

**Help-seeking behaviour for internalizing problems:  
Perceptions of adolescent girls from different ethnic backgrounds**

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## **Help-seeking behaviour for internalizing problems:**

### **Perceptions of adolescent girls from different ethnic backgrounds**

**Objective:** Although adolescent girls from ethnic minorities are at an increased risk of internalizing problems (e.g. depression), only a small fraction seeks formal help for these problems. To enhance help-seeking for internalizing problems among ethnic minority adolescent girls, insight into their help-seeking behaviour is required. This study explored the perceptions of adolescent girls from different ethnic backgrounds regarding their help-seeking behaviour for internalizing problems.

**Design:** A qualitative study using Focus Group Discussions (FGDs) was employed. Eight FGDs were conducted with 50 adolescent girls of mostly Turkish (n=23), Moroccan (n=13), and Dutch (n=10) backgrounds recruited from Rotterdam, a multicultural city in the Netherlands. FGDs were conceptually framed within a help-seeking model, facilitated by a vignette and analysed using NVivo software.

**Results:** When describing the internalizing problems presented in the vignette, participants of non-Dutch FGDs tended to state the causes of the problems (e.g. lack of attention) whereas participants of Dutch FGDs mentioned the emotional state. Participants did not perceive the presented internalizing problems as severe. If participants were to face internalizing problems of their own, their decision to seek help would be hampered by negative attitudes towards professionals and school-based services. Particularly in non-Dutch FGDs the fear of parental and friend's reactions was identified as a barrier. Participants identified their mother and a good friend as primary sources of help.

**Conclusion:** In this study, adolescent girls of Turkish, Moroccan and Dutch backgrounds had difficulty recognizing the severity of internalizing problems, and various barriers could hamper their decision to seek help. To enhance utilization of mental health services by youth, promoting

a change in their attitudes towards mental health/school-based services is recommended.

Guaranteeing confidentiality within school-based services, and training for professionals in communicating with adolescent girls, may also prove beneficial. In ethnic minorities, tackling the negative reactions of family/friends requires attention.

**Keywords:** Adolescents, mental health, help-seeking behaviour, culture, minority health, qualitative research

## Introduction

Internalizing problems, defined as problems that are mainly within the self (Achenbach and Rescorla, 2000), like depression and anxiety, have a great impact on adolescents. Declining school performance, school absenteeism, loss of social relations and substance abuse are some of the frequently reported outcomes of internalizing problems (Carlson, 2000, Simon, 2009). On the long run, internalizing problems can lead to co-morbidity and suicide (Harrington *et al.*, 1990, Shaffer *et al.*, 1996). Studies have shown that adolescent females are at an increased risk of developing internalizing problems compared to male counterparts (Jorm, 1987, Kuehner, 2003). The ethnic minority status has been found to place them at an even higher risk of internalizing problems (Stevens *et al.*, 2005, van Oort *et al.*, 2006, McLaughlin *et al.*, 2007). Therefore, early detection and treatment of these problems in this group is of utter importance.

Most ethnic minority adolescents do not seek formal help for mental health problems and rates of mental health service utilization are low compared to the majority group (Garland *et al.*, 2005). For example, a study in the United States found that African American and Asian American/Pacific Islander youth were half as likely to receive any type of mental health care compared to their White American counterparts, even after controlling for risk factors associated with mental health care use (Garland *et al.*, 2005). The differences were particularly large for outpatient care though differences were also found for informal care like self-help groups. A recent Dutch study revealed that Moroccan girls were less likely (RR 0.73) to use youth mental health care services than Dutch girls (de Haan *et al.*, 2012). Shame, stigma, fear of gossip and interethnic differences in help-seeking patterns such as solving problems within the ethnic and religious community have been suggested to contribute to the lower rates of mental health service utilization among ethnic minorities (Lawrence *et al.*, 2006, Goldston *et al.*, 2008). For ethnic minorities residing in the Netherlands, such as the

Moroccans and the Turks, it has further been suggested that “a strong commitment to Islamic religious practices” (Knipscheer and Kleber, 2005) and a collectivistic background, which “includes a sense of interdependence and of one's status as a participant in a larger social unit” (Sampson, 1988), as opposed to an individualistic background, which places emphasis on independence and is more common in the Dutch majority, may also contribute differences in utilization of mental health services (Knipscheer and Kleber, 2005).

