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Adolescent trust and primary care: Help-seeking for emotional and psychological difficulties

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A B S T R A C T

Although a quarter of adolescents are likely to experience emotional and psychological difficulties, only a third of them will seek professional help. In this exploratory study we undertook focus groups with 54 adolescents between the ages of 13 and 16 in eight post-primary schools in Northern Ireland. Young people do not trust their GPs, perceiving them as strangers, impersonal and uncaring. The basis of distrust is different among males and females. The findings are discussed in light of adolescents' developmental challenges of identity formation and the consequent demand to be respected and taken seriously by adults.
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1. Introduction

Most adult mental health problems originate in adolescence, and various epidemiological studies (e.g., Costello, Egger, & Angold, 2005; Meltzer, Gatward, Goodman, & Ford, 2003) indicate prevalence rates of mental health problems of between 20 and 25%. Despite this, most adolescents do not seek professional help (e.g., Chen et al., 2014; Grinstein-Weiss, Fishman, & Eisikovits, 2005; Rickwood, Deane, & Wilson, 2007). Among those with a diagnosable mental illness only between 18% and 34% seek professional help (Green, McGinnity, Meltzer, Ford, & Goodman, 2004, 2005; Gulliver, Griffiths, & Christensen, 2010; World Federation for Mental Health, 2009). Even those with severe problems avoid seeking help or experience considerable delay in getting appropriate help (Biddle, Donovan, Gunnell, & Sharp, 2006; Burns et al., 1995; Goodman, Ford, & Meltzer, 2002).

Barriers to help-seeking from professionals have been variously identified as a high reliance on self to solve problems, a lack of emotional competence, confidentiality, other people finding out, and negative attitudes about seeking professional help (Gulliver et al., 2010; Rickwood, Deane, Wilson, & Ciarrochi, 2005). Leavey, Rothi, and Paul (2011) identified lack of trust as a major barrier to help-seeking from their GP (General practitioner). Helpseeking from professionals can be mediated by remedying these barriers, and by social encouragement, knowledge, and the availability of established and trusted relationships with professionals such as GPs (Rickwood et al., 2007). Where such relationships are lacking, adolescents are not receiving necessary interventions, as a result of which their mental health problem remains untreated and likely exacerbates into adulthood. Mental health problems (behavioural and emotional) impair daily functioning in adolescence and carry on into adulthood if undetected and left untreated (Crutzen & De Nooijer, 2010). The costs incurred by late detection and

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untreated adolescent mental illness are considerable, impacting as they do on the individual, their families and communities. More widely there are considerable costs to education, employment, health, welfare and the criminal justice system.

Barker, Olukoya, and Aggleton (2005) proposed that help-seeking is determined by the interaction of individual factors such as personal beliefs, internalised gender norms, coping skills, self-efficacy, and perceived stigma, and structural factors, e.g., the national health system, accessibility and affordability of services, and social support. Caring, trusting relationships are important not only for fostering YP's social and ethical development, but also their academic growth (Watson & Ecken, 2003).

Adolescents commonly state that they prefer to turn to close and trusted friends and family members as a source of help (e.g., Rickwood & Braithwaite, 1994; Rickwood et al., 2007). This may be due to fears around stigma and embarrassment, which were the most frequently mentioned barrier in Gulliver et al.'s systematic review (2010), followed by concerns about confidentiality and trust, while positive past experiences with a health professional emerged as the biggest facilitator to help-seeking. Gulliver et al. (2010) observed that concerns about confidentiality and trust may relate to stigma, because a fear of breached confidentiality is rooted in the fear of stigma and embarrassment if peers and family find out that the adolescent has sought help for mental health problems.

Rotenberg (1994); Rotenberg, MacDonald, & King (2004); Rotenberg, McDougall, & Boulton et al. (2004); Rotenberg & Boulton et al. (2005); Rotenberg, & Fox et al. (2005) developed the *BDT framework of interpersonal trust* which includes three bases of trust: Reliability, emotional trust, and honesty. The BDT framework suggests that trust beliefs include an affective component primarily reflected in the strength of conviction that others showed reliability, emotional trustworthiness, and honesty. The framework highlights the importance of interpersonal trust for children and adolescents. The authors argue that when a child or adolescent believes that the people in their world (parents, teachers, peers, siblings, and doctors) are not honest, but deceptive and manipulative, or do not keep their word, they would withdraw from contact and fail to achieve, e.g., social skills, social support, peer group relationships, close relationships, academic achievement, and medical treatment. Dunn and Schweitzer (2005) found that the induction of positive emotional states (e.g., gratitude, pride, happiness) increased trust in an unfamiliar person, and that the induction of negative emotional states (e.g., anger, sadness) decreased trust in that person. In the first instance, this points to the importance of a person-centred care approach where the adolescent is an equal partner in the planning of their care; where his or her opinions are important and respected, and where they associate a visit to the GP with positive emotions, and feel they can trust their GP.

Chandra and Minkovitz (2006) found gender differences in negative attitudes to mental health, and subsequent willingness to use mental health services. Girls, initially, turned to a friend for emotional concern in the first instance, while boys preferred to confide in a family member. Boys had less mental health knowledge and higher stigma than girls, and were twice as unlikely to use mental health services.

Ruggeri, Gummerum, and Hanoch (2014) found that adolescents prefer to be involved in the medical decision making process. In recent years, there has been a shift from a paternalistic medical model, where physicians and parents hold an authoritative role in determining a child's treatment, to one advocating minors' involvement in their medical treatment (McCabe, 1996).

Against this background, the aim of the study was to explore adolescents' attitudes to consulting their GP about psychological problems. Ethical approval was provided by the UU Research Ethics Committee (REC/12/0201).

2. Method

2.1. Design

To facilitate this exploratory, cross-sectional, qualitative study, eight post-primary schools were selected from Education and Library Board databases and stratified by markers of urbanicity, school type, Education Board, and deprivation indices (NISRA), with the view to achieving a representative sample across Northern Ireland, and to allow for comparison in help-seeking attitudes and behaviours. In-depth, semi-structured focus group interviews were conducted in each school, transcribed verbatim and subjected to thematic analysis (Miles & Huberman, 1994).

2.2. Topic guide

Based on previous research and the literature we constructed a topic guide covering the following areas for discussion: (a) Familiarity with GP; (b) The roles of the GP for emotional and mental health; (c) Barriers to contacting GP about emotional or mental health issues; (d) Help-seeking preferences. Typical questions included "What are the reasons you usually go and see your GP (How often do you go/How well do you know your general practitioner)?"; "How do you feel about talking to your GP about emotional difficulties?"; "What are the main reasons you may not talk to your GP about emotional or mental health issues?"; and "Would you like to be able to talk to your GP about emotional/mental health issues (Why/why not?/What would have to change for you to feel comfortable to do that)?".

2.3. Participants

24 girls and 30 boys between the ages of 13 and 16 attending eight post-primary schools in Northern Ireland participated in nine focus groups, each consisting of between five and seven pupils. The groups were stratified by age and gender.

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