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Help-Seeking Behaviour and Beliefs about Psychological Services among University Students.

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Abstract

Mental disorders among young adults are a growing global health problem. Many changes occur during young adulthood, which can lead to both depression and anxiety. Therefore, it is important to reduce stigma in society regarding mental health and make the act of help-seeking easier and more accepted. This study aimed to explore help-seeking in relation to previous diagnosis of anxiety and depression along with previous help-seeking behaviour. Furthermore, gender differences were examined in relation to these factors. We used data from an Icelandic study conducted in 2017, which consisted of university students and revolved around mental health disorders and help-seeking. Participants were recruited through a convenience sample and were asked to answer a questionnaire online. A total of 375 participants took part in this study, all above the age of 18, 270 women and 101 men. This study showed that previous help-seeking behaviour was related to stronger intentions towards help-seeking in the future. Previous diagnosis of depression and anxiety was not significantly related to help-seeking attitudes. However, when looking only at help-seeking intentions, there was a significant difference between those with a previous diagnosis and those without. Another interesting finding was that women were more likely to have sought out help than men and showed stronger intentions towards help-seeking behaviour. These results highlight what can affect help-seeking and the growing concern that men are less likely to seek help for their mental health.

Key terms: Help-seeking, depression, anxiety, gender.

Útdráttur

Geðrænar raskanir hjá ungu fólki eru vaxandi vandamál í þjóðfélaginu sem ber að taka alvarlega. Yngri fullorðinsár eru krefjandi tími í lífi einstaklinga sem gjarnan einkennast af miklum breytingum sem geta leitt til bæði kvíða og þunglyndis. Mikilvægt er að takmarka skaðlegar staðalímyndir tengdar geðrænum röskunum og hjálparleit ásamt því að bæta aðgengi að sálfræðiþjónustu. Tilgangur þessarar rannsóknar var að skoða hjálparleit í tengslum við fyrri greiningar á kvíða og þunglyndi ásamt því að skoða tengsl fyrri hjálparleitar við viðhorf til hjálparleitar. Áhersla var lögð á kynjamun í tengslum við fyrri greiningar og hjálparleit. Notast var við gögn úr íslenskri rannsókn sem framkvæmd var árið 2017 þar sem tenging milli fyrri greiningar og hjálparleitar var skoðuð hjá háskólanemendum. Þátttakendur voru fengnir með hentugleikaúrtaki þar sem þeir svöruðu rafrænum spurningalista. Þátttakendur voru 375 talsins, þar af voru 270 konur og 101 karlar. Þeir þátttakendur sem höfðu áður leitað sér hjálpar sýndu sterkari áform til hjálparleitar. Fyrri greining á þunglyndi og kvíða hafði ekki marktæk áhrif á viðhorf til hjálparleitar. Hinsvegar þegar aðeins áform til hjálparleitar voru skoðuð, var marktækur munur milli hópanna tveggja. Niðurstöður sýndu að konur eru líklegri en karlar til að hafa leitað sér hjálpar, sem og sýna sterkari áform varðandi hjálparleit. Þessar niðurstöður varpa ljósi á þætti sem ýta undir hjálparleit, sem og þau vandamál að karlmenn eru ólíklegri til að leita sér hjálpar við geðrænum vandamálum.

Lykilhugtök: Hjálparleit, þunglyndi, kvíði, kyn.

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Help-Seeking Behaviour and Beliefs about Psychological Services among University Students

In the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), mental disorders are described as syndromes characterised by a disruption in individuals' cognition, emotion regulation, and/or behaviour. Mental disorders can affect an individuals' developmental process when looking at biological, psychological, and mental functioning (American Psychiatric Association, 2013). Mental disorders usually affect the person's abilities to participate in social activities or other daily activities (American Psychiatric Association, 2013). Mental disorders among young adults are a growing global health concern that affect 10 - 20% of young adults (Barker et al., 2019). It is crucial for these disorders to be recognized and treated effectively to minimize the negative effects that they can have on the individual's life. Kang et al. (2021) aimed to examine the prevalence of mental disorders among university students in the United States of America. The highest prevalence rates identified were for eating disorders ranging from 19 to 48%, depression 22%, followed by compulsive disorders ranging from 2 to 12.27%. Their findings highlighted the growing concern for mental health issues among university students (Kang et al., 2021).

Help-Seeking

Results from multiple previous studies have shown that the number of people experiencing mental disorders is higher than the number of people that seek help for those problems (Rickwood & Thomas, 2012). Mental disorders like depression and anxiety have major effects on people's daily lives and, if left untreated, can have severe negative consequences (American Psychiatric Association, 2013). For this reason, it is important to promote research that increases our understanding of the potential risk groups that may be less likely to seek and receive help for mental disorders (Rickwood & Thomas, 2012).

Several different definitions of help-seeking have been proposed, and they often vary depending on the aim of the researchers studying them (Rickwood & Thomas, 2012). In the *American Psychological Association Dictionary of Psychology*, help-seeking behaviour has been defined as "searching for or requesting help from others via formal or informal mechanisms, such as through mental health services" (American Psychological Association., n.d.).

According to Rickwood and Thomas (2012), help-seeking can be categorised into two main forms; formal and informal. *Formal help-seeking* can be identified as help from professionals who are educated or have a license to help people with their specific problems. These individuals can give relevant and professional advice, supported by science in the form of treatment. This includes advice from individuals who are psychologists, health-care providers and specialists. The *informal* type of help-seeking includes speaking to an individual who is not trained to give advice about the person´s problem, such as a friend or a family member (Rickwood & Thomas, 2012). The majority of studies have usually focused only on formal help-seeking, hence less is known about informal help-seeking (Rickwood & Thomas, 2012). Individuals who need help dealing with their mental health issues often look for assistance from their physician, a nurse, a guidance counsellor at school or a priest (Druss & Mauer, 2010). These professions all fall under *primary care interference* (Druss & Mauer, 2010). They often are the first line of contact and can make the decision of referring the patient to a specialist, which are often referred to as *secondary care professionals*. It is important that the relationship between primary and secondary care supporters is reliable for individuals to get proper help as quickly as possible (Druss & Mauer, 2010).

