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E-Help: Community perspectives on help-seeking using electronic forms of communication

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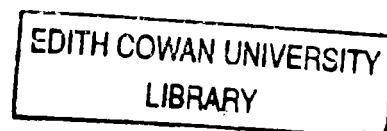
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E-Help: Community Perspectives on Help-Seeking Using Electronic Forms of
Communication

Jacqueline D. Myles-Pallister

A Report Submitted in Partial Fulfilment of the Requirements for the Award of
Bachelor of Arts (Psychology) Honours, Faculty of Computing, Health and Science,
Edith Cowan University

October, 2009

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E-Help: Community Perspectives on Help-Seeking Using Electronic Forms of Communication

Abstract

The provision of mental health services using telephones, the Internet, and mobile phones (*e-help*), has been widely recommended as part of a solution to closing the gap between high prevalence of mental illness and low rates of service uptake. However, little is known about how potential users of these services view them. To address this gap, three focus groups ($N = 17$, age 17 – 69 years) were conducted to explore general community perspectives on using e-help. Interpretative phenomenological analysis identified three themes with related subthemes: (1) awareness; (2) trust and feeling safe when seeking and using e-help; (3) it depends on the person really: e-help issues. This study found that many factors that may contribute to non-help-seeking for traditional forms of mental health services were also potential barriers to using e-help. The findings were integrated into a model of the help-seeking process. This model was discussed with relation to both e-help and general help-seeking for mental health concerns. Findings suggest that service developers and policy planners need to take into consideration people's preferences for help and comfort with mode of communication. It was concluded that in order for e-help to fulfil its promise, it will need to overcome some of the same barriers that face more traditional modes of service delivery.

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Submitted: October, 2009

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Dated 01/12/2007.

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E-Help: Community Perspectives on Help-Seeking Using Electronic Forms of Communication

Mental illness is a major global issue and is estimated to affect about one in five people in any given year (World Health Organization, 2003; Australian Bureau of Statistics [ABS], 2009). Almost a half of all Australians will experience a mental disorder at some point in their life and more than a half of those will have long-term conditions (ABS, 2009; Australian Institute of Health and Welfare, 2006). In addition, mental disorders are the leading cause of disability burden (ABS, 2009). However, despite the availability of effective treatments for common mental health conditions (Wampold, 2001), nearly two-thirds of Australians with mental disorders do not access services from a health professional (ABS, 2009). Thus, there is a large discrepancy between the high prevalence of mental illness and the low levels of service uptake to remedy the effects.

The widespread nature of mental health conditions indicates that there are and will be an ongoing need to provide services that people find acceptable and that meet the needs and preferences of those who may need to use them. Although telephones have long been used for the provision of mental health services, the delivery of these services using the Internet, mobile phones, and other forms of electronic communication is a new and growing field. Electronic communication methods of mental health delivery have been widely recommended as part of a solution to increase rates of treatment uptake for common mental health problems (Christensen & Griffiths, 2008; Cleary, Walter, & Matheson, 2008; Postel, De Haan, & De Jong, 2008; Whiteford & Groves, 2009). Furthermore, the Australian government has also acknowledged the potential of e-help exemplified by the allocation of \$60.9 million in funding to enhance telephone counselling, self-help and web-based support services (Council of Australian Governments, 2009).

Electronic modes of providing mental health services hold promise as one method of closing the gap between uptake of services and the prevalence of mental illness. This potential needs to be investigated. In particular, what requires a deeper understanding are the factors that might influence the use of electronic forms of communication to get help for mental health concerns.

Defining E-Help

There is little agreement between researchers regarding the definition or terminology of e-help. Some definitions focus on services provided over the Internet, such as *e-counselling*, *e-mail counselling*, *e-therapy*, *Internet therapy*, *on-line practice*, *web-based counselling*, and *web-based therapy* (Carlbring & Andersson, 2006; Finn, 2002; Skinner & Latchford, 2006). Other definitions stress therapist involvement, such as: *cybercounselling*, *cyber therapy*, *e-therapy*, *internet psychotherapy*, *online counselling*, *online therapy*, *telepsychiatry*, and *webcounselling* (Mallen & Vogel, 2005; Postel et al., 2008; Rochlen, Zack, & Speyer, 2004).

One definition that captures the broad nature of e-help is that given by Christensen, Griffiths and Evans (2002) who define *e-mental health* as “mental health services and information delivered or enhanced through the Internet and related technologies” (p. 3) and includes areas such as mental health delivery, mental health education, health promotion and illness prevention. Another broad definition provided by Mallen and Vogel (2005) used the term *online counselling*. This definition was limited to those services provided by a licensed practitioner, however, it also included both existing technologies as well as accommodating “new technologies and innovations that have yet to either be discovered or reach a critical mass in the marketplace” (p. 764).

The definition used here combines elements of both of these definitions and defines *e-help* as mental health services and information delivered or enhanced through distance communication technologies, such as telephone, mobile, Internet and videoconferencing and includes, although is not limited to areas such as mental health delivery, mental health education, health promotion and illness prevention. This definition remains open to include any relevant future innovations in communication technology.

This paper will first situate e-help in the greater context of help-seeking methods, by briefly reviewing the issues that are relevant to help-seeking and non-help-seeking for mental health concerns. It will then show how the use of telephones, mobile phones, and the Internet are widespread in our society and how they are used informally for support for mental health concerns. Next, this paper will briefly outline the vast choice of available e-help services that are on offer. It will also review the literature that has investigated these methods, with a focus on differing perspectives on its use for engaging with mental health services. The review will conclude by presenting the importance of investigating general community views on help-seeking for mental health concerns using these electronic modes of communication.

Help-Seeking Review of the Literature

E-Help is situated under the general umbrella of help-seeking methods for mental health concerns. Help-seeking for more traditional methods of treatment has received a great deal of attention in the literature. Researchers have investigated whether or not people would intend to seek help, their preferences for help, as well as the factors that can either promote help-seeking or contribute to non-help-seeking. The issues that are relevant to general help-seeking may also inform and impact on people's attitudes and views about seeking help for mental health services using electronic methods.

Help-Seeking Intentions and Preferences

There has been much research investigating help-seeking for mental health issues. In general, the literature indicates that people say they would intend to seek help if they were faced with mental health issues (Ten Have et al., 2009; Walters, Buszewicz, Weich, & King, 2008) and that their preferred source of professional help would be from a general practitioner (GP) (Barney, Griffiths, Jorm, & Christensen, 2006). However, studies have also indicated that recommendations can differ depending on how symptoms are interpreted. For example, the lay support system is recommended for help with depression or when a person is perceived as having a life crisis, whereas the expert system is recommended for help with schizophrenia or when a person is perceived as having an illness (Angermeyer, Matschinger, & Riedel-Heller, 2001; Lauber, Nordt, Falcato, & Rössler, 2001). In qualitative focus groups that investigated general community attitudes to stress and depression, one study (Coe, 2009) found that participants tended to have a hierarchy of help preferences. At the base of the hierarchy was self-management of symptoms, then help from one's family. This social network was highly influential in early help-seeking stages and decisions regarding subsequent help-seeking. Further up the hierarchy were GPs, then support groups and group therapy, followed by counselling, medication, and psychiatrists. The level of stigma attached to each form of help grew as one moved higher up the hierarchy. Thus according to this hierarchy of help preferences, the first preferences for help were those that were considered to be the least stigmatised.

Interestingly, none of these studies report e-help as an option. One reason may be that many studies limit participants' options and force ratings of specific health professionals (e.g., Barney et al., 2006). However, this reason cannot account for the absence of e-help methods in other studies in which participants were given freedom to

nominate their help preferences. Perhaps participants in these studies either did not view e-help as a viable option, or perhaps they are not aware of e-help options. While it is useful to know what people's preferences are for help, as many as two-thirds of those people with current disorders do not consult (Andrews, Issakidis, & Carter, 2001). Thus, there appears to be a discrepancy between reports of intentions to seek professional help, and the number of people who access this help. Therefore it is important to understand why people do not seek professional help for mental health issues.

Help-Seeking Barriers

Numerous barriers to help-seeking for mental health problems have been identified in the literature using survey research. These barriers can be categorised as attitudinal, structural, and those relating to mental health literacy. Attitudinal barriers include: being afraid to ask for help, preferring to manage on one's own, and believing that treatment would not help (Andrews et al., 2001; Mojtabai, 2009; Ten Have et al., 2009; Walters et al., 2008). Structural barriers to help-seeking include time and inconvenience (Sareen et al., 2007). Stigma is also a significant attitudinal barrier and includes both self-stigma (viewing oneself as weak) and perceived stigma (believing that others will view them negatively) (Barney et al., 2006; Sareen et al., 2007; Schomerus, Matschinger, & Angermeyer, 2009).

Mental health literacy refers to "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (Jorm et al., 1997, p. 182). The importance of mental health literacy in the help-seeking process is exemplified by the fact that for 60% of an Australian clinical sample, a lack of mental health literacy was a major reason for delaying treatment seeking (Thompson, Hunt, & Issakidis, 2004).

Biddle, Donovan, Sharp, and Gunnell (2004) presented the barriers to help-seeking in a model of non-help-seeking behaviour: the Cycle of Avoidance. This model was developed from the findings gleaned from in-depth qualitative interviews with young adults (aged 16 – 24). According to this model, when confronted with the signs and symptoms of psychological distress, people redefine and include more extreme notions of what is considered 'normal' distress. This kind of distress is considered something that everyone experiences in response to life stress and something that will pass. This normalisation process serves to avoid defining one's distress as 'real'. 'Real' distress is viewed as permanent, disabling and something for which a person needs to seek help. This distress is highly stigmatised and is associated with mental illness (e.g., schizophrenia, psychosis and 'manic' depression) and hospitalisations. Thus, non-help-

seeking in this model is partly attributable to stigma and a desire to avoid social disapproval.

