual judgements and decisions are not made in isolation but are made with the benefit of experience and knowledge of the particular domain in question (Gilovich, 1981). Thus, when making a decision about a person or a situation, we do not base our decision solely on the immediately available information about that person or situation, but by drawing on additional information from our past experiences and general knowledge. Leventhal's self-regulatory model (Leventhal et al., 1980; Leventhal et al., 1984) theorises how, as a result of previous experiences, individuals construct internal representations, which affect both how they view new experiences, as well as their future behaviour dealing with that experience (Odgen, 2004). A change in the symptoms draws the individual's attention and initiates the process of self-regulation, in order for the individual to return to his or her previous state. These somatic changes are compared with memories of prior symptom episodes, to generate a cognitive representation of the perceived aspects of the health threat (Cameron et al., 1993). For example the individual starts feeling low and finds it difficult to motivate him or her self in the mornings. The individual notices that something is different and if they have in the past experienced symptoms of depression they might attribute this current state to depression. The individual will then try to find ways to motivate him or herself in order to return a previous state of feeling better.

Leventhal's model places the experience of a symptom as the starting signal for the individual to solve the problem and re-establish their previous state. Problem solving happens in three stages: Interpretation (i.e., making sense of the problem), coping (i.e., approach or avoidance coping), and appraisal (i.e., assessing the effectiveness of the coping strategy). These stages are consistent with the stages of the decision-making process of help seeking described previously, of recognising and defining a phenomenon as a problem, and then deciding whether and from whom to seek help. This process results in the individual developing their own representation of their difficulties and in developing certain emotional reactions to the experience of symptoms. How severe the symptoms are will affect the individual's reactions.

Leventhal's self-regulatory model is also consistent with the cognitive approach of how we process our experiences and plan our actions. According to the cognitive approach individuals construct models, internal representations, or schemas, which reflect their pooled understanding of previous experiences (Weinman & Petrie, 1997). Schemata are long-term identifiable psychological patterns that influence attitude and behavioural responses (Kovacs & Beck, 1978). These cognitive representations form our beliefs about our self and the world around us and are used to interpret new experiences, and to plan behaviour relating to those experiences (Weinman & Petrie, 1997). One key feature of these beliefs is their capacity to influence behaviour and cognition and direct the way people think and behave by providing meaning about matters that have to do with the ideas we hold about our world and ourselves. In this sense, schemata can be viewed as implicit theories used by individuals to make sense of their own past behaviour and to direct the course of future behaviour (Markus, 1977). According to Markus (1977) people with developed self-schema are able to process information about their self in a given domain and make judgements and decisions, retrieve previous instances of their behaviour, predict their future behaviour, and resist or ignore information that does not fit the schema. Conversely, if someone has had relatively little experience in a given domain, then it is unlikely that she or he will have developed an articulated self-schema. In this way, schemas, or beliefs, shape how we appraise, explain and integrate new observations (Damasio, 2000). For instance, if someone has in the past experienced symptoms of depression she or he might have incorporated this knowledge into a schema about changes that have to do with their mood. This in turn will shape how the individual will explain their symptoms if they experience something similar in the future (where the appraisal delay might occur) as well as their judgement and decisions about what to do about their symptoms of depression (their intention of whether to seek help or not).

Therefore when faced with making judgements and decisions about something such as the appearance of symptoms of depression, individuals do not view each new decision or dilemma as entirely novel but will often relate new dilemmas to past events or decisions, and to how they previously interpreted and reacted to those events. For example if an individual starts experiencing symptoms of depression they might base their decision on what to do about it on their own previous experience with depression, or the experience of others in their

environment. According to Gilovich (1981) people see a little of the past in many of their current situations, and base their present decisions, and therefore behaviour, on what they believe to be the implications of these past events.

These theoretical models describe how people draw upon prior experiences, and the beliefs or schemas that they hold about those experiences, when assessing and responding to new experiences. In the same way that people construct representations of the external world to explain and predict events, they also develop similar cognitive models to make sense of both normal physiological changes and the symptoms of physical and psychological illnesses (Weinman & Petrie, 1997). Thus, it might be assumed that previous experience with a psychological difficulty, such as depression, can affect the beliefs people hold, and therefore the decisions they make, about seeking help for that difficulty if they experience depression, or something similar to it, again in the future. Beliefs shape the expectations people have about a form of help or treatment option, which can therefore affect treatment seeking. Beliefs also influence the way in which individuals collect and evaluate evidence (Reisberg, Pearson, & Kosslyn, 2003). For instance, individuals often use systematic cognitive biases based upon their beliefs, such as choosing to avoid information or being hyper-vigilant, or selectively attending and evaluating incoming evidence in support of their current beliefs (confirmation bias), in order to minimise the threatening nature of health information (Peter, 2007; Weinman & Petrie, 1997). Thus, in the case of depression, if an individual has never experienced depression in the past they might attribute symptoms such as tiredness and insomnia to having a bad week at work. On the other hand if someone has in the past experienced depression and can easily recognise it they might be hyper-vigilant and explain the same symptoms of tiredness and insomnia as depression, when they can indeed be due to something else, such as a recent and temporary stressor.

Theoretical models propose that prior experience, in the form of beliefs and schema about that experience, can shape our future evaluation of, and decision-making and actions about, similar experiences in the future. When they are faced with symptoms of an illness or a threat to their health, individuals construct cognitions and beliefs to conceptualise their condition (Hirani & Newman, 2005) and these beliefs influence how individuals manage and evaluate their situation and potential recovery and in this way play a part in the decision to seek help. Research in cognitive psychology has supported this aspect of the theoretical models that self-

schemas organise, summarise and explain behaviour (Markus, 1977). However, there appears to be a surprising paucity of empirical research that examines the relationship between, or the predictive utility of, past experience of a particular difficulty and an individual's intention to act in a certain way in the future if faced with a similar situation. The relationship between previous experience and future intention is a complex one, particularly because it is difficult to study past experience separately from past behaviour, in fact, the distinction is rarely made. Typically in studies examining the role of intentions on future behaviour, the variable used is past behaviour, and how past behaviour affects our future decisions and behaviour, rather than past experience *per se* (i.e., past experience being irrespective of the individual's behavioural response to it). For example breastfeeding intention was positively correlated with more breastfeeding experience (Humphreys, Thompson, & Miner, 1998) and history of experimentation with smoking predicts intention to smoke in the future (Kahalley et al., 2011). Experience in these cases indicates past behaviour as well as experience and significantly more research has examined the relationship between past behaviour and future decisions, which will be reviewed in the next section.

Thus, whilst it can be hypothesised that previous experience with symptoms of depression might affect someone's intention to seek help in the future if faced with something that seems similar to depression, it is difficult to make a prediction as to the existence, strength or direction of the relationship between past experience of depression and intention to seek help for future instances of depression, based on the existing literature.

There is only very limited evidence that having experienced depression might predispose someone to seek help again in the future. An Australian postal survey attempted to investigate the effect that experiencing depression and receiving treatment might have on beliefs about the helpfulness of interventions for depression. Jorm et al. (2000) presented over three thousand adults with a vignette describing a person with depression and asked them to rate the likely helpfulness of various types of professional and non-professional help and of pharmacological and non-pharmacological interventions for the person described in the vignette. The authors reported that participants who had a history of depression but had not sought help for it were more likely to rate counselling as helpful, and less likely to rate family as helpful. It is possible that past experience with depression might increase intention to

seek help by providing participants with more positive views of the helpfulness of seeking help (in contrast to their previous experience of depression when they did not seek help).

It is also possible that a prior history of depression might increase an individual's intention to seek help for depression in the future by reducing the perceived stigma of having a mental health problem. Calear, Griffiths, and Christensen (2011) investigated levels of personal and perceived depression stigma amongst 1,375 Australian adolescents. They reported that adolescents with no personal history of depression and no history of parental depression were more likely to report higher levels of personal stigma for depression. Young people with personal or family experience of depression held less stigmatising view about depression. As shame and stigma have been connected to help seeking delay (Fuller et al., 2000; Jorm, 2000; Komiya et al., 2000; Pederson & Vogel, 2007; Takeuchi et al., 1988; Vogel & Wade, 2009) lower personal stigma might therefore increase help seeking.

Additionally, common sense intuition would suggest that prior experience with the symptoms of depression (e.g., feeling low, being tearful, loss of appetite, etc.) might make it easier for an individual to recognise the problem if symptoms appear again and in this way the appraisal delay discussed earlier might be reduced. This is based on the assumption that when individuals experienced depression in the past they knew what it was, whether they sought help for it at the time or not. Previous experience with a difficulty and easier recognition might also make it more difficult to use cognitive biases, such as avoidance of relevant information (Weinman & Petrie, 1997) and therefore might increase an individual's intention to seek help. Based on the theories reviewed about the importance of prior experience on our beliefs and behaviour, it can be assumed that having previous experience with depression will increase future intention to seek help as people will recognise the problem earlier, might have less depression stigma and hold more positive attitudes about the helpfulness of counselling as a treatment option.

Thus, past experiences of depression are assumed to increase an individual's intentions to seek help for depression if they experience it again in the future, bearing in mind that intentions to act do not always translate into actual behaviour. However, this is likely to depend upon whether, in their previous experiences, the individual was aware that their initial experiences of the symptoms of depression *were* in fact "depression". Without having an appropriate prior experience, an individual will not

develop appropriate beliefs and schemas. This is where experiences of previous help seeking behaviour is likely to play a role: both in terms of helping an individual define or identify their symptoms, and in terms of their actual experiences of receiving help. The role of past help seeking behaviour, and its relationship to future intentions to seek help for similar problems is discussed in the following section.

2.4 The role of past help seeking behaviour upon future intention to seek help

The present study examines whether, and how, past help seeking behaviour influences an individual's intention to seek help in the future, if faced with a more severe situation. This section first describes findings within the health psychology domain that place past behaviour as an important predictive variable for understanding the future health behaviours and decisions people make. Some explanations for how past behaviour might interact with other social cognitive variables to predict future behaviour are discussed, followed by a review of past behaviour specifically for help seeking.

2.4.1 Past behaviour and health behaviours

In the wider literature on behaviour change and health related behaviours, a predictive relationship between past behaviour and future behaviour has been well established. For example past attempts to quit smoking predict future attempts to quit smoking (Borland et al., 1991; Norman et al., 1999), past blood donation behaviour has been found to be predictive of future blood donation for regular donors (Ferguson & Bibby, 2002) and past physical activity is a predictor of future physical activity (Hagger et al., 2002).

Given these and other similar findings within the health psychology literature, past behaviour has been identified as an important variable in predicting how individuals will behave in the future, and has often been included as a mediating or moderating variable in research that draws upon various models of health behaviour change (Ouellette & Wood, 1998). For instance, in a review of evidence supporting the extension of the Theory of Planned Behaviour (TPB; Ajzen, 1991) to include additional variables, Conner and Armitage (1998) reported that 13% of the variance in actual behaviour could be explained by past behaviour over and above the existing variables of the TPB. These findings have also been supported by

subsequent research for other individual behaviours, including exercise, where the inclusion of past behaviour increased the explained variance in intentions to exercise from 37.5% to 56.4% (Hagger et al., 2001). It has also been found that the predictive value of an individual's intention to perform a certain behaviour reduces as frequency of their past behaviour increases (Ouellette & Wood, 1998). Thus, for behaviours performed infrequently (e.g., annually) such as dental check ups, intention had a significantly stronger relationship with actual behaviour than did past behaviour. Conversely, for behaviours executed frequently (e.g., daily or weekly), such as flossing or exercise, past behaviour had a significantly stronger relationship with actual behaviour than did a person's intentions.

2.4.2 How past behaviour influences future behaviour

Several explanations have been proposed that attempt to account for how past behaviour is able to predict future behaviour, based on the idea that individuals' perceptions of their past behaviour influences their decisions to repeat the behaviour partly due to cognitions about specific behavioural consequences and the attitudes they based these cognitions on (Albarracin & Wyer, 2000). For instance, Taylor (1975) advanced the idea that, when the consequences of a behaviour are not serious, people seem to infer their attitudes from the observation of their past behaviour. Consequently, they might use their past behaviour as a heuristic basis for later decisions by assuming that the conditions that led to their earlier behaviour exist in the present situation as well. In this case, individuals fall into a habitual pattern with regard to their decision-making and decide something based not on an evaluation of information but on how they usually react (Vogel et al., 2006).

Another explanation for the influence of past behaviour on future intentions (and behaviour) has been proposed by Ouellette and Wood (1998). According to these researchers, past behaviour guides future responses through two processes. Frequent and therefore well-practised behaviours that occur in constant contexts (i.e., flossing the teeth every evening before bed) recur because the processing that initiates and controls their performance becomes automatic. In this case the frequency of past behaviour reflects habit strength and has a direct effect on future behaviour. Behaviour that is increasingly under the control of a habitual process can be automatically elicited by environmental cues without conscious decision-making processes (Bargh & Chartrand, 1999). Conversely, when a particular behaviour is not

frequent enough (i.e., a three-yearly cervical smear test) and therefore not well learned, or when it is performed in unstable or difficult contexts, then conscious decision-making might be necessary to initiate and carry out the behaviour.

Intention is one factor that has been shown to guide behaviour, and intentions have also been found to significantly mediate the past behaviour–future behaviour relationship (Armitage, 2007). Several social psychological models support the proposal that an important determinant and predictor of an individual's behaviour is their intention to perform it (Sheeran, 2002) and stable intentions are more likely to be translated into action (Sheeran & Abraham, 2003; Sheeran et al., 1999). Intentions, which reflect the effort that people plan to exert in order to perform the behaviour, are a function of two determinants (Ajzen, 1991; Luszczynska & Schwarzer, 2005): the individual's attitudes toward the behaviour and their perception of what other people think about the behaviour, called subjective norms. Attitudes are the overall evaluations of the behaviour by the individual (i.e., "giving up smoking would be a positive thing") and if the relevant attitudes towards performance of the behaviour are positive then intention to perform the behaviour will be higher. Subjective norms consist of a person's beliefs about whether significant others think he or she should engage in the behaviour (i.e., "my doctor thinks it would be good if I exercised regularly") and represents the perceived social pressure from others to perform the target behaviour. Significant others are individuals or groups whose preferences about a person's behaviour in this domain are important to him or her (Luszczynska & Schwarzer, 2005). The TBP model (Ajzen, 1991) also identified an individual's perceived control over the behaviour as a third determinant of human behaviour: the more a person feels able to control their behaviour, the more possible it is for them to act (Sniehotta, Scholz, & Schwarzer, 2005).

There is a wide body of evidence that intention is a reliable predictor of behaviour (Eccles et al., 2006; Freyer et al., 2007; Sheeran & Abraham, 2003; Van Hooft, Born, Taris, Van der Flier, & Blonk, 2005). For instance, behaviour was predicted from intentions and intentions were predicted by attitudes, perceived behavioural control, and perceived past behaviour, for healthy eating behaviour (Conner & Norman, 2002) and smoking cessation (Armitage, 2007). According to Armitage (2007) intention to quit smoking predicts 22% of the variance in subsequent behaviour. Research also provides evidence that both intentions and past

behaviour are able to predict future behaviour (Ouellette & Wood, 1998). Norman et al. (1999) found that at 6-month follow-up, intention and the number of previous attempts to quit predicted the making of an attempt to stop smoking, whereas the length of the longest recent quit attempt predicted the length of the quit attempt. Albarracin et al. (2001) found that intentions to perform a behaviour were more strongly correlated with past behaviour than they were with actual future behaviour. One explanation for this is that, whereas past behaviour directly affects distal behaviour, it influences proximal behaviour only through its impact on behavioural intentions. For instance, in a review of the theory of planned behaviour, past behaviour has been found to explain 7.2% of the variance in intentions (Conner & Armitage, 1998). Furthermore, Bagozzi (1981) found that for blood donation 30%-32% of the variance explained in distal behaviour was a function of attitude and intentions and that the extent of past behaviour reduced the impact of intentions on behaviour.

It is likely that the proximity of the behaviours (both past and future) and the frequency which they are (or should be) performed will be implicated in the way in which intentions and past behaviour act upon future behaviour. Likewise, within the health literature, differences are being observed in the relative role of intentions and past behaviour for different types of behaviour, such as between approach (i.e., doing something healthy, such as eating more fruit and vegetables) or avoidance (i.e., stopping doing something unhealthy, such as reducing alcohol intake) health behaviours.

Two mechanisms by which past behaviour is likely to increase an individual's intention to perform that behaviour again, is in the formation of more positive attitudes towards the behaviour (i.e., an individual remembers that they felt good after exercise), and by increasing perceived behavioural control over the behaviour (i.e., an individual feels that they are able to ask sexual partners to use a condom). For instance, past behaviour has been found to increase intention to undergo a smoking cessation treatment in 763 Dutch adult smokers (Van Der Rijt & Westerik, 2004) and attitudes predicted intention to seek help for depression in a large population sample in Germany (Schomerus, Matschinger, & Angermeyer, 2009b). Intentions will in turn increase the likelihood of behaving in a similar way in the future. According to Ouellette and Wood (1998) if a behaviour has been performed frequently in the past, we could infer that an individual held a favourable attitude

toward that behaviour. Albarracin and Wyer (2000) found that participants' perceptions of their past behaviour often influenced their decisions to repeat the behaviour and this influence was partly the result of cognitive activity that influenced participants' cognitions about specific behavioural consequences and the attitude they based these cognitions on. In this way, we can see how the consequences of past behaviour might influence our intention to behave in a similar way in the future and shape our attitude towards the behaviour. Consequently, it is possible that people who sought help in the past might have formed more favourable attitudes towards seeking help and have more positive expectations about the outcome of seeking help. This in turn might increase someone's intention to seek help when there is future need for it. Furthermore, the retrospective inferences people hold about their past behaviour can also influence their future intentions, since the more one has performed the behaviour in the past, the more likely it is that one will perceive control over that behaviour and this might increase his or her intention to perform it again in the future (Albarracin et al., 2001).

Perceived behavioural control is a person's expectancy that performance of the behaviour is within his or her control (Luszczynska & Schwarzer, 2005) and is influenced by beliefs concerning whether one has access to the necessary resources and opportunities to perform the behaviour successfully. Perceived behavioural control is similar to Bandura's (1977) concept of self-efficacy. According to Bandura, expectations of personal efficacy determine whether coping behaviour will be initiated, how much effort will be expended, and how long it will be sustained in the face of obstacles and aversive experiences. Self-efficacy expectancies are assumed to have a direct impact upon behaviour and an indirect effect via their influence upon intentions as individuals normally intend to perform behaviours they perceive to be within their control (Luszczynska & Schwarzer, 2005).

In a meta-analysis of 22 studies which examined a range of behaviours such as seat belt use, coffee drinking, exercise, flu shots, blood donation, Ouellette and Wood (1998) argue that "past behaviour" is simply a proxy variable for a number of other psychological factors that generate consistency in responses over time. They found that the frequency of past behaviour directly predicted intentions, and in 19 studies past behaviour was a significant predictor of intention, after controlling for attitudes and subjective norm. It therefore seems that, even though past behaviour is connected to more positive attitudes towards the behaviour and might increase an

individual's sense of control over the behaviour, it still affects future intention to perform the behaviour, after these variables are controlled for.

Similarly, there is support for the fact that that intention becomes more predictive of behaviour for those behaviours that occur more infrequently, whilst past behaviour is more predictive for more regularly performed behaviours. Ferguson and Bibby (2002) found that intentions were predictive for occasional (four or fewer previous donations) blood donors, whilst past behaviour was predictive for regular (five or more previous donations) blood donors. Other evidence suggests that past behaviour may affect future behaviour when intentions are not stable enough. Thus, even though past behaviour may better explain future actions than do behavioural intentions (Sheeran et al., 1999), past behaviour does not affect the intention-behaviour relationship for participants with stable intentions, regardless of the frequency or context of performance of past behaviour (Sheeran, 2002). However, past behaviour had a strong effect on subsequent behaviour when intention stability was low (Conner & Norman, 2002). Similarly, Sheeran et al. (1999) demonstrated that when intentions are stable, intentions are more predictive, and past behaviour is less predictive, of subsequent behaviour.

In other instances, past behaviour might cause that behaviour to be performed again in the future via post-behaviour cognitions about the possible consequences of that behaviour which guide an individual's future actions. Taylor (1975) reported that when one's future behaviour is affected by the expression of an attitude, that attitude seems to be weighted more carefully, and more available information is brought to bear on deciding what one believes. A person's estimate of the likelihood and desirability of the consequences of performing a behaviour leads to the formation of a new attitude towards the behaviour (Fishbein & Ajzen, 1975), and this attitude, in turn, might influence both their intentions and desire to repeat the behaviour and their actual decision to do so when the occasion arises.

2.4.3 Past help seeking behaviour

There is empirical evidence that having sought help for a problem in the past increases the likelihood of an individual seeking help again. Moreover, the research which has specifically examined help seeking for psychological difficulties, appears to support the findings from other domains that past behaviour affects future behaviour (Friedman & West, 1987; Robbins & Greenley, 1983; Sherwood et al.,

2007) and that this is by increasing an individual's intention to seek help (Chen & Mak, 2008; Halgin et al., 1987; Schomerus et al., 2009a).

For instance, Friedman and West (1987) studied treatment utilisation and outcome in a sample of 116 veterans psychiatric outpatients. Utilisation and outcome measures were obtained at a follow-up interview 18 months after a baseline assessment. Comparisons between patients with high and low rates of treatment utilisation revealed that previous use of psychiatric services and disability predicted utilisation of psychiatric care. Therefore past help seeking behaviour predicted future help seeking behaviour for veterans' psychiatric problems. In another study, measures of subjective evaluations of the severity of problems, attributions of the cause of problems and of the likely duration of problems, and past experience with psychiatric care were taken from undergraduate students in the USA. Those students with past help seeking experience for mental health, were almost six times more likely to seek help from the university clinic than students with no treatment experience (Robbins & Greenley, 1983). More recently, in a UK study for help seeking for depression, Sherwood et al. (2007) used self-report questionnaires to explore how severity of the difficulties, and beliefs and attitudes about depression are affected by previous treatment for depression, the type of treatment received, and current depression. A sample of 54 individuals previously diagnosed with Major Depressive Disorder or other psychological disorders was compared with a control group. Participants who had previously received psychological treatment (such as counselling) sought professional help for milder symptoms of depression than both those participants who had previously been treated with antidepressants and the non-clinical controls.

Past help seeking behaviour for psychological difficulties has also been associated with individuals reporting a higher likelihood of seeking help in the future. Using self-report questionnaires, Chen and Mak (2008) examined the contributions of cultural beliefs about the aetiology of mental illness to help seeking for psychological difficulties from mental health professionals among 747 undergraduate college students in four cultural groups (European Americans, Chinese Americans, Hong Kong Chinese, and Mainland Chinese). In all groups, previous help seeking history was a significant predictor of help seeking likelihood for future problems. Past help seeking experience has also been shown to lead to an increased intention to seek help for depression in the future. In a questionnaire study

with undergraduate students in the USA, Halgin et al. (1987) compared students who represented extremes of the depression continuum as measured by the Beck Depression Inventory (n=126) with non-depressed students. The authors reported that currently depressed students, regardless of whether they had previously sought help or not, had a higher intention to seek help in the future, than those who were not depressed. Moreover, depressed college students who actually had sought help in the past reported higher intent to seek help again than depressed students who had not previously sought help. Depressed students who had sought help generally held more positive attitudes about seeking help than did both depressed and non-depressed students who had never sought help. Halgin et al. concluded that it is not depression alone, but its combination with having previously sought help for depression that will significantly influence an individual's beliefs and attitudes about, and therefore intentions towards seeking help again in the future. Similarly, in a German study with a representative population sample (n=2303), using a depression vignette with a question on readiness to seek psychiatric care for this problem and two other questionnaires, previous contact with psychiatric treatment or psychotherapy was positively related to willingness to seek psychiatric help (Schomerus et al., 2009a).