According to Rickwood and Thomas (2012), young adults, from the age of 16 to the age of 24 years, are less likely to seek help for mental disorders than older adults (Rickwood & Thomas, 2012). In a cross-sectional survey from 2016 conducted by Salaheddin and Mason (2016), barriers to mental health help-seeking were explored. Participants were 203 UK citizens between the ages of 18 and 25 years. The sample was recruited by convenience and snowball sample techniques from various organizations and online sources. Participants answered a series of questionnaires measuring psychological distress and their help-seeking behaviour, along with potential barriers towards help-seeking. The survey included both closed and open-ended questions concerning barriers to help-seeking. Results revealed that 48% of the participants reported current mental health difficulty, and 65% reported a lifetime difficulty. Of those who reported lifetime difficulty, 35% did not seek help for their problems. Reasons were

divided into three main categories; *stigma related barrier items*, *attitudinal barrier items* and *instrumental barrier items*. *Stigma related barrier items* included examples such as feeling embarrassed or ashamed and concerns about what others might think. *Attitudinal barrier items* included examples such as fear of treatment and the feeling that professional help is not beneficial. *Instrumental barrier items* included examples such as financial worries and difficulties with service accessibility. The items mentioned by most participants as the main reason for not seeking help were "Wanting to solve the problem on my own" (85.3%), "Dislike of talking about my feelings, emotions, or thoughts" (84.4%), and "Feeling embarrassed or ashamed" (81.4%). Examples of other items mentioned by a high percentage of participants were "Thinking the problem would get better by itself", "Concern that it might harm my chances when applying for jobs" and "Concern that people might not take me seriously if they found out I was having professional care". Several other reasons were mentioned by a high percentage of participants, but these give a good example of why young adults may not seek help when needed (Salaheddin & Mason, 2016).

Help-Seeking Intentions

Ajzen (1991), came forward with a theory called *Theory of Planned Behaviour* (TPB). TPB was designed to explain and predict human behaviour in specific contexts. The central focus of this theory is the individual´s intention to perform a given behaviour, solemnly for the reason that intention is thought to be a measurement of the individuals´ willingness to change a specific behaviour. A crucial aspect for behaviour to change is that the person's intentions stay constant (Ajzen, 1991). Three other important factors play a role in how likely a person is to change a specific behaviour according to this theory. First is *perceived behavioural control*, in other words, the degree of how much the individual believes in their capability of changing a specific behaviour. The second factor is the individual's *attitude*, positive or negative, towards the specific behaviour. The third factor is *subjective norms*, which refers to the social pressure the individual perceives regarding performing or not performing the specific behaviour. All these three factors contribute to determining the person´s intention and thus the likelihood of the specific behaviour to change (Ajzen, 1991).

In a study by Tomczyk et al. (2020), which aimed to investigate help-seeking behaviour in a German community with untreated depressive symptoms, the process of seeking help was linked to the components of TPB. According to the theory, the individual´s intention to seek help is encouraged or discouraged through the theory´s three components. *Perceived*

behavioural control refers to the person's confidence in being able to seek help and the person's control over their performance in the process of help-seeking. *Attitude* refers to the individual´s evaluation of seeking help, or whether the individual believes that seeking help for mental disorders is more beneficial than harmful or vice versa. The component of *subjective norms* can be described as how the individual perceives others' opinion about help-seeking as well as the actual help-seeking behaviour of others (Tomczyk et al., 2020). In the study conducted by Tomczyk et al. (2020) on attitude towards help-seeking, all three factors; attitude, subjective norms and perceived behavioural control were measured by a questionnaire and the intention of seeking help was assessed by a question regarding how likely the participant was to seek help for their problems in the next three months. Results from the study concluded that all three components; Perceived behavioural control, attitude and subjective norms towards help-seeking, are positively related to intentions of seeking help. The intention of help-seeking showed significant prediction of subsequent help-seeking behaviour. According to this study, TPB can be used as an effective way to measure the likelihood of a person seeking help (Tomczyk et al., 2020).

The majority of psychiatric disorders emerge in young adulthood, yet individuals between the age of 18-24 are the least likely group to seek out help (Mitchell et al., 2017). According to Mitchell et al. (2017), the stigma regarding mental health problems in society and the need to feel independent are two of the reasons why young adults do not seek help (Mitchell et al., 2017). The difficulty of accessing help as well as expressing their problems reduces their help-seeking intentions as well (Mitchell et al., 2017). The act of speaking up about issues regarding mental health to a general practitioner is a common concern for young adults (Mitchell et al., 2017). Another obstacle regarding help-seeking intentions for young adults appears to be the dilemma of recognising their own mental health problems (Gulliver et al., 2010). Results from a previous study by Takeuchi and Sakagami (2018), led to the conclusion that greater knowledge about depression was associated with lower perceived stigma (Takeuchi & Sakagami, 2018). To increase the intention for help-seeking by young adults, an easier access regarding information about mental disorders and reduced stigma is needed (Gulliver et al., 2010). According to Mitchell et al., (2017), young adults who have a positive help-seeking experience show greater help-seeking intentions in the future (Mitchell et al., 2017). Young adults have also shown greater help-seeking intentions when they feel trust towards the person they are looking to for help (Gulliver et al., 2010). A study conducted in England in 2009

showed that greater knowledge about mental disorders and a more positive attitude of tolerance results in stronger intentions to seek professional help (Rüsch et al., 2011).

Gender Difference in Help-Seeking

Women are, in general, more likely to seek professional help than men (Thompson et al., 2016). According to Thompson et al. (2016), individuals are also more likely to seek help when they are dealing with physical illness rather than a mental illness (Thompson et al., 2016). Men tend to view having anxiety or depression as a weakness and therefore do often not admit suffering from those mental disorders (Lynch et al., 2018). There are numerous reasons why men do not seem to deal with their mental health problems and seek professional help. For example, compared to women, men may feel more pressure to conform to masculine gender norms, which has shown to be discrepant with the act of seeking help (Lynch et al., 2018). This could partly explain why men may be less likely than women to seek help when help may be needed. Adhering to masculine gender norms may also have a negative effect on men's mental health by promoting unhealthy ways to cope with distress instead of seeking professional help (Seidler et al., 2016). According to Lynch et al. (2018), men tend to self-medicate with alcohol more frequently than women. Men also often find it difficult to talk about their depression with friends or family, potentially leading to more problems in the future (Seidler et al., 2016).

Depression and Anxiety

A depressive disorder is an umbrella term that covers Disruptive Dysregulation Disorder, Dysthymia, Premenstrual Dysphoric Disorder, Substance/medication-induced Depressive Disorder, Depressive Disorder due to another medical condition, other Specified Depressive Disorder, Unspecified Depressive Disorder, and Major Depressive Disorder (American Psychiatric Association, 2013).

The World Health Organization ranked Major Depressive Disorder (MDD) as the third cause of burden disease worldwide in 2008 and has predicted that the disease will rank first by 2030 (World Health Organization, 2008). According to the fifth edition of the *Diagnostic and Statistical Manual* (DSM-5), the individual needs to have experienced at least five symptoms, and one needs to be loss of pleasure/interest or depressed mood, two weeks prior for MDD to be diagnosed (American Psychiatric Association, 2013). According to DSM-5, symptoms for MDD include; depressed mood, loss of pleasure/interest, weight loss or weight gain, insomnia

or hypersomnia, changes in energy, feelings of uselessness, trouble with concentrating, and suicidal thoughts (American Psychiatric Association, 2013). It is crucial to make sure that these symptoms are not caused by any physical reason before diagnosing MDD (American Psychiatric Association, 2013). A common tool to measure symptoms of MDD is the PHQ Depression scale (PHQ-9), a 9-item questionnaire measuring symptoms within the last two weeks (Kroenke & Spitzer, 2002).