Help-Seeking Prompts

Many prompts that initiate the help-seeking process for mental health concerns are similar in theme to the barriers to care. For instance, studies have found that prompts for people seeking mental health services include: increases in symptom severity, increases in mental health literacy, admitting one has a problem, and being prompted by one's social network (Thompson et al., 2004; Thompson, Issakidis, & Hunt, 2008; Vogel, Wade, Wester, Larson, & Hackler, 2007). In Coe's (2009) study on attitudes to stress and depression in a general community sample, she also found that participants talked about a process of stages that preceded a decision to seek help. First there was a gradual worsening of symptoms, then denial, and finally acknowledgement that one had a problem. Hence, an awareness and acknowledgement of one's problem preceded a decision to seek help.

This brief review of the help-seeking literature has provided an overview of factors involved in people seeking or not seeking mental health services, such as their intentions and preferences for help, as well as what may prevent or facilitate them seeking help. These factors and underlying processes may also need to be taken into consideration when endeavouring to understand how people perceive e-help in the help-seeking process. The section which follows will give an overview of electronic communication and the ways in which it is used to deliver mental health services.

E-Help

Electronic Forms of Communication Usage

The Australian use of newer communication technologies, such as the Internet and mobile telephones, is rapidly growing. In Australia, as at June 2008, mobile phone use had exceeded 100% of the population; in fact, mobile phone subscriptions were double that of fixed-line telephone subscriptions (Department of Broadband, Communications and the Digital Economy, 2009). Similarly, during 2007-2008, 72% of Australians aged over 15 years had accessed the Internet through their places of work, study, as well as local libraries and Internet cafés (ABS, 2008).

In addition, people are using the Internet for mental health related activities. For example, a recent study in the United Kingdom, revealed that 18% of Internet users had sought mental health information on the Internet and these rates were higher in those with either a past history of mental health problems or current psychological distress

(Powell & Clarke, 2006). Indeed, people with stigmatising conditions—such as anxiety, depression, herpes, or urinary incontinence—due to the potential threat of social disapproval, may be more likely to seek health information on the Internet (Berger, Wagner, & Baker, 2005). Furthermore, people are also seeking informal sources of support for mental health conditions by participation in online support groups (Atkinson, Saperstein, & Pleis, 2009) and by the consultation of “blogs” (a shortened form of “weblogs”). Blogs are online journals and commentaries intended for a general public audience which can be accessed on the Internet. These online activities point to the Internet’s potential for mental health. In the next section, the mental health services that are provided using the Internet, telephones and mobile phones will be briefly outlined.

E-Help: What are the Options for Consumers?

E-Help is available in a diverse range of options for seeking help for mental health concerns. These services have been delivered using the Internet, phones, and mobile phones. They can be used as stand alone services or in combination with more traditional forms of treatment. Many of these services can be provided to an individual or on a group basis, such as group therapy.

Internet options.

The provision of e-help via the Internet includes many options. Some forms of e-help involve no contact with others. These include: psychoeducation, and self-help web-based therapy, such as *MoodGYM* for depression (Barak, 1999; Christensen & Griffiths, 2008). Other Internet services involve interacting with others such as: email, chat groups and e-bulletin boards. Consumers can also engage with health professionals online. For example, using “asynchronous” time-delayed communications (e.g., email, and bulletin boards), or “synchronous” real-time interactions (e.g., online chat, online counselling, webtelephony, and videoconferencing) (Barak, 1999; Mallen & Vogel, 2005; Rochlen, Zack, et al., 2004). Furthermore, real-time services can be delivered as a single session, delivered as ongoing personal counselling, or be used as an adjunct to traditional face-to-face counselling (Barak, Hen, Boniel-Nissim, & Shapira, 2008; Rochlen, Zack, et al., 2004). In addition, modes of communication can be text-based (e.g., email, online chat), audio only (e.g., Voice over Internet Protocol), video (e.g., Skype), or a combination of these.

Telephones.

The provision of e-help using the telephone is also available in many forms. These forms can include either recorded interactions (e.g., smoking cessation programs

– listening to pre-recorded messages) or live interactions. Live interactions include informational or referral services, crisis intervention (e.g., Lifeline and Kidshelpline), and online counselling (Coman, Burrows, & Evans, 2001; Leach & Christensen, 2006).

Mobile phones.

The factors that differentiate e-help using mobile phones are potentially identical to those that differentiate e-help using landline telephones and the Internet. In addition mobile phones have been used to send and receive SMS messages. For example, SMS messaging has been used in prevention interventions, as part of counselling, in treatment delivery, maintenance and follow-up. The ability to use all of the methods offered by telephone and Internet may be dependent on the person's specific model of mobile phone, their signal coverage, battery life, as well as the price of the calls.

Technological advances in devices that support electronic communication are such that lines have become blurred between the different modes of communication. Hence, these descriptions of e-help applications need to be viewed as being transferable across different communication devices and inevitably subject to change with future developments in technology.

In addition to the widespread uptake of electronic communication in our society, e-help using these methods is available in many forms, and in ways that coincide with mental health related activities with which people are already engaged. Thus, e-help is a method likely to have wide appeal to those who would not or cannot access more formal mental health services. Although there is a vast array of services available using e-help, the mere provision of these services does not necessarily mean that people will use them. If e-help is to engage those who do not seek mental health services, what requires a deeper understanding are the factors that may facilitate or hinder help-seeking using these methods.

Review of e-Help Literature

The Debate

In recent years there has been an increasing amount of literature debating the benefits and challenges of using e-help methods and much of this literature has been focused on a specific aspect of e-help. For instance, the majority of this literature has focused on the Internet and ways it has been used to deliver mental health and behavioural services (e.g., Castelnovo et al., 2006; Christensen et al., 2002; Cleary et al., 2008). In contrast, there is a dearth of literature that looks at landline telephones or mobile phones (e.g., Centore & Milacci, 2008; Coman et al., 2001; Gilat & Shahar,

2007). Despite the differing emphases of this literature, some consistent strengths and limitations have been identified across all three technologies.

E-Help: Advantages

Some identified advantages of e-help include: time, cost, convenience, access, anonymity, safety and control. For example, the removal of time constraints is possible in many e-help modalities, for example, calling a 24-hour hotline or composing or replying to an email in asynchronous online counselling (Carlbring & Andersson, 2006; Gilat & Shahar, 2007). In addition, many e-help options are offered at reduced cost or at no cost to the consumer (Carlbring & Andersson, 2006; Christensen et al., 2002). A further benefit of e-help is improved access. For example, e-help can improve the access to and selection of mental health services for populations for whom access to traditional mental health services is limited or difficult (e.g., rural populations, people with disabilities and some mental disorders) (Carlbring & Andersson, 2006; Rochlen, Zack, et al., 2004). Furthermore, many forms of e-help are anonymous, which may serve to reduce the impact of social stigma (Carlbring & Andersson, 2006; Gilat & Shahar, 2007). Another advantage is that people can communicate their feelings and thoughts from the safety of their own home (Centore & Milacci, 2008). Finally, clients using e-help methods maintain control over their communication. For instance, they can control the content and their level of self-disclosures, as well as the termination of the communication (e.g., they can log-off or hang up the phone) (Centore & Milacci, 2008; Gilat & Shahar, 2007).

Some benefits have been associated with specific modes of e-help. In text-based distance counselling, the advantage of control is also evident as clients can reflect on, plan and review messages. Furthermore, the process of writing may be therapeutic (Centore & Milacci, 2008; Rochlen, Zack, et al., 2004). In fact, the client may direct their attention to addressing their central issues more easily compared to face-to-face treatment. This has been attributed to the disinhibiting effect of communicating online (Rochlen, Zack, et al., 2004). A specific advantage associated with Internet-delivered interventions is the ability to insert links to websites, assessment tools, information or other facilitating material that can then be instantaneously accessed by the client (Rochlen, Zack, et al., 2004).

E-Help: Disadvantages

In contrast, some potential challenges of e-help include: imperfect technology, security, privacy, confidentiality, lack of visual cues, time delay, and skill deficiency. For instance, there may be incompatibility between provider and service user software

and technological capabilities (Carlbring & Andersson, 2006). Also, computers can crash, mobile phones can freeze and be out of range, and power failures can prevent the use of many modes of e-help. In addition, privacy and security may be issues, for example, hackers or third parties may access emails, therapy transcripts or mobile phone messages. In addition, the lack of visual cues using phones or text-based e-help methods, may lead to misunderstandings (Carlbring & Andersson, 2006; Cleary et al., 2008; Mallen, Vogel, & Rochlen, 2005). Another limitation of e-help concerns the time delay inherent in many text-based asynchronous therapy methods which can result in misunderstandings as the client tries to make sense of reasons behind delayed responses (Rochlen, Zack, et al., 2004).

Furthermore, mental health professionals and providers of e-help have identified additional concerns. These include: confidentiality and legal and ethical considerations (Carlbring & Andersson, 2006; Christensen et al., 2002; Cleary et al., 2008). For instance, the anonymity of clients may present problems in crisis situations (Rochlen, Zack, et al., 2004).

While the outlined benefits and challenges associated with e-help methods may impact on people's attitudes towards using these types of services, it is also important to know whether or not these services are effective.

Effectiveness Studies

Recent reviews have provided early evidence in support of the effectiveness of e-help in the application of a variety of mental health applications and conditions. An extensive recent review, which included 72 papers that investigated telephone, Internet, videoconferencing and virtual reality studies, found that in over half of the studies e-help was considered potentially successful in the areas of child psychiatry, depression, dementia, schizophrenia, suicide prevention, posttraumatic stress, panic disorders, substance abuse, eating disorders, and smoking prevention (Hailey, Roine, & Ohinmaa, 2008). In addition, two recent meta-analyses have found that therapist delivered telephone, Internet, and videoconferencing studies evidenced a medium pooled effect (0.44) for the treatment of depressive disorders and a large pooled effect (1.15) for the treatment of anxiety disorders (Bee et al., 2008). Also, Internet-based psychotherapeutic interventions evidenced an overall medium effect size (0.53) and studies that included follow-up data indicated lasting positive therapeutic effects (Barak et al., 2008). Furthermore, there is also considerable evidence that many forms and modalities of e-help are comparable in effectiveness to face-to-face methods of mental health service

delivery (Barak et al., 2008; Cuijpers et al., 2009; Day & Schneider, 2002; Germain, Marchand, Bouchard, Drouin, & Guay, 2009; Kaltenthaler et al., 2006).