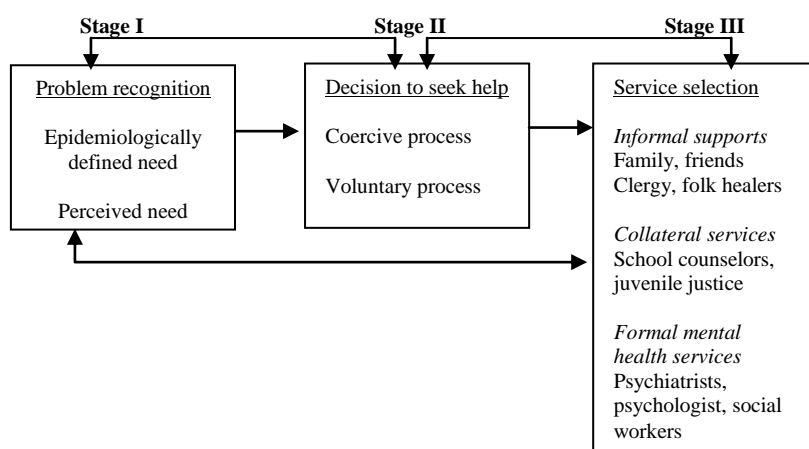
To enhance help-seeking for internalizing problems in adolescents from ethnic minorities, it is important to explore their help-seeking behaviour for these problems. As proposed by Cauce et al. (Cauce *et al.*, 2002) help-seeking behaviour should be considered a protracted process which begins with the time when a problem is first noticed. A focus on the process of help-seeking rather than help-getting will more fully account for the influence of culture and context (Cauce *et al.*, 2002). To date, a few studies have investigated the mental health help-seeking pathway of adolescents from different ethnic backgrounds (Molock *et al.*, 2007, Lee *et al.*, 2009) however; none of these studies have focused specifically on perceptions of adolescent girls regarding their help-seeking behaviour for internalizing problems. Since adolescent females from ethnic minorities are considered a high risk group with regard to internalizing problems (Stevens *et al.*, 2005, van Oort *et al.*, 2006, McLaughlin *et al.*, 2007) it is of interest to focus on the help-seeking behaviour of this specific group.

Hence, the aim of this study was to explore the perceptions of adolescent girls from different ethnic backgrounds regarding their help-seeking behaviour for internalizing problems.

### ***Theoretical framework***

A three-stage model for mental health help-seeking in adolescents, developed by Cauce et al.

(Cauce *et al.*, 2002), was used as a theoretical framework for exploring the influence of ethnic background on adolescent girl's perceptions of help-seeking behaviour for internalizing problems (Figure 1). Stage I in the pathway, referred to as problem recognition, takes epidemiologically defined need and perceived need into account. Stage II, the decision to seek help, consists of a coercive and voluntary process of which the latter is largely determined by attitudes and beliefs. Stage III, service selection, looks at whom adolescents and their families turn to when dealing with a mental health problem. Context and culture are hypothesized to influence all three stages of help seeking. It is important to note that the stages defined in this model are interrelated but not necessarily sequential, indicated by the double-headed arrows pointing forward and backward. A problem may be redefined differently once help has been sought. Additionally, it is not unusual for an individual to pass back to a stage more than once to consult different sources of information or help (Cauce *et al.*, 2002).



**Figure 1. A three-stage model for mental health help-seeking among adolescents**

In order to add depth to the three-stage model for mental health help-seeking among adolescents (Cauce *et al.*, 2002), concepts from the latest version of the health belief model by Rosenstock *et al.* (Rosenstock *et al.*, 1988) were also taken into account. These concepts related to perceived severity (how severe are internalizing problems), and perceived barriers and facilitating factors (what hampers or facilitates help seeking).

## **Methods**

### ***Design and Participants***

A qualitative study using Focus Group Discussions (FGDs) was employed. FGDs are an effective qualitative method that uses planned discussion in a non-threatening environment and makes use of the interactions between participants to obtain detailed information (Morgan, 1997). The Medical Ethics Committee of xx [blinded for review] gave a "declaration of no objection" for this study (MEC-2009-232).

Adolescent girls were recruited via migrant organizations and youth centres in a multicultural urban area (Rotterdam, the Netherlands) through convenience sampling. Recruitment via mental health services was avoided as the focus was on adolescent girls from the general population. Study information was sent to representatives of the entities who then invited the participants via telephone or email. Information letters were sent to the participants and their parents once they had shown initial interest. Participants were eligible to participate if their parents did not object to their participation, if they were female, aged between 12 and 20 years and with one of the following ethnic backgrounds: Dutch, Turkish or Moroccan. Turks and Moroccans made up respectively 7.8% and 6.5% of the population in Rotterdam, the Netherlands in 2011 (RotterdamDATA, 2012). After the Surinamese, the Turks and Moroccans are the largest migrant groups in Rotterdam. Most Turks and Moroccans immigrated to the Netherlands in the 1960's as guest workers. More recently, immigration took place mostly due to marital reasons. According to the latest statistics which date from 2010, Turkish and Moroccan immigrants in the Netherlands were on average lower educated and had a lower net family income than the majority population (CBS, 2010b, CBS, 2010a).