The onset age for MDD can occur all through the individual's lifespan, and it is most often gradual (Malhi & Mann, 2018). According to the DSM-5, the average onset age for MDD in the USA is approximately 20 years of age. It is also recognized in the DSM-5 that the progression of depression varies for each individual (American Psychiatric Association, 2013). It is important to recognize risk factors for MDD to be able to diagnose and treat the disorder (American Psychiatric Association, 2013). These risk factors are diverse, the most common being genetics (individuals of depressed parents are three to four times more likely to develop MDD) and environmental factors like trauma, difficult life events, bullying, death or loss, and illnesses (Thapar et al., 2012). According to the DSM-5, approximately 7% of Americans suffer from MDD with a twelve-month prevalence. Individuals aged between 18 to 29 have a threefold higher prevalence than individuals 60 years and higher (American Psychiatric Association, 2013). The risk of recurrence in MDD becomes higher for individuals who have experienced a severe episode of MDD and for young adults (American Psychiatric Association, 2013). According to the European Health Interview Survey in 2015, Iceland had the fourth-highest prevalence rate for depression among European countries. The prevalence rate for depressive symptoms for women in Iceland was 11% compared to 7% for men. Women in Iceland from the age of 15-24 had the highest prevalence rate for depressive symptoms, just under 18%, compared to other European countries (Hagstofan, 2017).

According to DSM-5, anxiety disorders are described as a group of mental disorders defined by extreme fear, anxiety, and similar behavioural disruptions. Individuals with anxiety disorders encounter unusual fear responses to a real or perceived threat. Anxiety, on the other hand, is anticipation of impending threats (American Psychiatric Association, 2013). According to DSM-5, there are multiple types of anxiety disorders which include; Generalized Anxiety Disorder (GAD), Separation Anxiety Disorder, Selective Mutism, Specific Phobia, Social Anxiety Disorder, Panic Disorder, Anxiety Disorder Due to Another Medical Condition, Other Specified Anxiety Disorder, Unspecified Anxiety Disorder and Agoraphobia (American Psychiatric Association, 2013). In the United States, the 12 months prevalence for GAD is

higher for adults, 2.9% compared to 0.9% among adolescents and the life-time prevalence rate is 7.7% for women and 4.6% for men (American Psychiatric Association, 2013). It is also important to notice that individuals from developed countries are more likely to report symptoms of GAD, and the prevalence rate outside of the United States is 0.4-3.6% (American Psychiatric Association, 2013).

The onset age is around middle age and decreases in the later years of life (American Psychiatric Association, 2013). GAD is described in the DSM-5 as disproportionate worry and anxiety about a number of various things. These worries are blown out of proportion by the individual and are unlikely to have the impact that is anticipated (American Psychiatric Association, 2013). The diagnostic criteria for GAD by DSM-5 states that individuals experience excessive worrying and anxiety, have no control over their worries, and have at least three out of six symptoms present nearly every day for the past six months (American Psychiatric Association, 2013). These symptoms are; restlessness or being on edge, fatigue, having trouble concentrating, irritability, muscle tension, and having trouble with sleeping (American Psychiatric Association, 2013). A common way to measure GAD is the use of GAD-7 (Spitzer et al., 2006). GAD-7 is a 7-item questionnaire where individuals assess their problems in relations to anxiety two weeks prior (Spitzer et al., 2006).

Adults with GAD have excessive worries about their abilities to perform in their daily life, whilst children worry about competence and how they act. Adults tend to worry about their finances, well-being, job performance and other life events. It is noted in the DSM-5 that there is not enough evidence to support the idea that environmental factors could be potential risk factors for GAD. However, it is important to understand that upbringing could be a factor. Genetics are a risk factor, and one-third of the risk factors for developing GAD seems to be due to genetics (American Psychiatric Association, 2013).

Gender Differences in Mental Disorders

Evidence show that anxiety is the most common psychiatric disorder among older adults, but it often goes unrecognized (Kiely et al., 2019). In relations to physical illness such as dementia and Parkinson's disease, depression and anxiety tend to follow (Kiely et al., 2019). Even at an older age, women are more likely to show evidence for depression and anxiety. However, men have a higher suicide rate than women (Kiely et al., 2019). In general, women tend to have a higher prevalence of anxiety and depression (Kiely et al., 2019).

Research has shown that women are more frequently victims of abuse, physical, sexual, and mental, which can often lead to anxiety and depression (Rubinow & Schmidt, 2019). This could be one of several reasons why women seem to be more frequently affected by mental disorders than men. Women are two times more likely to suffer from major depression than men, along with being more likely to suffer from anxiety disorders (Rubinow & Schmidt, 2019). According to Rubinow and Schmidt (2019), women's menstrual cycle can have an effect on both anxiety and depression. Pregnancy can also affect a woman's behaviour and feelings, which can lead to postpartum depression (Rubinow & Schmidt, 2019). Studies have shown that the genders react differently to medications made for treating mental disorders, and that can play a part in treating the disorder (Rubinow & Schmidt, 2019).

A study by Hansen and Høye (2015), conducted in Norway, looked at gender differences in help-seeking, amongst other things. Their results showed that 21.5% of women reported having anxiety or depression compared to only 12.3% of men. Women under the age of 50 were more likely to seek help at a psychiatric outpatient service. However, men over the age of 50 were more likely than women to seek out help at a psychiatric outpatient service. Their results also showed no significant difference in help-seeking at a psychiatric outpatient service between the sexes who had anxiety and/or depression, with 13.5% of women seeking help and 10.5% of men (Hansen & Høye, 2015).

Previous Diagnosis and Help-Seeking

Several factors can affect help-seeking behaviour among individuals. When it comes to requesting help after being previously diagnosed with a mental illness, there are many aspects to consider. Having parents who suffer from anxiety or mood disorders can often lead to the children themselves suffering from those same disorders (Havinga et al., 2018). A study done by Havinga et al. (2018) showed that 91.1% of children who had parents suffering from anxiety or depression showed signs of those disorders as well. However, about one-third of the children did not get help until about 2 years after the first sign of onset. A contributing factor to help-seeking was the age of onset (Havinga et al., 2018). Those who showed signs of mental disorder in adolescence or early adulthood were more likely to seek help sooner than those who showed first symptoms in childhood. Females were also more likely to seek help sooner than males and those suffering from a mood disorder or mood disorder and anxiety combined were more likely to get help sooner than those who suffered only from anxiety. More than one-third of

participants entered secondary care, which indicates that they needed more support than what the day-to-day healthcare could provide (Havinga et al., 2018).