Although these reviews and specific studies provide promising evidence for the effectiveness of e-help methods, many researchers caution that the evidence base is still small and there is a need for more quality studies with larger sample sizes (Bee et al., 2008; Leach & Christensen, 2006). In addition, these effectiveness studies represent how effective these treatments are for those who complete treatment. However, many e-help modes of delivery are subject to high attrition rates (Bee et al., 2008). Although high attrition is also common in face-to-face forms of treatment (Van Straten, Cuijpers, & Smits, 2008), these dropout rates indicate that there may be differences in consumer acceptability of different modalities of e-help treatment. It would appear that e-help may fail to engage many of those who may benefit from completing treatment. This suggests that more research is needed to understand what people think about e-help methods as a way of receiving help and if these modes of service delivery are subject to the same challenges as help-seeking for traditional face-to-face provision of services.

E-Help Perspectives

There may be differences in the importance of the issues regarding barriers, prompts and preferences for using e-help services depending on the perspective that is examined. Views about e-help have been investigated from the perspective of those who provide the services, those who have used the service, or from those who have not used the service. These perspectives do not always coincide.

Mental health professional perspective.

The service provider perspective has received some attention in the literature. Two recent studies reported that a large number of mental health professional are using some form of e-help with their clients, such as counselling by telephone, e-mail, text chat, videoconference or SMS (Centore & Milacci, 2008; Wangberger, Gammon, & Spitznogle, 2007). One of these studies found that mental health professionals who were surveyed had more negative than positive attitudes about using e-help modalities of offering care, although there were some differences depending on the method used. The most negative attitudes were towards text-chat counselling; more positive attitudes were towards telephone counselling (Centore & Milacci, 2008). The majority of psychologists in another study believed that e-help could only work as an adjunct to traditional face-to-face therapy, whereas only a third believed e-help could serve as the only therapist-client mode of communication (Wangberger et al., 2007).

Together these studies indicate that although many mental health professionals use some aspect of e-help, the majority of them have negative attitudes towards e-help and have doubts about e-help's use in its own right.

Current consumer perspective.

Literature pertaining to e-help perspectives has mostly been evaluation research from the perspective of those who have used the services. E-Help consumers consistently evaluate their experience of e-help as positive (e.g., Griffiths & Christensen, 2006; Kaltenthaler et al., 2008; Lange et al., 2003). In addition, attitudes to e-help can change after having used the service. For example, before using a telephone counselling service, less than half of the clients thought it would be helpful, compared to almost all of the clients after using the service. Also, for those clients who had previously received face-to-face counselling, over half reported a preference for telephone counselling (Reese, Conoley, & Rossart, 2006).

Thus, in contrast to the service provider views, current consumers of e-help have reasonably favourable views about these methods of receiving treatment. However, it would perhaps be cautious to keep these views in the context of the sample of participants that were used. Evaluations of e-help provided by treatment completers may offer more positive views compared to those who dropped out and perhaps also compared to attitudes towards e-help of those who have never engaged with these types of services. Considering the high rates of people who never seek treatment, it is also important to understand how people who have not used e-help services feel about the acceptability of these options.

Potential help-seeker perspective.

There is a paucity of research that examines attitudes to e-help from the perspective of potential consumers. The term potential consumer is often cited in the mental health literature, however, it is rarely defined. It would appear to be used broadly to refer to any individual who may potentially engage with some aspect of mental health services. Whether or not such individuals are or have been engaged with services is never clear. The potential consumer studies that do exist have all investigated attitudes to online counselling using American college student samples.

Chang and Chang (2004) examined the attitudes to online and face-to-face counselling of Asian American and Asian international students, aged 18 to 39 years. They used questionnaires to measure attitudes to professional psychological help and online counselling. They found that overall, Asian college students had more positive attitudes towards face-to-face counselling compared to online counselling. However,

most of these students had rather ambivalent attitudes towards face-to-face counselling. Furthermore, they found that general computer use predicted attitudes towards online professional psychological help. Stigma in this study was not found to be related with students' negative attitudes towards using online counselling and the authors attribute this result to their possible uncertainty regarding the credibility and effectiveness of online professional help.

In addition, Rochlen, Beretvas, and Zack (2004) conducted three studies to validate two surveys that the authors had developed to directly compare online and face-to-face counselling. Across the three studies they found that the undergraduate students had more favourable attitudes to face-to-face counselling, compared to online counselling. However, they noted there was considerable variability in students' attitudes towards online counselling and that overall the students had neutral to slightly positive attitudes towards online counselling. In addition, they found that participants who were more comfortable using email expressed greater value towards using online counselling than participants who were less comfortable using email. In contrast, participants who had a higher degree of fear of intimacy were more likely to have a greater discomfort with face-to-face counselling.

In another study conducted by Rochlen and colleagues, they investigated the effect of exposure to a simulated counselling session on attitudes to online counselling (Rochlen, Land, & Wong, 2004). The male undergraduate psychology students were exposed to either online or face-to-face counselling simulation in one of two treatments (emotion-focussed therapy or cognitive focussed therapy). Measurements of the men's attitudes to online counselling, were taken at baseline and after therapy exposure, as well as assessment of their level of emotional restrictivity. Overall the male students rated counsellors highly, regardless of treatment type. Moreover, men who were more comfortable expressing their emotions had more favourable views of face-to-face counselling. In contrast, those men who were not comfortable expressing their emotions had more favourable views of online counselling. An interesting finding was that all groups had improved attitudes towards online counselling after being exposed to their respective therapy condition. Thus, it would appear that preferences for counselling mode were dependent on people's level of comfort in expressing their emotions. Also, exposure to therapy, regardless of the technique focus or mode of delivery, had a positive impact on how online counselling was viewed.

These three studies have made an important contribution to our knowledge and understanding regarding potential consumer perspectives on e-help. However, each of

these studies examined potential consumer perspectives focussing on one form of e-help, namely online counselling. Also, these studies focussed on the views of American college students, with some specifically looking at Asian students or the male student perspective. As such, these views may add little to our understanding of general community views regarding e-help in general. Furthermore, these studies used surveys to determine attitudes to online counselling. Survey methodology presents a series of pre-determined statements, to which respondents indicate the extent to which they agree or disagree. While these methods are a useful means of obtaining general attitudes from large samples, the resulting data cannot provide the underlying reasons behind their ratings, nor do they allow respondents to freely express how they feel about a complex behaviour such as help-seeking.

Summary

In summary, mental illness is highly prevalent in the Australian society, yet few people with these conditions seek professional help. The provision of mental health services using e-help methods—such as services delivered using telephones, mobile phones, and the Internet—has been widely recommended as part of a solution to closing this gap in service uptake. E-help methods are provided in many forms and delivered via communication technologies that are widely available to the general community. The mental health help-seeking literature has highlighted several factors that may impede or facilitate a person to seek help. In addition, there has been debate in the e-help literature about the advantages and disadvantages of using these types of methods for delivering mental health services. Even though there has been some research that has investigated the perspectives of e-help service providers and current consumers, there has been little research conducted from the perspective of potential consumers.

Rationale for Conducting Research

There is a paucity of research looking at potential consumer perspectives on e-help. To date, there appears to be no research that has directly examined the views of the general community about using electronic forms of communication to seek help with mental health conditions. To address this gap, this exploratory study aimed to explore general community perspectives on using electronic communication for the provision of mental health services. Considering the prevalence of unmet need for treatment for mental health problems, research is needed that explores whether or not people perceive e-help methods favourably. The method chosen to explore this topic

was that of qualitative focus groups. Qualitative research can enable the researcher to explore the more complex and dynamic nature of non-help-seeking behaviour (Biddle, et al., 2007). In addition, focus groups are an ideal method for investigating people's ideas about and acceptances of health programs (Liamputtong & Ezzy, 2005). Focus group participants were asked to explore (1) their use of electronic communication (2) perceptions of help-seeking for psychological distress; and (3) their acceptance and willingness to use e-help treatment methods. The findings from this research provide a preliminary understanding of the concerns and expectations of general community members about mental health help-seeking using electronic methods.

Method

Research Design

This study used interpretative phenomenological analysis (IPA) as a guiding framework (Larkin, Watts, & Clifton, 2006; Smith & Eatough, 2007; Smith, Jarman, & Osborn, 1999; Smith & Osborn, 2004, 2008). IPA aims at obtaining an 'insiders perspective' of the participants' 'life-world' (Smith, 1996). The life-world is "the individual's world of their everyday life" and "includes taken-for-granted assumptions" (Liamputtong & Ezzy, 2005, p.18). The IPA researcher aims to 'give voice' and make sense of the participants' experience by situating them within the context of their social and personal world, and how they construct the meaning of their experience in this context (Smith & Osborn, 2003). IPA assumes a connection between people's verbal responses and their underlying thoughts and feelings as reflecting something about their 'inner world' (Quinn & Clare, 2008). The researcher was interested in the way the participants spoke about their views, perceptions, and experiences with using electronic communication and the assumptions they had about distress, mental illness, and help-seeking for these issues. The researcher was interested in interpreting the manner in which participants may draw on their life-world to construct their perceptions about e-help.