One specific form of formal help for psychological difficulties is counselling, and previous counselling experience has also been found to be a consistent predictor of more positive help seeking attitudes. As well as holding more positive attitudes about seeking help, individuals with prior professional assistance also have higher expectations about the benefits of seeking help than people who do not seek help (Cash, Kehr, & Salzbach, 1978; Dadfar & Friedlander, 1982; Edwards, Tinning, Brown, Boardman, & Weinman, 2007; Fischer & Turner, 1970; Jorm et al., 2000; Masuda, Suzumura, Beauchamp, Howells, & Clay, 2005; Utz, 1983). In the TPB model (Ajzen, 1991), intentions are a function of an individual's attitude toward the behaviour, and attitudes, together with other variables of the TPB, have been found to predict intentions (Armitage, 2007; Conner & Norman, 2002). Given the relationship between attitudes towards a behaviour and intention to perform it, past behaviour might increase intention via the formation of positive attitudes towards the behaviour.

In an early study examining previous help seeking for psychological problems, Cash et al. (1978) used a methodology that required participants to listen to taped counselling sessions and to then provide answers to questions measuring

several attitudinal constructs relating to the session. The authors reported that, in the sample of 219 female undergraduates, those who had previously received professional assistance for psychological problems espoused more favourable attitudes, including greater recognition of need, stigma tolerance, interpersonal openness, and confidence in mental health practitioners, than individuals without such professional contact. Those with past experience also had had more positive expectations of improvement across a variety of personal problems. Similarly, in a sample of 172 international students in the USA, Dadfar and Friedlander (1982) found that continent of origin and prior contact with mental health treatment were the most important determinants of attitudes towards seeking professional help, as measured by Fischer and Turner's scale of Attitudes Toward Seeking Professional Help. Participants with prior contact with mental health treatment held more positive attitudes towards seeking professional help than people with no such prior contact. Fischer and Turner (1970) found that students who sought and received professional help for psychological problems held more positive attitudes than those who have not sought such professional contact. Correspondingly, freshmen students with vocational problems who sought professional counselling at a university counselling centre held significantly more positive attitudes toward counselling and counsellors compared to students that enrolled in a class in career planning or sought no professional help (Utz, 1983). In regards to seeking help specifically for depression, Jorm et al. (2000) found that people who had sought help for depression in the past were less likely to believe in the helpfulness of lifestyle interventions, such as rest and exercise, and more likely to believe in the helpfulness of professional interventions. Similarly Masuda et al. (2005) reported that those with past experience of seeking professional psychological help held more favourable attitudes toward seeking professional psychological help than those who never consulted psychological professionals in both Japanese and US university students.

Having sought help in the past can also facilitate easier recognition of the problem and its consequences and need to seek help in future instances of the problem. This was demonstrated in a study by Edwards et al. (2007) in which members of the general public who had sought help were more likely to see the problems of the two vignette characters as having more serious consequences and to understand their problems better, compared with those who had not sought help.

Having seen a counsellor in the past, however, does not necessarily mean that an individual had a positive experience. The experience of having sought help in the past could have had either positive or negative outcomes for an individual, which could influence their intention to seek help for a similar difficulty in the future. A negative experience might lead to negative attitudes and subsequent avoidance of future counselling. For example, a negative experience with a counsellor who is not empathic and understanding to the client's experience, might lead an individual to avoid considering counselling as a solution to a recurrence of a problem in the future. Likewise, more positive experiences with seeking help (e.g., seeing a medical specialist who was able to prescribe an immediate and effective treatment) can lead to more positive attitudes and greater intention to seek help from this type of source again in the future. According to Vogel and Wester (2003) more positive counselling experiences were associated with more positive attitudes, greater intent to seek counselling, and an anticipation of better results.

There is extensive quantitative research that past behaviour predicts future behaviour, particularly in the field of health psychology as well as in decision-making research. When it comes to help seeking for psychological difficulties, the research that has been conducted has focused mostly on how past help seeking behaviour might shape expectations of seeking help in the future. However, this research would suggest that similar predictions might be made about the relationship between past experiences and intentions, as have been identified in the broader health psychology literature.

In conclusion, past behaviour and intention have been found to predict future behaviour, and it is possible that past behaviour might affect future behaviour by increasing an individual's intention to perform the behaviour again in the future. In the absence of extrinsic constraints on behaviour, people are likely to infer that if they performed the behaviour in the past it is because they intended to (Ouellette & Wood, 1998). It follows that when people are asked to state their future behaviour, because of cognitive consistency pressures or through a self-perception process, they may generate consistent intentions for future responses (Albarracin & Wyer, 2000) and therefore report increased intention to perform the behaviour again.

2.5 Summary

Help seeking behaviour is not a simple act that depends on someone's motivation but it is a decision-making process, which includes a series of steps and decisions from individuals, in order to handle their difficulties (Moller-Leimkuhler, 2002; Suchman, 1965; Vogel et al., 2006). Help seeking can be seen to follow the stages of symptom appraisal, attitudes towards help seeking and translating intentions into behaviour. These stages are decision-making points where individuals need to make judgements and appraisals and take decisions about how to behave.

When people initially experience difficulties, the first step in the decision making process of help seeking is the detection of symptoms and the appraisal of their seriousness. Both health and illness beliefs and cognitions influence how someone feels and behaves (Odgen, 2004): beliefs regarding the degree of seriousness of the condition may encourage or discourage healthy behaviours. Therefore, the assessment and cognitive representation of symptoms is an important influence upon help seeking behaviour and an individual's perception of the seriousness of the symptoms will influence their decision to seek help. The more severe the symptoms of the difficulty and their impact on daily life, the more motivated people might be to seek help.

Following the detection of symptoms and the appraisal of their seriousness, the next step in the decision making process of help seeking is deciding if and where to go for help (i.e., to act upon the decision). Seeking professional treatment is only one of the possible behavioural responses to be considered when someone has recognised their symptoms, appraised their seriousness and decided to seek help (Carrol & Johnson, 1990; Rogers et al., 1998). People usually have a number of available choices, such as doing nothing, self-care, using their lay support network and/or consulting professionals (Horwitz, 1977; Morin et al., 2006). The informal support network seems to be preferred and individuals seek professional help when their difficulties become more severe.

Throughout this process several factors have been found to affect help seeking, and the present study will focus on three of them as they relate to help seeking for depression: the severity of the symptoms of depression, past experience or history of depression, and past help seeking behaviour for symptoms of depression.

2.6 Aims and hypotheses

Whilst many physical and psychological problems can be addressed early on before symptoms develop and severity and disruption escalate, the research reviewed in this chapter indicates that people can delay seeking help for both physical and psychological problems. Consequently, it is important that people are encouraged to feel able to seek help early on. It is therefore of value to study and understand what factors influence individuals' decisions, in order for practitioners and policy makers to find ways to encourage help seeking and to prevent or minimise help seeking delays.

As the review of the literature has established, researchers are faced with a wide array of factors that might influence use of services and help seeking for psychological difficulties, such as depression. The main aim of the present study is to view help seeking for depression as a decision-making process, by examining certain factors that have been shown to influence this process: the severity of the difficulties experienced, previous experience of depression and past help seeking behaviour for symptoms of depression.

Whereas intentions and past behaviour have been extensively studied for many other health behaviours the present study aims to examine these variables for depression specifically, in order to add to the literature on help seeking for mental health difficulties. The present study examines how past experiences with depression, as well as past help seeking behaviours for depression affect an individual's intentions to seek help for more severe symptoms of depression in the future and these variables were chosen as their relationship to future intention has not been examined in many studies.

The study aims to improve upon prior research by focusing on help seeking intention as well as examining previous experience of depression. The severity of the symptoms has been connected to increased help seeking behaviour and even though the same has been found for intention to seek help (Vogel & Wei, 2005) less research has examined the connection between symptom severity and help seeking intention. The present study is an attempt to look at how the severity of the symptoms of depression, as presented in a depression vignette, affects both ratings of help seeking intention (in participants who have not experienced symptoms of depression) as well as help seeking behaviour (in participants who have in the past experienced symptoms of depression).

Moreover, this study includes a broad range of sources of help. Previous help seeking research has mainly focused on seeking professional help (e.g., from primary care, mental health service, counsellors) for mental health difficulties in general (Bland et al., 1997; Oppenheimer et al., 1988; Robbins & Greenley, 1983; Thompson et al., 2004) as well as more specifically for depression (Dew et al., 1991; McCracken et al., 2006). Some studies have included both professional help as well as informal sources of help (Angermeyer et al., 1999; Biddle et al., 2004; Oliver et al., 2005; Rickwood & Braithwaite, 1994) and it has been pointed out that the fact that an individual is not receiving or seeking professional sources of help does not mean that he or she is not seeking help at all. It might be that the individual is seeking help from an informal or lay network. By failing to include a full range of potential sources of psychological treatment or care, results can be confounded, particularly by underestimating the number of people who are receiving help, and overestimating help seeking delays. The present study seeks to improve upon this limitation of prior research, specifically for depression, by including a wider variety of sources of informal help that might be utilised by an individual with depression (i.e., partner, close friends, a family member, acquaintances and colleague) and formal sources of help (i.e., GP, nurse, a mental health professional, psychologist, counsellor, or psychotherapist, NHS service, social worker, charity).

Finally, this study is an attempt to examine past help seeking behaviour, as well as past experiences with depression, and how each of these factors affects help seeking intention for more severe symptoms of depression. The relationship between beliefs, shaped by past experience, and behaviour has been supported by theory as well as the literature, but how experience affects intention has received less attention in the literature and this study is an attempt to address this gap in the literature.

A further aim of the present study is to make methodological improvements to the field of help seeking research. Help seeking has predominantly been studied using self-report measures of current or past symptom severity and variables including beliefs and attitudes towards seeking help (Biddle et al., 2004; Cash et al., 1978; Chen & Mak, 2008; Dadfar & Friedlander, 1982; Friedman & West, 1987; Frostholm et al., 2005; Halgin et al., 1987; Oliver et al., 2005; Oppenheimer et al., 1988; Rickwood & Braithwaite, 1994; Robbins & Greenley, 1983; Sherwood et al., 2007; Vogel & Wei). Another way help seeking has been studied is by reviewing medical notes (Frostholm et al., 2005) as well as referrals to services (Robbins &

Greenley, 1983), and the use of interviews (Bland et al. 1997; Dew et al., 1991; Neighbors, 1985; Oppenheimer et al., 1988; Rudell et al., 2008), as well as a combination of these methods. Reasons people delay to seek help have also been explored using qualitative methodologies (MacInees, 2006; Smith et al., 2005; Spoor et al., 2007).

One limitation of studies that solely employ self-report measures is that self-report measures are open to distortion by response biases and lack of honesty when participants want to present themselves in a certain way, and by lack of self-awareness, when participants are not aware of their opinions and attitudes (McLeod, 2003). Thus, whilst the present study also utilises certain self-report measures, it also employs a vignette methodology (Alexander & Becker, 1978; Hughes & Huby, 2002) to explore the decision-making process people use to decide to seek help. Even though there has been more use of vignettes in recent studies to study intentions and willingness to seek help (Barney, Griffiths, Jorm, & Christensen, 2006; Brown et al., 2011; Lau & Takeuchi, 2001; Schomerus et al., 2009a; Schomerus et al., 2009b), it is still a methodology with great potential for further exploration. Vignettes have been used mostly to study attitudes towards seeking help (Angermeyer et al., 1999; Brimstone, Thistlethwaite, & Quirk, 2007; Holzinger, Matschinger, & Angermeyer, 2010) and explore perceptions about the helpfulness of different interventions (Cotton, Wright, Harris, Jorm, & McGorry, 2006; Jorm et al., 2000; Jorm, Korten, Jacomb, Christensen, Rodgers, & Pollitt, 1997; Jorm, Korten, Jacomb, Rodgers, & Pollitt, 1997), yet there is more room for vignettes to be used for the study of help seeking behaviour and intentions to seek help. The vignette approach has certain strengths that will be discussed in more detail in the methodology section of this paper. In the present study, vignettes allow the manipulation of variables of interest in order to examine how this might affect participants' responses. For example by changing the severity of the symptoms of depression. Each vignette represents a different level of severity of the difficulties experienced and a different step in the help seeking process. By building on the previous vignette, it is hoped that a progressive picture of help seeking is built, which allows an examination of how help seeking intentions and/or behaviour for depression might change according to the severity of difficulties and how previous experience and past actions might affect help seeking intentions. The point where someone might seek help is measured by either the likelihood of approaching help (for more severe symptoms in the future) or

the extent to which help was sought (for symptoms in the past). By adopting this approach it is also hoped that problems with memory and retrospective reports of seeking help are minimised.

The final aim of the study is to inform the practice of counselling psychology, by studying different factors that have been connected to help seeking behaviour and intention to seek help. The connection between severity of the difficulties, the use of informal sources of help and intention to seek help is an important one, as clinicians should find ways to increase access to services and facilitate clients' help seeking as early as possible. Furthermore, knowledge of clients past history of depression as well as their past help seeking behaviour and its connection to intention to seek help in the future could assist clinicians in increasing mental health literacy so people will recognise symptoms of depression, as well as improving service users' experience of seeking help.

The present study examines past experience, past hep seeking behaviour, and severity of the symptoms of depression, as intentions have been relatively neglected in the help seeking research as well as the role of past experience and past help seeking behaviour upon intentions to seek help in the future.

Past research has examined how the severity of difficulties can influence help seeking intentions and behaviour for physical as well as for psychological problems. Generally, the severity of the symptoms experienced has been correlated with increased help seeking behaviour (Biddle et al., 2004; Bland et al., 1997; Dew et al., 1991; McCracken et al., 2006; Oliver et al., 2005; Oppenheimer et al., 1988; Rickwood & Braithwaite, 1994; Robbins & Greenley, 1983). The more severe the difficulties the more they interfere with the individual's functioning, meaning help is considered more necessary so that the person will return to their previous functions as predicted by the Leventhal's self-regulation theory (Leventhal et al., 1980; Leventhal et al., 1984). Higher severity also makes it easier for people to recognise the problem (MacInees, 2006; Smith et al., 2005) and severity has also been shown to influence more positive attitudes towards seeking help (Komiya et al., 2000) and increased intentions to seek help (Vogel & Wei, 2005). Conversely, low severity (or perceived severity) of the symptoms has been linked to help seeking delay. In the present study it is expected to find a similar relationship between severity of depression symptoms, and help seeking for depression.

The majority of people seem to prefer to use informal help only or informal help in combination with professional help when they have to deal with life stressors. Moreover, informal networks seem to be preferred for mental health difficulties (Neighbors & Jackson, 1984), especially initially. When difficulties associated with a problem become more severe individuals might seek help more from formal sources (Angermeyer et al., 1999; Neighbors, 1985).

Hypothesis 1a: Individuals' rating of help seeking behaviour (in the past) and intentions to seek help (in the future) will be higher when the symptoms of depression, as described in a vignette, are more severe.

Hypothesis 1b: When the symptoms of depression, as described in a vignette, become more severe, participants' future intentions and past behaviour to seek formal help would also increase.

The second hypothesis is tentative and semi-exploratory due to the limited research examining this connection. Theoretical models lend support to the view that past experiences shape our beliefs, attitudes, intentions and behaviour when similar experiences occur in the future (Markus, 1977; Leventhal et al., 1980; Leventhal et al., 1984; Odgen, 2004; Weinman & Petrie, 1997). However, no extant research was identified which examined past experience *per se*, irrespective of past help seeking behaviour, of either a psychological or physical health problem as a variable in help seeking behaviour and intention to seek help. Thus, whilst it is unclear if having experienced depression before is an important variable in an individual's future intentions and behaviours about help seeking for recurrences of depression, it is important for the effect of experience on help seeking to be examined. Previous experience with the symptoms of depression might make it easier to recognise the problem if it recurs, and in this way the misattribution and under-recognition of symptoms, which is a significant cause of delays in help seeking, is avoided. Furthermore, past experience with depression might increase intention to seek help by participants having more positive views of the helpfulness of seeking help (Jorm et al., 2000) and by reducing perceived stigma of experiencing depression (Calear et al., 2011).

Hypothesis 2: Participants who experienced symptoms of depression in the past will rate their intention to seek help in the future for more severe symptoms of depression higher than participants who have not experienced depression in the past.

According to the research reviewed, past help seeking behaviour for psychological difficulties has been found to predict future help seeking behaviour (Friedman & West, 1987; Robbins & Greenley, 1983; Sherwood et al., 2007) as well as intention to seek help (Chen & Mak, 2008; Halgin et al., 1987; Schomerus et al., 2009a). One way that past behaviour might influence future behaviour is via post-behaviour cognitions about the possible consequences of that behaviour, which can guide an individual's future actions (Taylor, 1975). Thus, people who sought help for depression in the past might form more favourable attitudes towards seeking help and might have more positive expectations about the outcome of seeking help for depression in the future (Cash et al., 1978; Dadfar & Friedlander, 1982; Fischer & Turner, 1970; Jorm et al., 2000; Masuda et al., 2005; Utz, 1983). Because positive attitudes predicts intentions (Ajzen, 1991; Armitage, 2007; Conner & Norman, 2002) the final prediction of the present study is that previous help seeking behaviour will be positively correlated with intentions to seek help for more severe symptoms in the future.

Hypothesis 3: Higher ratings of past help seeking behaviour for milder symptoms of depression will correlate with higher ratings of intention to seek help for more severe symptoms of depression.

Chapter III: Method

3.1 Epistemological position of the present study

The epistemological position adopted in the present study is empiricism – positivism. Positivism is a form of philosophical realism adhering closely to the hypothetico-deductive method (Ponterotto, 2005). This position, which is taken for granted within natural sciences and is also dominant in the social sciences (Smith, 2008), stresses that knowledge claims must be based on objectively observable facts verifiable against sense experience (Woolfe, Dryden, & Strawbridge, 2003). Objectivity is a focus on events which are open to observation by someone other than the person undergoing the experience and which can be reported reliably and are not prone to idiosyncrasy (Smith, 2008). The central tenet of positivism is that only events that can be observed or propositions that are testable (at least in principle) have a claim to truth and can be considered a scientific methodology. According to Smith (2008) ongoing development gives positivism a historical optimism, that is, the sense that each study, based on what is known and available in the established literature, is potentially a contribution to the "total knowledge" of the future. Positivism operates from both a nomothetic and etic perspective. The nomothetic perspective focuses on uncovering general patterns of behaviour that have a normative base, with the primary goal to predict and explain phenomena, rather than obtain an individual in-depth understanding. Nomothetic writing is most often objective and impersonal with a focus on generalisable findings. Etic refers to universal laws and behaviours that transcend nations and cultures and apply to all humans (Ponterotto, 2005).

Given this epistemological framework, the present study adopts a qualitative methodology. Through the use of self-report instruments, the main aim is to examine general patterns in participants' responses across the entire dataset using statistical analysis in order to study help seeking, rather than focusing on the ratings given by any single participant. Quantitative methods focus on the strict quantification of observations and on careful control of empirical variables (Ponterotto, 2005) with the use of tests, rating scales and questionnaires, which are interpreted via statistical analysis of the data (McLeod, 2003). The main advantages of quantitative methods lie in their ability to deal with large number of cases, examine complex patterns of

interactions between variables, and verify the presence of cause and effect relationships between variables (McLeod, 2003). According to McLeod (2003), the primary advantages of self-report methods are that they are relatively easy to administer and interpret, and are generally acceptable to research participants. The main limitations of these methods are that they are open to faking or distortion by participants' lack of honesty or self-awareness, are difficult for people with literacy problems to use, and may not always measure what they appear to measure (McLeod, 2003).

3.2 Design

A cross-sectional factorial design was used, including between- and within-group comparisons. To examine the first hypothesis, that individuals' rating of help seeking behaviour and intentions to seek help would be higher when the symptoms of depression are more severe, a two way repeated measures analysis of variance (ANOVA) was used. Each participant was presented with three vignettes, each depicting a different severity level of depression, and had to rate each of the three vignettes for their intention to seek, or their past experiences of seeking a variety of sources of help for that degree of severity. Thus, the within-subjects factors were severity of difficulties, with three levels (mild, moderate, severe) and help seeking with two levels (informal, formal). Separate analyses were conducted for participants who had never experienced depression in the past, with dependent variable the ratings of intention to seek help in the future, and for participants who have experienced symptoms of severe depression, with dependent variable the ratings of past help seeking behaviour.

To explore the second hypothesis, that participants who experienced symptoms of depression in the past would rate their intention to seek help in the future for more severe symptoms of depression higher than participants who have not experienced depression in the past, a multivariate analysis of covariance (MANCOVA) design was employed, with intention to seek help in the future for more severe symptoms of depression as the dependent variable. Separate analyses were conducted for intention to seek help for moderate symptoms of depression, with previous experience of depression as the fixed factor (with two levels: never experienced depression, experienced up to mild symptoms of depression) and for intention to seek help for severe symptoms of depression, with previous experience

of depression as the fixed factor (with three levels: never experienced depression, experienced up to mild symptoms of depression, experienced up to moderate symptoms of depression) and current anxiety and depression scores as the covariate.

Finally, a correlational design was used to test the third hypothesis, which was that higher ratings of past help seeking behaviour for milder symptoms of depression would be associated with higher ratings of intention to seek help for more severe symptoms of depression.

3.3 Participants

Prior to participant recruitment, *a priori* power analysis was conducted, using G*Power (Faul, Erdfelder, Lang, & Buchner, 2007), to calculate a suitable sample size to detect an effect for each of the hypotheses. Statistical power (1-β) is the probability of obtaining a statistically significant result and therefore the probability that the null hypothesis will be rejected when it is false, and it is recommended that a power estimate of .80 is suitable (Field, 2005). Effect size is the degree to which the null hypothesis is believed to be false and is calculated by the discrepancy between the null hypothesis and the alternative hypothesis; accounting for 9% of the total variance. If there are no other reasons (i.e., from prior or previous studies) to anticipate a small or large effect size, Cohen (1992a, 1992b) has recommended that researchers aim to detect a medium effect size, and, consequently it was hoped to recruit a sample that would produce a power estimate of .80, to detect a medium effect.

Power analyses revealed at least 39 participants in each of the two groups (participants who never experienced depression and reported intention only, and participants who experienced severe symptoms of depression and reported behaviour only) would be required to test the first hypothesis. The second hypothesis required 36 participants for each level of depression: never, mild, moderate. Finally, the third hypothesis required 141 participants in each group (mild and moderate symptoms of depression). The results of the power analyses are presented in Appendix A. However, although participants were approached and recruited via several online sources described in more detail in Section 3.5.2 (page 68), a smaller number of participants than required for the third hypothesis correctly and fully completed the questionnaire.

A total of 230 potential participants followed the link to the study during the study period and saw the information sheet. One person indicated that they did not consent to taking part in the study and did not continue; three people indicated they were less than 18 years old and exited the study; and 11 people indicated they did not currently live in the UK and also exited the study. Of the remaining 216 participants, 14 did not fully complete the measures and were also removed from any subsequent analysis, a dropout rate of 7%.

A total of 202 participants accurately completed an online questionnaire, of which 60.9% were female. Participants were aged between 18 and 65 (M=33.5, SD=9.80). In terms of other demographic variables, 61.9% were employed, and 38.1% were either unemployed (4.5%), retired (0.5%), a home-maker (1%), student (29.7%), or other (2.5%). A total of 73.3% were white (White British = 29.7%, White Other = 43.6%) and 26.7% reported other ethnic backgrounds. Of the participants, 76.8% held university level qualifications to at least undergraduate level, while 23.2% had either no education, high school education or other. Finally, 52.9% of the participants were in a relationship (19.8% married, 16.8% in a relationship, 16.3% cohabiting) while 47.1% were not (42.1% single, 3.5% divorced, 1.5% other).

3.4 Instruments

A broad range of quantitative and qualitative research methodologies have been employed in counselling psychology research (Woolfe et al., 2003). The most widely used quantitative instruments are self-report questionnaires and rating scales (McLeod, 2003) that require the person to respond to questions about their experience, behaviour and attitudes.

To investigate the process of help seeking, the present study adopted a quantitative methodology, by using self-report measures. Specifically, participants were presented with a set of questionnaires that collected demographic information: gender, age, marital status, education, occupational status, and ethnic origin (Appendix B). This was followed by three short vignettes describing a person experiencing depression, and the Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983). Self-report relies on the ability of the person to report on their experience, behaviour and attitudes, with at least a moderate degree of accuracy, and so it is essential that the instructions to the respondent and wording of

items are as clear and unambiguous as possible. Consequently, the instructions and guidelines presented to participants with their questionnaires were developed carefully.