Studies conducted both in the United States and the Netherlands showed that about one-third of people with mood disorders (e.g., depression) sought help, and around one in five people with anxiety sought help in the first 12 months of onset (ten Have et al., 2013). Individuals with lifetime prevalence do usually seek help eventually, more so those suffering from mood disorders than anxiety (Wang et al., 2005). Delay in requesting help from the first onset can range from 6 to 8 years when it comes to mood disorders and from 9 to 23 years regarding anxiety (Wang et al., 2005). According to ten Have et al. (2013), lifetime treatment ranges from 60.9% for those suffering from anxiety disorders to 81.8% for those who suffer from mood disorders (ten Have et al., 2013).

A study done by Seidler et al. (2020) looked at satisfaction regarding previous and future help-seeking among Canadian men. Participants were 133 men between the ages of 19 and 71. The purpose of the study was to examine if previous experience with psychotherapy had any impact on future help-seeking and the likelihood of informing their doctor about mental health issues. Results showed that greater doubt about the effectiveness of psychotherapy led to men being less likely to seek help for any mental issues. The study also showed that men with more severe symptoms of depression were less likely to tell their doctor about their mental problems than those with milder symptoms. About 25% of participants reported having a negative previous experience with psychotherapy, and because of that, they were less likely to seek professional help in the future. Seidler concluded that because of negative attitude and experience, and negative beliefs about psychotherapy, men were less likely to seek help for any mental issues, potentially contributing to a higher prevalence rate of suicide in men than women (Seidler et al., 2020).

Most mental health problems emerge pre or around young adulthood which is the most common age of university students, yet that age group is not receiving enough help for their problems (Ramón-Arbués et al., 2020). There are many aspects to consider when researching why university students are so vulnerable to mental disorders. As mentioned by Ramón-Arbués et al. (2020), financial burden, academic pressure, the fear of not meeting expectations, and moving to a new location are just a few stressors in a university students' life (Ramón-Arbués et al., 2020). When emerging into adulthood, individuals often tend to feel overwhelmed and anxious regarding the future (Kosyluk et al., 2020). That especially applies to university

students since they are experiencing many new adventures at the same time, along with learning new things about themselves and the world (Kosyluk et al., 2020). Therefore, at university, many students struggle with their mental health. According to Kosyluk et al. (2020), it is important to educate individuals better about mental illness since that can lower their personal stigma regarding mental health, and therefore they might be more likely to seek help themselves (Kosyluk et al., 2020). Kosyluk et al. (2020) also mentioned that the fear of being negatively labelled in relation to mental health diagnosis predicted students to be less likely to seek help for their mental problems (Kosyluk et al., 2020). A research conducted in Belgium by Bruffaerts et al. (2018) showed that around one third of freshman university students reported having mental health problems in the past 12 months. These mental health problems had a negative effect on their performance at college and on their grade point average (Bruffaerts et al., 2018).

The mental health of young adults, specifically university students, is a growing health concern. It is important for those who suffer from these disorders to seek help because the negative effects can be severe. The current study aimed to examine if current attitudes towards help-seeking relate to both previous diagnoses of depression and anxiety and previous help-seeking behaviour. Furthermore, the aim was to explore whether help-seeking intentions, attitudes, and behaviours differed depending on whether University students had previously been diagnosed with depression or anxiety. These questions will also be discussed in relations to gender.

Method

Participants

Participants were university students from all of the seven universities in Iceland. In total 375 participants took part in the study, all above the age of 18. Out of the participants, 195 (53.13%) were between the ages of 18-26, 111 (30.25%) were between the ages of 27-35, and 61 (16.62%) were 36 years old and above. In this study, 72% of the participants identified as women (n=270) and 27% identified as men (n=101). All participants were required to be fluent

in Icelandic and had to have access to the Internet and a smartphone, tablet or computer to access the survey.

Measures

Background variables

The online survey included questions about gender, previous diagnosis of anxiety and depression, help-seeking attitudes and help-seeking intentions. Participants were only able to identify as male or female in this survey. Regarding help-seeking, in the current study, we focused on help from psychologists. Participants were asked whether they had ever sought out help from a psychologist using a multi-response scale. Response categories were “yes, within the past 30 days”, “yes, within the past 12 months”, yes, more than 12 months ago” or “no”. In this study, a new variable was created with these responses combined. One group consisted of participants who had sought out help, and the other one consisted of those who had not. For the purpose of this study, it did not matter when participants had sought out help but rather whether or not they had. The possible answers were either “yes”, for those who had at any point sought out help and “no” for those who had never sought help from a psychologist. The reason behind this decision was that, for simplicity, having received professional help from a psychologist was seen as the only relevant factor, but not when that help was received nor for how long.

A variable called “previous diagnosis” was made, consisting of answers from those participants who reported having been diagnosed with either anxiety or depression more than 12 months prior to the study. In addition, a variable was made for previous diagnosis where one group consisted of those who had only been diagnosed with depression and the other group consisted of those who had only been diagnosed with anxiety prior to the study. These individuals had been diagnosed with either anxiety or depression more than 12 months prior to the study. Those who had a diagnosis of both anxiety and depression were excluded in this particular variable.

General Anxiety Disorder Scale (GAD-7)

A 7-item self-report scale was developed to screen for General Anxiety Disorder in individuals called GAD-7 (Spitzer et al., 2006). The questions measure problems that the individual is experiencing over the previous two weeks, both their severity and their frequency. Each of the seven items gets a score from 0-3, ranging from “not at all” to “nearly every day”. The final

score on the GAD-7, therefore, ranges from 0 to 21. The higher a score a person gets, the more severe their general anxiety symptoms are (Spitzer et al., 2006). In this study, those who scored 10 points or higher on the GAD-7 scale were assessed as having clinical signs of General Anxiety Disorder.

PHQ Depression Scale (PHQ-9)

The PHQ-9 depression scale is a nine-item module within the *patient health questionnaire* that screens for symptoms of major depression for the previous two weeks (Kroenke & Spitzer, 2002). Each of the nine items on the questionnaire has a score range from 0-3, with a higher score representing more severe symptoms of depression (Kroenke & Spitzer, 2002). The total score on the PHQ-9 scale ranges from 0-27, with scores equal to or greater than 10 being above the threshold for major depression (Kroenke & Spitzer, 2002). In this study, those who scored 10 points or higher on the PHQ-9 scale were assessed as having clinical signs of depression.

Icelandic version of the Beliefs about Psychological Services (I-BAPS)

Help-seeking attitudes, intentions, stigma and expertness were measured using the Icelandic version of the BAPS scale. The Icelandic version of the Beliefs About Psychological Services (I-BAPS) is a 22-item questionnaire adapted from the 18-item self-report measure, Beliefs About Psychological Services (BAPS; Ægisdóttir & Gerstein, 2009). The scale contains three subscales; *Stigma Tolerance*, *Intent* and *Expertness*. Each question on the scale ranges from one to six, with one being *"strongly disagree"* and six being *"strongly agree"*. The total score is calculated as the sum of each response divided by the number of items. The range of scores is from 1-6, where a higher score indicates a more positive attitude towards psychological services in the future (Ægisdóttir & Gerstein, 2009). To measure attitudes towards help-seeking in general, all answers from the I-BAPS scale were combined after item 7, 9, 12, 14, 16, 20, 21 and 22 had been reverse scored. It is important to note that item number 10 (which is within the Stigma Tolerance subscale) was missing from the data due to a coding error. In the current study, Cronbach's alpha was 0.93, which is consistent with the results of Ægisdóttir and Gerstein (2009) using the original scale, even though one item was missing from the data (Ægisdóttir & Gerstein, 2009). Items 1, 2, 3, 4, 5 and 11 combined make up the Intent subscale of the I-BAPS scale, which used to measure participants' help-seeking intention. Items 7, 9, 12, 14, 16, 20, 21 and 22 make up the Stigma tolerance subscale which was used to measure

participants' stigma towards psychologists. Items 6, 8, 13, 15, 17, 18 and 19 make up the Expertness subscale and were used to measure participants' beliefs about psychologists.