The focus group discussions (FGDs) took place in youth centres, centres for women, or mosques and were facilitated by one of two trained female researchers (IF and TB, both health psychologists) of Dutch ethnicity. A third researcher was present to take field notes.

As all participants spoke Dutch, the FGDs were held in Dutch. Attention was paid to saturation of data. When no new themes arose data collection was ceased.

### ***Ethnic background***

Ethnic background was determined on the basis of the country of birth of the participant and her parents, a classification system employed by Statistics Netherlands (CBS, 2000). If the participant's parents were both born in the Netherlands, she was considered Dutch. If one of the participants' parents was born outside the Netherlands, she was considered non-Dutch. We further distinguished between first and second generation immigrants. Participants were considered first generation if they were born abroad. Participants were considered second generation if they were born in the Netherlands but if their mother or father was born abroad. Using country of birth as an indicator of ethnic background fits with the concept of a common geographical and ancestral origin in the conceptualization of ethnicity (Aspinall, 2001).

### ***Study instruments***

#### ***Vignette***

According to Barter and Renold (Barter and Renold, 1999) "vignettes are useful in social research for three main purposes: (1) to allow actions in context to be explored; (2) to clarify people's judgments; and (3) to provide a less personal and therefore less threatening way of exploring sensitive topics". As mental health problems are seen as a sensitive topic in the Netherlands and elsewhere and the participants were selected from the general population, a vignette (presenting 'an internalizing problem') was employed to create a clear context and safe atmosphere in which to discuss the topic (Appendix 1). The vignette used for this study was based on real life stories and was reviewed by a child psychiatrist.



### *Focus group guide*

The FGDs were structured by means of a guide/list of questions (Appendix 2). The guide comprised three sections, each corresponding to the three stages of help-seeking. The guide had both general and probing questions framed on the three stages of help-seeking, the concepts of perceived severity, barriers and facilitating factors and, the vignette. Two additional prompts explored the influence of religion and ethnic background.

### *Questionnaire*

In order to gain an idea of the characteristics of the participants and the FGDs, participants were invited to complete a questionnaire after the FGDs had ended. This questionnaire included items on background characteristics (i.e. education, religion, living situation), and the use of health services in the past year (i.e. general practitioner, mental health services, hospital). To take psychosocial well-being into account, the Strengths and Difficulties Questionnaire (SDQ) was also included (van Widenfelt *et al.*, 2003). The SDQ is a brief behavioural screening instrument that asks about children's and teenagers' symptoms and positive attributes (Goodman, 1997, Goodman *et al.*, 1998, Goodman, 2001). For this study the Total Difficulties scale was of interest. A cut-off value of 16 was used for this scale with a score above 16 indicating signs of emotional and social distress (Goodman, 1997, Goodman, 2001). The results of the questionnaire per FGD are presented in table 1.

### *Content analysis*

Recordings from the FGDs were transcribed verbatim and entered into the NVivo (version 8) software program by the primary researcher (IF). A directed approach to content analysis was used to analyse the data. The goal of a directed approach is to “validate or extend conceptually a theoretical framework or theory” (Hsieh and Shannon, 2005).

Firstly, a coding scheme using predetermined ‘major themes’ that were based on the three stages of mental health help-seeking (i.e. problem recognition, decision to seek help and service selection) and the Health Belief Model (i.e. perceived severity, barriers and facilitating factors) was developed by the first coder (IF) (Potter and Levine-Donnerstein, 1999, Hsieh and Shannon, 2005). All text that represented a ‘major theme’ was coded as such by the first coder (IF). Text that was deemed relevant for the study aim but that could not be highlighted with the coding scheme was given a new code.

In a next step, the coded text was analyzed extensively by two coders (IF & TB). Firstly, all coded text was reviewed to determine whether it adequately represented the ‘major theme’. This resulted in some minor changes (e.g. one passage was moved to another ‘major theme’). Hereafter, the coders went on to identify ‘subthemes’ of the major themes. Data that were given a new code in the first step were re-analyzed to determine if the data represented a new ‘major theme’ or a ‘subtheme’. This resulted in the addition of two new ‘major themes’ (i.e. consequences of not seeking help and causal attribution).