3.4.1 The Hospital Anxiety and Depression Scale

To control for the effects of a participant's current distress on their reported intentions to seek help and reported actual help seeking behaviour, participants completed the Hospital Anxiety and Depression Scale (HADS). This 14-item self-administrated rating scale, developed by Zigmond and Snaith (1983), can be used in non-psychiatric settings to provide a brief state measure of anxiety and depression. The scale excludes items that express physical symptoms and consists of a sub-scale for anxiety (A) and one for depression (D). Respondents are asked how they have felt during the past week with respect to seven anxiety items (e.g., "I get a sort of frightened feeling as if something awful is about to happen") alternating with seven depression items (e.g., "I still enjoy things I used to enjoy"). Each item is scored along a four-point scale with six items being scored from 0-3 and eight reversed items scored from 3-0. The total score for each subscale ranges from 0-21 and overall distress (the sum of both scales) from 0-42, with higher scores indicating greater anxiety, depression and distress.

The HADS has been found to discriminate well between samples with high, medium, and low prevalence of anxiety or depression and many studies have used the HADS, and reported satisfactory reliability (Johnston, Pollard, & Hennessey, 2000). For instance, in a sample of cancer patients (n=568), the internal consistency of the two subscales was high with α=.93 for the anxiety scale and α=.90 for the depression scale (Moorey et al., 1991). Olssøn, Mykletun and Dahl (2005) similarly reported α=.89 and α=.86 for the anxiety and depression subscales respectively. In a large (n=51930) population-based study in Norway, Mykletun and colleagues (2001) gave support to the HADS scale as an instrument with good psychometric properties in terms of factor structure, intercorrelation, homogeneity and internal consistency for the general population (α=.80 for anxiety, and α=.76 for depression), and for people with mental health difficulties (α=.85 for anxiety and α=.83 for depression). In a systematic review of over 700 papers that had used the HADS, Bjelland, Dahl, Haug, and Neckelmann (2002) concluded that the instrument performs well in screening for the separate dimensions of anxiety and depression and seems to have at

least as good screening properties as similar instruments used for identification of anxiety disorders and depression. In this meta-analysis Cronbach's alpha for the anxiety subscale ranged from .68 to .93 and from .67 to .90 for depression.

The HADS can be used to measure anxiety and depression separately, or to provide a measure of overall distress (Zigmond & Snaith, 1983). Many studies have supported the two structures of the HADS (Bjelland et al., 2002; Herrmann, 1997; Moorey et al., 1991; Mykletun et al., 2001) although others have challenged this and proposed either three structures (Caci et al., 2003; Martin, Lewin, & Thompson, 2003; Rodgers, Martin, Morse, Kendell, & Verrill, 2005) or made a case for using the overall measure, without distinguishing anxiety and depression (Johnston et al., 2000). In the present study the score of overall distress was used, and the instrument demonstrated good inter-item reliability (α=.89).

3.4.2 The vignette methodology

The vignette methodology was adopted in the present study because it has been successfully used in help seeking research and been applied to explore intentions, attitudes and decision-making. Vignettes are short systematically elaborated or manipulated descriptions of a person or a social situation which contain precise references to what are thought to be the most salient factors in the decision-making or judgement-making process of respondents (Alexander & Becker, 1978). Each vignette is a complex, multidimensional description of a person or an event and can consist of text, images or other forms of stimuli to which research participants are asked to respond. They can be presented to participants in a number of different forms, ranging from short written prompts to live events (Hughes & Huby, 2002). It is assumed that making vignettes as concrete and detailed as possible would more closely approximate a real-life decision-making or judgement-making situation of a particular phenomenon.

Vignettes or written case simulations have been widely used in different areas of health research and by educators, demographers, and health service researchers to measure processes in a wide range of practice settings (Ganong & Coleman, 2006; Johnson, Newton, & Goydera, 2006; Peabody, Luck, Glassman, Dresselhaus, & Lee, 2007; Peabody et al., 2004). In terms of help seeking, vignettes have been used to study intentions and willingness to seek help (Brown et al., 2011; Lau & Takeuchi, 2001; Schomerus et al., 2009a; Schomerus et al., 2009b), the impact of stigma about

depression on intentions to seek help (Barney et al., 2006; Yap, Wright, & Jorm, 2011), attitudes towards help seeking for emotional and physical health problems and towards different interventions (Angermeyer et al., 1999; Brimstone et al., 2007; Holzinger et al., 2010), and illness perceptions (Edwards et al., 2007). Vignettes have also been used to explore health professionals' perceptions about the helpfulness of different interventions (Cotton et al., 2006; Jorm, Korten, Jacomb, Rodgers, & Pollitt, 1997) and the public's "mental health literacy" (Hernan et al., 2010; Jorm et al., 2000; Jorm, Korten, Jacomb, Christensen et al., 1997; Klineberg, Biddle, Donovan, & Gunnell, 2011). In the field of counselling psychology, vignettes have also been used in qualitative research, for example as source material for focus groups (Utsey, Gernat, & Hammar, 2005). The vignette approach has been found to be a valid method for measuring process of care compared with actual physician clinical practice (Peabody et al., 2004; Peabody et al., 2007).

The vignette methodology has several advantages over other alternative approaches (Alexander & Becker, 1978; Finch, 1987; Ganong & Coleman, 2006; Hughes & Huby, 2002; Trochim, 2006). For instance, vignettes can improve the quality of data by reducing socially desirable responses, as participants are asked to assume the role of a vignette character rather than answering questions from their own personal viewpoints, and they can capture some of the socially situated context surrounding the study topics. Using this methodology, it is not necessary for participants to have in-depth knowledge of the topic under study, and the researcher can simultaneously examine multiple independent and dependent variables, as well as manipulate levels of the independent variables. Moreover, information contained within the vignettes can be defined and standardised so that more uniform data might therefore be gathered. Vignettes are a cost-effective measure, they are easy to use and generally have high internal and external validity. They can be used when participants are difficult to reach and for examining sensitive topics. Vignettes used within factorial survey designs are flexible and can be employed to efficiently study a wide variety of types of concepts and they generally have high internal and external validity because they combine random assignment to experimental conditions with usually large, representative samples.

Like any other methodology, vignettes have some limitations that will be considered in Chapter V. If the difference between the actual experiences of research respondents and the vignette characters they are asked to assume are too great, this

can cause problems (Hughes & Huby, 2002) and it is therefore important to try to match vignette characters to the participant group under study. The application of the vignette methodology should ultimately be determined by the requirements of individual research studies, the specific research design and the research questions of interest. By using vignettes to study help seeking behaviour, many important variables are eliminated and standardised across respondents. For example, participants' actual somatic morbidity and mood are standardised, which provides a mechanism for controlling for need and therefore study help seeking behaviour by eliminating confounding variables. Within the present study, the use of vignettes provides an opportunity to include many variables at the same time, for example severity of the difficulties experienced, experience with depression and different possible sources of help.

Creating the vignettes

To examine participants' previous help seeking behaviours and their future intentions for help seeking, five vignettes were constructed, which it was hoped would present a simple uncomplicated description of someone experiencing depressive symptoms. In this context, a simple uncomplicated case is one where a person presents with difficulties falling in only one DSM-IV classification, with no other co-morbid difficulties presented.

The story presented was the same in all five vignettes, but with difficulties progressively escalating from mild to severe. Thus, the first vignette described the mildest difficulties and the fifth vignette the most severe difficulties as defined by the Global Assessment of Functioning Scale (GAF) of the DSM-IV. Behavioural descriptions were used within the vignettes according to the DSM-IV criteria for depression (American Psychiatric Association, 2000). Gender-neutral language was used to eliminate potential gender bias and the pronoun "you" was used to indicate that the participant should imagine and answer as if she or he was the person in the story. A full description of the five vignettes is presented in Appendix C.

It is suggested that written material given to the general public should be at a level that can be read and understood by children of 12-13 years of age. Consequently, two readability formulae, the Fry graph and the Fog index (Gunning, 1952; Schrock, 1995), were performed on each of the five vignettes to quantitatively test the lower age that someone needed to be in order to be able to read and

understand the material presented to them. Both formulae showed similar and acceptable results across all five vignettes: that they could be read and understood by someone with an average readability level of 11-12 years old.

Pilot studies

Since the vignettes were constructed specifically for the purposes of this study, three pilot studies were performed to examine the intended experimental manipulation of the vignettes, that is, whether each vignette produced a significantly different response from the others and that the vignettes increased in severity, in the expected direction, and that participants were able to differentiate between the different levels of severity. The language used was also considered to ensure that it was simple and jargon free. Ultimately, the purpose of the pilot studies was to help the researcher in making clear the distinction between the three severity levels of mild, moderate and severe depression presented descriptively in the vignettes and to then select the three vignettes that most clearly represented these three severity levels for use in the final research.

The first pilot study was conducted with a convenience sample of 12 third year counselling psychology trainees at London Metropolitan University who were enrolled on the same course as the researcher and currently working with clients. Ten participants were female, and the age of the group ranged from 24 to 43 (M=30.42, SD=5.62). The purpose of this study was to elicit feedback and modify the instructions that were given for the rating of the vignettes for severity. After the first pilot study, it was judged that the instructions used in the pilot study were suitable and were therefore kept the same.

The purpose of the second pilot study was to seek professional opinion about the severity of the difficulties, as presented in the vignettes by the behavioural descriptions of the symptoms of depression. This study was conducted with 12 health professionals currently working with clients, including doctors, counselling psychologists, psychotherapists, a psychiatric nurse, psychosexual therapists and social workers. Half the sample were female with ages ranging from 27 to 55 (M=41.00, SD=8.86). This was also a convenience sample, recruited from the researcher's counselling placements.

The participants of the first and second pilot studies were informed that the main research project was exploring help seeking behaviour and intentions, using

vignettes. They were informed that their participation at the pilot phase would contribute to the construction of the vignettes, and were given an information sheet that purposefully included only minimal information about the study to avoid confounding the results with expectations and priming effects (Appendix D and E). Participants were then asked to read the vignettes and, using their clinical judgement and their experience in working with clients, to rate how severe the difficulties experienced by the person presented were along a scale of 0-100% (0=*no significant difficulties experienced*...100=*severe difficulties experienced*).

Finally, the third pilot study used a sample of 12, drawn from the general public, of which 50% were female, with ages ranging from 22 to 38 (M=28.17, SD=4.80). The purpose of this study was to provide information about how the vignettes were likely to be perceived by the final research sample, which would also be drawn from the general population. It was important to establish if participants in this pilot study were able to separate the vignettes in terms of severity. Potential participants were approached in public places such as the London Metropolitan University cafeteria and two other cafeterias. Participants were given an information sheet (Appendix F) and a consent form to sign, also containing limited information about the purpose of the study to avoid confounding the results with response biases. Those who agreed to participate were asked to read the vignettes and rate how severe the difficulties experienced by the person presented were, using the same 0-100% scale used in the first and second pilot study. This was also a convenient way of sampling that was judged satisfactory for the purposes of the pilot study, since the data were used only for testing the measures, were not related to the main aims of the study, and were not used as data for the main study.

The full instructions used in the three pilot studies are presented in Appendix G and Appendix H. To reduce the effect of fatigue or learning effects, the five vignettes were presented to each participant in a different order, so that no two participants in the same pilot study read the vignettes in the exact same order and each of the five vignettes was presented in a different order across participants. The table in Appendix I shows the order the vignettes were presented to each of the twelve participants.

For the aims of the three pilot studies to be achieved, the analysis needed to establish that: (a) different respondents tended to agree in their ratings for the same vignette; (b) the same participant was able to differentiate between the different

levels of severity, and; (c) responses for each vignette were given in the desired direction (i.e., most symptomatic vignettes were given a higher severity rating). The data from each pilot study were analysed separately. The five vignettes, increasing in severity level, were the independent variable in the analysis, and the dependent variable was participants' rating of the severity of each vignette.

To examine if different respondents tended to agree with ratings for a given vignette, the non-parametric Kendall's Coefficient of Concordance test *(W)* was performed. This test provides a measure of the degree to which a number of judges agree and ranges from 0 (no agreement) to 1 (complete agreement) (Howell, 2007). The results of the Kendall's W test showed agreement between participants in the first pilot study of W=.80, in the second pilot study of W=.93, and in the third pilot study of W=.66. Across all three pilot studies the agreement between raters was W=.79, which was judged to be satisfactory.

To explore if participants were able to differentiate between different levels of severity and if the severity of the vignette affected participants' rating of each vignette in a positive direction, the non-parametric Page's L trend test (Greene & D'Oliveira, 1999; Miller, 1991) was performed. This test was judged to be appropriate because it can be used to evaluate a predicted trend across k-related samples (different vignettes) when the same participants are taking part in all conditions (Greene & D'Oliveira, 1999; Miller, 1991). A k-sample design involves comparisons between more than two conditions or levels of the independent variable (Miller, 1991). This test was performed by hand with k=5 (vignettes) and n=12. For all three pilot studies, the Page's L trend test revealed a significant trend in the data ($p < 0.01$) for the first (L = 644.0), second (L = 654.0) and third (L = 628.5) pilot studies. Participants rated the severity of the vignettes in the predicted order from the first to the fifth vignette. All L values are higher than the critical value of the test indicating a trend in the data (Miller, 1991). The mean rating along a scale of 0-10 for each of the five vignettes are shown in Table 1, which shows that there is an increase in the participants' rating for severity, from the first to the fifth vignette.

Table 1

Mean (and Standard Deviation) Rating of Symptom Severity (0-10) for Each Vignette by Pilot Study

Pilot Study	V1	V2	V3	V4	V5	*N*
1: Trainees	4.00 (2.22)	4.67 (1.92)	6.58 (1.24)	8.08 (1.00)	8.92 (0.80)	12
2: Health professionals	3.75 (1.22)	4.58 (1.08)	6.17 (1.59)	7.25 (1.36)	8.92 (0.79)	12
3: General public	3.83 (1.40)	5.08 (2.11)	6.42 (1.93)	7.83 (1.75)	8.75 (1.86)	12
Total	3.86 (1.62)	4.78 (1.73)	6.39 (1.57)	7.72 (1.41)	8.86 (1.22)	36

After the completion of all three pilot studies and the analysis of the data, three vignettes were chosen for inclusion in the main study. The selection criterion was to select those vignettes rated by all 36 participants as the least, medium and most severe, and therefore representing mild, moderate and severe level of depression. Those that were selected were the first (mild), third (moderate), and fifth (severe) vignettes. A Kendall's W test was performed for these vignette, and overall there was a high agreement (W=.90) between the participants (n=36).

Instructions and response sheets to accompany the final three vignettes were also created. The "behaviour instructions" (Appendix J) were created for participants who had experienced some depression. Thus, they asked participants to read the description of what might be the typical experience of someone who is depressed and try to think back to the time when they personally had a similar experience to that outlined in the story. The "intentions instructions" (Appendix K) were created for participants who had not experienced depression, and instructed participants to read the story and imagine that they were the person presented in the vignette.

The "intention answer sheet" (Appendix L) asked participants to state their likelihood (intention) of approaching various sources help on a five-point Likert scale (ranging from 1=not at all, to 5=a great deal). The "behaviour answer sheet" (Appendix M) asked participants to rate the extent to which they actually had approached various sources of help in the past (past behaviour) along the same five-point scale. The sources of help included both informal and formal sources. Informal

help referred to assistance from someone from the immediate social or family environment, including partner, close friend, family member, acquaintance/colleague or any other person within the social network of the person. Formal help referred to seeking support or assistance from professionals, and included a GP, a mental health professional such as psychologist or counsellor, NHS service, charity, or anyone else outside the person's social network that works as a health professional. Participants were asked to rate both informal and formal help. Participants were also presented with a third choice, "other", that they were asked to rate only if it represented their own experience. For a summary of the vignettes presented as well as all the instructions see Appendix N.

3.5 Procedure

3.5.1 Website creation

The online questionnaire was constructed using SurveyMonkey, a website tool that enables users to create their own surveys and administer them via the internet. The information sheet was placed first, followed by a page asking potential participants to confirm they were over 18 years old and one asking them to confirm they were UK residents. This was followed by the demographic questions, followed by the three vignettes and the HADS questionnaire, and finally the debriefing sheet and a list of counselling services. To maximise return rates, the questionnaire was set in a way that potential participants needed to answer all the questions before they were able to progress to the next page. If any questions were not completed participants were prompted to answer them in order to proceed.

3.5.2 Recruitment

Participants were recruited from a non-clinical population and consisted of males and females. The inclusion criteria were that participants should be adults, over 18 years of age. Participants also had to be able to read and write English, be a resident in the UK, have access to, and be able to use, a computer connected to the internet. Members of the general public who had access to a computer and the internet were invited to complete an online questionnaire by receiving an online message, sent as an instant message and posted to online groups. The message informed the potential participants of the topic of the study and the approximate time it would take to complete, and provided the link to the study (Appendix O).

Participants were approached and recruited via several sources simultaneously, taking advantage of social media and internet technologies. First, the instant messaging service Skype was used by searching Skype for users who indicated UK as their current location. Each Skype search generates 100 results, and therefore to generate a large pool of potential participants, several additional criteria were used to produce more "hits"– including searching for all ages and again by age group (20-23, 24-27, 28-32, 33-39, 40-49, 50+), filtering results by UK city, and trying searches at different times of the day. Approximately 6000 users were found using these different search criteria, and were sent an instant message inviting them to take part in the study. It should be noted that several users appeared in the results of more than one search category, and a duplicate message was not sent to them, therefore fewer messages were actually sent than the number of users generated. It is also difficult to estimate how many of the messages sent were delivered to users, as many Skype accounts are inactive and additionally for a message to be delivered both sender and receiver need to be online at the same time. The same message was also posted on four groups catering for UK students on the social networking site Facebook: University Students UK; National Union of Students; City University Alumni; and London Metropolitan University. The groups between them contained over 35,000 members. The invitation to participate was also posted as a "message of the day" on the London Metropolitan University intranet, inviting both students and staff to take part in the study. It should be noted that it is not possible to know how many people actually saw the "message of the day" on the London Metropolitan University intranet, or the message posted on the Facebook groups. At the time the message was posted on Facebook, users did not get any notification that something was posted on the group page, but they could only see it if they visited the group's page during the time the message was still visible and the members as well as the groups themselves keep changing, and many members of the groups are in fact inactive members. It is not possible to gauge the response rate from any one source as the survey tool was unable to provide information regarding where the participants had followed the link to the study from.

Data collection took place between March and May 2010. When entering the landing page of the study website, participants were presented with a study information page (Appendix P) which contained general information about the purpose of the study, and the average time it would take to complete the study.

Participants then had to indicate that they agreed to take part in the study before proceeding to the next page. This constituted their informed consent. On the following page participants indicated that they were at least 18 years of age, which was followed by a page asking the participants to indicate whether they were or were not UK residents. Participants were only able to proceed to the demographic information sheet if they responded "yes" to both of the previous two questions (those who did not were thanked for taking part and exited the study).

Following the demographic information sheet, participants were asked to indicate if they had ever suffered from or been diagnosed with depression. If they responded "yes" they were taken to the first vignette (mild) but presented with the "behaviour instructions". If they responded "no" they were presented with the same vignette, but with the "intentions instructions". The instructions, either behaviour or intentions, were the same for all three vignettes representing different severity levels, depending on the participants' previous response.

Following the mild vignette, participants were asked to indicate if they had ever had a similar experience. If they answered "yes" then the "behaviour answer sheet" was presented, whilst if they answered "no" the "intention answer sheet" was presented. If the participant answered the "behaviour answer sheet" in the first severity level (mild) then s/he moved to the "behaviour instructions" for the next severity level. Similarly, if the participant answered the "intention answer sheet" in the first severity level (mild), then s/he moved to the "intention instructions" for the next level. To avoid making assumptions about the participant's experience, following the presentation of a new vignette, the participant was again asked to indicate if in the past they had a similar experience and were presented with either the "intention answer sheet" (if they said "no") or the "behaviour answer sheet" (if they said "yes").

In this way each participant responded to all three vignettes according to their personal experience. Figure 2 presents the logic that was used to present the vignettes to the participants.

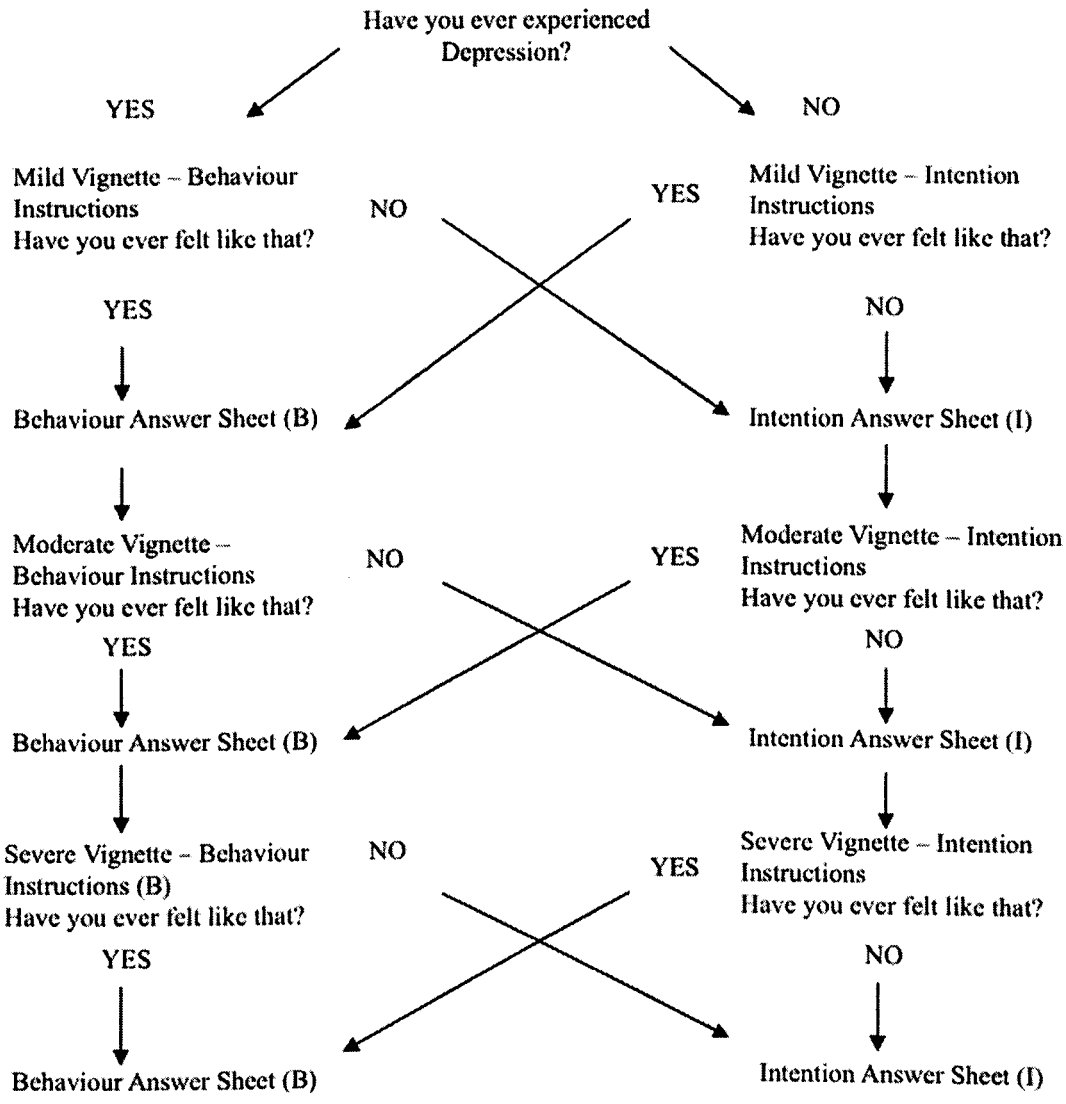

Figure 2. Logic used for the presentation of the vignettes to participants

By following this process, four groups of participants were created: (a) those who had never experienced depression and answered all three intention answer sheets; (b) those who had experienced depression in the past up to severe levels and answered all three behaviour answer sheets; (c) those who had experienced only mild symptoms of depression in the past and completed the behaviour answer sheet for the mild vignette and the intention answer sheet for the moderate and the severe vignettes, and: (d) those who had experienced mild and moderate symptoms of depression and completed the behaviour answer sheet for the mild and moderate vignette and the intention answer sheet for the severe vignette.