Procedure

A convenience sampling method was used to recruit participants. The original data set also included data from an athlete sample, but those participants were excluded in the current study. All seven universities in Iceland were contacted with the intention of recruiting participants. Six out of seven universities agreed to cooperate and advertised the survey on their website along with sending out emails to all students. The survey was also advertised on the social media platform Facebook with a short description of the survey, the purpose of it and a direct link to the online questionnaire.

Statistical analysis

To assess the relationship between previous diagnosis and scores on the I-BAPS scale, four Independent Sample t-test were conducted where previous diagnosis (depression and/or anxiety) was the independent variable, and total score on the four scales were the dependent variables. To examine help-seeking behaviour in relation to scores on the I-BAPS scale, four Independent Sample t-tests were conducted. In each of these tests, the dependent variable was the total score on the four scales, and the independent variable was help-seeking from a psychologist. To measure the difference in scores on the I-BAPS scale between those with a previous diagnosis of depression and those with a previous diagnosis of anxiety, four Independent Sample t-tests were conducted. The independent variable was those who had a previous diagnosis of depression compared to those with a previous diagnosis of anxiety. The dependent variables were the total scores on the four scales.

I-BAPS scores, help-seeking behaviour and previous diagnosis of anxiety or depression between men and women were examined as well. Four Independent Sample t-tests were conducted to compare I-BAPS scores between men and women with gender as the independent variable. To examine if there was an interaction between the effect of previous diagnosis of anxiety or depression between men and women, four factorial analyses of variance (fANOVA) were conducted. Gender and previous diagnosis were the independent variables in all of these analyses. The total scores on the four scales were the dependent variables. A chi-square test was conducted to examine help-seeking behaviour between men and women for those who had

sought out help from a psychologist. All of the statistical analyses in this study were based on a 95% confidence limit.

Results

Descriptive analysis

The sample consists of 101 (27.2%) men and 270 (72.8%) women, all university students. Four did not define their gender. 94 (28.3%) reported having been diagnosed with depression 12 months prior to the study, and 100 (31.3%) with anxiety. 202 (55%) reported receiving help from a psychologist any time prior to the study. From the sample of this study, 34 (9.1%) showed clinical symptoms of general anxiety disorder (based on GAD-7), 46 (12.3%) showed clinically relevant symptoms of depression (based on PHQ-9), and 80 (21.3%) of participants showed clinical symptoms of both general anxiety disorder and depression.

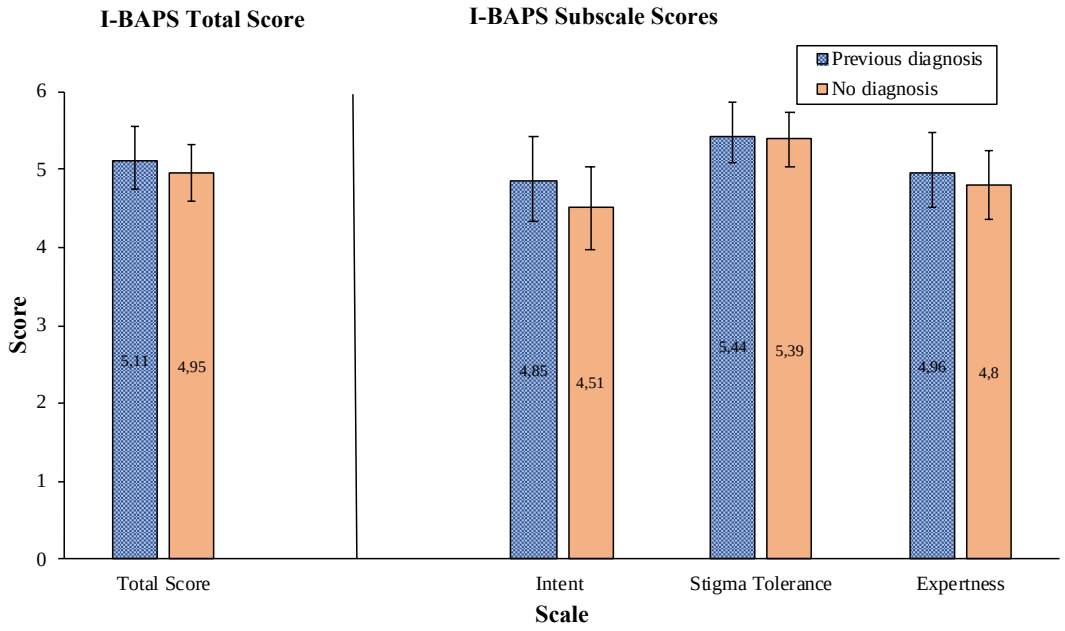
Relationship between previous diagnosis and beliefs about psychological services

Figure 1 shows the mean scores on the I-BAPS scale based on whether participants reported having a previous diagnosis of depression or anxiety, or no previous diagnosis. Participants with no prior diagnosis of anxiety or depression scored on average 4.95 (*SD*=0.73) points on the I-BAPS scale, and participants with a diagnosis scored on average 5.11 (*SD*=0.89) points. Independent Sample t-test showed that the difference between the groups was not statistically significant (p=0.078). These results indicated that on average, there was no difference between people with and those without a previous diagnosis in relations to attitude towards help-seeking. Participants with no prior diagnosis of anxiety or depression scored on average 4.51 (*SD*=1.05) points on the Intent subscale, and participants with a diagnosis scored on average 4.85 (*SD*=1.17) points. Independent Sample t-test showed a statistically significant difference between the groups (t[337] = -2,79; p=.006). Participants with no prior diagnosis of anxiety or depression scored on average 5.39 (*SD*=.68) points on the Stigma subscale and participants with

a diagnosis scored on average 5.44 (*SD*=0.85) points. Independent Sample t-test showed that the difference between the groups was not statistically significant (*p*=0.56). Participants with no prior diagnosis of anxiety or depression scored on average 4.80 (*SD*=0.89) points on the Expertness subscale, and participants with a diagnosis scored on average 4.96 (*SD*=1.02) points. Independent Sample t-test showed that the difference between the groups was not statistically significant (*p*=0.145). Having previous diagnosis of either anxiety or depression was related to the intention to seek help but showed no difference in relations to stigma and expertness.