In a last step, a more quantitative approach in which frequency of categories (how many times a subtheme was mentioned) and extensiveness (how many participants mentioned the subtheme) was applied to identify the most important subthemes and potential differences between FGDs (Morgan *et al.*, 1998, Pope and Mays, 2000). As a rule, it was decided that subthemes should be discussed in a majority of the FGDs by a majority of the participants to be considered an ‘overall’ finding (table 2). As a result of this analysis framework, five ‘overall’ subthemes were excluded. The coders additionally agreed that if a subtheme arose exclusively in a Turkish, Moroccan or Dutch FGD, it was considered as specific for that ethnic group (table 2).

In total, 7 major themes were identified with 21 corresponding subthemes (table 2). Both coders were involved in selecting appropriate passages of themes that could thereafter

be translated into English by a bilingual researcher (IF). Each FGD and participant was numbered so that each selected passage could be labelled with this information.

## **Results**

### ***Characteristics of the participants and the Focus Group Discussions***

A total of 50 girls participated in the eight FGDs, which were organized according to the participants' ethnic background (table 1). Three FGDs were classified as 'Turkish' (FGD 1, N=8; FGD 2, N=8; FGD 3, N=8), two as 'Moroccan' (FGD 4, N=8; FGD 5, N=5) and three as 'Dutch' (FGD 6, N=3; FGD 7, N=6; FGD 8, N=4). Four participants had an ethnic background other than Turkish, Moroccan or Dutch (i.e. Colombian, Bosnian and Surinamese). In view of small numbers, these participants were excluded from the content analysis. All participants provided their informed consent.

Most of the participants in the Turkish and Moroccan FGDs were second generation immigrants and felt most affiliated to the Muslim faith (table 1). In the Dutch FGDs most participants reported to have no religion. Median age of the FGD participants ranged from 13 (IQR 2) in FGD 6 (Dutch) to 21 (IQR 2) in FGD 1 (Turkish). In the Turkish FGDs, median age of the participants was slightly higher than in the other FGDs. In a majority of the FGDs, participants had a medium level education with the exception of one Turkish and one Dutch FGD where half of the participants had a high level education. In all FGDs most of the participants reported to live with both their parents. At least one participant in all FGDs had visited a General Practitioner (GP) the past year. A small minority had used other health services. In all FGDs the median score of the SDQ total difficulties scale was below the cut-off for psychological distress. Six participants presented a score above the cut-off.

1 ***Table 1 Characteristics of the participants and the Focus Group Discussions (FGDs)***

	FGD 1	FGD 2	FGD 3	FGD 4	FGD 5	FGD 6	FGD 7	FGD 8
	‘Turkish’	‘Turkish’	‘Turkish’	‘Moroccan’	‘Moroccan’	‘Dutch’	‘Dutch’	‘Dutch’
	(N=8)	(N=8) <sup>1</sup>	(N=8)	(N=8)	(N=5) <sup>2</sup>	(N=3)	(N=6) <sup>3</sup>	(N=4) <sup>4</sup>
<b>Generational status</b>								
% (N) Second generation	100 (8)	88 (6)	100 (8)	75 (6)	100 (4)	0 (0)	0 (0)	25 (1)
<b>Age (years)</b>								
Median (IQR)	21 (2)	17 (4)	19 (5)	16 (2)	16 (2)	13 (2)	14 (2)	15 (2)
<b>Educational level % (N)</b>								
High	25 (2)	12 (1)	50 (4)	38 (3)	0 (0)	0 (0)	17 (1)	50 (2)
Medium	75 (6)	88 (7)	38 (3)	50 (4)	100 (4)	100 (3)	83 (5)	50 (2)
Low	0 (0)	0 (0)	12 (1)	12 (1)	0 (0)	0 (0)	0 (0)	0 (0)
<b>Religious affiliation % (N)</b>								
Muslim	100 (8)	100 (7)	100 (8)	100 (8)	100 (5)	N.A. <sup>5</sup>	0 (0)	25 (1)
Christian	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	N.A. <sup>5</sup>	33 (2)	25 (1)
Other religion	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	N.A. <sup>5</sup>	17 (1)	0 (0)
No religion	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	N.A. <sup>5</sup>	50 (2)	50 (2)

