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ORIGINAL ARTICLE

Help-negation in suicidal youth living in Switzerland

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Abstract
Objectives: To examine whether help-negation (i.e. not accepting or accessing available helping resources) among suicidal youth could also be found in a Swiss sample.
Methods: Data from 7335 16–20-year olds, who participated in the 2002 *Swiss Multicentre Adolescent Survey on Health*, were analyzed. Logistic regression analyses were conducted to predict if a person would generally talk with *no one* when having a mental health problem (e.g. feeling depressed or anxious). Not talking about such problems was interpreted as indicator for help-negation. The main predictor was suicide severity. Additionally, an indicator of depression and socio-demographic variables were included in the statistical models.
Results: People with higher levels of suicidality and depression were more likely to report that they would not talk about mental health problems. More non-Swiss (vs. Swiss) participants and apprentices (vs. students) reported high suicidality. Furthermore, these specific sub-groups seemed to be particularly likely to negate help.
Conclusion: Help-negation can also be found in a Swiss sample of young people and seems to be particularly pronounced in some socio-demographic subgroups. By reducing this reluctance to seek help, premature death due to suicide might be reduced.

Introduction

Suicide is one of the most important reasons for premature death among young people living in Switzerland[1] and other countries.[2–4] The risk of suicide increases with increasing levels of suicidal intent[5] and is heightened among people with a mental health problem.[2–4,6] Reducing these risk factors (e.g. through effective treatment for particular mental health problems) might contribute to a reduction of suicide rates.[2–4]

However, several studies have shown that young people's intentions to seek informal or formal help for suicidal thoughts or a personal-emotional/mental health problem decrease with increasing levels of suicidal ideation, psychological distress or depressive symptoms.[7–15] Furthermore, intentions to seek help from anyone seem to decrease with increasing symptom load.[8,10–12,14] In other words, youths who are experiencing suicidality or mental health problems show

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help-negation, which was defined as a ''*refusal to accept or access available helping resources*''.[16] Accordingly, suicidal youths and those who were depressed were found to score higher on a ''maladaptive coping strategies'' factor (including items such as ''people should be able to handle their own problems without outside help'').[17] Accordingly, it has been described that some people with mental health problems (including suicidality) prefer to rely on themselves.[18–20] Furthermore, the fear of getting stigmatized might lead to the reluctance to disclose mental health problems and to seek professional help.[18,19,21,22]

Existing studies about help-negation mainly originated from English-speaking countries. However, evidence for help-negation was recently also found in a sample of 15–75+-year olds who participated in the Swiss Health Survey 2012[23]: only a small proportion of people with a high level of suicidality were currently in treatment for depression and those with the highest need were especially reluctant to access or accept help. Furthermore, it has been found that help-negation was pronounced among males and young people (15–24-year olds). The present article aims to study whether help-negation in young people can also be found by using data from the ''*Swiss Multicentre Adolescent Survey on Health*'' (SMASH) 2002 that included 16–20-year olds. The outcome used is the variable ''*Generally speaking with no one about mental health problems*'', which is an indicator of not wanting to access or accept informal or formal help.

Methods

Procedure

The SMASH study was conducted in 1992/1993 and again in 2002.[24,25] Data from 2002 were analyzed for the current article. The SMASH 2002 aimed to assess young people's health status, health behaviour, health care utilization and health determinants (e.g. socio-economic status) as well as changes in these parameters since 1992/1993. The collected data intended to serve as a basis for optimizing the health care and health-related programmes for this particular age group. The study protocol was approved by the Ethics Committee of the University of Lausanne.[25] The survey targeted 16–20-year olds from post-compulsory schooling (i.e. high school students and apprentices). A random cluster sample of school classes was used. Questionnaires (available in German, French or Italian) were filled out voluntarily and anonymously during school hours. More details about the survey have been published elsewhere.[24,25]

Predictors

- *Depression and suicidality*: Participants were asked if they currently were experiencing any of the following eight symptoms of depression: (1) I am often depressed, without knowing why; (2) every now and again I think that everything is so hopeless so that I am not in the mood for anything; (3) every now and again I think that I have nothing that brings me joy; (4) every now and again I am so depressed that I would like to stay in bed all day; (5) I am often sad/depressed, without knowing why; (6) I find my life is quite sad; (7) recently, I often thought about death; and (8) every now and again I think that life is not worth living. A 4-point response format ranging from ''completely disagree'' (0) to ''completely agree'' (3) was used. A sum score of items 1–6 was built, with higher scores indicating higher levels of depression (Cronbach's alpha = 0.90). Items 7 and 8 were added together to get an indicator of suicidal severity (Cronbach's alpha = 0.74). This sum score was then categorized into ''*not suicidal*'' (sum-score: 0; both items about suicidality were answered with ''completely disagree''), ''*low suicidality*'' (sum-scores: 1–2), ''*moderate suicidality*'' (sum-scores: 3–4) and ''*high suicidality*'' (sum-scores: 5–6; at least one item about suicidality was answered with ''completely agree'').
- *Language region*: German-, French- and Italian-speaking.
- Gender.
- Age.
- *Nationality*: Swiss vs. Non-Swiss.
- *Academic track*: high school vs. apprenticeship. Students of the former academic track often enter university after concluding high school. Apprentices attend classes at a vocational school 1–2 days per week and are trained in a company related to their chosen professional field during the remaining working days.

Outcome

Participants were asked if they would generally speak with no one if they had a mental health problem (e.g. feeling depressed or anxious). The answers were coded into not mentioned (0) vs. endorsed the statement that they would generally speak with no one if they had a mental health problem (1).

Analytical sample

The original data file included 8740 people who participated in the survey in 2002. Of these, 1405 were excluded because they were younger or older than the target age group (16–20 years) or had missing data on gender, age, nationality or on any of the items about suicidality or depression. The final analytical sample consisted of 7335 people.

Statistical analysis

Socio-demographic characteristics of the sample were presented descriptively. Chi-square tests were used to describe associations between socio-demographic variables and suicidality. Logistic regression analyses were conducted to identify predictors associated with the outcome. Firstly, crude odds ratios (OR) were calculated for each individual predictor (see above). Secondly, adjusted ORs (AOR) were calculated (all predictors were concurrently considered in the logistic regression analyses). Interquartile ORs[26] were calculated for the sum score describing depression. All variance inflation factors were $\leq$10, indicating that multicollinearity was not a concern in the present study.[27]