Participants responded to three vignettes in total, and following the final vignette (severe) were taken to a web page with the HADS questionnaire. Following

completion of the HADS, participants were presented with a web page that contained the debriefing information (Appendix Q) followed by a list of counselling services (Appendix R) if they had any issues following their participation in the study. Finally, the last web page thanked participants for taking part in the study.

3.5.3 Ethical considerations

The research project was approved by the London Metropolitan University Psychology Department Research Ethics Committee and followed the Code of Human Research Ethics, as set out by the British Psychological Society (2010) and the ethical guidelines of London Metropolitan University.

To ensure ethical responsibility, care was taken when creating the information sheet to ensure the research aims were comprehensible to the general public and technical language was avoided as much as possible, although without revealing the specific hypotheses of the study. Participants were assured that the information they provided would remain confidential and that it would not be possible to identify and connect individuals to the data in written output. Each completed questionnaire was later given a number and the responses were coded and entered into SPSS for statistical analysis. All the data were kept only in electronic form. It was stressed that participation was completely voluntarily and that the participants could withdraw at any time. After reading the information sheet, participants were asked to indicate that they agree to take part in the study and that they are over 18 years old, before proceeding with completing the measures. The debriefing information explained more explicitly that the study sought to investigate the process people follow to seek help for difficulties they may face and who they turn to in terms of informal and formal sources of help. The list of counselling services was presented after the debriefing sheet, in case any participants were affected by the study or if they generally felt they wanted to seek professional help. Participants were given the opportunity to contact the researcher with any questions via an email address provided on the information and debriefing sheet. They were also invited to ask for further information about the findings of the study if it interested them, and that this would be provided in a summary form, in language accessible to the general public. Participants were also given the option of contacting the investigator's research supervisors with questions or concerns. The investigator's

gratitude for the participants' contribution was clearly expressed on the information and the debriefing sheet and on completion of the measures.

Chapter IV: Results

The data were analysed using SPSS19.0 for Mac and a p-value of $< .05$ was set as the criterion for statistical significance, except in cases where a correction of the alpha was made and this is clearly stated. In all cases, the dependent variable was help seeking, which represents the ratings (on a scale of 1-5) of either having sought (behaviour) or the likelihood of approaching (intention) one of the available informal and formal sources of help, in each of the three vignettes representing mild, moderate and severe symptoms of depression respectively. The ratings of seeking help from informal and formal sources were analysed separately. This created a total of six variables: mild informal, mild formal, moderate informal, moderate formal, severe informal, and severe formal. Each participant's rating represented either intention or behaviour and in each case, it is clearly stated whether the dependent variable represents an intention rating or a behaviour rating.

Each participant was coded, according to the level of his or her reported previous experience of depression, on each of the three vignettes completed. Participants' group allocation indicates whether their individual score referred to intention or behaviour, for each severity level. Table 2 defines the four groups that were created and for each severity level whether the score represents participants' responses to intention (I) or behaviour (B) questions.

Table 2

Allocation of Participants and Description of Each Group per Severity Level (N=120)

Group	Label (previous experience of depression)	Description	Responses to Symptom Vignettes			*N*
			Mild	Moderate	Severe	
0	Never	Intention only: participants reported never experiencing depression in the past and answered all three intention vignettes	I	I	I	37
1	Mild	Participants reported experiencing up to mild levels of depression in the past	B	I	I	66
2	Moderate	Participants reported experiencing up to moderate levels of depression in the past	B	B	I	57
3	Severe	Behaviour only: participants reported experiencing all three levels of depression in the past and answered all three behaviour vignettes	B	B	B	42

Note. Responses to symptom vignettes: I = reported intention (depressive symptoms were not experienced); B = reported behaviour (depressive symptoms were experienced)

In order to make the descriptive statistics clearer and easier to understand, some of the demographic variables were re-coded to produce only two categories for each variable. Thus, marital status was coded as either "not in a relationship" (to include people who were single, divorced or other; M = 95) or "in a relationship" (including people who were married, in a relationship, or cohabiting; M = 107); occupational status as "employed" (M = 125) and "not employed" (including people who were unemployed, retired, homemaker, student or other; M = 77); education level as "university education" (including people who had a BA/BSC, MA/MSC, or PHD; M = 155) and "no university education" (including those with no education, O' Level / GCSE, A' Level, higher non degree, or other; M = 47); and ethnic origin as "white" (including White British and White Other; M = 148) and "non-white" (including people of Mixed, Asian, Black, Chinese, or Other ethnicities; M = 54). As each of these demographic variables has many categories that do not indicate any order, with smaller number of participants in each category, the purpose of this re-coding was to create two broad groups for each variable that would make interpretation of the results more meaningful. Gender was not re-coded as it only consisted of two categories, male and female. Table 3 presents the demographic characteristics of each group.

Table 3

Demographic Characteristics of Each Group

Group	*N*	Gender		Age		Marital status		Occupational status		Education		Ethnic Origin	
		Men (%)	Women (%)	Mean	Standard deviation	In a relationship (%)	Not in a relationship (%)	Employed (%)	Not employed (%)	University (%)	No university (%)	White (%)	Not white (%)
Never	37	46	54	34	10.4	59.5	4.5	51	49	78	22	65	35
Mild	66	39	61	33	10.1	48.5	51.5	64	36	77	23	73	27
Moderate	57	32	68	34	10.1	61	39	65	35	81	19	77	23
Severe	42	43	57	32	8.6	43	57	64	36	69	31	76	24

The descriptive data are presented in Table 4, which includes clinical information about the levels of anxiety and depression, as measured by the HADS questionnaire for each of the four groups, and further reported by demographic variables. A one-way ANOVA was conducted to explore whether the four groups significantly differed in their current levels of anxiety and depression as measured by the HADS. There was a significant difference in the HADS score according to group, $F(3, 201) = 14.67$, $p < .000$. Current anxiety and depression scores are significantly higher as the previous experience of depression reported is higher. Because of this difference the HADS score was controlled for, in the main analyses.

To investigate whether there were any significant differences between HADS scores according to demographic variables, t-tests were conducted on gender, marital status, ethnic origin, occupational status and education level. Levene's test for equality of variance was not significant in any of the tests and therefore the equity of variance assumption was not violated. The HADS score did not differ significantly for gender $t = -.181$, $p > .05$, marital status $t = -.143$, $p > .05$, and ethnic origin $t = .518$, $p > .05$. There was a significant difference in the HADS score according to occupational status $t = -.216$, $p = .032$, and education $t = -.254$, $p = .012$. Overall, participants who were not employed had higher anxiety and depression scores and it was the same for people with no university education.

A further series of two-way ANOVAs were conducted to check whether there was an interaction between the four groups and the demographic variables. There was no significant interaction between gender and previous experience of depression $F(1, 194) = .89$, $p > .05$, marital status and previous experience of depression $F(1, 194) = 1.80$, $p > .05$, occupational status and previous experience of depression $F(1, 194) = 2.50$, $p > .05$, education and previous experience of depression $F(1, 194) = 2.16$, $p > .05$, and ethnic origin and previous experience of depression $F(1, 194) = .39$, $p > .05$. Thus, depression and anxiety scores did not differ significantly in different groups and according to participants' demographic characteristics.

Table 4
Mean (and Standard Deviation) of HADS scores by Demographic Group

Group	N	Gender		Marital status		Occupational status		Education		Ethnic Origin		Total
		Men	Women	In relationship	Not in relationship	Employed	Not employed	University	No university	White	Not white	
Never	37	8.12 (5.69)	6.65 (5.66)	6.27 (4.57)	8.87 (6.80)	7.26 (5.90)	7.39 (5.53)	6.34 (4.73)	10.88 (7.47)	8.00 (5.26)	6.08 (5.64)	7.32 (5.64)
Mild	66	9.38 (5.24)	9.23 (5.69)	7.56 (4.12)	10.91 (6.12)	9.17 (5.76)	9.50 (5.06)	9.51 (5.25)	8.53 (6.31)	9.15 (5.07)	9.67 (6.57)	9.29 (5.47)
Moderate	57	13.17 (6.37)	12.18 (7.58)	12.60 (7.22)	12.32 (7.28)	10.54 (6.90)	16.10 (6.37)	11.37 (6.96)	17.18 (6.40)	12.24 (7.20)	13.38 (7.31)	12.49 (7.18)
Severe	42	14.39 (6.86)	17.21 (8.09)	17.11 (8.26)	15.17 (7.19)	14.26 (7.09)	19.13 (7.80)	15.21 (8.53)	17.77 (4.92)	16.13 (8.39)	15.60 (4.72)	16.00 (7.63)
Total	202	11.11 (6.40)	11.30 (7.59)	10.55 (7.21)	11.99 (7.01)	10.38 (6.75)	12.60 (7.55)	10.54 (6.95)	13.51 (7.31)	11.39 (7.16)	10.80 (7.12)	

4.1 Checking assumptions for parametric tests

Certain assumptions need to be met to ensure that data are suitable for parametric tests to be performed, and if they are not met, data should be transformed, or alternative non-parametric tests must be selected (Field, 2005). These assumptions are that the data follow the normal distribution, that the variance is the same throughout the data (homogeneity of variance), that data are measured at least at the interval level, and that data from different participants are independent. The last two assumptions need only be tested by common sense (Field, 2005). Specifically, the dependent variables in this study were measured along a 1-5 Likert scale and the distances between the points of the scale are equal, therefore the data are measured at an interval level (Miller, 1991). The data from different participants are independent from each other (i.e., an individual can not simultaneously be in both a prior experience of depression and a no prior experience of depression group). The assumption of homogeneity of variance is tested in different ways for different statistical tests and is described in the main analysis. The most important of the assumptions is the assumption that the data are normally distributed (Field, 2005).

4.1.1 Normal distribution

The normality assumption was checked using the Kolmogorov-Smirnov test which revealed that all the variables were significantly non-normal. To explore the potential reasons for this finding, the data were first checked for the presence of outliers. Only one participant had an outlying score on the HADS questionnaire and this was not a data-entry error. The Kolmogorov-Smirnov test was performed again following the removal of the outlier. Table 5 shows the D value for all the variables, before and after removing the outlier.

Table 5

Results of the Kolmogorov-Smirnov Test of Normality

Dependent Variable	D*	
	Whole sample (N=122)	Sample after removal of the outlier (N=121)
Mild Informal	.152	.152
Mild Formal	.302	.303
Moderate Informal	.188	.188
Moderate Formal	.190	.190
Severe Informal	.215	.215
Severe Formal	.213	.215
HADS Total	.113	.113

Note. *all values are significant at $p < .001$.

As Table 5 shows, removing the outlier did not correct the problem, as all the variables are significantly non-normal, both with and without the outlier. For this reason the outlier was not removed from the data. Further exploration of the data was performed by calculating the z-score of the skew and the kurtosis for each of the six dependent variables and the HADS total. Data transformations were performed in an attempt to correct the non-normality problem in the data (Field, 2005). Specifically square root, log, and reciprocal transformations were performed on the data, of which only the square root transformation improved the normal distribution of the variables.

Table 6 shows the z-scores for skew and kurtosis for all the variables before and after the square root transformation. The full results of all three transformations are shown in Appendix S.

Table 6

Z-scores for Skew and Kurtosis Before and After Transformation (N=122)

Dependent Variable	Original Data		Data after square root transformation	
	Skew	Kurtosis	Skew	Kurtosis
Mild Informal	-0.83	-3.28**	-1.15	-3.22**
Mild Formal	5.54***	-1.44	4.15***	-2.88**
Moderate Informal	-2.56*	-2.51*	0.51	-3.30***
Moderate Formal	2.04*	-3.70***	0.53	-4.16***
Severe Informal	-3.21**	-2.64**	1.46	-3.60***
Severe Formal	-3.37***	-2.66**	1.55	-3.49***
HADS Total	4.06***	0.73	-1.62	0.14

Note. *absolute values greater than 1.96 are significantly different than the normal distribution at $p < .05$, **absolute values greater than 2.58 are significantly different than the normal distribution at $p < .01$, ***absolute values greater than 3.29 are significantly different than the normal distribution at $p < .001$ (Field, 2005).

As Table 6 shows, in the original data, for three out of seven variables skewness was significantly different from the normal distribution at the $p < .001$ level, and for one of the seven variables the kurtosis was significantly different from the normal distribution at the $p < .001$ level. The square root transformation improved the problem of skewness such that only one of the seven variables had skewness that was still significantly different from the normal distribution at $p < .001$. However, the transformation seems to have made kurtosis deviate more from the normal distribution, as after transformation six of the seven variables had kurtosis z-scores that were significantly different from a normal distribution at the at $p < .001$ level.

As transformation did not correct the problem of normality in the data, it was decided that the original variables would be used for the analysis. However, care was taken to select tests of significance that are considered to be robust to violations of normality (Field, 2005).

4.2 Correlation analyses

To explore the relationships between the main variables, a correlation analysis was performed using the non-parametric Spearman test. This test was selected as it is recommended when the data have violated parametric assumptions, such as the normality assumption, as was the case in the present study (Field, 2005).

The correlation table is presented in Table 7. As the results show, an individual's prior experience of depression significantly negatively correlates with informal help seeking for all three severity levels of depression. Specifically, the more severe someone's previous experience of depression was, the lower was the likelihood that they would seek help from informal sources of help. On the other hand, there is no correlation between an individual's prior experience of depression and formal help seeking for all three severity levels of depression. Previous experience of depression was also positively correlated with HADS total, so that the more severe an individual's previous experience of depression was, the higher their total score on the HADS questionnaire was, and the more distressed they were at the time of taking part in the study. Current distress, as measured by the HADS questionnaire, also negatively correlates with informal help seeking for moderate levels of depression and formal help seeking for severe levels of depression. Specifically, the more severe someone's current distress was, the lower was the likelihood that they would seek help from informal sources of help for moderate symptoms of depression and the lower was the likelihood that they would seek help from formal sources of help for severe symptoms of depression. Educational level significantly positively correlates with HADS total, people with no university education had a higher score on current distress. Occupational status significantly positively correlated with formal help seeking for mild levels of depression and with HADS total. Specifically, people who were not employed had a higher likelihood of seeking formal help for mild levels of depression and had a higher score on current distress. Finally, age significantly negatively correlated with informal help seeking for mild and for severe levels of depression. The older someone was, the lower the likelihood they would seek informal help for mild and for severe levels of depression.

Table 7

Spearman's Correlation between level of Previous Experience of Depression, Demographics, HADS, and Dependent Variables (N=122)

	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Previous experience depression	1												
2 Gender	.040	1											
3 Age	-.012	.016	1										
4 Marital Status	.053	-.139*	-173*	1									
5 Occupational status	-0.76	-.081	-.440**	.139*	1								
6 Education level	.052	.009	-.187**	.068	.195**	1							
7 Ethnic origin	-.086	-.043	-.218**	.215**	.194**	.038	1						
8 Mild informal	-.161*	.043	-.143*	-.067	.081	-.106	.094	1					
9 Mild formal	.067	-.008	-.081	.109	.162*	.055	.096	.369**	1				
10 Moderate informal	-.276**	-.029	-.104	-.099	.035	-.042	.083	.753**	.213**	1			
11 Moderate formal	-.136	.031	.001	.031	.075	.012	.047	.299**	.658**	.341**	1		
12 Severe informal	-.250**	-.026	-.143*	-.032	.021	-.024	0.78	.551**	.035	.733**	.152*	1	
13 Severe formal	-.132	.022	.051	.064	-.035	.029	.122	.172*	.361**	.339**	.602**	.388**	1
14 HADS	.414**	-.014	-0.97	.123	.140*	.181*	-.033	-.127	.088	-.187**	-.036	-.137	-.143*

Note. *p< .05 (2-tailed), ** p< .01 (2-tailed)

A series of analyses were performed to examine each of the hypotheses.

4.3 Hypothesis 1

The first hypothesis was that when difficulties become more severe, participants' intention and/or behaviour to seek help would also increase. Specifically it was expected that the ratings of help seeking behaviours and intentions to seek help in response to each vignette would be higher when the symptoms of depression described in the vignette representing either the participants' own experiences or possible future experience, were more severe. This was tested using participants in the intention only group (group 0, n=37) and behaviour only group (group 4, n=42) because only in these two groups did participants' responses refer exclusively to the same construct (i.e., intention only or behaviour only) for all three vignettes.

In order to test the first hypothesis, separate repeated-measures ANOVA were conducted for each of the two groups. In both analyses, severity (mild, moderate, severe) and type of help (informal, formal) were the within-subjects variables and current anxiety and depression scores (as measured by the HADS total) was the covariate. Additionally, a mixed (between and within group) ANOVA was conducted comparing the two groups. In this case previous experience of depression was the between-subjects factor, with two levels (never and severe). Severity (mild, moderate, severe) and type of help (informal, formal) were the within-subjects variables and current anxiety and depression scores (as measured by the HADS total) was the covariate.

In all the ANOVAs, the ratings (on a scale of 1-5) of informal and formal sources of help, either of help seeking behaviour (group 4) or intention (group 0), in each of the three vignettes representing mild, moderate and severe symptoms of depression respectively, were the dependent variables. The results are discussed below for the intention to seek help group first. The results for the help seeking behaviour group are discussed in the following section.

4.3.1 Intention to seek help

Only participants in the intention only group (N=37) were entered in the first repeated-measures ANOVA to investigate the effect of the severity of the difficulties on future intention to seek informal and formal help. Severity (mild, moderate,

severe) and type of help (informal, formal) were the within-subjects variables and current anxiety and depression scores (as measured by the HADS total) was the covariate. The ratings (on a scale of 1-5) of intention to seek informal and formal sources of help, in each of the three vignettes representing mild, moderate and severe symptoms of depression respectively, were the dependent variables. Mauchly's test indicated that the assumption of sphericity had been violated for the main effect of Severity $\chi^2(2) = 19.23$, $p < .001$. Therefore for Severity degrees of freedom were corrected using Greenhouse-Geisser estimates of sphericity (ε=0.70).

There was a significant main effect of the severity of the difficulties experienced, $F(1.397, 48.882) = 11.32$, $p < .001$. Thus, if we ignore the type of help sought, participants' intention to seek help is affected by how severe the difficulties they might experience are. There is an increase in the intention to seek help as the symptoms of depression become more severe (M(mild symptoms of depression) = 3.04, M(moderate symptoms of depression) = 3.49, and M(severe symptoms of depression) = 3.88). Post-hoc contrasts, comparing the moderate level to the mild level and the severe level to the moderate level, revealed that participants rated their intention to seek help for moderate symptoms of depression higher compared to mild symptoms of depression, $F(1, 35) = 14.31$, $p = .001$, $r = .15$, and rated their intention to seek help for severe symptoms of depression higher compared to moderate symptoms of depression, $F(1, 35) = 4.66$, $p = .038$, $r = .06$. There was a significant main effect of the type of help someone sought, $F(1, 35) = 9.73$, $p = .004$. Pairwise comparisons revealed that participants were significantly more likely to report more intention to seek informal help ($M = 3.98$) than formal help ($M = 2.96$) at $p < .001$, $r = .11$.

There was a significant interaction effect between the severity of the difficulties experienced and the intention to seek help from different sources of help $F(1.956, 68.470) = 8.85$, $p < .001$. Participants rated their intention to seek informal help compared to formal help differently for different levels of severity of depression. Table 8 shows the participants' mean rating of intention to seek informal or formal help for different levels of severity (mild, moderate, severe).

Table 8

The Interaction Between the Severity of the Difficulties and Intention to Seek Different Types of Help (N=37)

Vignette Severity	Type of Help	Mean rating of seeking help	*SE*
Mild	Informal	3.81	.21
	Formal	2.27	.18
Moderate	Informal	4.08	.19
	Formal	2.89	.21
Severe	Informal	4.05	.20
	Formal	3.70	.22

Contrasts, comparing the moderate level to the mild level and the severe level to the moderate level, revealed that in terms of seeking different sources of help (informal versus formal help), there was no significant difference between mild and moderate symptoms of depression, $F(1, 35) = 2.44$, $p = .13$, $r = .03$, but there was significant difference between the moderate and severe symptoms of depression, $F(1, 35) = 7.75$, $p = .01$, $r = .09$. Looking at the means in Table 8 and the interaction graph (Figure 3), this suggests that participants rated informal sources of help higher than formal sources of help, and this difference was similar for mild and moderate symptoms of depression whereas this difference decreased as the severity of the depression increased.

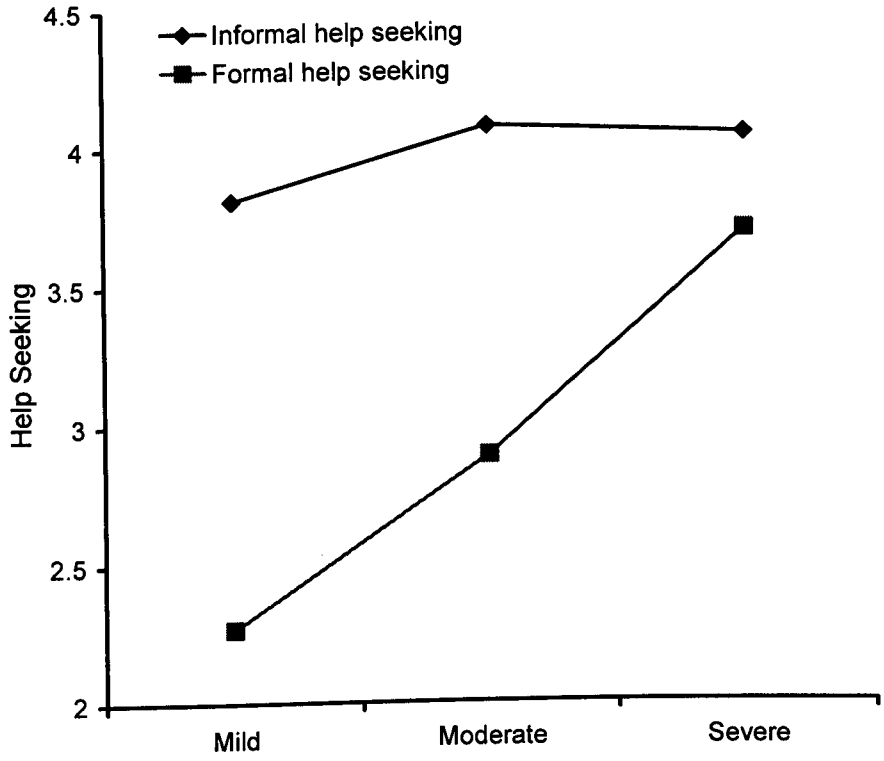

Figure 3. The interaction between help seeking intention (informal vs. formal) and severity

4.3.2 Help seeking behaviour

Only participants in the behaviour only group (N=42) were entered in the second repeated-measures ANOVA to investigate the effect of the severity of the difficulties on informal and formal help seeking behaviour. Severity (mild, moderate, severe) and type of help (informal, formal) were the within-subjects variables and current anxiety and depression scores (as measured by the HADS total) was the covariate. The ratings (on a scale of 1-5) of reported informal and formal help seeking behaviour, in each of the three vignettes representing mild, moderate and severe symptoms of depression respectively, were the dependent variables. Mauchly's test indicated that the assumption of sphericity has been met for the main effect of Severity $\chi^2(2) = 4.55, p = .10$.