<b>Living situation</b>								
% (N) Living with both parents	100 (7)	75 (6)	88 (7)	63 (5)	60 (3)	N.A. <sup>5</sup>	67 (4)	75 (3)
<b>Health service use past year (N)</b>								
General practitioner	3	4	8	5	2	N.A. <sup>5</sup>	3	3
Mental health care	1	0	0	0	0	N.A. <sup>5</sup>	0	1
Medical specialist	2	0	0	0	0	N.A. <sup>5</sup>	1	0
Social worker	1	0	0	0	1	N.A. <sup>5</sup>	0	1
Peer help	0	0	0	0	0	N.A. <sup>5</sup>	0	1
Youth health care	0	0	0	0	0	N.A. <sup>5</sup>	0	1
<b>SDQ total difficulties score <sup>6</sup></b>								
Median (IQR)	14 (6)	9 (4)	12 (6)	6 (5)	13 (4)	14 (13)	13 (6)	13 (5)
<b>SDQ total difficulties score &gt;16 % (N)</b>	25 (2)	0 (0)	0 (0)	0 (0)	0 (0)	33 (1)	33 (2)	25 (1)

<sup>1</sup> FGD included one participant of Colombian background

<sup>2</sup> FGD included one participant of Bosnian background

<sup>3</sup> FGD included one participant of Surinamese background

<sup>4</sup> FGD included one participant of Surinamese and one participant of Moroccan background

<sup>5</sup> Data not available

<sup>6</sup> Normal range 0-16 for girls. Score >16 indicates some form of distress (Goodman, 2001)

## 9 *Qualitative findings*

### 10 *Phase I Problem recognition: perceived severity and consequences of not seeking help*

11 Participants of the FGDs recognized that the character described in the vignette had a  
12 problem. Suicide or contact with ‘lover boys’ (pimps) were mentioned as a possible  
13 consequence of not seeking help: “If she keeps on crying then at some point she’ll probably  
14 think she doesn’t want to live anymore. I think you’ll get those kinds of thoughts quite  
15 quickly” (Turkish FGD 2, participant 1), “I think things are only going to get worse if she  
16 doesn’t talk to anyone. It may even lead to suicide or she might get in touch with a lover boy”  
17 (Dutch FGD 8, participant 4).

18 Despite stating these consequences, participants of the FGDs did not perceive the  
19 problem in the vignette as severe. They indicated that it was a normal problem that every  
20 teenager has to deal with “But it could be any random girl. She’s just going through puberty. I  
21 think any girl who’s 15 feels like this” (Moroccan FGD 4, participant 5).

22

### 23 *Ethnic background, problem recognition and causal attribution*

24 A marked difference between Dutch and non-Dutch FGDs was the way participants described  
25 the problem. When asked what was ‘wrong’ with the character in the vignette, participants of  
26 Dutch FGDs more often identified the emotional state (i.e. depression) whereas the  
27 participants of Turkish and Moroccan FGDs more often named the cause. Facilitator: “So  
28 what do you think is wrong with this girl?” “I think that she’s just depressed about  
29 everything” (Dutch FGD 7, participant 5) “I think she’s getting too little attention” (Moroccan  
30 FGD 4, participant 10).

31

### 32 *Phase II Decision to seek help: perceived barriers and facilitating factors*

33 In all FGDs, distrust was identified as an important barrier to seeking help. In particular,

34 school-based services (i.e. teachers) were identified as untrustworthy by participants: “Some  
35 teachers immediately tell others” “But of course you do have counsellors or doctors; they also  
36 come to the schools.” “Either way, you need to know how a teacher will react otherwise  
37 you’ll never tell them” (Turkish FGD 2, multiple participants). “They’re always going to tell  
38 your parents. They’ll tell you that they won’t - but they’ll phone them anyway” (Dutch FGD  
39 7, participant 5).

40 In Turkish and Dutch FGDs, participants who had been in contact with formal mental  
41 health services had negative attitudes towards these services based on previous experiences.  
42 Participants indicated that professionals often “talk things into your head” which makes the  
43 problem even worse: “Well at some point I even got into a fight with the professional at the  
44 institution, I wasn’t allowed to come back. They’d ask me the same question 100 times. At  
45 some point I said: if “yes” is what you want to hear then I’ll say YES!” (Dutch FGD 8,  
46 participant 4).

47 Even the participants without direct experience had negative attitudes: “Well I haven’t  
48 been there myself, but a friend of mine went and she said that all those stories - that your  
49 problems only get worse and that you need to talk about your problems all the time - are true.  
50 At least that’s what I understood. It must be a method or something” (Turkish FGD 1,  
51 participant 7).

52 Participants of the FGDs felt that having more self-confidence would facilitate help  
53 seeking, but would also be a solution to the problem: “If you’re self-confident then things will  
54 just be better” (Turkish FGD 2, participant 1).