Figure 1

Total (mean values) and subscale scores on the I-BAPS scale in relation to previous diagnosis of anxiety and/or depression.



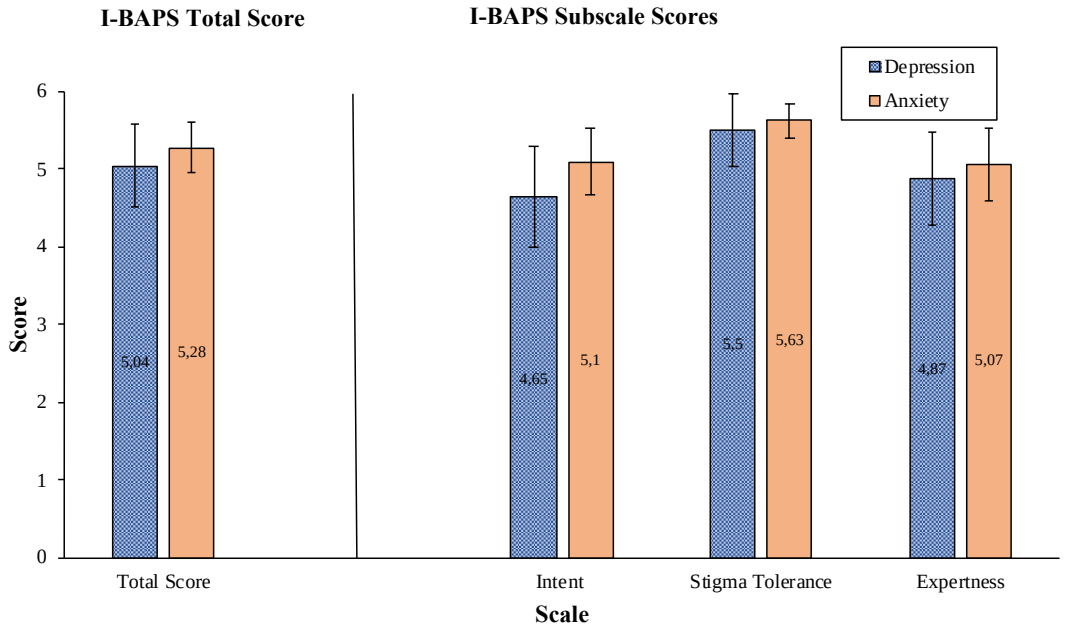
Note. Error bars show standard deviation.

Figure 2 shows the mean score on the I-BAPS scale based on whether participants report having previous diagnosis of only depression or only previous diagnosis of anxiety. The participants who had both a diagnosis of anxiety and depression were excluded in this analysis. Participants with a previous diagnosis of depression scored on average 5.04 (*SD*=1.06) points on the I-BAPS scale, while participants with a previous diagnosis of anxiety scored on average 5.28 (*SD*=0.63) points. Independent Sample t-test showed that there was no statistically significant difference between the two groups (*p*=0.289). Participants with a previous diagnosis of depression scored on average 4.65 (*SD*=1.34) points on the Intent subscale, while participants

with a previous diagnosis of anxiety scored on average 5.10 (*SD*=0.85) points. Independent Sample t-test showed that there was no statistically significant difference between the two groups (p=0.109). Participants with a previous diagnosis of depression scored on average 5.50 (*SD*=0.93) points on the Stigma subscale, while participants with a previous diagnosis of anxiety scored 5.63 (*SD*=0.44) points. Independent Sample t-test showed that there was no statistically significant difference between the two groups (p=0.493). Participants with a previous diagnosis of depression scored on average 4.87 (*SD*=1.20) points on the Expertness subscale while participants with a previous diagnosis of anxiety scored 5.07 (*SD*=0.93) points. Independent Sample t-test showed that there was no statistically significant difference between the two groups (p=0.453).

Figure 2

Total (mean values) and subscale scores on the I-BAPS scale in relation to previous diagnosis of only anxiety and only depression.



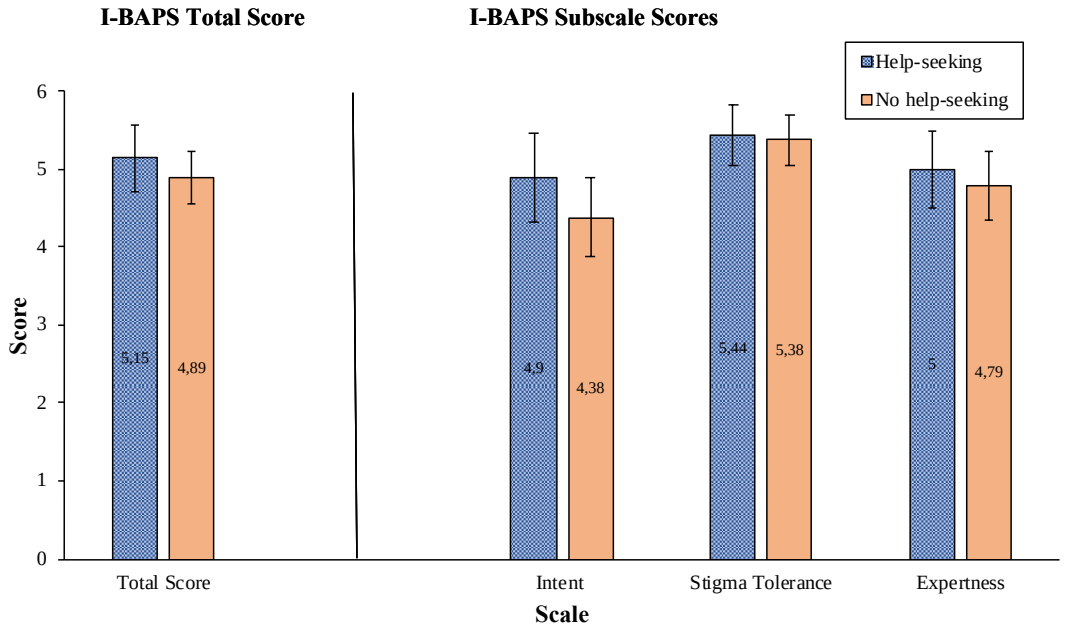
Note. Error bars show standard deviation.