There was a significant main effect of the severity of the difficulties experienced, $F(2, 80) = 4.54, p = .01$. This means that if we ignore the type of help sought, participants' help seeking behaviour is affected by how severe the difficulties they experience are. There is an increase in reported help seeking behaviour as the

symptoms of depression become more severe (M(mild symptoms of depression) = 2.68, M(moderate symptoms of depression) = 2.85, and M(severe symptoms of depression) = 3.13). Contrasts, comparing the moderate level to the mild level and the severe level to the moderate level, revealed that participants rated their help seeking behaviour for severe symptoms of depression as higher compared to moderate symptoms of depression, $F(1, 40) = 4.20$, $p = .05$, $r = .05$. However, the ratings of help seeking behaviour for moderate symptoms of depression did not differ significantly from help seeking for mild symptoms of depression, $F(1, 40) = 1.52$, $p = .23$, $r = .02$. There was no significant main effect of the type of help someone sought, $F(1, 40) = 1.47$, $p = .23$, $r = .02$, meaning that participants rated having sought informal help ($M = 3.03$) similarly to having sought formal help ($M = 2.74$).

There was a significant interaction effect between the severity of the difficulties experienced and the rating of having sought help from different sources, $F(2, 80) = 8.25$, $p = .001$. Participants rated seeking help from informal compared to formal sources differently for different levels of severity of depression. Table 9 shows the participants' mean rating of seeking informal or formal sources of help for different levels of severity (mild, moderate, severe).

Table 9

The Interaction between the Severity of the Difficulties and the Type of Help Sought (N=42)

Vignette Severity	Type of Help	Mean rating of seeking help	*SE*
Mild	Informal	2.95	.19
	Formal	2.41	.22
Moderate	Informal	3.05	.20
	Formal	2.64	.24
Severe	Informal	3.10	.21
	Formal	3.17	.23

Contrasts, comparing the moderate level to the mild level and the severe level to the moderate level, revealed that in terms of seeking help from different sources (informal versus formal help), there was a significant difference between moderate and severe symptoms of depression, $F(1, 40) = 9.03$, $p = .05$, $r = .09$. There was no significant difference between seeking informal or formal help for mild or moderate

symptoms of depression, $F(1, 40) = 0.98$, $p = .33$, $r = .01$. Looking at the means on Table 9 and the interaction graph (Figure 4), this suggests that participants rated informal sources of help higher than formal sources of help, and that this difference decrease as the depression severity levels increase until there was no significant difference between the two types of help in severe symptoms of depression.

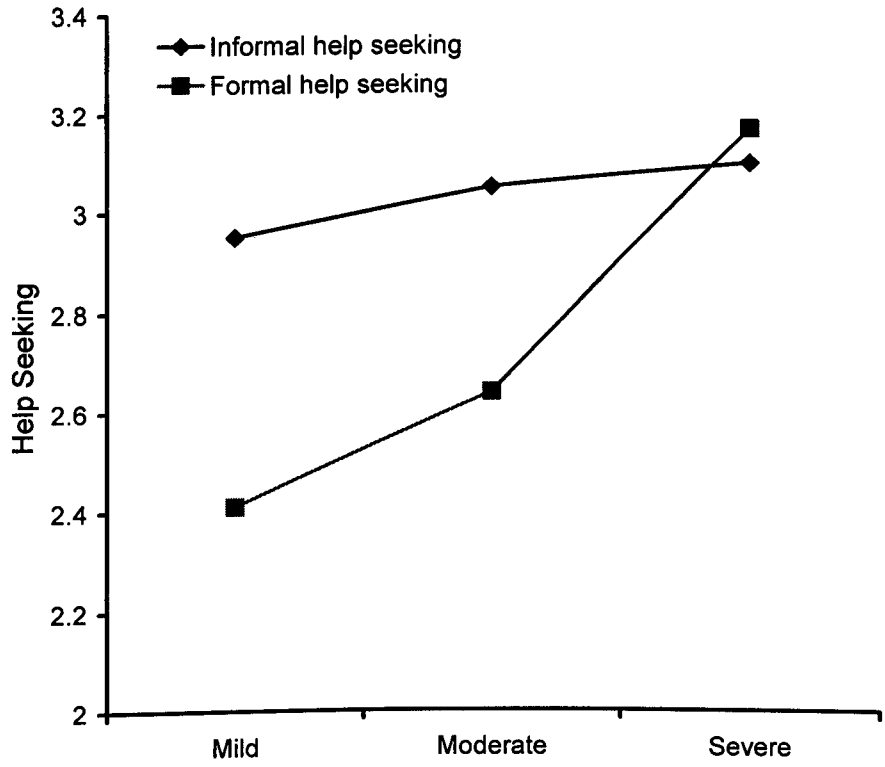

Figure 4. The interaction between help seeking behaviour (informal vs. formal) and severity

4.3.3 Intention to seek help versus help seeking behaviour

To examine whether the pattern of increased ratings of help seeking with increasing severity of depressive symptoms was similar between participants who reported having experienced depression in the past and those who did not, both the intention only and behaviour only groups were compared using a mixed (between and within group) ANOVA. Previous experience of depression was the between-subjects factor, with two levels (never and severe). Severity (mild, moderate, severe) and type of help (informal, formal) were the within-subjects variables and current anxiety and depression scores (as measured by the HADS total) was the covariate.

The ratings (on a scale of 1-5) of informal and formal sources of help, either of help seeking behaviour (group 4) or intention (group 0), in each of the three vignettes representing mild, moderate and severe symptoms of depression respectively, were the dependent variables.

Mauchly's test indicated that the assumption of sphericity had been violated for the main effect of severity $\chi^2(2) = 18.19$, $p < .001$. Therefore the degrees of freedom were corrected using Greenhouse-Geisser estimates of sphericity (ε=0.82). Levene's test indicated that the equality of variance assumption was violated for two of the repeated-measures variables: the values for the rating of formal sources of help for mild symptoms of depression and the rating for formal sources of help for moderate symptoms of depression. However, according to Field (2005) it is useful to also examine the variance ratio (i.e., between the group with the biggest variance and the group with the smallest variance). In this analysis there were only two groups, and the variance ratio between them was greater than two, which, according to Field (2005) suggests that the equality of variance can be considered acceptable in this instance.

The ANOVA summary table indicated that there was no significant main effect for the overall ratings of intentions and behaviours, indicating that the ratings from participants who reported not having experienced depression in the past and therefore rated their intention to seek help ($M = 3.35$) and participants who reported having experienced depression in the past and therefore rated their past behaviour ($M = 2.99$) did not significantly differ, $F(1, 76) = 2.45$ $p = .12$, $r = .18$. Thus, the pattern of change between the two groups did not differ significantly.

There was no significant interaction effect for the severity of the difficulties and intentions versus behaviour, $F(2, 152) = 0.09$, $p = 0.91$, indicating that the pattern of change in help seeking for different levels of severity was the same for the two groups. Contrasts revealed no significant differences between mild and moderate levels for the two groups $F(1, 76) = 0.25$ $p = .62$, $r = .06$, and between severe and moderate levels for the two groups $F(1, 76) = 0.07$, $p = .80$, $r = .03$.

Table 10 shows that the ratings of help seeking was slightly higher for participants who reported not having experienced depression in the past (i.e., who rated their intention to seek help) than it was for participants who reported having experienced depression in the past (i.e., who rated their past behaviour). However,

these differences are not significant, and the pattern of change in help seeking for different levels of severity is the same for the two groups.

Table 10

The Interaction between the Severity of the Difficulties and Intention versus Behaviour (N=79)

Vignette Severity	Previous experience of depression	Mean rating of seeking help	*SE*
Mild	Intention*	3.02	.18
	Behaviour**	2.70	.17
Moderate	Intention	3.37	.18
	Behaviour	2.95	.17
Severe	Intention	3.67	.19
	Behaviour	3.31	.18

Note. *Intention: participants reported never experiencing depression in the past, **Behaviour: participants reported experiencing all three levels of depression

4.4 Hypothesis 2

The second hypothesis was that participants who had experienced symptoms of depression in the past would rate their intention to seek help in the future for more severe symptoms of depression higher than participants who had not experienced depression in the past. In order to test if intention to seek help varies according to previous experience of depression, groups of participants who had reported having experienced depression of different severity levels in the past were compared in terms of their future intention to seek help for more severe difficulties.

For moderate symptoms of depression a MANCOVA analysis was performed comparing the group with no prior experience of depression (group 0) with those who had experienced only mild symptoms of depression in the past (Group 1) for future intention to seek help in moderate symptoms of depression. For severe symptoms of depression a MANCOVA analysis was performed comparing those who had not experienced depression in the past (Group 0), those who had experienced only mild symptoms of depression in the past (Group 1), and those who had experienced moderate symptoms of depression in the past (Group 2) on their future intention to seek help in severe symptoms of depression.

4.4.1 Intention to seek help for moderate symptoms of depression

The ratings of intention to seek informal and formal help for moderate symptoms of depression were the dependent variables in the first MANOVA and the current anxiety and depression scores (HADS total) was the covariate. Contrasts were performed comparing the intention to seek help for moderate symptoms of depression between participants who reported no experience of depression (Group 0, N=37) and participants who have experienced only mild symptoms of depression in the past (Group 1, N=66). Box's test of equality of covariate was not significant (p = 0.40) and therefore the homogeneity assumption was not violated. There was no significant effect of the previous experience of depression on the future intention to seek help for moderate symptoms of depression, $F(2, 99) = 1.63$, $p = .20$. For the intention to seek informal help, the mean rating was 4.08 (SD=1.14) for participants who reported no experience of depression and 3.59 (SD=1.18) for participants who had experienced only mild symptoms of depression in the past. For the intention to seek formal help, the mean rating was 2.89 (SD=1.24) for participants who reported no experience of depression and 2.77 (SD=1.29) for participants who had experienced only mild symptoms of depression in the past. Since the MANOVA was not significant the contrasts are not reported here.

4.4.2 Intention to seek help for severe symptoms of depression

The ratings of intention to seek informal and formal help for severe symptoms of depression were the dependent variables in the second MANOVA, and the current anxiety and depression scores (HADS Total) was the covariate. Contrasts were performed comparing the intention to seek help for severe symptoms of depression between participants who reported no experience of depression (Group 0, N=37), participants who have experienced only mild symptoms of depression in the past (Group 1, N=66) and participants who have experienced moderate symptoms of depression in the past (Group 2, N=57). Box's test of equality of covariate was not significant (p = 0.11) and therefore the homogeneity assumption is not violated. There was no significant effect of the previous experience of depression on the future intention to seek formal or informal help for severe symptoms of depression, $F(4, 312) = 0.87$, $p = .48$. For the intention to seek informal help, the mean rating was 4.05 (SD=1.25) for participants who reported no experience of depression, 3.79 (SD=1.18) for participants who had experienced only mild symptoms of depression

in the past, and 3.53 (*SD*=1.31) for participants who had experienced moderate symptoms of depression in the past. For the intention to seek formal help, the mean rating was 3.70 (*SD*=1.35) for participants who reported no experience of depression, 3.71 (*SD*=1.15) for participants who had experienced only mild symptoms of depression in the past, and 3.39 (*SD*=1.51) for participants who had experienced moderate symptoms of depression in the past. Since the MANOVA was not significant the contrasts are not reported here.

4.5 Hypothesis 3

The final hypothesis was that participants who had sought help in the past for milder symptoms of depression would rate their intention to seek help for more severe symptoms of depression higher, and therefore higher ratings of past help seeking behaviour for milder symptoms of depression would correlate with higher ratings of intention to seek help for more severe symptoms of depression. This was tested using a partial correlation analyses, where the effect of the current anxiety and depression scores (HADS Total) was held constant.

In the first series of analyses only participants who had experienced up to mild symptoms of depression in the past (Group 1) were included. The mild level (indicating help seeking behaviour) was correlated with the moderate and the severe level (indicating help seeking intention). Informal help seeking behaviour for mild symptoms of depression was correlated with informal and with formal intention to seek help for moderate and for severe symptoms of depression. Formal help seeking behaviour for mild symptoms of depression was correlated with formal intention to seek help for moderate and for severe symptoms of depression. Therefore in total six partial correlations were performed on participants with past experience of mild symptoms of depression.

Similarly, in participants who had in the past experienced up to moderate symptoms of depression (Group 2), the ratings of help seeking behaviour for mild symptoms of depression as well as the ratings of help seeking behaviour for moderate symptoms of depression were separately correlated with intention to seek help for severe symptoms of depression. Informal help seeking behaviour for mild and for moderate symptoms of depression was correlated with informal and with formal intention to seek help for severe symptoms of depression. Formal help seeking behaviour for mild and for moderate symptoms of depression was correlated

with formal intention to seek help for severe symptoms of depression. Therefore six partial correlations using participants who had in the past experienced up to moderate symptoms of depression were performed in total.

Since six correlation analyses were performed using each group of participants, a correction was made for the error by dividing the .05 probability value with the total number of analyses performed (12), giving a value of .004. This adjustment means that only results significant at the .0039 probability level would be accepted as significant. Table 11 shows the results of the partial correlation analysis.

For participants who had in the past experienced up to mild symptoms of depression (Group 1), past informal help seeking behaviour for mild symptoms of depression was positively correlated with intention to seek informal help if they experienced moderate symptoms of depression in the future $r = .63$, p(one-tailed) < .001 and with intention to seek informal help if they experience severe symptoms of depression in the future $r = .40$, p(one-tailed) = .001. On the other hand, past informal help seeking behaviour for mild symptoms of depression was not significantly positively correlated with intention to seek formal help for moderate, $r = .24$, p(one-tailed) = .03, and for severe symptoms of depression $r = .09$, p(one-tailed) = .23. Furthermore, past formal help seeking behaviour for mild symptoms of depression was positively correlated with intention to seek formal help if they experienced moderate symptoms of depression in the future $r = .54$, p(one-tailed) < .001, but not for severe symptoms of depression, $r = .32$, p(one-tailed) = .005.

For participants who had in the past experienced up to moderate symptoms of depression (Group 2), past informal help seeking behaviour for mild symptoms of depression was positively correlated with intention to seek both informal $r = .57$, p (one-tailed) < .001 and formal help $r = .42$, p(one-tailed) < .001, if they were to experience severe symptoms of depression in the future. Additionally, past formal help seeking behaviour for mild symptoms of depression was positively correlated with intention to seek formal help $r = .42$, p(one-tailed) = .001, if they were to experience severe symptoms of depression in the future. Past informal help seeking behaviour for moderate symptoms of depression was positively correlated with intention to seek both informal $r = .70$ and formal help $r = .56$, (p(one-tailed)=.001), if they experienced severe symptoms of depression in the future. Finally, past formal help seeking behaviour for moderate symptoms of depression was positively

correlated with intention to seek formal help r = .50, p(one-tailed) = .001, if they experienced severe symptoms of depression in the future.

Table 11

Correlation between Past Help Seeking Behaviour and Future Intention to Seek Help (N=123)

Ratings of Behaviour		Ratings of Intention			
		Moderate symptoms of depression		Severe symptoms of depression	
		Informal help	Formal help	Informal help	Formal Help
		r	*r*	*R*	*R*
Group 1 (n=66)	Mild symptoms – informal help	.63*	.24	.40*	.09
	Mild symptoms – formal help		.54*		.32
Group 2 (n=57)	Mild symptoms – informal help			.57*	.42*
	Mild symptoms – formal help				.42*
	Moderate symptoms – informal help			.70*	.56*
	Moderate symptoms – formal help				.50*

Note. *p<.0039 (1-tailed)

Chapter V: Discussion

This section provides an overview of the main findings of the study, summarising the three hypotheses, the existing literature that these predictions were based on, and the results of the analysis. These findings are placed in the context of theory and the existing literature that was presented in the literature review. Potential implications of the findings and their contribution to the theory and practice of counselling psychology are discussed, followed by the strengths and limitations of the study, and future research directions.

The process of help seeking can be seen as a decision-making process that follows the stages of symptom appraisal, attitudes towards seeking help and help seeking behaviour, where individuals need to make judgements and appraisals and take decisions about how to behave (Carrol & Johnson, 1990). The present study quantitatively examined certain factors that might affect an individual's decision to seek help for depression, specifically how severity of the symptoms of depression, past experience of depression, and past help seeking behaviour might affect future intentions to seek help for depression of different severity levels. A vignette methodology was adopted (Alexander & Becker, 1978; Finch, 1987; Ganong & Coleman, 2006; Hughes & Huby, 2002; Peabody et al., 2007; Peabody et al., 2004; Trochim, 2006), manipulated to represent escalating symptom severity for depression. Participants provided a score of their intention to seek help, or past experience of seeking help, for each severity level vignette, and completed the Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983) so that current anxiety and depression could be controlled for.

The first variable examined was the severity of the symptoms of depression. When people initially experience difficulties, the first step in the decision making process of help seeking is the detection of symptoms and the appraisal of their seriousness. Beliefs regarding the degree of severity of the condition may encourage or discourage help seeking behaviours (Odgen, 2004). Therefore, the assessment of our symptoms and our perception of their seriousness influence our decision to seek help or not. The results supported the first hypothesis, that participants would rate their actual help seeking behaviours or their help seeking intentions higher when the symptoms of depression were more severe. In the present study, participants' intention to seek help, and help seeking behaviour for depression increased as the

symptoms of depression depicted in the vignette got more severe. The pattern of change between participants who reported their intention (i.e., who had not previously experienced depression of that severity level) and participants who reported their behaviour (i.e., who had previously experienced depression of that severity level) did not differ significantly.

There were significant differences between the intention to seek help scores across the three severity levels. Thus, intention to seek help for mild symptoms of depression were significantly lower than intentions to seek help for moderate symptoms of depression, which were in turn significantly lower than intentions to seek help for the highest symptom severity of depression. Generally, participants' intentions to seek informal help were higher than their intentions to seek formal help, a difference that was greater for mild and moderate symptoms of depression than for severe symptoms of depression. Thus whilst participants' are more likely to consider seeking informal help more than formal help for all severity levels of depression, their intentions to seek formal help reaches similar levels as informal help when the symptoms of depression described are severe.

Examining help seeking behaviours in those participants who had experienced depression in the past revealed that participants reported having sought help more as their symptoms of depression became more severe. This increase was significant only for severe symptoms of depression: the difference between help seeking for mild and moderate symptoms of depression was not significant. Participants who had experienced mild and moderate depression in the past had sought more informal help than formal help for their difficulties, although this difference was not significant. There was a significant increase in formal help seeking between moderate and severe depression symptoms. Similarly to the trend observed in help seeking intentions, as the symptoms of depression become more severe, participants' formal help seeking behaviour increased and participants sought similar levels of both formal and informal help when their difficulties were severe.

These findings are consistent with previous research, in which increasing symptom severity is associated with increased help seeking behaviour for mental health difficulties (Biddle et al., 2004; Bland et al., 1997; Dew et al., 1991; McCracken et al., 2006; Oliver et al., 2005; Oppenheimer et al., 1988; Rickwood & Braithwaite, 1994; Robbins & Greenley, 1983) and increased intention to seek counselling (Vogel & Wei, 2005). These findings also support prior research which

has shown that whilst people are generally more likely to seek help from informal sources than they are from formal sources, for severe difficulties people seek help equally from formal and informal sources of help (Angermeyer et al., 1999; Neighbors, 1985). As well as actual severity, it is also likely that the way in which a problem is perceived will affect help seeking behaviour, that is, when people perceive their problem as severe they are more likely to seek help for it (Cramer, 1999). Although an individual with severe symptoms of depression might also have lower self-efficacy beliefs, which in turn could result in reduced attempts to seek help and solve the problem (Bandura, 1977; Luszczynska & Schwarzer, 2005), the results of this study indicate that when the symptoms of depression are severe, individuals' help seeking behaviour and intention increases. Leventhal and colleagues (1980; 1984) have proposed that one reason for this is that the more severe a problem is, the more it will interfere with an individual's functioning, increasing their motivation to solve the problem and return to their previous state of functioning. It would appear to follow that when difficulties are severe enough to start interfering with an individual's functioning, then the likelihood of them seeking formal help increases and reaches similar levels as seeking informal help.

These results are also consistent with theoretical models which attempt to explain or predict health behaviours, and which emphasise the importance of problem severity in increasing an individual's likelihood of engaging in behaviours to overcome their difficulties (Odgen, 2004). The health belief model (Abraham & Sheeran, 2005; Becker et al., 1977; Rosenstock, 1974) and protection motivation theory (Norman et al., 2005; Rogers, 1983) are two cognitive models of behaviour change which include threat appraisal as a variable that can predict help seeking. Specifically, the more threatening a problem is considered, the more likely it will be that people will seek help for resolving that problem. Furthermore, more severe difficulties allow people to recognise more easily when they are experiencing a problem (MacInees, 2006; Smith et al., 2005), may reduce the likelihood of using biases like avoidance of relevant information (Weinman & Petrie, 1997), and may facilitate seeking help without the person worrying about being seen by others as a time waster (Smith at al., 2005). This reduces the appraisal delay (Andersen et al., 1995), where individuals might fail to recognise that they are experiencing a problem and therefore might not seek help for it. The results of the present study indicate that increased severity facilitates symptom recognition. Possibly, the symptoms of

depression depicted in the severe vignette were easily recognised by participants, who were able to consider how they would behave (intention) if they were in that position. This indicates that the vignette method is potentially a useful tool for exploring intention to seek help, as well as help seeking.

There is empirical evidence to suggest that not only are people more likely to seek help for more severe problems, they will also express more positive attitudes towards seeking help when their problems are severe (Komiya et al., 2000) and their reported intention to seek help is higher (Vogel & Wei, 2005). Research examining the effect of the symptom severity on help seeking intention is more limited because the outcome examined in the majority of studies is actual help seeking behaviour (e.g., Biddle et al., 2004; Dew et al., 1991; Oppenheimer et al., 1988; Rickwood & Braithwaite, 1994). One study which did examine help seeking intentions for counselling (Vogel & Wei, 2005) explored the connection between current distress and intentions to seek help in a different way. This study asked participants to consider hypothetical future experiences of more severe symptoms of depression, and participants' intentions to seek help in the future increased as the imagined scenarios became more severe. The present study adds to the relatively limited literature about help seeking intentions for psychological difficulties, and supports the hypothesis that severity of difficulties will be associated with increased intentions to seek help in the future.

In more general terms, the findings of the present study also demonstrate how help seeking can take many forms, such as seeking help from friends and family first and initially trying to resolve difficulties with the use of informal help. As Angermeyer et al. (1999) have emphasised, lay support networks deal with a lot of distress and professional help is usually sought when the difficulties reach severe levels and have not been resolved with the use of informal sources of help. Therefore, just because someone is not seeking professional help does not mean that they are not seeking help, or that the help they are receiving is not adequate for their needs at the time.

It was predicted that participants who had experienced symptoms of depression in the past would rate their intention to seek help for more severe symptoms of depression in the future higher than would those participants who had not experienced depression in the past. Although this prediction was made tentatively, it was nevertheless based on information processing models of

behaviour, which advance the notion that our view of future situations, and our behaviour in those situations, is, to some extent, shaped by our previous experiences and the beliefs we have formed about them (Leventhal et al., 1980; Leventhal et al., 1984; Markus, 1977; Odgen, 2004; Weinman & Petrie, 1997). It was assumed, therefore, that previous experience with depression would have shaped participants' knowledge and beliefs about depression, enabling easier recognition of the problem in future. It might also make it less likely that these individuals would use biases such as avoidance of relevant information (Weinman & Petrie, 1997) and reduce the misattribution of the symptoms (MacInees, 2006; Smith et al., 2005). The results, however, did not support this hypothesis and revealed that participants who had never experienced depression in the past rated their intention to seek both informal and formal help for moderate symptoms similarly to participants who had experienced mild symptoms of depression in the past. Similarly, after controlling for the current levels of distress, intention to seek informal and formal help for severe symptoms of depression did not differ between participants who had never experienced depression in the past, and those who had previously experienced mild or moderate symptoms of depression. In this study, therefore, previous experience of depression did not affect ratings of future intentions to seek help for more severe symptoms of depression.

A possible explanation for the lack of significant findings in this instance is that the relationship between past experience with depression and future intention to seek help for it is mediated or moderated by other variables, such as past experiences of help seeking (which this study also examined) or a variable that was not measured or controlled for, including attitudes towards help seeking. It seems likely that the experience of depression alone might not always be enough to affect help seeking intentions, as some individuals might not have labelled or recognised their symptoms as depression in the past. As well, a negative previous help seeking experience might lead to avoidance of help in the future whereas more positive experiences with seeking help might lead to more positive attitudes and greater intention to seek help again (Vogel & Wester, 2003).