#### 56 *Ethnic background, perceived barriers and facilitating factors*

57 The fear of negative reactions of family/friends represented a barrier for participants of the  
58 FGDs. However, in Turkish and Moroccan FGDs the fear of negative reactions was identified

as a barrier more often than in Dutch FGDs. Additionally, different types of negative reactions were identified compared to Dutch FGDs; most participants of non-Dutch FGDs particularly feared disappointing, worrying or shaming their parents: “Well I think shame plays a role - but also being scared that they’re going to be too worried about you. You want to show your parents that things are going well with you - and that you’re doing well at school for instance” (Moroccan FGD 4, participant 1). Participants also feared the reactions of friends “There might be friends that will think that you’re crazy or something” (Turkish FGD 1, participant 1). Participants of Dutch FGDs preferred not to tell their parents because they thought they would not take them seriously: “I don’t even dare tell anything. I know that my mom won’t react negatively but I’m just scared that she won’t understand me” (Dutch FGD 8, participant 4).

In Dutch FGDs, participants agreed that they would not go to a professional because they are not familiar/known to you: “Well you’re not familiar with those people. You’re not really sure if the things you tell them will be interpreted in the right way” (Dutch FGD 6, participant 2).

Opinions about whether a professional should have the same ethnic background were not unanimous. Participants of Turkish and Moroccan FGDs indicated that a professional with the same cultural background would be able to help them better: “I don’t understand how someone with a different cultural background can understand me if I have problems at home that they don’t experience” (Turkish FGD 1, participant 1). However, others indicated that it did not matter to them, or that they would even prefer to visit a Dutch professional:

Facilitator: “Would it help if the psychiatrist was Moroccan?” “I would be ashamed, maybe it’s family. That’s often the case in the Moroccan community” (Moroccan FGD 4, participant 1). Participants of Turkish FGDs in particular mentioned that seeking help from a Dutch professional would make help-seeking easier because the conversation is confidential and



because you do not know them personally: “I would convince her to seek help from a psychologist that she doesn’t know. That’s always easier” (Turkish FGD 3, participant 1).

### *Phase III Service selection*

When asked whom they would talk to about their problems first, participants of the FGDs said this would either be a close friend or their mother. The reason for choosing their mother was because she is trustworthy and knows you very well: “Moms can just feel everything. I, for instance, can’t lie to my mom. I find it so weird - but she always knows the truth!” (Moroccan FGD 4, participant 1). Friends were identified as the first person to talk to because you see them regularly: “I think my friends will be the first to notice that things aren’t going well with me ... so because of that I’d speak to my friends about it first” (Dutch FGD 7, participant 1).

Although participants preferred not to go to a teacher for help related to internalizing problems, school counsellors and teachers were nonetheless identified as helpful when it came to issues related to school: “Well it depends, look - if I’m not feeling well but at school everything is going all right I won’t tell a teacher. But if things aren’t going well at school either, then I’d tell them rather than keep quiet” (Moroccan FGD 5, participant 6).

Participants of the FGDs indicated that seeking help from a formal mental health service was only necessary if you have a very serious problem. They considered that the problems of the character in the vignette were not severe enough: “If you have very serious problems - not like this girl because her problems aren’t that serious - well then I’d seek some professional help” (Turkish FGD 2, participant 4).

107 **Table 2 Major themes and subthemes identified in Turkish, Moroccan and Dutch FDGs**  
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Major themes	Subthemes			
	All FGDs (overall findings)	Turkish FGDs	Moroccan FGDs	Dutch FGDs
Problem recognition & causal attribution		Puberty  Lack of attention	Puberty  Insecurity	“Depressed” or “psychological” problem
Perceived severity	Normal for teenage girls			
Perceived consequences of not seeking help	Suicide  loverboys (pimps)			
Perceived barriers of help- seeking	Distrust professional help at school	Fear of parental shame	Fear of parental shame	Shame of disclosing to strangers (professionals)
	Negative experience with mental health care	Fear of parental disappointment	Fear of parental disappointment	Fear of not being taken seriously or believed
	Negative attitudes towards mental health care			
Facilitating factors	Self-security	Anonymity (Dutch professional)	Anonymity (Dutch professional)	
		Cultural understanding (Turkish professional)	Cultural understanding (Moroccan professional)	
Service selection	Mothers			
	Friends			
	School (school- related problems)			
	Formal help through mental health professional (last option)			

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## Discussion

This study showed that, although adolescent girls could clearly envision the long-term consequences of internalizing problems, the problems presented in the vignette were not identified as severe. Participants indicated that if they were to face an internalizing problem of their own, negative attitudes towards professionals and school-based services, as well as fear of certain reactions from parents and friends, might hamper them from seeking help. Despite these feared reactions, participants indicated they would first seek help from friends or their mothers when dealing with internalizing problems.