Help-seeking behaviour and beliefs about psychological services

Figure 3 shows the mean score on the I-BAPS scale based on whether participants reported having sought out help from a psychologist or not. Participants who had sought help from a psychologist prior to the study scored on average 5.15 (*SD*=0.86) points on the I-BAPS scale, while participants who had never sought out help from a psychologist scored on average 4.89 (*SD*=0.68) points. Independent Sample t-test showed a statistically significant difference between the groups (t[334] = -3.06; p=.002). Therefore, these results indicate that participants who had sought out help from a psychologist have a more positive attitude towards help-seeking. Participants who sought help from a psychologist prior to the study scored on average 4.90 (*SD*=1.14) points on the Intent subscale, while participants who have never sought out help score on average 4.38 (*SD*=1.0) points on the Intent subscale. Independent Sample t-test showed a statistically significant difference between the groups (t[357] = -4.51; p<.001). Participants who had sought help from a psychologist prior to the study scored on average 5.44 (*SD*=0.80) points on the Stigma subscale. Participants who had never sought out help from a psychologist scored on average 5.38 (*SD*=0.65) points. The Independent Sample t-test did not show a statistically significant difference between the groups (p=0.434). Participants who sought out help from a psychologist prior to the study scored on average 5.00 (*SD*=0.99) points on the Expertness subscale. Participants who had never sought out help from a psychologist scored on average 4.74 (*SD*=0.88) points. Independent Sample t-test showed a statistically significant difference between the groups (t[343] = -2.651; p=.008). These results indicate that previous help from a psychologist does not affect the total score on the Stigma subscale. However, scores on the Intent and Expertness subscales are affected by previous help-seeking from a psychologist.

Figure 3

Total (mean values) and subscale scores on the I-BAPS scale in relation to previous help-seeking from a psychologist.



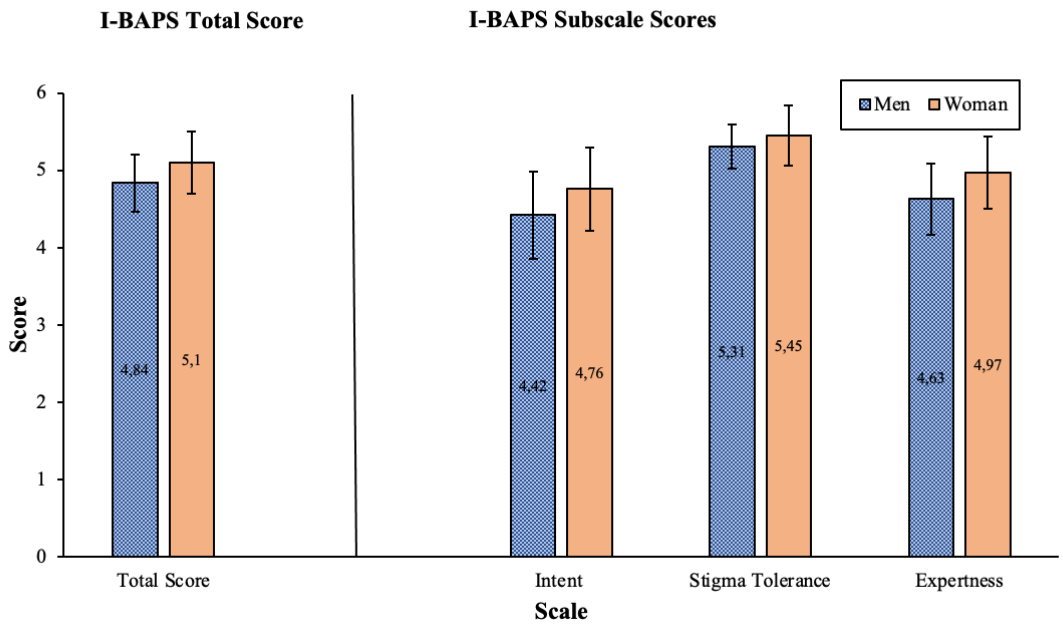
Note. Error bars show standard deviation.

Gender difference in beliefs about psychological services

Figure 4 shows the total score on the I-BAPS scale in relation to gender difference. 58.65% of the women participating reported having sought help from a psychologist, in comparison to 46.46% of men. Chi-square test showed that this difference was statistically significant (X^2[1, n=365]=4.332; *p*=.04). Women scored on average 5.10 (*SD*=0.80) points on the I-BAPS scale, and men scored on average 4.84 (*SD*=0.74). Independent Sample t-test showed a statistically significant difference between the groups (*t*[336] = -2,68; *p*=.008). Women scored on average 4.76 (*SD*=1.08) on the Intent subscale, and men scored on average 4.42 (*SD*=1.14). Independent Sample t-test showed a statistically significant difference between the groups (*t*[360] = -2,69; *p*=.008). Women scored on average 5.45 (*SD*=0.78) on the Stigma subscale, and men scored on average 5.31 (*SD*=0.58). The Independent Sample t-test did not show a statistically significant difference between the groups (*p*=0.11). Women scored on average 4.97 (*SD*=0.94) on the Expertness subscale, and men scored on average 4.63 (*SD*=0.92). Independent Sample t-test showed a statistically significant difference between the groups (*t*[345] = -3.031; *p*=.003).

Figure 4

Total and subscale scores (mean values) on the I-BAPS in relation to gender difference.



Note. Error bars show standard deviation.

To examine if there was an interaction between the effect of gender and previous diagnosis on I-BAPS total score, a factorial ANOVA (fANOVA) was conducted. The main effect of gender was significant, but the main effect of previous diagnosis was not, which is in line with the t-test results. The interaction effect was not statistically significant (p=0.368). To examine if there was an interaction between the effect of gender and previous diagnosis on I-BAPS subscales total scores, three separate factorial ANOVAs (fANOVA) were conducted. Results from the factorial ANOVAs showed no interaction effects between gender and previous diagnosis with the three subscales. The main effect of gender and previous diagnosis was significant in relation to the Intent subscale. Only gender was related to the total score on the Expertness subscale but not previous diagnosis. Neither gender nor previous diagnosis was related to the total score on the Stigma subscale. These results combined show that women have a more positive attitude towards help-seeking along with stronger intentions and beliefs about the expertness of psychological services and that this effect was independent of previous diagnosis. Women also seek out help from psychologists more often than men do.

Discussion

The aim of this study was to examine the relationship between previous diagnosis of anxiety and depression and help-seeking. Furthermore, the aim was to examine the link between previous help-seeking behaviour and help-seeking attitudes, intentions, stigma tolerance and beliefs about expertness. These factors were also examined in relation to gender differences.

In this study, 28.3% of participants reported having been diagnosed with depression 12 months prior to the study, while 12.3% showed current clinical symptoms. Out of the participants, 31.3% reported having been diagnosed with anxiety 12 months prior to the study, while 9.1% showed current clinical symptoms of General Anxiety Disorder. Out of the participants, 21.3% showed comorbidity of current clinical symptoms of depression and General Anxiety Disorder. According to the American Psychiatric Association, 2.9% of adults in the United States of America suffer from General Anxiety Disorder (American Psychiatric Association, 2013). Regarding depression, 7% of individuals suffer from Major Depressive Disorder, with individuals between the ages of 18-29 being more likely to suffer from it than older adults (American Psychiatric Association, 2013). These prevalence rates indicate that individuals show more frequently current signs of Major Depressive Disorder than General Anxiety Disorder, which aligns with the prevalence rates from DSM-5. However, our results show a higher percentage regarding both depression and General Anxiety disorder, which can show that university students are more likely to experience them. These results are in line with a study done by Kang et al. (2021; Kang et al., 2021).