Previous behaviour is recognised as a variable that can help predict future behaviour (Borland et al., 1991; Chen & Mak, 2008; Dadfar & Friedlander, 1982; Hagger et al., 2001; Norman et al., 1999; Van Der Rijt & Westerik, 2004). Consequently, the present study recognises that it is likely to be the combination of

past experiences of depression, as well as past experiences of seeking help for it, that will affect the beliefs and attitudes an individual holds about depression and help seeking, and their intentions about seeking help again in the future. Partial correlation analyses, controlling for current levels of anxiety and depression, indicated that participants who had experienced mild symptoms of depression in the past and had sought informal help for it were correlated with higher rating of intention to seek informal help in the future for more severe symptoms of depression. Having sought formal help for mild symptoms of depression was also positively correlated with higher intention to seek formal help for moderate, but not for severe symptoms of depression. Participants who had previously experienced moderate depression and had sought informal help for it were positively correlated with intentions to seek both informal and formal help for severe symptoms of depression in the future. Having previously sought formal help for moderate symptoms of depression was also positively correlated with intentions to seek formal help for severe symptoms of depression. Taken as a whole, these findings suggest that having sought help for less severe symptoms of depression in the past leads to increased intentions to seek help for more severe symptoms of depression in the future. It also suggests that, at least for those who have in the past experienced up to moderate depression, having sought informal help is connected with increased intention to seek formal help. The third hypothesis of the current study was therefore supported.

This is in line with previous research that has identified past help seeking behaviour for psychological difficulties as an important predictor of future help seeking behaviour (Friedman & West, 1987; Robbins & Greenley, 1983; Sherwood et al., 2007) and there are different explanations as to how past behaviour might affect future behaviour. Similarly in Ouellette and Wood's review (1998), in the majority of the studies examined, the frequency of past behaviour directly predicted intentions to perform that behaviour again in the future, for several health behaviours. Intentions have been identified as a predictor of future action (Chen & Mak, 2008; Halgin et al., 1987; Schomerus et al., 2009a; Sheeran, 2002; Sheeran & Abraham, 2003) and have been found to significantly mediate the past behaviour–future behaviour relationship (Armitage, 2007).

Our past help seeking behaviour might be used as a basis for future decisions regarding seeking help, by assuming that what led us to behave in a certain way in the past will also contribute to how we will behave in the future and therefore

increase our future intention to seek help. According to Ouellette and Wood (1998) people infer their attitudes from the observation of their past behaviour which they might use as a heuristic basis for their later decisions, by assuming that the conditions that led to their earlier behaviour exist in the present or future situation as well. Furthermore, when the behaviour is not frequent enough and therefore not well-learned conscious decision-making might be necessary to initiate and carry out the behaviour. In this case past help seeking behaviour may contribute to intentions to seek help in the future, which then guides future help seeking behaviour.

In the theory of planned behaviour framework (Ajzen, 1991) intentions to perform a given behaviour are determined by the attitudes one holds towards the behaviour, subjective norms (i.e., the person's perception of what other people think about the behaviour) and perceived behavioural control. The more one has performed a behaviour successfully in the past, the more likely it is that one will perceive that one has control over that behaviour (Albarracin et al., 2001) and their sense of self-efficacy might be higher, which is connected to improved attitudes, and increases in intention to perform that behaviour again in the future. In the present study, it is possible that individuals who had sought help for depression in the past might have formed more favourable attitudes towards seeking help and might have more positive expectations about the outcome of seeking help for depression in the future, which would explain their increased intentions to seek help in the future (Ajzen, 1991; Armitage, 2007; Cash et al., 1978; Conner & Norman, 2002; Dadfar & Friedlander, 1982; Fischer & Turner, 1970; Jorm et al., 2000; Masuda et al., 2005; Utz, 1983).

The determinants of behaviour explained by the theory of planned behaviour appear to be implicated in the findings of the present study, although measures of attitudes, perceived control and subjective norms were not taken. Future researchers could investigate the relative contribution of these variables to the intention-behaviour relationship for help seeking for depression. Self-efficacy is another important variable and future research could investigate the interaction between depression, self-efficacy and help seeking.

In summary, there is a general overlap between the findings of the current study and earlier research examining the effects of severity of the symptoms on help seeking behaviour. Overall, the results indicate that help seeking behaviour is affected by how severe the symptoms of depression experienced have been, or are likely to be in the future. The present study also adds to the extant body of literature

on symptom severity and intention to seek help, as even those participants who had never experienced depression in the past had higher intentions to seek help in the future when the symptoms of depression described in the vignette were most severe. On the other hand, intention to seek help in the future did not differ in participants with different levels of past experience of depression. The fact that this study was unable to confirm some of the original hypotheses could be attributed to the fact that past help seeking behaviour, which was as expected related to future intentions to seek help, might be more important than experience alone. Finally, consistent with earlier research, participants generally sought or were more likely to seek in future, more informal help than formal help for both mild and moderate symptoms of depression. Only when the symptoms of depression were most severe did participants seek or intend to seek similar levels of formal and informal help.

5.1 Theoretical and clinical implications

Overall, the results of the present study are consistent with existing theory presented in the literature review such as the health belief model (Abraham & Sheeran, 2005; Becker et al., 1977; Rosenstock, 1974) and protection motivation theory (Norman et al., 2005; Rogers, 1983), which recognise the role of symptom severity in directing help seeking behaviour. Most studies which have examined these models empirically have focused on help seeking behaviour (e.g. Biddle et al., 2004; Dew et al., 1991; Oppenheimer et al., 1988; Rickwood & Braithwaite, 1994). Research which examines the effects of the severity of the symptoms upon intentions to seek help in the future is far more limited, as is research that has examined intention to seek help for mental health difficulties. The current study addresses both these gaps in the literature. The findings show that like actual help seeking behaviour, intention to seek help is also greater when the hypothetical symptoms of depression are most severe. This finding might be expected, given the predictive utility of intentions upon future behaviour (Armitage, 2007; Bagozzi, 1981; Conner & Norman, 2002; Eccles et al., 2006; Freyer et al., 2007; Norman et al., 1999; Ouellette & Wood, 1998; Sheeran, 2002; Sheeran & Abraham, 2003; Van Hooft et al., 2005).

The results of the study are also consistent with the proposition that people tend to seek more help from informal sources than formal sources but for severe difficulties people seek help equally from formal and from informal sources of help

(Angermeyer et al., 1999; Neighbors, 1985). It is important that any models trying to predict help seeking from professionals also take into account the fact that people might initially seek help from their friends and family rather than from professionals. Thus, the problem might be resolved without engaging the help of professionals at all, or friends and family might facilitate formal help seeking by encouraging distressed individuals to seek help and providing information about how to do so. Whilst past research has predominantly focused on help seeking from professional or formal sources, the current study examined both informal and formal sources of help equally. This sheds more light on patterns and choices of help seeking, and contributes to our knowledge on the relationship between informal and formal sources of help, as the problem gets more severe.

The study also contributes to the understanding of the complex relationship between past experiences with a difficulty, past help seeking behaviour and future intention to seek help. Whilst past experience of depression alone can not account for intentions to seek help for depression in the future, having sought help for depression in the past is significantly related to intentions to seek help again in the future for more severe symptoms. Previous studies have focused on help seeking behaviour and less attention has been given to the relationship between variables such as past experiences and behaviour and intentions to seek help.

From an applied perspective, this project has been conducted in the context of counselling psychology research and the values of the discipline. Counselling psychologists are trained to adopt many identities and a number of different roles (British Psychological Society, 2011). They are therapists but at the same time psychologists and researchers, contributing to the development and improvement of the services offered to clients. There is evidence that in counselling and psychotherapy, systematic research can make a vital contribution to the quality of service that is offered to clients (McLeod, 2003). According to Woolfe et al. (2003) the values of counselling can be the framework for understanding and facilitating the work of organisations and at the same time psychology can act as a facility for the community and promote the wider educative and preventive aspects of mental health.

Together with earlier investigations, the results of the study offer useful insights in understanding help seeking behaviour and facilitating help seeking in people in distress. In the UK, help seeking for mental health difficulties is low (Biddle at al., 2004; Oliver et al., 2005) as is seeking professional help for depression

(Andrews et al., 1999; Bland et al., 1997; Burns et al., 2003; Henderson et al., 1992; Jorm et al., 2000; Roy-Byrne et al., 2000; Thompson et al., 2008). Health professionals can be actively involved in encouraging people to seek early help for their mental health difficulties, and one way in which counselling psychologists can serve their clients and potential clients is to improve access to therapy by helping people identify their difficulties and to seek help early on, before difficulties become more severe, which will make recovery more likely. Consequently, an understanding of the factors that facilitate or hinder use of services is a primary issue for service providers who are required to improve access to care for those in need, and reach out to them with messages tailored to address the reasons why certain groups might be prompted to seek (or delay seeking) care. Such an understanding is one of the aims of this research project. It is an attempt to investigate factors that have been connected in the literature with help seeking behaviour and intention, such as the severity of difficulties, the use of the informal help, as well as previous help seeking experiences and behaviour. By gaining an insight into the behaviour and intention of clients beyond the consulting room can help clinicians understand them better, better facilitate help seeking when someone experiences distress, and ultimately be in a better position to help.

The fact that individuals' past behaviour is related to their future behavioural decisions may seem rather obvious. It is important, however, for health professionals to explore past help seeking behaviour with clients, as past behaviour might have contributed to positive attitudes about seeking help and therefore higher likelihood of seeking help in the future for mental health difficulties. For example people who have not sought help in the past have lower expectations about the benefits of seeking help than people who do seek help (Cash et al., 1978; Fischer & Turner, 1970; Utz, 1983) and might be reluctant to do so even if they experience severe distress. This is consistent with the suggestion that we infer our attitudes by observing our past behaviour and that this is used as a heuristic basis for later decisions (Ouellette & Wood, 1998).

It is therefore paramount that past experience of seeking help and attitudes towards seeking help are explored by professionals such as general practitioners (GPs), who have regular contact with potential counselling clients, in order to encourage people to seek help for their difficulties. Many people will have GP consultations for the physical symptoms of a mental health problem, such as

tiredness or difficulty sleeping, without necessarily realising that they have a mental health difficulty. Given that mental disorders comprise about 25% of GP consultations in the UK, and up to 80% of referrals to specialist psychiatric services come from primary care (Craig & Boardman, 1997), only a small proportion of people are referred on to psychological services. It has been suggested that this might partly reflect the low rate of detection of mental health difficulties by GPs (Craig & Boardman, 1997). It is important that health professionals work closely with GPs in order to increase their mental health literacy and skills in identifying mental health difficulties in order to facilitate potential clients' access to appropriate help. Craig and Boardman (1997) have reported that detection of mental health difficulties has been shown to reduce the number of subsequent consultations, to shorten the duration of an episode, and to result in far less social impairment in the long term. They also suggest that GPs could also directly offer interventions such as explaining the rationale for treatments, negotiating compliance, checking that advice and treatment are understood, and providing straightforward psychosocial advice on managing distress.

Clinicians should routinely explore their clients' previous experiences with depression and their past help seeking behaviour, as it could provide an insight into their behaviour and intentions. The field of counselling psychology can be broader than simply delivering psychological interventions for those clients who present for help. The discipline can also facilitate a deeper understanding of potential clients for counselling services, that is, those people who do not present, but might need to. Methods could be found for promoting and encouraging people to recognise and then seek help for more mild symptoms of depression as this could potentially increase their intention and the likelihood they will later on seek help for more severe symptoms of depression. This might be done by providing information and educating the public on the benefits of early help seeking, reducing stigma and shame about seeking help for mental health difficulties, and ultimately giving clients a positive experience when they seek help from services. According to Bandura (1986), individuals are more disposed to engage in positively valued behaviours that are believed to be achievable. One of the ways that self-efficacy beliefs can be enhanced is through verbal persuasion by others (e.g., a health professional) and this might further increase intention and willingness to seek help. It seems likely, therefore, that this approach would contribute to positive attitudes towards seeking help (Vogel &

Wester, 2003), increased intention to seek help again in the future and increase peoples' belief that seeking help will be beneficial.

It is also evident that help seeking takes many forms, not all of which are conventional or involve contact with a professional service. People seem to seek help the vast majority of the time from informal sources and counselling psychologists can actively encourage their clients to use their informal support networks. The informal support network might help resolve the problem or encourage help seeking from professionals if the problem is severe, is becoming worse or does not get resolved (Birkel & Reppucci, 1983; Gourash, 1978; McKinlay, 1973). Reducing the stigma associated with mental health difficulties such as depression will also help encourage people to seek help from friends and family, especially if they do not initially want to go to professionals.

5.2 Strengths, limitations and directions for future research

Both the strengths and limitations of the present study can be used to guide future research. The vignette methodology has been successfully utilised to explore people's past experiences of, and future intentions to seek help for depression. The advantages of this approach have already been reviewed in Chapter III (Alexander & Becker, 1978; Finch, 1987; Ganong & Coleman, 2006; Hughes & Huby, 2002; Peabody et al., 2004; Peabody et al., 2007; Trochim, 2006). Using vignettes to examine help seeking allowed for the information presented to each participant to be standardised so that more uniform data could be gathered. It also allowed via manipulation for a number of independent and dependent variables to be examined simultaneously such as severity of the difficulties experienced, past experience with depression, past help seeking behaviour and different possible sources of help. It is assumed that with the use of vignettes variables such as the participants' actual somatic morbidity and mood were kept constant across participants and therefore current help seeking need was controlled for. The fact that the results of the present study are consistent with previous findings generated by alternative methods, relating to symptom severity and help seeking, indicates that vignettes are another useful research tool for help seeking research. Future researchers can adopt a similar design to explore other variables implicated in the intention-behaviour relationship, such as attitudes and decision-making processes, both for psychological difficulties, and other health behaviours.

Intentions have been relatively neglected in the help seeking research, which has instead focused mostly on actual help seeking behaviours. Likewise, the role of past help seeking behaviour for depression, and past experiences with depression, upon intentions to seek help in the future have not been examined in many studies. Given that intentions and past behaviour have been extensively studied for many other health behaviours, the present study sought to add to the literature on help seeking for mental health difficulties by examining how past experiences with depression, as well as past help seeking behaviours for depression affect an individual's intentions to seek help for more severe symptoms of depression in the future. There are likely to be many variables that will influence the strength of the intentions an individual forms to perform a given behaviour, and whether those intentions are subsequently translated into actual behaviour. In particular, the theory of planned behaviour offers several determinants of behaviour that could be utilised in future research on help seeking for depression, such as perceived control, attitudes and subjective norms. Whilst it was outside the scope of the present study, and recognising the complexity of implementing such a recommendation, it would also be valuable to examine whether intentions do translate into actual behaviour through longitudinal studies that follow up with participants for several years after initial measures are taken.

Despite the contribution of the present study to the extant literature on help seeking for depression, it also has several limitations that can be improved upon in future research. Arguably the most serious limitation of the present study stems from the fact that help seeking behaviour was examined retrospectively rather than prospectively. Findings from the retrospective approach are prone to memory distortion and it is difficult to ascertain how accurate an individual's memory of their past behaviour might be, or the severity of their symptoms of depression. It is also possible that participants based their rating of their future intentions on their past behaviour, in an effort to appear consistent (Albarracin & Wyer, 2000). This is clearly easier to do when the measures of behaviour and intentions are obtained at the same time. Studies that use samples of people who are currently seeking help and which investigate the process they followed to seek help would be of value as would a more objective measure of depression severity. The taking of measures such as previous behaviour and future intentions could be staggered so that participants are

less able to attempt to answer consistently, rather than honestly, about their future intentions.

Methodologically, the vignette methodology can pose some challenges to researchers. Even though a vignette can simulate elements of the research topic under study, for example a description of depression of different severity levels, they can (like the majority of research paradigms) never mirror completely the reality and dynamism of peoples' lives and they can be less easily retained and remembered than observed behaviour (Hughes & Huby, 2002). Every individual has unique experiences with depression that can never be completely captured by a short description offered in a vignette. Due to the partial representation of real life situations offered by vignettes it is not easy to produce data that are easily generalisable outside the context of the particular vignette scenarios and therefore the generalisability of the findings of the present study outside the context of the particular vignette scenarios should be made with caution. The specific vignettes used in this study represent a description of what health professionals might consider to be the symptoms of depression, based on the diagnostic criteria (American Psychiatric Association, 2000). However, the vignettes have not been validated with individuals who are currently depressed and it cannot be claimed that they necessarily capture an accurate experience of depression. As well, even though participants in the present study were asked about their previous experience of depression which may have primed them about what the vignettes were attempting to describe, it is not clear whether they did actually identify the descriptions within the vignettes as "depression". A further limitation of the vignette approach is that responses to hypothetical scenarios might differ from responses to real situations, particularly as the symptoms of depression might affect an individual's decision-making. Future researchers could benefit from exploring help seeking behaviour with a combination of quantitative and qualitative methodologies. For instance, participants can report their help seeking intention and behaviour with the use of quantitative measures with interview techniques being used to explore participants' idiosyncratic experiences and responses in more depth.

The vignettes were presented to participants according to a progressive change in the severity of the difficulties (mild to severe), so that three stages of the story were presented (Finch, 1987). At each stage respondents were asked to make a choice about what they would do in the future (intention) or did in the past

(behaviour). This way of presentation contributes to building in a time element of how decisions taken at one point might structure or constrain future choices. The order of presentation used created the situation whereby some respondents might have felt that they had previously given a "wrong" answer, heightening the tendency to subsequently give what they might perceive to be a more socially acceptable answer (Finch, 1987). Whilst this limitation is recognised, the aim of the study was to examine the process of help seeking as the difficulty becomes more severe, and it was considered important to present a progressive change of the situation. To minimise the impression that there might be a "right" or "wrong" answer the vignettes were carefully worded so that they contained only a behavioural description of the situation, without incorporating any value judgements.

In the present study participants were asked to rate on a Likert scale either the likelihood that they would approach various sources of formal and informal help (intention to seek help) or the extent to which they had sought help from those sources in the past (help seeking behaviour). In the rating approach, participants are asked to rate each choice using a scale. An alternative is the ranking approach in which participants are asked to prioritise their choices in order of preference. The ranking approach would have more clearly showed order of preference of the various sources of informal and formal help. However, in the present study, the rating approach was adopted to investigate the behaviour or intention of participants approaching either source of help with the added advantage that according to the rating of each option we can also assume order of preference of each choice.

As discussed in Chapter III, whilst social networking was taken advantage of as a source of participants and it can be assumed that there was a large potential participant pool, it was not possible to ascertain the response rate. Firstly, because there is no accurate way of assessing how many people saw the message, and secondly because information about where the participants who did respond had followed the link from could not be captured. Consequently it is not possible to know which social networking source was the most successful in terms of generating participants, although it would be of value to understand this, as social networking becomes more of a viable source for researchers. As with most sampling methods, there are certain disadvantages to using online samples (Wright, 2005). In addition to the difficulty of tracking the non-response rate, relatively little is known about the characteristics of people who use specific online media such as Skype or Facebook,

and it is difficult to know whether certain participants provide multiple responses. Moreover, participation in online communities may be sporadic and it is unclear who viewed the message about the present research. As it becomes more common for users of social media to be bombarded with targeted advertising, it also becomes more likely that they learn to ignore what they perceive as unwelcome "spam" when browsing sites. The invitation to participate in the survey used in the present study might also have been viewed as spam or an invasion of privacy. Finally, self-selection bias might also be an issue as in any given internet community, there are undoubtedly some individuals who are more likely than others to complete an online survey and they might have different characteristics than individuals who do not chose to complete the survey.

Whilst *a priori* power analysis was conducted to ensure an adequate sample was recruited, the sample was nevertheless too small in each of the two groups (past experience of mild depression and past experience of moderate depression) included in the analysis to test the third hypothesis. Despite this, most of the correlations conducted to test this hypothesis still reached statistical significance. It is possible that the correlation between having sought informal help for mild symptoms of depression and the intention to seek formal help for moderate and for severe symptoms of depression would have been significant with a larger sample size, and the same could be the case for the correlation between having sought formal help for mild symptoms of depression and the intention to seek formal help for severe symptoms of depression. It was hoped to recruit a sample that contained individuals who had experienced various severity levels of depression (and some with no past experience of depression). However, purposive sampling was not used to ensure adequate sizes in each of the final groups because it was beyond the time and resource limitations of the present study. Future research can ensure adequate sample sizes by adopting a purposive approach to participant selection.

As mentioned previously, the present study focused mainly on two constructs: past behaviour and intentions to perform the behaviour. Upon reflection, capturing data relating to a wider set of constructs known to influence the intention-behaviour gap, such as attitudes, perceived control, or subjective norm would have offered a greater insight into help seeking for depression. Additionally, future research might also examine the quality of the past help seeking experience, whether positive or negative, and how this might affect an individual's future intention to

seek help. Self-efficacy is another variable that future research could investigate in order to better understand its interaction with depression and help seeking.

A final potential limitation of the present study relates to the theoretical basis used. The information-processing framework was used as a way of understanding the decision making process for seeking help, and whilst this model emphasises the individual as a processor of information, it consequently does not give enough attention to emotional and motivational factors that might affect individuals' decisions (Mayer, 1996), or the social and environmental contexts in which learning occurs and decisions are taken (Eggen & Kauchack, 2007). When studying help seeking behaviour it is important to consider the context in which difficulties such as depression occur as well as the individuals' social network, as these are likely to affect seeking help from both formal and informal sources. Informal support networks can influence how important decisions are made, as well as supporting individuals in implementing those decisions. Qualitative methodologies could be used in addition to quantitative methodologies, to explore the contexts in which individuals' difficulties develop, and the role and features of their social networks and informal sources of help in more depth.

Chapter VI: Conclusions

The present study explored how past experiences with the symptoms of depression and past help seeking for depression might affect the intentions an individual has to seek help for more severe symptoms of depression in the future.

The first hypothesis was supported: the more severe the difficulties of depression the higher the reported help seeking behaviour was for those people who had experienced depression in the past, and the higher the intentions to seek help were for those who had not previously experienced depression. This held true for both formal and informal sources of help. For mild and moderate symptoms of depression, intention to seek informal help as well as help seeking behaviour from informal sources was higher than from formal sources of help. For severe symptoms of depression similar levels of both formal and informal help seeking intention and behaviour was observed. The second hypothesis of the study was not supported: merely having had past experience of depression did not lead to stronger intentions to seek help for more severe symptoms of depression in the future. Past help seeking behaviour was on the other hand correlated with increased intention to seek help for more severe symptoms of depression.

The findings of this study coincide with previous studies on help seeking behaviour for other health difficulties. Consistent with previous studies, it was found that increased severity of the difficulties as well as past help seeking behaviour is connected with increased help seeking behaviour. The study also provides a new set of results since it was derived from the use of a different methodological technique, and has addressed the relative paucity of research that examines the relationship between symptom severity and intentions to seek help in the future.

The present study would have benefited from measuring some of the other constructs that can influence the relationship between intention and behaviour, such as attitudes towards help seeking and quality of past help seeking experiences. Purposive sampling would have provided a more balanced design allowing more between group comparisons to be made, and improving statistical power.

The findings of the present study make a small contribution to the help seeking literature and more studies should be conducted investigating the factors that are most influential in the decision to seek professional help. This paper highlights how many people are likely to first seek help from informal sources for less severe

symptoms of depression, turning to formal sources of help only when their problems become more severe. Whilst informal support networks can provide people with essential care, helping people recognise their symptoms and turn to formal help for less severe problems, informal networks might also help increase the likelihood that they will intend to use formal help sources if they have more severe problems in the future. Past experiences inevitably shape our future decisions, but more importantly, it is the quality of those experiences that will encourage or discourage that behaviour to be repeated again. Counselling psychologists are, therefore, in a position to ensure that their clients have positive experiences with help seeking, in order to facilitate help seeking again should they need it.