Differences between Dutch and non-Dutch FGDs were found with regard to recognition of the problem described in the vignette. Participants of Turkish and Moroccan FGDs more often referred to the cause of the problem (e.g. lack of attention) while participants of Dutch FGDs referred to the emotional state (e.g. depression). Other studies have also shown that causal attributions may differ according to ethnic background (Cho et al, 2008; Karasz, 2007). In turn, it has been found that causal attributions influence help-seeking pathways, communication with clinicians, treatment compliance and the course of illness (Kirmayer *et al.*, 1994). In a Turkish study, Gulek (Gulec, 2008) found that normalizing attribution (when a person looks for an external or environmental explanation of disease) negatively influences help-seeking behaviour for fibromyalgia and contributes to non-help-seeking. Han et al. (Han *et al.*, 2006) found that attribution to an internal cause of a problem (i.e. insecurity) hampers help-seeking whereas holding a more biological conceptualizing of a disease enhances help-seeking. The differences in causal attributions found in this study may be a possible explanation for the underutilization of mental health services in ethnic minority youth.

We further found that the adolescent girls in this study had difficulty recognizing the severity of the internalizing problems presented in the vignette. This is in line with a study on

136 suicidality and help-seeking in African American adolescents (Molock *et al.*, 2007). A  
137 probable explanation for this finding might be that internalizing problems are more often  
138 overlooked, since they are less disruptive than externalizing problems (Leighton, 2010). In  
139 addition, adolescence might be a phase of life that makes it more difficult to distinguish  
140 between puberty-related issues and serious ongoing problems.

141         This study revealed that, should an internalizing problem arise, negative attitudes  
142 towards mental health professionals and school-based care would form a barrier to the  
143 decision to seek help. Other studies on ethnic minority groups and adolescents reported  
144 similar findings (Barker, 1994, Garland and Zigler, 1994). We found that these attitudes are  
145 often caused by a negative experience, e.g. a teacher contacts the parents and the problem  
146 subsequently gets known by others. This also explains why our participants preferred to seek  
147 help from a friend or their mother rather than from a professional or school social worker.  
148 This study further revealed that participants of Turkish FGD's perceived seeking help from a  
149 professional, some one that is unknown to you, as a facilitating factor, whereas participants of  
150 Dutch FGDs perceived this to be a barrier. This may be because particularly in this study  
151 adolescents from ethnic minority groups feared 'shame and gossiping' and would therefore  
152 prefer to seek help from an anonymous/confidential source.

153         Another difference between the Dutch and non-Dutch FGDs was that participants of  
154 Moroccan and Turkish FGDs more often feared negative reactions of parents and friends than  
155 participants of Dutch FGDs, and also indicated that the reactions of parents/friends would  
156 hamper disclosure. Studies among Asian migrants in the USA and the UK reported similar  
157 results (Lawrence *et al.*, 2006, Lee *et al.*, 2009). One reason for this may be the differences in  
158 family roles, parenting style and stigmatization of mental health problems, which are often  
159 influenced by cultural norms (Varela *et al.*, 2004, Lawrence *et al.*, 2006). Though this  
160 research did not indicate a specific role of religious norms, these factors may have also

contributed to the differences in perceptions, particularly given that participants from the ethnic minority groups were mostly Muslim.

In the present study adolescent girls preferred to firstly turn to their friends or mothers when dealing with an internalizing problem, as also reported by others (Offer *et al.*, 1991, Boldero, 1995, Frojd *et al.*, 2007, Rickwood *et al.*, 2007). We found no differences between the Dutch and non-Dutch FGDs regarding whom adolescent girls would turn to. It is noteworthy that the fear of negative reactions from mothers and/or friends would not stop the participants in this study from seeking help from them. As found in this study and others (Rickwood *et al.*, 2007) this is probably because once they have overcome the barriers, mothers and friends are the most trustworthy and accessible persons to turn to. Additionally, this may also be related to the fact that they are adolescents (i.e. neither children nor adults) and thus fall in between various social systems (Cauce *et al.*, 2002).

Some methodological issues need to be addressed. A positive aspect of this study is that it included adolescent girls from ethnic minorities and the majority group hence facilitating the cross-cultural comparison of perceptions regarding mental health help-seeking. This study also had several limitations. Firstly, the facilitators were of Dutch origin, which might imply that they had more difficulty interpreting the discussions and asking appropriate questions in the Moroccan and Turkish FGDs. To reduce this influence, prompts on cultural and religious factors (e.g. whether the participants would turn to a religious clergy) were available for Moroccan and Turkish FGDs. These however proved unnecessary as the participants openly discussed these topics without the prompts. To make the FGDs as comparable as possible, a focus group guide was applied. This created a clear context but the use of these tools might also have restricted the discussion. In addition, the text used to illustrate the results of this study was translated from Dutch to English by a bilingual researcher; some information may have been lost during the translation process. Also, two of

the groups had less than five respondents; the results from these groups were only used when they were confirmed in other larger groups. Four participants had an ethnic background other than Dutch, Turkish or Moroccan. Although we excluded these participants from the content analysis it should be noted that these girls nevertheless participated in three focus group discussions and they may have had a minor influence on the discussions.