In general, those with a previous diagnosis of either anxiety or depression showed stronger intentions towards help-seeking than those with no previous diagnosis. The reason behind these results could be explained by the fact that individuals with anxiety have a lifetime treatment prevalence of 60.9%, and those with depression have an 81.8% lifetime treatment prevalence according to ten Have et al. (2013; ten Have et al., 2013). Individuals who have sought out help before might therefore be more likely to do so again or even to be in treatment throughout their lives. The difference between those with a previous diagnosis of depression and with a previous diagnosis of anxiety was not statistically significant in relation to attitude towards help-seeking, which may result from a small sample size. Interestingly, previous diagnosis did not have an obvious effect on neither stigma nor expertness regarding help-seeking attitude. The score on the Stigma Tolerance subscale throughout the analysis were consistent. These results cannot

determine the causal relation between previous diagnosis and help-seeking attitudes. That is, whether having a more positive attitude towards help-seeking leads to help-seeking behaviour, or previous help-seeking behaviour leads to a more positive help-seeking attitude, or both. When comparing those with a previous diagnosis of depression to those with a previous diagnosis of anxiety, there was not a statistically significant difference on any of the scales. However, those with a previous diagnosis of anxiety scored higher than those with a previous diagnosis of depression on all the scales which might indicate that, in general, people with anxiety have a more positive attitude towards help-seeking. According to ten Have et al. (2013), individuals with depression are more likely to seek out help than those with anxiety. However, that does not necessarily mean that they have a positive attitude and intentions towards it (ten Have et al., 2013). Symptoms of depression, like depressed mood, loss of energy, and the feeling of uselessness (American Psychiatric Association, 2013) could be one of the attitudinal barriers reported by Salaheddin & Mason (2016) for having negative attitude towards help-seeking (Salaheddin & Mason, 2016).

Results from this study showed that individuals who had sought help from a psychologist have a more positive attitude and stronger intentions towards help-seeking. Stronger beliefs in psychologists´ expertise were also found with those who had sought out help from a psychologist, on average. Interestingly, previous help-seeking behaviour seemed to have no effect on stigma. This is not in line with a previous study done by Salaheddin and Mason (2016), who showed that stigma related barrier items are one of the main reasons why individuals do not seek out help (Salaheddin & Mason, 2016). This may be caused by the fact that participants in our study were all university students, and therefore might be more informed regarding the positive effects of help-seeking (Takeuchi & Sakagami, 2018).

As stated previously, scores on stigma tolerance were consistently higher than on the other scales with little variability. According to Mitchell et al. (2017), those who have a positive experience regarding help-seeking are more likely to seek help in the future (Mitchell et al., 2017). Though it is not possible to determine the cause of this, it is likely that those who had previously sought out help had a positive experience, and therefore, show stronger intentions towards help-seeking in the future. As stated by Ajzen (1991), in his theory of Planned Behaviour, attitude is a crucial aspect for an individual to change their behaviour. Therefore, a positive previous help-seeking experience could be an important factor for an individual to seek out help again (Ajzen, 1991). To make individuals view help-seeking as a more positive thing,

it is crucial to reduce stigma and provide better information regarding mental disorders (Gulliver et al., 2010).

On average, women in this study had a more positive attitude towards help-seeking and showed signs of stronger help-seeking intentions than men. Women also showed stronger beliefs in psychologists' expertise than men. Even though there were more women than men participating in this study, all results were statistically significant. These results are in line with previous research conducted on gender differences in help-seeking and mental disorders (Lynch et al., 2018; Seidler et al., 2016; Thompson et al., 2016). It is not clear why men are less likely than women to seek help, but a common theory is that men tend to feel that seeking help reduces their masculinity and makes them seem weak (Lynch et al., 2018). According to Seidler et al. (2020), men who had a negative previous help-seeking experience, were less likely to seek out help in the future (Seidler et al., 2020). This could have affected men's intentions to seek out help in this study. As mentioned before, results in this study showed that men are less likely to seek help for mental disorders which can be caused by the need to help themselves instead of seeking professional help (Lynch et al., 2018). They also tend to find unhealthy ways to cope (Seidler et al., 2016). Unfortunately, men have a higher suicide rate due to mental disorders (Kiely et al., 2019) which could be prevented by better understanding regarding mental health along with reduced stigma in society (Seidler et al., 2020).

There are a few limitations regarding this study that need to be addressed. The main limitation is that causal relationships cannot be determined. Also, there was one question missing from the Stigma subscale under the I-BAPS scale due to a coding error. For that reason, results from this study cannot be compared accurately to other studies on the total score on the BAPS scale and the Stigma subscale. One of the aims of the study was to compare previous anxiety diagnosis to previous depression diagnosis. Due to a small sample size, the results were not reliable enough to conclude anything about the difference regarding those disorders. Because of the way participants were recruited, by a convenience sample and not with a randomized method, it is not possible to generalize the results over all university students in Iceland or university students in general. Because the gender difference is so strong in relation to help-seeking attitudes and behaviour, it would be interesting to examine that difference further. The subset of the sample in this study, including those with only a diagnosis of depression or anxiety (and not both), was quite small. It would be interesting to examine the difference with larger sample size to compare help-seeking attitudes and behaviour across those diagnoses. It is important to know that the data was collected before the Covid-19 pandemic.

Therefore, it is likely that had the study been done today, the prevalence rate of anxiety and depression would be higher. Further research could also include other diagnostic categories like Obsessive-Compulsive disorder or personality disorders and explore their link to help-seeking and beliefs about help-seeking. As mentioned before, the main limitation to this study was the inability to determine causal relation. To examine the possible causal relationship, future research could emphasize using longitudinal research methods to determine whether receiving help from a psychologist affects help-seeking attitudes in the future, or whether the difference is merely a result of people with more positive attitudes being more likely to seek help.

Conclusion

This study shows that there are many aspects to consider regarding help-seeking. Mental disorders are a serious issue worldwide. Therefore, help-seeking is a crucial aspect when it comes to recovery from mental disorders. It is clear that men are less likely to seek help, which can have severe consequences. Results from this study showed that intentions to seek help were the strongest predictor when it came to help-seeking behaviour. Previous diagnosis of anxiety and depression did not seem to determine attitude towards help-seeking, but gender and previous help-seeking behaviour seemed to. This study shows that there are many aspects to consider, and it is clear that attitude plays a key role when it comes to help-seeking behaviour. To encourage individuals to seek help, it is important to minimize the negative attitude towards help-seeking and make psychological services more accessible. It is important that those who suffer from depression and anxiety get the help they need. University students experience many changes in their lives which can make them vulnerable to mental disorders. Therefore, it is important to figure out what makes them more likely to seek help along with finding out what prevents them from seeking help. By educating individuals about the importance of help-seeking and about mental disorders in general, we as a society can move forward in a more positive way when it comes to mental health.

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