Chapter VII: Reflective Account

An important aspect of any research project is a recognition and consideration of the contribution of the researcher's knowledge, beliefs and skills to the process and outcome of the research. Whilst more consideration is often paid to the role of the researcher in qualitative approaches, researcher factors can impact on quantitative studies, starting with the selection of a research question and hypotheses, but also including selection of methodological approach, collection of the data and analyses, and the interpretation of the results. Consequently, even quantitative researchers must demonstrate awareness during the process of their projects, keeping a reflexive account of decisions that were taken, and the effect that his or her own participation in the project might have upon the research process (McLeod, 2003). Moreover, reflexivity is the human capacity to monitor our reactions to situations, actions and inner feelings, a process of continual reflection, analysis, evaluation and decision-making (Woolfe et al., 2003). This is more generally aligned with the value base of counselling psychology.

Honouring the reflective account, this section is written now in the first person. It is my attempt to map out my position in relation to the research topic itself, and how this relates to my identity, background, attitudes and motivations for engaging in the research. I also endeavour to reflect upon the decisions I have taken regarding the selection of the specific methodology and the process of conducting the research.

7.1 Context of the study

This research project was conducted in the context of a Professional Doctorate in Counselling Psychology and investigated help seeking for depression, a topic I believe is very relevant to the profession of counselling psychology. Counselling psychology is a relatively new field of psychology, which has quickly expanded both as a recognised profession and in terms of the broad range of activities that counselling psychologists engage in. As the British Psychological Society (2011) have stated: "Counselling psychologists are a relatively new breed of professional applied psychologists concerned with the integration of psychological theory and research with therapeutic practice". Counselling psychologists are trained to adopt a number of different roles, including assessing clients' mental health needs,

working psychotherapeutically with clients using several potential therapeutic frameworks, being active members of multidisciplinary teams, service and organisational development, research and development, and management of services. Consequently, there are many potential domains and research topics that are of relevance for the profession of counselling psychology.

It is obvious from the roles and tasks adopted by counselling psychologists that they are not only concerned with counselling and psychotherapy with clients but are also called to draw upon their psychological background and knowledge and contribute to service organisation and development. According to Woolfe et al. (2003), counselling psychology in Britain represents a return of counselling to psychology initiated by psychologists trained in counselling and psychotherapy. Counselling is rooted in humanistic and existential-phenomenological psychology in which the search for understanding and meaning is central and in which the focus is upon the engagement with subjective experience, values and beliefs. Psychology on the other hand has emphasised its roots in experimental behavioural science. It is therefore important that counselling psychologists maintain their identity and keep a balance between being involved with psychotherapy whilst at the same time being psychologists, contributing their psychological knowledge for the development and improvement of the services offered to clients. This is my own stance professionally: I believe that counselling psychologists have valuable contributions to make to service development and making services more accessible to clients.

A valuable role counselling psychologists can play is in finding ways to improve access to psychological therapies and to encourage people to seek help as early as possible when faced with a psychological difficulty. Counselling psychologists usually see people in distress for psychotherapeutic work but seeking help from professionals is only one route in the pathway to seeking help. Clients will usually progress through a series of stages and make several decisions before they contact professionals (Moller-Leimkuhler, 2002). It is of great importance for counselling psychologists to study and be aware of the factors that have been connected with seeking help for psychological difficulties, in order to be in a better position to help their clients, as well as find ways to encourage people to seek help earlier. As I will explain later in this chapter, finding ways to encourage people to use services earlier has been a core part of my work and professional development so far.

Psychologists are "scientist-practitioners". Whilst a psychologist may focus more on one aspect of this role than the other, what this essentially means is that the applied work we do in service of our clients (or our potential clients) is grounded in theoretical and empirical evidence that what we are doing is effective. Thus, counselling psychologists have an equally important role to play in the research and development of more effective applied practice and should be able to conduct research, or interpret the research of others, and use it to offer clients evidence-based treatments, improve access to services, and improve clients' experiences of those services. This research project also holds this dual aim of using science to inform practice. I wanted to investigate help seeking behaviour and the actions that people take in order to get support when they have a problem so that clients in real-world settings can be encouraged to seek appropriate forms of help as soon as it becomes important for them to do so. Moreover, I also wanted to contribute to the practice of research by first piloting and then using empirically a new methodological approach to the research question, the vignette, and by addressing some gaps in the help seeking literature.

7.2 Positioning myself: Origins of the study and development of the topic

My interest in help seeking behaviour is unavoidably bound to my interest in counselling psychology and the helping professions. When I first began to study psychology, I hoped to one day work psychotherapeutically with people. This is the reason I pursued the pathway to training as a counselling psychologist, rather than another sub-division of our field, although I had previously completed a masters degree in health psychology. The combination of my four-year undergraduate course in psychology and a postgraduate qualification in health psychology has provided me with a strong psychological background and knowledge about health and illness behaviours, the extant research in the field and knowledge of psychological research methods. Rather than operating closely within our own divisional "silos" I believe that psychologists can learn from one another's sub-divisional specialities to inform the work that we do in our own field. In this sense, I feel that studying health psychology prior to counselling psychology has perhaps given me a different or alternative perspective. What I mean by this is that I recognise that beyond people's specific physical or mental health problems, what is also important is the process someone goes through in order to seek help and support for their difficulties.

Counselling psychologists are in an ideal position to study people's help seeking behaviour, the actions people take when faced with emotional difficulties, since working psychotherapeutically with clients with emotional problems is one of their main roles and fields of working. I consider that one of the professional aims of counselling psychologists should be to improve access to therapy, by helping people identify their difficulties and to seek help early on, before their difficulties become too severe, an action that will make their recovery more likely. An array of factors that have been examined specifically in relation to help seeking for mental health issues were discussed in "Chapter I". An understanding of the factors that affect use of services was one of the aims of this research project. By gaining an insight into the behaviour of clients beyond, and before, the consulting room might help clinicians understand them better and ultimately be in a better position to help.

Mostly, counselling psychologists see people when they are in distress and consequently we try to be facilitators in the process of overcoming their difficulties. Whatever the particular therapeutic approach we adopt within our practice, we regularly attend to the process of therapy, the space between our clients and us and what happens during therapy, and the process people go through to get better. It is my belief that we do not pay equal attention to the processes our clients might have gone through already before they come to us. This is important because it can provide us helpful information about our clients, their resources, their problem-solving skills, and how these resources and problem-solving skills might be employed at times of need and during therapy. As well, we should keep in mind that most people have started a process of recovery long before they reach professionals and have often made some previous attempts to get support. It might therefore be helpful to explore how these previous experiences of help seeking might be affecting clients in the present and how they might have shaped their expectations of clinicians and of therapy. Clients' expectations of health professionals and of therapy can have important implications for their willingness to engage and progress in therapy and clinicians need to be aware and attentive to these expectations and previous experiences. For instance, negative previous experiences might potentially undermine a client's sense of hope about being helped in the present and can shape his or her view of the future. Through my own professional training I have encountered several clients who were angry at heath professionals and were disappointed at their previous failed attempts to get help. This was a factor that I

believe seriously hindered these clients' engagement in therapy and their progress and I consequently feel that more attention should be paid to previous experience with seeking help or the reasons that someone had for not seeking help.

This research project was an attempt to investigate the processes that people follow to seek help from professionals and from their informal support networks. Specifically it was hoped to explore factors that might affect their future intention to seek help for more severe symptoms of depression than they had faced in the past. Beyond the research paradigm, counselling psychologists could routinely explore the process their clients have gone through until they sought help. This can be performed not only by requesting whether someone had contact with other health professionals in the past (something done regularly by health professionals when assessing clients) but by also regularly requesting whether they attempted to get support from their social networks and exploring help seeking behaviours and outcomes they have found helpful in the past. By exploring their past attempts to get help, clinicians can learn a lot about their clients, their resources and their coping strategies and might be able to explore with them ways they can utilise their social networks and get support when they are faced with difficulties. For instance, a counselling psychologist who works within a cognitive behavioural framework can utilise the clients' social network to help the client plan activities and increase their general activity levels. Someone who works more psychodynamically can use insights about their clients' trusting relationships outside therapy during therapy. I personally work from a cognitive behavioural framework and have found it incredibly helpful to explore in therapy the kind of help clients sought in the past, what kind of problem-solving strategies they have used and how effective those were. I came to realise that sometimes clients have many resources they can utilise but their distress might cause them to give them up easily without using them to their full extent.

This research project investigates help seeking specifically for depression. Depression is a very common difficulty (Kessler et al., 1994; Kringlen et al., 2001) very frequently encountered in clinical practice, and it is therefore important for counselling psychologists to study and understand peoples' help seeking for it, particularly as so many of us work within the NHS where depression is the most common psychological difficulty people present with. During my training in counselling psychology and contact with clients over six years, I have worked with people presenting with different problems but depression has been the most

prominent. My main difficulty has been working with people who have severe depression, who are far more challenging to motivate within therapy, whilst I could see very different results when working with people with mild to moderate symptoms of depression. This led to my developing an interest in why some people appear to wait so long before seeking help.

In psychotherapy, clients' intentions to act are regularly explored, as well as future scenarios and possibilities. The theoretical construct of "intentions" and their relationship upon behaviour is more commonly investigated within health psychology, although I believe that it is also important that counselling psychologists have an awareness of our clients' intentions to behave in specific ways. Specifically, if we contextualise help seeking for psychological problems as a "health behaviour" we can see how it is also important to find ways to investigate our clients' (and potential clients') intentions to seek help, as well as other variables involved in the process of seeking help. This research project was an attempt to investigate what factors affect intention to act in a certain way in the future, such as previous experience of depression and past help seeking behaviour for depression, as well as severity of the difficulties.

Vignettes and hypothetical scenarios have been used in research investigating people's values, opinions and intentions, although have been rarely used to explore the present research topic. Besides the opportunities afforded by the approach within research, I believe that I also selected this method because of my own training experiences. The use of vignettes has been a main teaching tool during my counselling psychology training: to prepare us for future encounters with clients, to make us think of different scenarios and possibilities, and to enhance our problem-solving skills. It was a way to measure our intentions to act as clinicians and teach us new ways of thinking, by examining different possibilities. I valued this approach myself, and consequently I was more open to adopting it for my research.

The choice of a quantitative methodology has been affected by my previous research experiences. My first contact with research was my undergraduate research project, a quantitative study looking at test anxiety and its relationship to substance use in undergraduate university students. This initial research project got me involved in thinking how to design a study and how to use statistical analysis to look at the data in a more meaningful way. I conducted another quantitative study at postgraduate level, examining the psychological variables that might predict

restrained eating. Whilst neither of these projects related to seeking help or counselling psychology directly, I feel that any psychology topic can be relevant to counselling psychology practice, as long as it studies human behaviour and gives us some useful insights into how people behave. Substance use and restrained eating are behaviours that could lead people to seek help from counselling psychologists and are topics worth investigating, in order to understand potential clients better. When I started my academic training as a counselling psychologist, I selected a qualitative approach, using semi-structured interviews and analysing the data using Interpretative Phenomenological Analysis (Smith, Jarman, & Osborn, 1999). I explored the lived experiences of being in personal therapy with trainee counselling psychologists. Personal therapy is mandatory for trainee counselling psychologists, both for their personal development as well as to seek help for any issues that could potentially impact on their work with clients. My own experience of having personal therapy as a trainee and psychotherapy client was a form of "mandatory" help seeking at a time I was not ready for it. This thought developed into a broader interest in the process of seeking help voluntarily, and factors that might facilitate (or not) this process. This was an important question for me personally. When I had experienced depression in the past myself, I did not seek help for it at the time. I reached a point when other people started suggesting that it might be a good idea to talk to someone and even though I agreed that it was a good idea, I still waited for the depression to "pass". Being encouraged by others however was important as it at least started me thinking about seeking help. Furthermore, I feel that it was the lack of social support that was contributing to my depression at the time. Not seeking help was also affected by my tendency to feel uncomfortable about showing vulnerability. On reflection I should have addressed my problem earlier and I have now started to realise that seeking help is part of being human and there are times we need to ask for help, practical as well as emotional.

According to Woolfe et al. (2003), the discipline of counselling psychology embraces all potential research methodologies and the superordinate research approach should be methodological pluralism, incorporating both qualitative and quantitative methodologies. The critical point for the researcher is to select the approach that is most appropriate to the question being asked (Woolfe et al., 2003). My experiences with both the method and the content of my prior research projects converged upon the selection of methodology for the present study. I considered that

a quantitative methodology would be appropriate for the investigation of the process of help seeking behaviour and the research questions of the study, as the main aim was to look at general patterns in the responses using statistical analysis in order to study help seeking, and not focus on the ratings given by any single participant.

This research project therefore is an integration of all the above. It is an integration of my psychological background and contact with theories and research from heath psychology. Most importantly this present study draws upon my counselling psychology training and my work with clients in distress. This topic has developed from my previous experiences as well as personal interest and I hope it can make a contribution to the field of counselling psychology.

7.3 The process of conducting the research

7.3.1 Hypotheses selection

During the time I have been working on the study the focus of the study changed twice before the final research questions and hypotheses were selected. Initially my supervisors and I planned to conduct two studies, one involving the general population and one involving a clinical sample. The purpose of this was to study help seeking in people who sought help (examining help seeking behaviour) as well as the general population (examining intention to seek help) and at the same time explore the usefulness of the vignette methodology with these two samples. The initial idea however turned out to be very difficult to implement due to both poor planning, as accessing a clinical sample proved very difficult, as well as due to the inclusion of too many variables that made forming and testing the key hypotheses very difficult. Following those initial difficulties I felt hopeless and disheartened and could not think of a way to change the situation. I found it incredibly difficult to ask for help from my supervisors as I was mostly feeling that I might be blamed for the difficulties.

Around the same time, my primary supervisor Dr Sanders had to retire and was replaced by Dr Cohen, my current supervisor. Even though I felt sadness as well as anxiety for losing Dr Sanders who was a valuable source of support and encouragement, the change of supervisor proved to be an excellent development. Dr Cohen brought a fresh perspective and with the changes she suggested we were able to plan the study again, form new research questions and hypotheses and have a

study that I could implement with the limited resources and time I had. Despite the many difficulties, I felt satisfied with our new-formed research questions as I could form specific testable hypotheses and engage more with the existing literature to identify what has been found so far as well as gaps I could study.

7.3.2 Data gathering and writing up

Due to the initial difficulties with the design and implementation of the study as well as external circumstances the research turned out to be a lengthier piece of work than originally anticipated. While this situation created some frustrations and difficulties, the longer time span also provided an opportunity for me to learn how to overcome difficulties when conducting research and reflect on the topic as well as my own strengths and weaknesses.

I found data gathering one of the most stressful parts of the process. Initially I felt guilty that I was going to be asking people directly for a "favour" (i.e., to satisfy my needs, rather than to meet any of their own). Using online methods to gather a sample made it easier for me, not because I feel I lack the interpersonal skills to do so, but because asking for help face-to-face made me feel uncomfortable. Reflecting upon this now I can see that I have a general tendency to avoid making myself vulnerable, and that seeking help is something that particularly makes me, and others feel vulnerable.

I was also aware of my high expectation that I needed to confirm all my hypotheses, even the more tentative one, and my worry about how I could possibly generate a study worthy of doctoral quality if I found nothing significant. Aside from debate that continues within the community, about publication biases towards only significant results, I eventually came to realise that the point of research is to investigate something interesting, and to do this well, but that the process of learning for me was to conduct the study, rather than the results per se. Given that I was confident that I was drawing upon relevant theoretical and empirical literature when forming my hypotheses, but that I was also implementing a relatively new approach to the topic, I also became more confident that I would cope with the results I obtained.

Writing up the thesis was labour intensive, not least because by this time I was working full time. I was writing during my weekends, after a long and emotionally draining week at work and other additional projects I have been

involved in. Inevitably, my work-life balance suffered, and eventually I started feeling exhaustion as well as resentment for something I felt had taken over my life. As I was getting closer to completing it I felt relief, as well as anxiety about the outcome.

7.3.3 Personal influences

The present study adopted the epistemological position of empiricism–positivism and used a quantitative methodology to study help seeking. By using this methodology the influence of the researcher's own interpretation is minimised as the data were analysed using statistical analysis. Positivism assumes that the researcher, the research participants, and the topic are independent of one another and that by following rigorous standard procedures, the participant and topic can be studied by the researcher without bias, which gives objectivity to the research (Ponterotto, 2005). Furthermore, it is claimed that the investigator can study her or his research participants without influencing them and vice versa and if values and biases of the researcher influence the study in any way, the study becomes flawed (Ponterotto, 2005). Quantitative methodologies are therefore considered to have objectivity, as they focus on events that can be reliably reported, and are open to observation by someone other than the person undergoing the experience (Smith, 2008).

As researchers however, we need to recognise our role and influence in the process of research and at the same time recognise that a clear separation between the researcher and those participating in the research might not be possible (Woolfe et al., 2003). Even in a quantitative research project, especially one that is not blind or double blind, and has no control group, there is a possibility of influencing the behaviour of the participants and the way they completed the measures. This might happen especially if participants have formed an idea of what they might be expected to answer and which answer might be desirable for the researcher. These biases can confound the results, and attempts should be made to avoid them, such as changing the order and scaling of questions, and not revealing the hypotheses in consent forms. I attempted to address and minimise potential response biases by having standardised instructions. Moreover, by delivering the questionnaires via the internet, I was not able to subconsciously or consciously influence the outcomes. Nevertheless, I am aware that some participants might still have answered in an expected manner, for example by rating higher help seeking for the more severe

symptoms of depression. Finally the possibility that the way the vignettes were designed and ordered might have also affected the responses cannot be ruled out.

7.3.4 Learning

Conducting a research study at Doctoral level has been extremely challenging. When I started planning the study I did not realise how difficult it could be. I had previously completed an undergraduate dissertation and two master dissertations and I therefore thought that I would not have many difficulties with conducting another, albeit larger, one.

The task proved much more difficult than my expectations and I experienced difficulties since the very start of the project. What I initially thought to be a well designed study proved to be impossible to execute well. The idea my supervisors and myself started working on initially involved conducting two studies, one with a clinical population. As I did not have access to the clinical sample I had to struggle to find participants and organisations to help me. I tried contacting health professionals and voluntary organisation asking for help. I had always assumed that people who work therapeutically with clients would be the perfect people to ask for help from, particularly as I was hoping to inform our applied practice. I was sorely disappointed. I realised that most people had their own things to do and they were not willing to go out of their way to help someone they did not know. Even though this makes sense to me now, at the time I was so emotionally charged that I became despondent, even angry, and wondered how could people who work in helping professions be so seemingly unwilling to help.

I tried to reflect upon what this experience could teach me about seeking help, as I felt I was desperately asking for help and I was not getting any. After discussion of the difficulties and negations with my supervisory team we decided to slightly amend the topic and not use a clinical sample. This was a relief for me although I still felt quite desperate regarding getting a totally new sample, because having spent months trying to get 120 questionnaires, I had to start all over again. Now I see that this was the best decision we have taken. Redesigning the study helped me regain my focus and try to take every step again and this time do it right. Conducting this study has been a real journey for me. I felt very negative towards it so many times but at the same time I have learnt so many things from doing it.

I have learnt how difficult it is to design a research study. I had to learn how to formulate research questions and finding a meaningful way of answering them. I realised that statistical analysis and interpretation is not an easy task but something I needed to really understand. Furthermore, conducting and writing up the study was much more time consuming that I thought. I underestimated the time each step took me and at some point conducting this study became a real burden in my life. Despite all of these I managed to complete it and I am very proud of it.

I attempted to get help and support from different people and I learnt that seeking help is not an easy task. It is a complicated process that requires courage and putting yourself in a vulnerable position. It requires taking the risk of being rejected. When you do however find support it is rewarding. I realised who really cared about my wellbeing. I believe I have learnt to be a better practitioner too because this process made me think how my potential clients might be feeling when they attempt to get help from professionals as well as from their friends and family, and how many times in the past they may have asked and not received help from others. Like me, they are putting themselves in a vulnerable position and risking being refused the help they need, which can sometimes be more harmful than not seeking help at all. This study has also taught me a lot about being vulnerable and depending on other people. At the same time I learnt too how to work independently, and take full responsibility for the process and output of my work, and overcoming difficulties. I hope that this study makes a small contribution to the study of help seeking.

7.4 Reflections on supervision

One of the most challenging aspects of conducting this research was negotiating the dynamics of supervision. The university allocates two supervisors to each trainee, one of which is the primary supervisor and director of the trainees' studies. When I initially started this process I found it difficult to be assertive with my opinion and say no to different ideas I wasn't sure about, and having a second supervisor complicated the situation. I felt I would seem to be ignorant if I asked too many questions, or disagreed with a suggestion, so within my supervision sessions I preferred to agree with whatever was said, and then go home and research the ideas more. Many times I felt I had to justify myself for having to ask questions or help, as I feared I would be judged.

I think this was probably due to a sense of powerlessness and dependency I was feeling at the beginning. This situation improved after the change of the primary supervisor, as Dr Cohen wanted to make changes so the research will be more feasible, and she took charge and was assertive with her opinion. Her later departure from the university and therefore change in the director of studies for a second time created further panic but I am grateful that she remained my supervisor and supported me throughout. Even though these changes made me feel resentful towards the university and angry with myself for my inability to find solutions, I did not give up and managed to complete it, something I am very proud of considering the difficulties I had.

7.5 Reflections on personal and professional development as a counselling psychologist

The journey of becoming a counselling psychologist has proved to be much more difficult and much more exciting that I ever thought initially. When I embarked on this journey I saw counselling psychology in a different light than I do now. My main concern at the beginning was seeing clients for therapy. Today I see counselling psychologists as scientist-practitioners, using evidence-based practice influenced by research. According to the BPS Board of Examiners in Counselling Psychology (BPS, 2006), counselling psychology is strongly influenced by human science research as well as the principal psychotherapeutic traditions and combines the scientific demand for rigorous empirical enquiry with a firm value base grounded in the primacy of the counselling or psychotherapeutic relationship.

My engagement with this research project has increased my knowledge on how to plan and conduct research as well as my ability to read academic articles in a more critical and in depth way. I feel more confident about reading literature and making my own judgements about its usefulness as well as strengths and weaknesses. I also feel more able to get involved in research in the future, possibly via my work, as well as academic writing in the form of literature reviews, in topics of interest to the area of counselling psychology.

Conducting this study and reflecting on my own help seeking style made me more understanding of the clients I see and the severity of the difficulties they present with, as I now have a better insight of help seeking delay and the range of factors that might hinder or delay help seeking. My work in the last three years as

well as conducting this research, have contributed to my development as a counselling psychologist and enriched my knowledge of barriers potential clients might face.

Finding ways to encourage people to use services earlier has been a core part of my work and professional development so far, as I work for a primary care psychological service where everybody is expected to be part of the service development and promotion, in order to increase the clients' access to services. More recently I have been involved in a diverse number of projects to encourage people to seek help early on, including promotional events, providing mental health awareness training, educating GPs, running groups and workshops, as well as being involved with the development of the service's leaflets and website. Prevention and targeting people in the mild to moderate level of difficulties is the main philosophy of the service, as it is believed that it will be much more beneficial to help people before their difficulties become too severe. I have now moved from the position of delivering therapy to thinking more proactively about different and more creative ways to help people in distress. I feel that being involved in research is crucial, in order to evaluate one's work and effectiveness and I think being a scientist-practitioner is the only way I can do this successfully.

My engagement in this research has been an exciting, enriching and transformative journey. It enabled me to gain a fuller understanding of how I relate to other people and my own attitudes towards help seeking. It made me evaluate the "double standards" I hold, that it is acceptable for others to seek help but that for me it shows weakness. I have since re-evaluated and tried to address this issue.