The participants in this study were recruited through convenience sampling hence making it difficult to generalize this study's findings to the larger population of adolescent girls in Rotterdam with Dutch, Moroccan and Turkish backgrounds. For instance, the great majority of the ethnic minority participants included in this study were second-generation immigrants and results can therefore not be generalized to 1<sup>st</sup> generation immigrants, who are likely to vary in their levels of acculturation and help-seeking behaviour (Knipscheer and Kleber, 2005, Cabassa and Zayas, 2007). Furthermore, the presence of internalizing problems was not an inclusion criterion for participation. Findings may therefore not be representative to adolescents with internalizing problems. It should also be noted that the FGDs varied according to age and educational level. Consequently, we cannot rule out that these characteristics may have partly influenced the participant's perceptions.

This study indicates that priority should be given to making internalizing problems better known to teenage girls (e.g. via awareness-raising campaigns in schools and communities) and facilitating help-seeking from friends or mothers. School resources like peer discussion groups or parent-teacher meetings may be helpful in this regard. Besides this, little is known about the roles and perceptions of peers and mothers in the help-seeking process. More research insights into this issue are recommended. Considering the negative attitudes of the adolescent girls towards mental health services and school-based services found in this study, it may be beneficial to more closely match the available services to the needs of adolescent girls from diverse ethnic backgrounds. This study also showed that

guaranteeing confidentiality in the school setting, and specific training for professionals in working with adolescent girls and their problems, may be important.

#### **Key messages**

This study explored how adolescent girls with different ethnic backgrounds perceive help-seeking behaviour for internalizing problems. We found that participants of mostly Turkish, Moroccan and Dutch backgrounds had difficulty assessing the severity of internalizing problems and, should a problem arise, they would be hampered by negative attitudes towards school-based services and mental health professionals. Mothers and friends were identified as primary sources of help by all participants. In non-Dutch FGDs, participants were found to describe the internalizing problems presented in the vignette differently than participants of Dutch FGDs and the fear of reactions of their parents and friends was more often identified as a barrier than by participants of Dutch FGDs.

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352

## **Appendix 1. Vignette**

Dina, aged 15 years

Dina is from a family with four children. For some time now things haven't been going well for her. She cries a lot and doesn't sleep well. For nights in a row she lies worrying: about school, about boys and about the situation at home. At school, her classmates bully her and laugh at her. She thinks it's because she always blushes during presentations. Also, her grades are not good: there's even a possibility she won't pass this year. Her parents don't agree with this and have spoken to her teacher several times. At home they're always moaning about her low grades. Her brothers and sisters don't interfere with her life. Dina thinks they're better at everything anyway.

For some time, she hasn't been in the mood for school. She has skipped some classes already, preferring to stay in bed all day, to listen to music and to ponder.

## Appendix 2. Questions used as prompts during the focus group discussions

1. What do you think is wrong with Dina?
2. Do you think it's serious/severe?
3. What could happen to Dina if she doesn't seek help?
4. Why do you think she has these problems?
5. (for Moroccan and Turkish groups only) Do you think that a Moroccan or Turkish girl could also have these kinds of problems?
6. How would your friends react if you had such a problem?
7. How would other people from your environment react (i.e. mother, father, teachers or other family members)?
8. How important do you find it is for Dina to seek help?
9. Imagine you're dealing with the same problems, who would you approach for help?
10. Which obstacles would hold you back from seeking help?
11. What would make seeking help easier?
12. Do you think Dina can seek help by herself?
13. Do you know anyone that has sought help for problems like these?
14. Can you tell us a little more about it?
15. Should Dina have sought help earlier?
16. When should she have done that?
17. Can Dina solve her problems by herself?
18. How can friends help?
19. How can parents help?
20. How can teachers help?
21. How can professionals (GPs, social workers, psychologists) help?
22. (for Moroccan and Turkish groups only) Say Dina is a Moroccan or Turkish girl, are there any members of the clergy or religious gatekeepers she can turn to?
23. Are some groups more vulnerable for these kinds of problems?
24. What do you think causes these problems?