Qualitative focus group methodology was adopted for this study. This method meant that it was possible for an exploration of a range of views and experiences relating to electronic communication and help-seeking to be directly explored in the group context from the perspective of the participants (Joyce, 2008; Morgan, 1997). There are several advantages to using the focus group methodology. First, the group interaction, which is a distinguishing feature of focus groups, serves as a source of valuable insight into participants' complex behaviours, motivations, experiences and

perspectives (Morgan, 1997). Second, focus groups are an ideal method for exploring a range of participants' ideas, feelings and experiences about the topic, as well as providing direct evidence of similarity and difference in these accounts (Morgan, 1997). Third, they are useful for revealing factors that influence participants' opinions, behaviours and motivations (Krueger & Casey, 2009). Thus, the focus group was well suited for the exploration of community perspectives on help-seeking methods.

Even though in-depth interviews were not planned from the outset of this project, follow-up interviews were conducted when several participants left the discussions before the conclusion of the focus group. The interview methodology provided the opportunity for a more in-depth exploration and probing of participants' views and experiences (Joyce, 2008).

Participants and Recruitment

The researcher was interested in obtaining the views of general community members who were non-university students and who were not associated with a particular mental health service. In order to fulfil this aim, the researcher constructed a list of existing community and support groups. The selection criteria for focus group participation were broadly defined as groups whose members were aged 18 years and over and were conducted in the Perth metropolitan area. As this research targeted people from the general community in the metropolitan area, exclusion criteria included: groups situated in rural areas; groups that met for serious illness support, such as cancer support groups; groups that met for mental health reasons; or groups in which the presence of issues relating to mental illness was potentially likely, such as groups for the children of alcoholics.

Initial contact with groups was made by the researcher using an introductory email or word of mouth to the group contact person. This initial contact introduced the researcher, briefly outlined the research topic, and invited the group to participate in a one-off focus group. A flyer (see Appendix A) with details of the focus groups was distributed to the group. If the group was interested in participating, the researcher provided the group with invitations to participate (Appendix B), and consent forms (Appendix C). A time to conduct the focus groups was negotiated.

The number of participants in each focus group ranged from five to eight. In total, seven men and 10 women participated. The age range of participants was 17 to 69 years ($M = 42.65$, $SD = 18.78$). Focus Group 1 (FG1) was an early childhood education parents committee and consisted of all females (age range: 37 – 47 years). Focus Group

2 (FG2) was a church group and consisted of males and females (age range: 48 – 69 years). Focus Group 3 (FG3) consisted of all males and was an indoor cricket team (age range: 17 – 26 years). One interview was conducted with a 38 year old female from FG1 and the other interview was conducted with a 61 year old male from FG2.

Groups were conducted at different venues: the parent committee took place at one of the participants' homes; the church group was conducted in a church hall room; and the cricket team was conducted in a room attached to a community centre with which the males were all familiar.

The small number of groups conducted in this study is consistent with IPA's idiographic focus and the exploratory nature of this project. The goal of IPA is to obtain "full and rich personal accounts" (Hale, Treharne, & Kitas, 2008, p. 94). Thus, as an idiographic approach, the concept of saturation—the point at which no new information arises—is not the intention of IPA (Brocki & Wearden, 2006).

Materials

A focus group discussion guide (Appendix D), comprising seven general questions together with probes was used. These questions aimed to gain an understanding of participants' experiences with using electronic forms of communication (e.g., "How do you feel about using electronic methods for communicating?"); participants' views on help-seeking in times of distress (e.g., "What kinds of words or phrases come to mind when you hear the word 'distress'?"); as well as their perceptions and attitudes towards using e-help methods (e.g., "What do you think is involved in somebody deciding whether or not to seek help using their phone, mobile or the Internet?"). The questions took the form of an "hour glass": general at the beginning, then more specific, then general catch all questions at the end. This broadening of discussion topic at the end allowed a more detailed exploration of previously raised topics. It also gave the participants the opportunity to propose issues that had not been discussed earlier (Morgan, Fellows, & Guevara, 2008).

A brief demographic and evaluative questionnaire (Appendix E) was utilised. This questionnaire collected basic demographic information such as age, gender, as well as information about the participants' electronic communication use. In addition the questionnaire gave participants an opportunity to provide any views on the topic that they had preferred not to share with the group. This served as a check on whether or not an element of group dynamics had affected a person's willingness to disclose their

experience. In addition, two electronic audio-recording devices as well as pen and paper notes were used to fully capture each focus group discussion.

Procedures

Ethics approval to proceed with this research was obtained from the Faculty of Computing, Health and Science Ethics Sub-committee for the conduct of Human Research before the researcher approached potential groups.

Prior to the focus group discussion commencing, there was an informal greeting period that allowed the researcher and the note taker to develop a rapport with participants. During this time, light refreshments were served and written consent to participate and to be audio-recorded was obtained from all participants. Written parental consent was obtained for the two males who were under 18 years.

To begin the session, the researcher explained the purpose of the study to the participants and outlined the focus group process. The participants were reminded that their participation was voluntary and that they could withdraw at any time or refrain from answering any question, without consequence. All participants in the group agreed to keep any information that was shared in the discussion confidential. In addition, the researcher informed participants that the confidentiality of their comments would be preserved by the removal of all names and identifying information in the transcription process.

The discussion during the running of the focus groups followed the focus group discussion guide (Appendix D). The groups started with an ‘ice-breaker’ question: “what kinds of electronic communication do you use?” This set the tone for the discussion and allowed each person a turn at speaking (Kreuger & Casey, 2009). The discussion guide was used flexibly and when topics arose naturally in the discussion, these were probed for further elaboration.

At the end of the focus group session, participants filled in the demographic questionnaire (Appendix E) and were given a certificate of participation. As the discussion may have triggered some distress in participants, all participants were debriefed and given the opportunity to ask questions. In addition, the researcher pointed out that they could make contact with somebody from the provided list of counselling services (Appendix F) should they need to discuss any issues further.

The focus group sessions were audio-recorded to ensure that no information was lost. In addition, the note taker took extensive notes of the discussion, with a focus on noting the order in which participants spoke to aid in the accuracy of the transcription process. The focus group sessions lasted between 70 and 140 minutes.

Immediately after the focus group session, the researcher and note taker debriefed – discussing the main themes, any remarkable incidents, and group dynamics. The researcher also updated a reflexive journal with memos about the content of the focus group, as well as the process of conducting the focus groups.

The group numbers during two of the focus groups changed during the session. During FG1, one female participant left after 75 minutes into the session. In FG2, two people left after about 60 minutes and one lady arrived after 15 minutes into the discussion. The participants who were ‘early departers’ were invited by the researcher to be interviewed to complete the topics discussed after their departure. All of these participants agreed to be interviewed, however only two of the participants were able to be scheduled for an interview. These interviews were conducted by the researcher in the participants’ homes within a few days of their corresponding focus group. Each of these interviews lasted about 60 minutes. The focus groups and interviews were conducted between June and August, 2009.

Following each focus group and interview, the audio recordings were transcribed verbatim by the researcher. When transcribing, all participants’ identifying information was removed and participants were allocated a pseudonym in order to protect their confidentiality.

Data Analysis

The data were analysed using IPA (Larkin et al., 2006; Smith, 1996; Smith & Eatough, 2007; Smith et al., 1999; Smith & Osborn, 2003, 2004, 2008). Data analysis progressed through a series of steps. In the first stage, the researcher immersed herself in the data to become familiar with the content of the transcript accounts. This immersion involved the transcribing process, reading and rereading the transcripts and listening to the recordings several times. Throughout each reading annotations of comments were made in the right hand margin. In a subsequent reading, emergent themes were extracted from the transcripts and noted in the left hand side margin. The researcher considered these themes in detail and produced thematic clusters based on connections between the themes.

In the second stage of analysis, a table of thematic clusters was made and related themes were given superordinate theme labels. Using NVivo 8, a directory of relevant participant comments was compiled that exemplified the identified themes. Previous research using IPA to analyse the data from both interviews and focus groups together have not identified any adaption to the analysis process (e.g., Flowers, Duncan, & Frankis, 2000; Vandrevalla, Hampson, Daly, Arber, & Thomas, 2006). Thus, interviews

were analysed in relation to the focus group from which the participant had taken part. The themes that emerged from the first focus group analysis were used to inform analyses of subsequent transcripts. However, the researcher looked at each transcript as a separate case and was mindful of new themes that had not appeared before. If a new theme emerged in a later transcript, the earlier transcripts were cross-checked for any evidence of that theme.

In the third stage of analysis, the thematic clusters and superordinate themes tables were compared and contrasted across all focus groups. Next, the researcher compiled a master list of superordinate themes that exemplified all transcripts and addressed the research aims.

Rigour

To ensure rigour in this study, a range of techniques were adopted. First, the researcher kept a reflexive journal with memos detailing all methodological and analytical decisions and research events. This served as an audit trail and enhanced methodological rigour in this study (Liamputtong & Ezzy, 2005; Morse & Richards, 2002). In addition, the researcher used memoing as a way to address the possibility of researcher bias and to ensure interpretative rigour (Liamputtong & Ezzy; Maxwell, 2005; Morse & Richards, 2002). She engaged in reflexivity, or theoretical rigour, by keeping memos of her preconceptions, experiences, and assumptions regarding the different aspects of the topic. Third, the quality of data collected was enhanced in the focus group discussion using several techniques. These included: stressing to the participants that there were no right or wrong answers (to address participant reactivity); asking open-ended questions that permitted participants to express what was important to them; and moderating group dynamics (e.g., encouraging the “shy” participant to speak and limiting the speaking time of “dominant” participants). Also, the quality and accuracy of the data were enhanced by the use of electronic recording devices, as well as the note-taker recording the order of participants’ speech to aid with transcription accuracy. Fourth, the researcher engaged in researcher triangulation by discussing emerging themes and the final analysis with the research supervisor and research colleagues (Hale et al., 2008). Last, the credibility of the analysis was addressed by using direct quotations to illustrate interpretations in the final report (Quinn & Clare, 2008).