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Appendix A – Power Analysis

Hypothesis 1: F tests - MANOVA: Repeated measures, within factors

Options:	Pillai V, O'Brien-Shieh Algorithm		
Analysis:	A priori: Compute required sample size		
Input:	Effect size f	=	0.30
	α err prob	=	0.05
	Power (1-β err prob)	=	0.8
	Number of groups	=	1
	Number of measurements	=	3
	Corr among rep measures	=	0
Output:	Noncentrality parameter λ	=	10.5300000
	Critical F	=	3.2519238
	Numerator df	=	2.0000000
	Denominator df	=	37.0000000
	Total sample size	=	39
	Actual power	=	0.8028227
	Pillai V	=	0.2125984

Hypothesis 2: F tests - MANOVA: Special effects and interactions

Options:	Pillai V, O'Brien-Shieh Algorithm		
Analysis:	A priori: Compute required sample size		
Input:	Effect size $f^2(V)$	=	0.30
	α err prob	=	0.05
	Power (1-β err prob)	=	0.80
	Number of groups	=	3
	Number of predictors	=	1
	Response variables	=	2
Output:	Noncentrality parameter λ	=	10.8000000
	Critical F	=	3.2945368
	Numerator df	=	2.0000000
	Denominator df	=	32.0000000
	Total sample size	=	36
	Actual power	=	0.8079238
	Pillai V	=	0.2307692

Hypothesis 3: z tests - Correlations: Two independent Pearson r's

z tests - Correlations: Two independent Pearson r's

Analysis:	A priori: Compute required sample size		
Input:	Tail(s)	=	One
	Effect size q	=	0.30
	α err prob	=	0.05
	Power (1-β err prob)	=	0.80
	Allocation ratio N2/N1	=	1
Output:	Critical z	=	1.6448536
	Sample size group 1	=	141
	Sample size group 2	=	141
	Total sample size	=	282
	Actual power	=	0.8015397

Appendix B – Demographics Information Form

Please complete the following details:

Gender: Male / Female

Age: _____

Marital status:

Single / Married / Divorced / Widowed / Cohabiting / In a relationship / Other

Highest Educational Qualifications obtained:

None / O' Level/GCSE / A' Level / Higher non-degree award / BA/BSc degree / MA/MSc degree / PhD or equivalent / Other

Occupational Status:

In Full or part time employment / Unemployed / Retired / Homemaker / Student / Other

Ethnic Origin:

White	British
	Any other white background
Mixed	White and Black Caribbean
	White and Black African
	White and Asian
	Any other mixed background
Asian or Asian British	Indian
	Pakistani
	Bangladeshi
	Any other Asian background
Black or Black British	Caribbean
	African
	Any other Black background
Chinese	Chinese
Other ethnic group	Please state:

Appendix C – Five Vignettes

Vignette 1

There are some days recently when you are not in a very good mood. Sometimes you find it a bit difficult to sleep. You are feeling a bit tired recently and your interest in things you enjoy is a little bit less. Also, the pleasure you get from things is not exactly the same as before. However, you still do everything like you used to. You've also noticed a small change in your appetite that doesn't seem worrying. You sometimes lose your concentration, for example when reading. There are minor impacts on your everyday life but the situation doesn't seem serious.

Vignette 2

Recently you sometimes feel a bit down. There are some days when you find it a bit difficult to sleep, or have a little difficulty getting out of bed. You don't have as much interest or get as much pleasure in doing things as before. Your energy to do things that you enjoy is a bit less. You've also noticed a small change in your appetite and feel like eating a bit less or more than before. Sometimes it is a bit difficult to concentrate, for example you find it difficult to read a book. You also have some small physical complains, like feeling tired. Even though the situation doesn't seem too serious, you have started feeling a bit bad and guilty about your situation.

Vignette 3

Quite often recently you are feeling down and have a low mood for a large part of the day. There are nights when you are finding it difficult to sleep and many mornings you have difficulty getting out of bed. Your interest or pleasure in activities is less than it was. You have less energy than before to do things you enjoyed. You started eating less or more than you used to and your weight has changed, without this being your intention. You are finding it difficult to concentrate, for example to read something. You have started having different physical complains. You started doubting your worth as a person, feeling guilty and you sometimes wonder what the point in doing things is.

Vignette 4

Quite often recently you are feeling down and sad for a large part of the day. There are nights when you are finding it difficult to sleep and many mornings you have difficulty getting out of bed. Your interest or pleasure in activities is significantly less. You have no energy to do things you used to find enjoyable and you spend a lot of time in the house. You have started eating less or more than you used to and your weight has changed recently, without you wanting it to do so. You can't concentrate, for example to read something. You have started having physical problems. You started doubting your worth as a person, feeling guilty and can't see the point in things. There are times when you have thoughts of death.

Vignette 5

You have been feeling very depressed most of the day, nearly every day. It is very difficult to sleep almost every night and every morning you can't get out of bed. You don't feel like doing anything. The way you eat has completely changed since you started feeling that way and your weight has changed considerably, without this being your intention. You can't do almost anything and it's impossible to concentrate. You have many physical problems, like feeling very tired, having aches and pains. You hardly go out and you spend almost all day in bed. You are feeling worthless and very guilty almost every day. You can't see the point in things and you started having persistent thoughts of death.

Appendix D – Information Sheet (Pilot study 1)

Dear Counselling Psychology Trainee,

I am conducting a doctoral level research project as part of my course "Professional Doctorate in Counselling Psychology" at London Metropolitan University. This study has been approved by the Psychology Department Research Ethics Committee.

Prior to finalising my measures, I am conducting a pilot study with 3rd year counselling psychology trainees, health professionals, and general public in order to obtain an expert view. To this end I would be very grateful if you would be able to take the time to read five short vignettes and to use your clinical judgement and your experience in working with clients to rate the severity of the difficulties presented. You are encouraged to comment on the vignettes and suggest improvements. I estimate that participation will take approximately 10 minutes.

The data you provide will be used ***only*** as part of piloting the measures and will be kept ***strictly confidential*** to my self and my supervisors.

Thank you very much for your time and please do not hesitate to contact me if you have any further queries.

Yours faithfully

Evi Aresti

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Appendix E – Information Sheet (Pilot study 2)

Dear Health Professional,

I am conducting a doctoral level research project as part of my course "Professional Doctorate in Counselling Psychology" at London Metropolitan University. This study has been approved by the Psychology Department Research Ethics Committee.

Prior to finalising my measures, I am conducting a pilot study with 3rd year counselling psychology trainees, health professionals, and general public, in order to obtain an expert view. To this end I would be very grateful if you would be able to take the time to read five short vignettes and to use your clinical judgement and your experience in working with clients to rate the severity of the difficulties presented. You are encouraged to comment on the vignettes and suggest improvements. I estimate that participation will take approximately 10 minutes.

The data you provide will be used ***only*** as part of piloting the measures and will be kept ***strictly confidential*** to my self and my supervisors.

Thank you very much for your time and please do not hesitate to contact me if you have any further queries.

Yours faithfully

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Appendix F – Information Sheet (Pilot study 3)

Dear Participant,

I am conducting a doctoral level research project as part of my course "Professional Doctorate in Counselling Psychology" at London Metropolitan University. This study has been approved by the Psychology Department Research Ethics Committee.

Prior to finalising my measures, I am conducting a pilot study with 3rd year counselling psychology trainees, health professionals, and people from the general public in order to obtain opinions on my measures. To this end I would be very grateful if you would be able to take the time to read five short vignettes and to use your judgement to rate the severity of the difficulties presented. You are encouraged to comment on the vignettes and suggest improvements. I estimate that participation will take approximately 10 minutes.

The data you provide will be used ***only*** as part of piloting the measures and will be kept ***strictly confidential*** to my self and my supervisors.

Thank you very much for your time and please do not hesitate to contact me if you have any further queries.

Yours faithfully

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Appendix G – Pilot study 1 and 2 Instructions

The following statements are descriptions that a woman or a man might give when talking about a difficulty that they are experiencing. At first glance the statements may seem very similar but a closer reading may reveal that some of the difficulties described are greater than others.

The purpose of this pilot study is to assess the different levels of severity that each person is experiencing and to estimate the extent to which each experience is different from the others.

Please read each description that follows and, using your clinical judgment and experience with clients, rate how severe you think each difficulty is on the scale provided. Different clients / patients may present with similar kinds of difficulties but those difficulties may be present at different levels of severity. Try to imagine different clients / patients presenting you with each description and rate how severe you judge each individual person's difficulties to be.

Gender:
Age:
Profession:

Appendix H – Pilot study 3 Instructions

The following statements are descriptions that a woman or a man might give when talking about a difficulty that they are experiencing. At first glance the statements may seem very similar but a closer reading may reveal that some of the difficulties described are greater than others.

The purpose of this pilot study is to assess the different levels of severity that each person is experiencing and to estimate the extent to which each experience is different from the others.

Please read each description that follows and rate how severe you think the difficulties are on the scale provided. Different people may experience similar kinds of difficulties but those difficulties may be present at different levels of severity.

When reading the stories try to imagine how it would have been if you were actually feeling that way, even if you have never felt like the person in the description. It might be helpful to imagine a situation in your life you found particularly difficult to cope with or you might find difficult at some point in the future. Try to put your self in the position of the person described, even if you can't currently identify with the description

Gender:

Age:

Appendix I – Vignettes' order of presentation

Table 16.

Vignette's order of presentation

P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12
1	2	3	4	5	5	3	4	1	2	3	2
4	1	5	2	3	3	4	2	5	1	4	5
2	5	1	3	4	2	5	1	3	4	2	3
3	4	2	5	1	4	1	5	2	3	5	1
5	3	4	1	2	1	2	3	4	5	1	4

Note. P = participant, each number represents a vignette

Appendix J – "Behaviour Instructions"

The following descriptions present examples of what might be the typical experience of someone who is depressed. Please read the descriptions that follow and try to think back at the time when you had a similar experience to that outlined in the stories. After reading each story, please answer the question that follows.

Appendix K – "Intention Instructions"

Please read the descriptions that follow and try to put your self in the position of the person described. When reading the stories try to imagine how it would have been if you were actually feeling that way, even if you have never felt like the person in the description. It might be helpful to imagine a situation in your life you found particularly difficult to cope with or you might find difficult at some point in the future. After reading each story, please answer the question that follows.

Appendix L – "Intention answer sheet"

Imagine that you are the person described in the story and assume that the sources of help presented here are equally available to you. Please rate the LIKELIHOOD of approaching EACH ONE of the following sources of support, using the following scale:

1	2	3	4	5
Not at all	Very little	Somewhat	Quite a bit	A great deal

Appendix M – "Behaviour answer sheet"

Please think of that time and what YOU DID THEN IN ORDER TO SEEK HELP. Please rate the extent to which you were seeking help for your depression by approaching EACH ONE of the following sources of support, using the following scale. When answering please consider your ACTUAL BEHAVIOUR and what you did to seek help:

1	2	3	4	5
Not at all	Very little	Somewhat	Quite a bit	A great deal

Appendix N – Summary of Vignettes and Instructions

Appendix N – Summary of Vignettes and Instructions

Have you ever suffered from or been diagnosed as having depression? YES/NO
If NO – Please read the descriptions that follow and try to put your self in the position of the person described. When reading the stories try to imagine how it would have been if you were actually feeling that way, even if you have never felt like the person in the description. It might be helpful to imagine a situation in your life you found particularly difficult to cope with or you might find difficult at some point in the future. After reading each story, please answer the question that follows.

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1) There are some days recently when you are not in a very good mood. Sometimes you find it a bit difficult to sleep. You are feeling a bit tired recently and your interest in things you enjoy is a little bit less. Also, the pleasure you get from things is not exactly the same as before. However, you still do everything like you used to. You've also noticed a small change in your appetite that doesn't seem worrying. You sometimes lose your concentration, for example when reading. There are minor impacts on your everyday life but the situation doesn't seem serious.
Have you ever had a similar experience? *YES/NO* – If YES then the "Behaviour" instructions will be presented

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2) Quite often recently you are feeling down and have a low mood for a large part of the day. There are nights when you are finding it difficult to sleep and many mornings you have difficulty getting out of bed. Your interest or pleasure in activities is less than it was. You have less energy than before to do things you enjoyed. You started eating less or more than you used to and your weight has changed, without this being your intention. You are finding it difficult to concentrate, for example to read something. You have started having different physical complains. You started doubting your worth as a person, feeling guilty and you sometimes wonder what the point in doing things is.
Have you ever had a similar experience? *YES/NO* – If YES then the "Behaviour" instructions will be presented

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3) You have been feeling very depressed most of the day, nearly every day. It is very difficult to sleep almost every night and every morning you can't get out of bed. You don't feel like doing anything. The way you eat has completely changed since you started feeling that way and your weight has changed considerably, without this being your intention. You can't do almost anything and it's impossible to concentrate. You have many physical problems, like feeling very tired, having aches and pains. You hardly go out and you spend almost all day in bed. You are feeling worthless and very guilty almost every day. You can't see the point in things and you started having persistent thoughts of death.
Have you ever had a similar experience? *YES/NO* – If YES then the "Behaviour" instructions will be presented

Imagine that you are the person described in the story and assume that the sources of help presented here are equally available to you. Please rate the LIKELIHOOD of approaching EACH ONE of the following sources of support, using the following scale:

1	*2*	*3*	*4*	*5*
Not at all	*Very little*	*Somewhat*	*Quite a bit*	*A great deal*

1a) I will seek support or assistance from someone from my immediate social or family environment (e.g. partner, a close friend, a family member, acquaintance/colleague)	
1b) I will seek support or assistance from professionals (e.g. GP, nurse, a mental health professional like psychologist, counsellor, or psychotherapist, NHS service, social worker, charity)	
1c) Other (Rate this choice only if it represents your specific actions and rate each other source of support separately if you wish)	
2a) I will seek support or assistance from someone from my immediate social or family environment (e.g. partner, a close friend, a family member, acquaintance/colleague)	
2b) I will seek support or assistance from professionals (e.g. GP, nurse, a mental health professional like psychologist, counsellor, or psychotherapist, NHS service, social worker, charity)	
2c) Other (Rate this choice only if it represents your specific actions and rate each other source of support separately if you wish)	
3a) I will seek support or assistance from someone from my immediate social or family environment (e.g. partner, a close friend, a family member, acquaintance/colleague)	
3b) I will seek support or assistance from professionals (e.g. GP, nurse, a mental health professional like psychologist, counsellor, or psychotherapist, NHS service, social worker, charity)	
3c) Other (Rate this choice only if it represents your specific actions and rate each other source of support separately if you wish)	

If YES

The following descriptions present examples of what might be the typical experience of someone who is depressed. Please read the descriptions that follow and try to think back at the time when you had a similar experience to that outlined in the stories. After reading each story, please answer the question that follows.

1) There are some days recently when you are not in a very good mood. Sometimes you find it a bit difficult to sleep. You are feeling a bit tired recently and your interest in things you enjoy is a little bit less. Also, the pleasure you get from things is not exactly the same as before. However, you still do everything like you used to. You've also noticed a small change in your appetite that doesn't seem worrying. You sometimes lose your concentration, for example when reading. There are minor impacts on your everyday life but the situation doesn't seem serious.

Have you ever had a similar experience? ***YES/NO*** **– If NO then the "Intentions" instructions will be presented**

2) Quite often recently you are feeling down and have a low mood for a large part of the day. There are nights when you are finding it difficult to sleep and many mornings you have difficulty getting out of bed. Your interest or pleasure in activities is less than it was. You have less energy than before to do things you enjoyed. You started eating less or more than you used to and your weight has changed, without this being your intention. You are finding it difficult to concentrate, for example to read something. You have started having different physical complains. You started doubting your worth as a person, feeling guilty and you sometimes wonder what the point in doing things is.

Have you ever had a similar experience? ***YES/NO*** **– If NO then the "Intentions" instructions will be presented**

3) You have been feeling very depressed most of the day, nearly every day. It is very difficult to sleep almost every night and every morning you can't get out of bed. You don't feel like doing anything. The way you eat has completely changed since you started feeling that way and your weight has changed considerably, without this being your intention. You can't do almost anything and it's impossible to concentrate. You have many physical problems, like feeling very tired, having aches and pains. You hardly go out and you spend almost all day in bed. You are feeling worthless and very guilty almost every day. You can't see the point in things and you started having persistent thoughts of death.

Have you ever had a similar experience? ***YES/NO*** **– If NO then the "Intentions" instructions will be presented**

Please think of that time and what YOU DID THEN IN ORDER TO SEEK HELP. Please rate the extent to which you were seeking help for your depression by approaching EACH ONE of the following sources of support, using the following scale. When answering please consider your ACTUAL BEHAVIOUR and what you did to seek help:

1	*2*	*3*	*4*	*5*
Not at all	*Very little*	*Somewhat*	*Quite a bit*	*A great deal*

1a) I sought support or assistance from someone from my immediate social or family environment (e.g. partner, a close friend, a family member, acquaintance/colleague)	
1b) I sought support or assistance from professionals (e.g. GP, nurse, a mental health professional like psychologist, counsellor, or psychotherapist, NHS service, social worker, charity)	
1c) Other (Rate this choice only if it represents your specific actions and rate each other source of support separately if you wish)	
2a) I sought support or assistance from someone from my immediate social or family environment (e.g. partner, a close friend, a family member, acquaintance/colleague)	
2b) I sought support or assistance from professionals (e.g. GP, nurse, a mental health professional like psychologist, counsellor, or psychotherapist, NHS service, social worker, charity)	
2c) Other (Rate this choice only if it represents your specific actions and rate each other source of support separately if you wish)	
3a) I sought support or assistance from someone from my immediate social or family environment (e.g. partner, a close friend, a family member, acquaintance/colleague)	
3b) I sought support or assistance from professionals (e.g. GP, nurse, a mental health professional like psychologist, counsellor, or psychotherapist, NHS service, social worker, charity)	
3c) Other (Rate this choice only if it represents your specific actions and rate each other source of support separately if you wish)	

Appendix O – E-mail Invitation

Dear participant,

I am a doctoral student in Counselling Psychology at London Metropolitan University. I would like to invite you to take part in my study investigating help seeking behaviour, which aims to explore the ways in which people seek help when faced with difficulties.

If you agree to take part, you will be asked to complete a questionnaire online. This will take approximately **10-15 minutes**.

The results of the study are hoped to increase our understanding of the needs of people who face difficulties, and through that to contribute to the improvement of psychological service providers.

If you wish to participate please follow the following link:

http://www.surveymonkey.com/s/KZDVCWH

All responses will remain confidential and secure. Thank you in advance for your valuable help and time, it is very much appreciated.

Kind Regards,

Evi Aresti
Trainee Counselling Psychologist

E-mail: evistudy@gmail.com

Appendix P – Information Sheet

Please read the Information Sheet before proceeding with taking part in the study.

Dear Volunteer,

I am conducting a doctoral level research project as part of my course "Professional Doctorate in Counselling Psychology" at London Metropolitan University. This study has been approved by the Psychology Department Research Ethics Committee.

The study is aiming to investigate the process people follow until they seek help for some difficulties they may face. To participate in this study you will be required to complete some questionnaires that will take approximately 10-15 minutes.

It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw at any time and if you find any of these questions particularly difficult you do not have to answer them.

All information collected from you during the course of this research will be kept ***strictly confidential*** to my self and my supervisors and will only be used for the purposes of this study. It would not be possible to identify your name or any other information about you and the questionnaire you will complete will be kept in electronic form only.

Please complete the survey in one sitting and use the buttons at the bottom of the page to navigate.

Thank you very much for your time, it is very much appreciated.

Kind Regards,

Evi Aresti
Trainee Counselling Psychologist

E-mail: evistudy@gmail.com

Supervisors
Dr Keren Cohen: k.cohen@londonmet.ac.uk
Justin Parker: j.parker@londonmet.ac.uk

I agree to take part in the study: YES / NO (If YES the participant continues)

Appendix Q – Debriefing Sheet

Dear participant,

Thank you for taking the time to participate in the current study.

It is very important to know how people act when they are faced with a difficulty, how they get support and what process they follow when this difficulty and its consequences become more serious. This may give us some new insights in order to offer suggestions on how to make it easier for people to receive help earlier and more appropriately.

The current study aimed to investigate the process which people follow until they seek help for some difficulties they may face and who they turn to in terms of informal and formal sources of help, as the difficulty becomes more severe.

If the questionnaires have raised issues or feelings which cause you some distress and you feel that you would like to discuss them further or receive some support; please see the following list of available Counselling Services.

I would like to thank you again for your participation in this study.

If you have any further questions regarding this study of if you interested in the study's results, please contact the researcher:

Evi Aresti
Trainee Counselling Psychologist

E-mail: evistudy@gmail.com

Supervisors
Dr Keren Cohen: k.cohen@londonmet.ac.uk
Justin Parker: j.parker@londonmet.ac.uk

Appendix R – Counselling Services

If the questionnaires have raised issues or feelings which cause you some distress and you feel that would like to discuss them further or receive some support you can contact one of the following services:

In case of emergency dial **999**

NHS direct
Telephone: 08 45 46 47 available 24 hours
Or 08457 909192 for people with hearing and/or speech difficulties
www.nhsdirect.nhs.uk

Patient UK
Find me a (psychologist, psychotherapist etc): http://www.patient.co.uk/find_me.asp

British Psychological Society (BPS)
Find a psychologist: http://www.bps.org.uk/bps/e-services/find-a-psychologist/psychoindex$.cfm

British Association of Counselling and Psychotherapy (BACP)
Find a therapist: http://wam.bacp.co.uk/wam/SeekTherapist.exe?NEWSEARCH

UK Council for Psychotherapy (UKCP)
Find a therapist: http://www.psychotherapy.org.uk/find_a_therapist_search.html

British Association for Behavioural and Cognitive Psychotherapies (BABCP)
CBT Register UK: http://cbtregisteruk.com/

Samaritans helpline
Telephone: 08457 90 90 90
jo@samaritans.org (usually they respond within 24 hours)

Calm
A helpline for young people with depression and who are suicidal
Tel: 0800 585858

Domestic Violence Helpline 08082000247

Depression Alliance Tel: 020 7633 0557

Manic Depression Fellowship: Tel: 020 7793 2600

MIND: Tel: 020 8519 2122

SANE: 0845 767 8000

Appendix S – Normal Distribution: Results of three transformations of the data

	Original Variables			Square Root Transfomration			Log Transformation			Reciprocal Transformation		
	S or K	SD	Z	S or K	SD	Z	S or K	SD	Z	S or K	SD	Z
TOTALMild Informal Skewness	-0.14	0.17	-0.83	-0.20	0.17	-1.15	-0.54	0.17	-3.14	1.36	0.17	7.98
TOTALMild Informal Kurtosis	-1.12	0.34	-3.28	-1.10	0.34	-3.22	-0.92	0.34	-2.70	0.37	0.34	1.09
TOTALMild Formal Skewness	0.95	0.17	5.54	0.71	0.17	4.15	0.50	0.17	2.94	2.04	0.17	11.92
TOTALMild Formal Kurtosis	-0.49	0.34	-1.44	0.98	0.34	-2.88	-1.36	0.34	-3.98	2.79	0.34	8.19
TOTALModerate Informal Skewness	-0.44	0.17	-2.56	0.09	0.17	0.51	-0.24	0.17	-1.41	1.94	0.17	11.36
TOTALModerate Informal Kurtosis	-0.86	0.34	-2.51	-1.12	0.34	-3.30	-1.21	0.34	-3.56	2.67	0.34	7.85
TOTALModerate Formal Skewness	0.34	0.17	2.04	0.09	0.17	0.53	-0.15	0.17	-0.90	1.50	0.17	8.77
TOTALModerate Formal Kurtosis	-1.26	0.34	-3.70	1.42	0.34	-4.16	-1.48	0.34	-4.35	0.88	0.34	2.57
TOTALSevere Informal Skewness	-0.55	0.17	-3.21	0.25	0.17	1.46	-0.03	0.17	-0.17	2.14	0.17	12.52
TOTALSevere Informal Kurtosis	-0.90	0.34	-2.64	-1.23	0.34	-3.60	-1.41	0.34	-4.13	4.01	0.34	11.77
TOTALSevere Formal Skewness	-0.58	0.17	-3.37	0.26	0.17	1.55	-0.04	0.17	-0.24	1.67	0.17	9.76
TOTALSevere Formal Kurtosis	-0.91	0.34	-2.66	-1.19	0.34	-3.46	-1.35	0.34	-3.96	1.26	0.34	3.71
HADS Total Skewness	0.69	0.17	4.06	-0.28	0.17	-1.62	-1.35	0.17	-7.87	13.72	0.17	80.22
HADS Total Kurtosis	0.25	0.34	0.73	0.05	0.34	0.14	1.19	0.34	3.49	192.63	0.34	565.66