Findings and Interpretations

Background Issues

In two of the focus groups, some participants who were scheduled to attend did not show up. Three participants did not attend in FG2 and two participants did not attend in FG3.

Although there were differences in the access and frequency of use of different modes of electronic communication, all participants used at least one of these modes of communication. An overview of the participants' electronic communication use is presented in a table in Appendix G. Most participants owned a landline telephone and used it once or twice a day. Almost a half the participants used their mobile phones once a day or less, whereas other participants used it up to 10 times a day. Most of the participants accessed the Internet from home or work.

The majority (15/17) of participants reported being either very comfortable or extremely comfortable during the discussions. None of the participants reported any additional comments that they had not wanted to share in the group discussion. During the focus group the participants compared and contrasted their different experiences, views, and preferences regarding the topics under discussion.

General Themes

In the focus group discussions, when participants were asked to explore different aspects of e-help, they often redirected the conversation to highlight what they perceived as issues relating to seeking help in general for mental health conditions. Thus, the themes that emerged and are reported here reflect aspects of both general help-seeking and views specific to e-help. Three themes and related subthemes were identified from the analyses of the focus group and interview transcripts: *awareness, trust and feeling safe when seeking and using e-help*, and *it depends on the person really: e-help issues* (see Table 1). These themes were not mutually exclusive and interacted in complex ways. Each of these themes and subthemes are discussed using examples from the transcripts to illustrate the dimension of the themes.

Table 1

Superordinate Themes and Subthemes Related to Participants' Perspectives on e-Help.

Superordinate themes	Subthemes
Theme 1: "Awareness"	<ul style="list-style-type: none"> • Mental health literacy • "Self-admitting": The self-realisation process • "The stigma of being mental" (self-stigma) • The threat of social disapproval (social stigma)
Theme 2: Trust and feeling safe when help-seeking and using e-help	<ul style="list-style-type: none"> • Need to feel safe and trust • Concerns about trust and lack of control • "Deal with it – get over it": Acceptable ways of coping
Theme 3: "It depends on the person really": e-help issues	<ul style="list-style-type: none"> • Feelings about electronic modes of communication • Willingness to use e-help

Note: The names of themes in inverted commas are taken from participants' comments

Theme 1: Awareness

This theme encompassed four subthemes that are related to participants' views on using e-help and the help-seeking process: *mental health literacy, self-admitting: the self-realisation process, the stigma of being mental (self-stigma), the threat of social disapproval (social stigma)*.

Mental Health Literacy

Mental health literacy was discussed in terms of knowledge about when help was needed and an awareness of help options. There was widespread uncertainty regarding the signs that someone needed help for mental health concerns. Naomi's comment illustrates this blurred line: "... sometimes you feel like saying you are not depressed – and you know there's that fine line between ... just get up and just get over it and get on with it, to know that actually makes it so hard..." (FG1). The participants in this study had a lack of awareness about how to recognise when to get professional help. This finding is consistent with the literature that indicates that a lack of mental health literacy is a barrier to people seeking help for mental health issues (Thompson et al., 2004). The mental health literacy literature indicates that the general public are not able to accurately recognise or label mental disorders (Jorm et al., 2006). In all three

groups, participants suggested that there was a need to increase awareness of mental illness, especially about disorders other than depression.

Furthermore, participants in the church group and the all female group identified a lack of awareness about available help options as a barrier to seeking help. A specific barrier for the use of e-help was that participants across all three focus groups had limited knowledge about the extent of help available via e-help methods. For instance, none of the participants mentioned any of the free self-help interventions, such as *MoodGYM*. The e-help options that were mentioned in the groups included: helplines, online counselling, and *beyondblue* (an Australian organisation that provides information about depression to consumers, carers and health professionals). Interestingly, the young adult male participants did not think that a lack of awareness about help options was in fact a barrier to seeking help. In their view people in general knew that there was help available, such as from psychologists, helplines, and “googling” on the Internet. Perhaps this belief stems from their education and schooling in which computers and the Internet would have been significant education tools. If this is the case, then they may feel confident that they can find out anything they want to know by “googling”. This may not be the case for the other two groups.

In addition, the young males argued that if people really wanted to seek help, they could find out about their options and access that help. In FG3 the following interaction occurred:

Noah: I suppose it brings the helplines back into play
 Landon: the internet, just go to the internet and look for...
 Dave: google... so yeah
 Moderator: so you reckon that if they really wanted to know – they could easily find out?
 Jeff: that's it... the phone book... ...
 Dave: most libraries would have ahhh a computer or something for them to have access to... ...
 Landon: and Subway's and that have free internet...
 Jeff: somewhere that's free for them to use the internet... ... you can get onto the internet for free pretty much somewhere... if you look hard enough...
 Moderator: so if they really wanted to...?
 Noah: if the person... if they want help...
 Jeff: the ball's in their court... it depends on how far they want to go seeking help... so the means of doing it can vary.... (FG3)

Another aspect of lack of mental health literacy was participants' beliefs about distress and mental illness. For example, for many participants, mental illness was viewed as “*a bad thing*” (Landon, FG2) and as having “*problems in the head*” (Jake, FG3). According to the young adult males, nobody wanted to think that they had an

illness and mental illness was considered to be serious, and something from which a person would never recover. The following extract illustrates this point:

Landon: mental illness is for life...

Noah: yeah...

Landon: ... if I've got a mental illness you think to yourself, well shit.... Oh man – what's going to happen

Noah: like do I have a future or... whatever (FG3).

However, one participant reflected on how the experience of living with her husband who had depression had changed her beliefs about mental illness. Michelle explained that: *“years ago I would have said – there's no such thing, people make it up, build a bridge get over it, what's wrong with you... or you're weak as piss or...”*. Whereas due to her experience, Michelle stated that depression had a *“different meaning” “because now I am living it”* (FG1).

“Self-Admitting”: The Self-Realisation Process

A second aspect of awareness involved the person admitting that they have a problem and admitting that they need to seek help. The extent of a person's awareness of their problem appeared to be related to a process of self-realisation. In this process, the person went through different levels of awareness and acceptance of their problem. Participants identified that delays in help-seeking can be attributable to the stages of a process in which people initially are not aware or do not acknowledge their problem. For example, Noah made the following comment: *“self-admitting... If the person who has the problem doesn't think they've got the problem – then why would they look for help...?”* (FG3).

This process of self-realisation in which the individual may admit to themselves that they have a problem reflects Coe's (2009) findings that indicated denial and self-acknowledgment of a problem as stages that preceded help-seeking. The general help-seeking literature also identified slow problem recognition as reasons for long delays in help-seeking and problem recognition as a prompt to help-seeking (Thompson et al., 2008).

However, the participants' in this study felt that awareness of a problem was not sufficient to instigate help-seeking - the person also needed to be willing to get help. Leanne alludes to this need for a willingness to seek help, *“...if you know you need it, you basically don't necessarily seek”* (FG1). The young adult males believed that this reluctance to seek help was common. According to these young men, the biggest hurdle to overcome with regards to seeking any kind of help, including e-help was: *“self*

acceptance that you've got to get some help..." (Jeff, FG3). They believed that there were no real barriers to people accessing and seeking help. In fact, when asked what might prevent some people from using e-help options, even though they did propose some general issues—such as lack of credits on your mobile, congestion on mobile phone services, or mobiles freezing—these young males were adamant that it all comes down to: "... *the person... there is nothing really to stop you using it if you want to...*" (Landon, FG3).

It appeared that the importance that these young men placed on the person admitting that they have a problem and that people would have a reluctance to seek help, was much greater compared to the same issues expressed by the other two groups. The importance of these issues for the young males in this study is consistent with the literature which has found that young men were unlikely to seek help (Biddle et al., 2004; Oliver, Pearson, Coe, & Gunnell, 2005) and that they may have a general reluctance to seek help, that they may want to avoid appearing weak, and that they are socialised to deal with problems on their own (Davies et al., 2000).

The Stigma of Being 'Mental' (Self-Stigma)

Participants also talked about "*the stigma of being mental*" (Leanne, FG1) and the negative associations with mental illness – "*it hinges on a lot of people's perception of mental illness doesn't it*" (Catherine, FG2). Examples given of such negative associations were "*sanatoriums*" (Vera, FG2), "*being of low intelligence*" (Catherine, FG2), and being "*retarded*" (Landon, FG3). Further associations were: "*mental hospitals, mental homes...*", and "*lunatics*" (Michael, FG2, Interview). These negative attitudes and associations with mental illness were spoken about as if they served as a threat if an individual were to admit that they needed help and were to seek it. Thus self-stigma acts as a barrier to help-seeking. As Jorm et al. (2006) pointed out, these negative attitudes become internalised by the person and applied to themselves.

The young adult male participants and a woman from the church group suggested the underlying reason for the avoidance of admitting one had a problem and avoidance of help as a "*pride thing*" (Catherine, FG2; Jeff, FG3) and spoke about it as if it was a threat to the self. Another of the young males explained this further as mental illness was considered to be: "...*admitting a fault or a something wrong with you*" (Noah, FG3) and another participant commented that admitting a fault "*it's not an easy thing to do*" (Jeff, FG3). The young males further explained how self-realisation of a problem had adverse implications for their sense of self-identity, "*because you're like*

undermining who you are ... yourself and what you stand for...” (Jeff). Due to the implications of what seeking help would mean for their sense of self, the young men identified how this may prevent people from seeking help. For example, Landon commented that: *“you can also admit to yourself that you have got a problem, but still going and doing something you don’t...”* (FG3). Thus, self-stigma—viewing oneself as weak—appeared to motivate a person to avoid admitting that they had a problem as well as avoid seeking help. Self-stigmatising attitudes have been reported in the general help-seeking literature as barriers that reduce a person’s willingness to engage with mental health services (Barney et al., 2006; Jorm et al., 2006; Schomerus et al., 2009).

The Threat of Social Disapproval (Social Stigma).

Participants perceived themselves to be vulnerable to social disapproval if they were to have or seek help for a mental illness. Due to this threat, the young males admitted that they would be cautious about who they would trust with the information that they were seeking help, because their mates *“might give you shit...”* (Jeff, FG3). The participants expressed opinions that social disapproval would also reduce the likelihood of continued help-seeking. Jeff explains that it would *“make you ... more reluctant to even go and do it, then it would even get worse and worse... and accumulate and bottle up...”* (FG3). Furthermore, Michelle explained how her husband’s depression had been their *“dirty secret”* and she had felt ashamed and hidden it from her friends and family (FG1). The literature on help-seeking has found that perceived stigma (social stigma) is linked to people believing that others will view them negatively and with a reduced likelihood of seeking help from professional sources (Barney et al., 2006).

Social stigma and self-stigma have implications on the potential use of e-help methods. The anonymous nature of some modes of e-help is thought to reduce social stigma (Carlbring & Andersson, 2006; Gilat & Shahar, 2007). However, unless security and privacy can be assured to the e-help client, then the threat of an unintended audience and thus, the threat of being stigmatised by others would remain. Furthermore, e-help methods of seeking mental health services are not able to bypass a person’s self-stigmatising attitudes if they were to regard themselves as having a mental illness and needing to seek help. Thus, self-stigma remains as a specific barrier to seeking help using e-help methods.

Theme 2: Trust and Feeling Safe when Help-Seeking and using E-Help

This theme revolved around a person's need to feel safe and have trust when dealing with distress and seeking help. The issue of trust was discussed in terms of who could help. A sense of feeling safe when expressing and disclosing their emotions was paramount. There are three subthemes associated with the overarching theme of trust and feeling safe: (1) need to feel safe and trust, (2) concerns about trust and lack of control, and (3) deal with it – get over it: acceptable ways of coping.

Need to Feel Safe and Trust

The importance of being able to trust and feel safe when seeking help was a primary concern expressed by participants. Participants talked about needing a safe environment with people they trusted in order to feel safe expressing their emotions. Noah stressed that “... *if you're talking about yourself, you have to have confidence in who you're speaking to... and you know that it's not going to go any further....*” (FG3).

The participants had suggestions about what ideal e-help would be like in order for it to be a safe and trusted way of seeking help. For instance, many participants felt that e-help methods of delivering services could be made to feel safer by the person being anonymous and any information shared being kept confidential. As Henry stressed: “*confidentiality I think is of supreme importance really, especially when you do have problems, you don't want this to come back on you...*” (FG2). Similarly, Michael expressed the importance of anonymity, as he put it “*if you know you're anonymous – you can say anything...*” (FG2). He added that if the helper stressed anonymity, then it would be a safe place to express oneself and a safe way to get help.

Many participants expressed that confidence and willingness to use e-help services would be greatly increased if these services were recommended by “*the people you trust and respect*” (Noah, FG3). This person could be a friend, colleague, family member or one's GP. When recommended by someone they trusted, the service by association was also trusted and the person was more likely to use it sooner. The following quote serves to illustrate this point: “*yes you would probably go there quicker... if someone is already a significant person to you, and they had said: 'now hang on – how about, have you considered this'...*” (Vera, FG2). Findings by Vogel and colleagues (Vogel et al., 2007) indicated that 75% of participants in their study who had sought psychological help had someone recommend that they seek help. They also found that being prompted to seek help was related to positive expectations about mental health services and positive attitudes towards help-seeking.

Concerns about Trust and Lack of Control

Participants expressed concerns regarding privacy and security of using electronic modes of communication. For example, participants in the young adult male group expressed concerns about privacy and security with regards to using their mobile phones and other people getting unauthorised access to their private information. For example, Landon remarked that: *“people can get all of your messages, all your contacts, just anyone can do it...”* (FG3).

For some participants, the threat of an unintended audience made using text-based forms of communicating feel unsafe. For instance, writing about one's feelings and sharing these using these modes of communication was considered unsafe due to the threat of that information being used against them at a later date, as Helen put it: *“no I wouldn't want to have that in writing in case it comes back to hit me later on.... it could even be used against me and there is hard evidence...”* (FG2). Due to this threat, some participants expressed a need to control and regulate their feelings by editing what they expressed in writing. This editing process usually involved the removal of emotional content. Hence, this issue of feeling unsafe using some forms of electronic communication may have lead some participants to prefer seeing someone face-to-face. For example Noah remarked that *“for a topic that's yourself and you're talking about your faults and what's wrong on the inside, then yeah you're not going to send a message about that are ya... you want to talk to someone face-to-face ...”* (FG3). In contrast to the e-help literature, feeling safe and control were not given as advantages of using e-help by participants in this study (Centore & Milacci, 2008; Gilat & Shahar, 2007). Moreover, the findings from this study are more consistent with the e-help literature that identified privacy, confidentiality and lack of security as disadvantages of e-help (Carlbring & Andersson, 2006; Cleary et al., 2008; Mallen, et al., 2005).

As well as concerns regarding a safe way to express oneself, there was also distrust and suspicion surrounding the type of help that may be encountered when using e-help services. Some participants reported a reluctance to use e-help services due to uncertainty regarding the qualifications and ability to trust online and phone helpers. These beliefs appeared to stem from perceptions and examples they had of bad helpers. The following extract illustrates this uncertainty about online and phone helpers:

Michelle: ..and I worry about this whole volunteer thing...

Leanne: ...whose trained enough...

Michelle: ...my sister did a counselling course so you

Leanne: yeah my Auntie's a counsellor and I wouldn't want to ...

Michelle:... and I wouldn't go to her for advice about anything..

Leanne: yeah my Auntie's the same...

Michelle: ...I would worry how qualified that person was... ..

Leanne: for that reason I would steer away from the internet (FG1)

Furthermore, shared knowledge and lived experiences of bad help also served as deterrents to help-seeking. For example, Sam shared: "*My brother went to one with his missus and he come out saying that he felt like an alcoholic and a sex addict*" (FG1).

Deal With It – Get Over It: Acceptable Ways of Coping

When discussing ways that people may deal with distress and mental illness, seeking professional help was not proposed as an option. There was one exception; a 69 year old male suggested that a person could get help from the Samaritans. The types of things that participants thought that people did to deal with distress were: taking drugs, drinking alcohol, withdrawal, keeping busy, shopping, praying, suicide, playing computer games, and working out. The participants in FG1 and FG2 also suggested that people might seek support from their family or friends to help deal with distress. Participants spoke about ways people have learnt to deal with distress and what is considered to be acceptable ways of coping with distress in the familial and societal context.

Dealing with distress.

When discussing ways that people deal with distress, the participants talked about different ways of coping. For instance, Landon commented that sometimes "*it's easier to block stuff out than face it...*" (FG3). Some participants suggested that people may deny they have a problem or try and deal with the problem alone:

Michelle: ... the first important thing is for people to realise that they have a problem... [Michelle's husband] has been living in denial for a long time ...

Sam: ...or they think they can deal with it ...

Naomi:...sometimes you do... you just think that get over it – get over it – get over it.... (FG1)

In addition, participants described other ways of coping that served to prevent people from admitting that they needed to seek help, and thus would contribute to non-help-seeking. For instance, participants could avoid help by making a downward social comparison: "*you look at it and go – why why am I so sad when that person has nothing,*" (Kate, FG1) or by identifying oneself as a helper, but not someone to be helped: "*I'm an ear on a stick...*" (Sam, FG1).

Another way of dealing with distress that acted to avoid help was considering that help was for others. The participants gave an extensive list of who they thought

e-help *would* be suited. Some of these suggestions included: people in rural areas, war veterans, people with anxiety related illnesses, rape victims, and people without social networks. Furthermore, the attribution of locus of control and cause of one's problem also served to avoid help. For instance, Kate perceived the locus of control of her symptoms as internal, "*more a me thing*", which resulted in her feeling less worthy of receiving help compared to someone with whom their symptoms were attributed to an external locus of control, such as a "*a rape victim or a child abuse*" (FG1). These different ways of dealing with distress may serve as coping strategies to avoid facing the distress and avoid admitting that help might be needed.

Self-management of symptoms.

Most participants indicated that their first coping strategy was the self-management of symptoms. Some participant's indicated that these accepted coping strategies were acquired during one's upbringing, as the following quote from Leanne illustrates: "*if you were raised in a deal with it – get over it kind of way, people will still try and do that, not realising that you can go and get someone to help....*" (FG1). Thus, there was a cultural expectation to deal with distress alone in a self-reliant manner. This expectation appeared to be internalised and seen as a preferred way of coping, Catherine stated that: "*...I don't unload my problems to other people actually ... I will sort it out myself ...*" (FG2). The current finding of self-management is also consistent with other studies. For example, Andrews et al. (2001) reported that the main reason given for non-help-seeking by people with a mental disorder, was a preference for managing on their own. Similarly, Mojtabai, (2009) found that one in four participants in their study who had depression, reported not seeking help because they believed that they could deal with it on their own.

Compartmentalising the bits of your life.

Many participants explained how coping with distress was accomplished by compartmentalising their private and public self: "*I think the other thing that comes with age too is to compartmentalise the bits of your life that you want to put out there, the bits you want to keep to yourself, the bits you can kind of share and stuff...*" (Leanne, FG1). This compartmentalisation of the self, allowed a person to maintain a public façade, as well as to maintain control over the private self. This control of the private self served to prevent people from becoming overwhelmed by their emotions. Thus, emotional regulation was perceived as necessary to function in day-to-day activities.

Participants described in detail the need to keep the private and public selves separate and the need to trust and feel safe in the environment in which the private, emotional self was expressed. For some participants this could be achieved by guaranteeing anonymity and confidentiality in the e-help environment (need to feel safe and trust). Whereas for other participants, there was suspicion, distrust, and concerns about privacy and security of using e-help methods (concerns about trust and lack of control).

Theme 3. It Depends on the Person Really: E-Help Issues

The theme it depends on the person really encapsulated two subthemes, including people's feelings about using electronic forms of communication and their willingness to use e-help methods of engaging with mental health services.

Feelings about Electronic Modes of Communication

There were diverse feelings about using electronic forms of communication. For some participants, electronic means of communication were viewed extremely favourably and these forms of communication were fully integrated into their lives. For example: *"yeah I am on the computer for like – forever... I would hear my computer at least every 15 minutes"* (Kate, FG1) and *"I am fully electronic ..."* (Michael, FG2). Jeff described his mobile as a companion on which he felt dependent: *"it's a companion sort of... the convenience you build up the reliance I suppose without even knowing"* (FG3).

For other participants, their feelings about electronic communication use were more ambivalent. Communication via mobiles and the Internet was perceived as something that needed to be controlled and regulated and used for a specific practical purpose, such as keeping a mobile phone in case of an emergency: *"I don't live by it"* (Michelle, FG1).

In contrast, other participants had extremely negative feelings about newer forms of electronic communication and its use. For many of these participants, face-to-face communication was considered more personal: *"I don't like internet, email... I prefer people to come and talk"* and she further explained how she preferred face-to-face contact: *"I think it's more personal – it's showing that people do care, not sort of again just press a button"* (Sam, FG1). Also, Michelle felt that electronic communication was invading her life and commented that she hated *"that technology is invading my precious time with all this shit"* (FG1).

For the participants who had negative feelings towards mobile phones and the Internet, there was a distinct nostalgia for the past and distrust and resentment towards mobile phones and the Internet. Notably, this nostalgia was absent in the young adult male group. For some of the participants in the church group, negative views of e-help were extended to blame it for leading to mental health problems, addiction, crime, and increased social isolation.

Catherine: ... I do firmly believe that there are these kids that are allowed to just play on the internet day and night... I mean it leads to a lot of mental... mental health problems, doesn't it with children... if ummm...or even adults if they are allowed to just... they can become overly addicted ... and ummm it can lead to all sorts of problems ... rubbish in, rubbish ... who knows what that's going to create in that person and if they are not going to be able to... you know to become criminals or... (FG2)

Vera: I actually think it's a *bad thing*....ahhhhh.... [agreement from some others in the group] the lack of person to person communication is building up a lot of isolation... (FG2)

The absence of the nostalgia for the past in the young males may possibly be attributable to the greater level of exposure to and the extent to which newer communication technologies had been a part their upbringing. In contrast, the older participants would have lived a life prior to mobile phones, home computers and the Internet being pervasive parts of everyday life.

In addition, for some participants, electronic communication and technology were seen to have contributed to a loss of connection with a higher meaning and connection with others. Naomi stated: "... *that's what I think we've lost a lot in our modern life...it doesn't have to be religious, but a spiritual – just somewhere where you can get away from this technology...*" Michelle stated, "... *it's like you've lost that connection...*" and Naomi further commented that now "*there's just an emptiness...*" (FG1). Similarly, Michael also described a sense of something lost. He attributed this loss to a shift in the respectability of certain people and their prescribed roles in the community for providing support: "*traditionally there was a hierarchy and set people who you might've, you would know, if I feel this way I'm going to see the pastor, or if I'm feeling this way I'm going to see... The wise woman of the village....*" (FG2, Interview).

Willingness to use E-Help

When a person was willing to seek help from outside sources, most of the participants expressed an initial preference for seeking help from their family, friends

and colleagues. For instance, many of the participants had a preference for turning to their family first. Sam commented that: *“I’m quite a personal person so I would keep any of my business in my family”*. She further commented regarding e-help options that: *“I think I could, but I would go to family first”* (FG1). This preference to seek help from one’s social network to deal with psychological distress indicates that there is a discrepancy between initial preferences for treatment of participants, compared to clinical views on the benefits of early intervention and evidence-based treatments. Jorm et al., (2006) highlighted that this gap between the lay beliefs and professional beliefs about what is considered appropriate management of the mental disorders, is another aspect of the community lack of mental health literacy.

However, Michael expressed his doubt about the reality of people actually seeking help from their family and friends about certain issues. As can be seen from Michael’s comments, he speculated that this reluctance may be attributable to the threat of stigma and alludes to the way that people tend to hide these things from others. This quote also indicates the coping strategy of compartmentalisation of the private and public self:

Michael: I think we like to tell ourselves that we would talk to close friends or family, I don’t know if that is a reality ... I think that most people would shy away from it and talk to other people ... especially if they have any feelings of guilt that they’ve let people down... or that it’s not quite normal... or that they will lose friendships because they won’t think the same of them – anything that’s got a stigma attached to it ... we like to put up a façade... (Interview, FG2)

It was recognised that sometimes these initial help preferences would not be suitable under certain situations. Sometimes the decision about who to seek help from was based on the specific problem, on the expected reaction of the person, or what was wanted from the help. For instance, Leanne gave an example of a problem for which she would seek professional help: *“... let’s say I was abused as a child – I wasn’t—that’s not something that I would necessarily bring up at a coffee afternoon or something, but that would be something that I would go externally for... so to me it depends on the magnitude of the problem”* (Leanne, FG1). A further example from Leanne demonstrates that the decision about who to get help also depended on the type of help that they wanted. She commented that sometimes there was a need for: *“... expressing it and getting out...”* *“rather than having someone...fix it for you ... which is what friends and family want to[do]...”* (FG1). People may also seek help outside their family and friends, if the initial help using these sources had not been helpful. For instance, Landon commented that a person may turn to e-help, *“when you’ve got*

nobody else to talk to... and don't want to talk to a mate this time... because you know that they're not listening" (FG3). These mediating factors also need to be taken into account in Coe's (2009) hierarchy of help preferences.

For the majority of participants in each of the focus groups, there was a willingness to use the Internet as a research tool to get information and find out more about the help options available for coping with distress and mental health services. Participants expressed how they would be willing to seek out information to assist with self-management strategies. For example, Naomi remarked that she would be *"more likely to use it to get information for myself..."* and Leanne added, *"to then cope"* (FG1). Kate shared that she consults forums to see how others are coping with issues similar to hers: *"you just see how other people react to it and stuff..."* (FG1, Interview). There were concerns raised about the quality of some of the information that is available on the Internet. Vera aptly summed this up in the following comment: *"the internet doesn't have a decent editor..."* (FG2). However, *"too much information"*, it was noted by several of the participants, could be *"overwhelming"* (Henry, FG2).

Many participants stressed that they would use the internet to find a number to contact somebody that they could see in person, and that they would not be interested in receiving services or treatment via the Internet. Leanne's comment is typical of this preference for face-to-face services: *"but for the electronic thing – I wouldn't necessarily go looking for somebody to help me, but I would use it to find [information]..."* (FG1).

Furthermore, several participants expressed doubt regarding the effectiveness of e-help methods relative to face-to-face treatment: *"... the electronic forms – I don't think as clearly give you that opportunity to work through those processes to actually get to the nut of what is the real issue..."* (Mel, FG2). Similarly, the young males recognised that e-help methods, such as those delivered over the Internet may be anonymous, however, they were not perceived as effective as face-to-face modes of treatment:

Jeff: yeah.... Like I wouldn't want to be consulted over the Internet... it's anonymous and that, but not..

Noah, Landon, and Jake: yeah yeah it's not a good... (FG3).

These views are inconsistent with the e-help literature which had found early evidence for the effectiveness of e-help (Barak et al., 2008; Bee et al., 2008; Hailey et al., 2008) and the comparability in effectiveness between some forms of e-help and face-to-face

treatment (Barak et al., 2008; Cuijpers et al., 2009; Day & Schneider, 2002; Germain et al., 2009; Kaltenthaler et al., 2006).

Some participants felt that they would potentially use e-help if their symptoms prevented them from using other forms of help, for example, “...*if I was physically incapable of moving out of the house*” (Naomi, FG1). However, it was also noted by many participants that symptoms of distress could prevent people from seeking help and having the capacity to use e-help options. Naomi put it the following way, “*if you’re in a bit of a mindset where things aren’t going right and you’re feeling out there... if you’re there in front of technology you might just go – that’s too overwhelming I’m going to close it off because it’s just too hard*” (Naomi, FG1).

A contributing factor to the willingness to use e-help services was a participant’s preference and comfort with mode of communication. For instance, some participants felt uncomfortable using certain modes of electronic communication, such as talking on the phone. Jake explained, “*I can’t seem to talk on it... yeah if I’m face-to-face I seem to be able to get it out and yeah*” (FG3). Kate contrasted her preference for help with one of the other participants: “*Michelle was very – no I don’t like it [e-help], no I don’t think that that is personal enough... whereas I’m a different person and I think that I don’t often want it to be personal – I just want to say what I want to say.. be steered in the right direction...* ” (Kate, FG1, Interview).

The level of comfort with the mode of communication was also found as factors that affected participants’ attitudes to online counselling in the e-help literature. For example, Rochlen, Beretvas, et al. (2004) found that participants who had a fear of intimacy were uncomfortable with face-to-face counselling. Whereas more positive attitudes towards online counselling were found in participants who were comfortable using email (Rochlen, Beretvas, et al., 2004) and in participants who had difficulties expressing their emotions (Rochlen, Land, et al., 2004). These latter two findings were reflected in comments made by some participants in this study. These participants felt that e-help options, such as online text-based counselling, would be appealing for people who felt uncomfortable and anxious when disclosing with people in face-to face interactions. For this reason, some participants suggested that the impersonal and anonymous nature of e-help, for those people, was an advantage for e-help compared to face-to-face treatment. For example, Kate explains how she liked the idea of using online counselling:

Kate: that would be very good because you don’t have a face...so you don’t have to get really embarrassed if you say things like later on you go – oh my god [I]

obviously lost control... I told you too much or you get worried if you see some people if you disclose too much, I really thought that was a good idea because I would type constantly, like I would do back and forth... (FG1, Interview).

Even though a few participants identified that a lack of visual cues associated with mobile phone communication and text-based online communication could potentially lead to misinterpretations and misunderstandings, this was not a consensus across the groups. Several participants perceived this lack of visual cues as an advantage for people who find face-to-face interaction confronting. For these types of people, some participants noted that the visual cues in face-to-face therapy may be interpreted as judgemental. For example, Noah commented, *“for some people it’s confronting and they don’t want to be judged...”* (FG3). The importance of this factor is highlighted by comments made by Kate, in which she indicated that she would drop out from face-to-face therapy if she had felt judged by the therapist: *“if somebody did a little flick of their eyes or something ... I would probably be all right there, but I would probably never go back again ...”* (FG1, Interview). In contrast, she hypothesised that the lack of visual cues using text-based online counselling would reduce the risk of her feeling judged compared to face-to-face counselling; she explained: *“yeah and you can’t tell whether they’re feeling pity or whether they’re ummm thinking you’re an absolute lunatic...”* (FG1, Interview). This was a surprising and important finding. The e-help literature had indicated that a lack of visual cues was only a disadvantage of e-help methods (e.g., Carlbring & Andersson, 2006).

General Discussion

This exploratory qualitative study aimed to explore general community perspectives about using electronic forms of communication to seek help with mental health conditions. The focus groups allowed the participants to speak freely. These discussions yielded a diverse set of views on e-help and issues relating to help-seeking for psychological distress and mental illness.

Using IPA as a guiding framework, this study identified that participants’ perceptions of e-help were embedded in their knowledge and beliefs about mental illness, what it would mean to have a mental illness, and what it would mean to seek help for such a condition. In addition, this study found that participants had a lived experience with using electronic communication in their everyday lives. These beliefs and experiences appeared to provide a backdrop against which participants formed their

perceptions of help-seeking using e-help. When asked about their views on e-help, the participants in this study spoke extensively about barriers to help-seeking. Some of these were explicitly stated, others were gleaned from the interpretative analysis. This study found that factors that act as barriers to general help-seeking, were also significant barriers when considering the use of e-help services.

The interpretative analysis of the transcripts identified three superordinate themes and related subthemes. The first theme was awareness. This theme emerged from participants' general lack of mental health literacy regarding when to seek help and a lack of awareness of e-help options (lack of mental health literacy). This theme also involved the participants' referral to a process of self-realisation in which people may be at different stages of awareness of their problem ("self-admitting": the self-realisation process). Participants also had an awareness of negative associations with mental illness and that having a mental illness could be viewed as a personal fault (self-stigma). Furthermore, participants talked about a vulnerability to social disapproval if one were to seek help for mental health problems (social stigma).

The second theme was trust and feeling safe when help-seeking and using e-help. This theme reflected participants' descriptions about needing a safe environment with people they trusted in order seek help (need to feel safe and trust). However, some participants expressed concerns regarding privacy and security of using electronic modes of communication (concerns about trust and lack of control). Another aspect of trust and feeling safe was related to perceived acceptable ways of dealing with distress (deal with it – get over it: acceptable ways of coping).

The third theme that emerged was it depends on the person really: e-help issues. This theme reflected personal perspectives about using electronic forms of communication (feelings about electronic modes of communication). Participants had diverse feelings and lived experiences with using electronic communication, ranging from very positive, ambivalent, through to very negative feelings. This theme also included participants' preferences for help and willingness to use e-help methods (willingness to use e-help).

The different issues that arose under these themes are presented in Table 2. As can be seen in the table, there were many factors that contributed to non-help-seeking or facilitated a decision to seek help for mental health issues. Some of these issues are relevant to help-seeking in general, some are specifically related to factors that may hinder or facilitate consideration of e-help methods. These issues are explored in the following discussion with relation to a model of help-seeking.

Table 2.
Perceptions of e-Help: Help-Seeking and Non-Help-Seeking Factors

Non-Help-Seeking Factors
Lack of mental health literacy
<ul style="list-style-type: none">- Problems with recognition of mental disorders- Ideas about appropriate management- False beliefs about mental illness
Coping mechanisms and coping strategies
<ul style="list-style-type: none">- Denial- Repression- Help is for others- Self as helper- Downward social comparison- Attribution of cause of distress as internal locus of control
Avoidance of Self-admitting
<ul style="list-style-type: none">- Not admit have a problem- Not admit that need help- Not willing to seek help
Preferences for non-professional help
<ul style="list-style-type: none">- Self-management of symptoms- Support from family and friends
Implications of help-seeking (Attitudinal barriers)
<ul style="list-style-type: none">- Stigma<ul style="list-style-type: none">Social stigmaSelf-stigmaThreat to self identity
<i>Specific e-Help Non-Help-Seeking</i>
Lack of awareness of e-help options
Belief that e-help is not helpful
Negative lived experience of electronic communication
Not comfortable using electronic communication
Preference for face-to-face help
Distrust and suspicion of e-help methods
Help-Seeking Factors
Mental health literacy
<ul style="list-style-type: none">- Need to recognise that have a problem- Need to know about professional help options- Need to know about effectiveness of treatment
Need to be willing to seek help
Recommendation by someone trust
<i>Specific e-Help Factors</i>
Need to feel safe and trust
<ul style="list-style-type: none">- Ensure privacy, security, guarantee anonymity
Use as Research tool
<ul style="list-style-type: none">- Information to make sense of symptoms- Self-management strategies- Options for help, especially contacts of face-to-face help
Discomfort with face-to-face services
Exhausted preferred initial sources of help (e.g., family and friends)

The findings from this study have been integrated into a model which is displayed in Figure 1. It depicts the process of self-admitting and other factors in help-seeking and non-help-seeking. The model is an adaptation of Biddle et al.’s (2007) Cycle of Avoidance (COA) model and it also includes elements of Coe’s findings that denial and acknowledgement precede help-seeking. In the COA, non-help-seeking takes place as the individual attempts to normalise their distress and avoid considering the distress as ‘real’ by the movement of the threshold of real distress. Thus, by the avoidance of help, the individual also avoided defining their distress as real and the associated stigma. The current model of help-seeking was conceptualised when no evidence was found in this study that was consistent with the COA’s normalisation or moving threshold of distress.

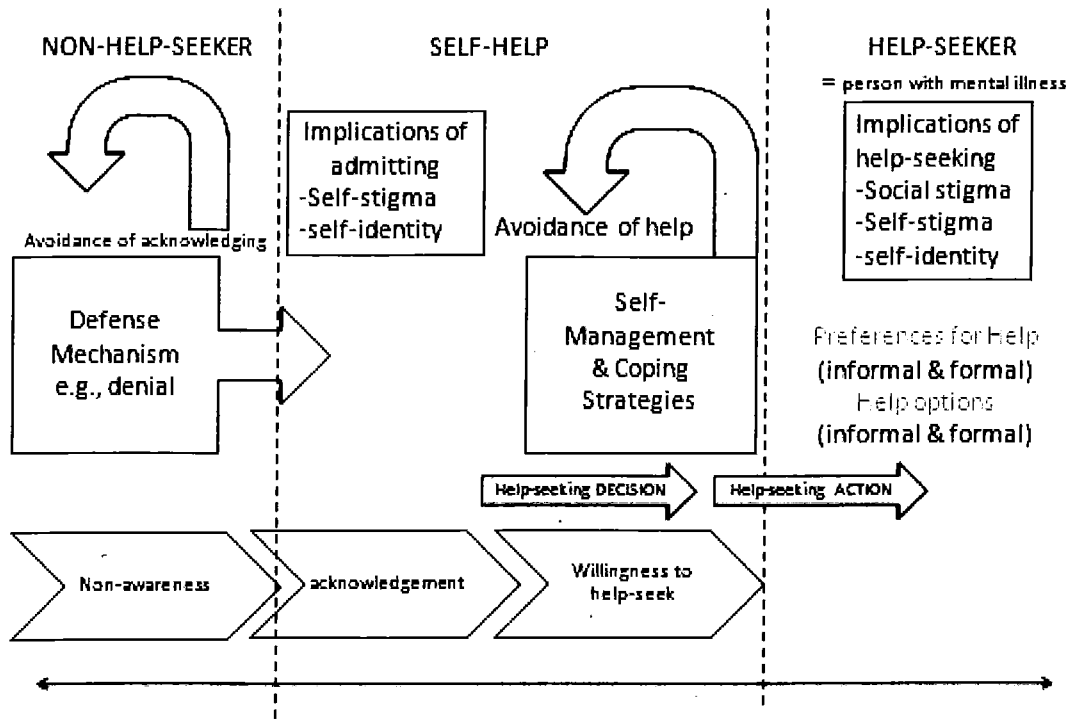


Fig. 1. The process of “self-admitting” in the non-help-seeking and help-seeking process

In the current model there are different stages of “self-admitting”, which represent different levels of awareness of a problem. Consistent with the COA, the avoidance of help in this model is also based on a desire to avoid stigma and social disapproval; however, different mechanisms contribute to non-help-seeking. For instance, defense mechanisms serve to keep the awareness of the problem out of the individual’s consciousness. For instance, the participants in this study spoke about the

denial of a problem and “*blocking stuff out*” as ways of dealing with distress and barriers to help-seeking. In addition, participants in this study had negative associations with mental illness and considered it as a personal fault. The implication of admitting that one had a problem would risk the individual thinking that there was something wrong with them (self-stigma), and thus serve as a threat to their self identity.

Once the individual admits that they have a problem, professional help may still be avoided by using self-management strategies to cope with their distress. For example, this study found that participants talked about coping strategies that functioned to avoid help-seeking; these included: viewing the self as a helper, making downward social comparisons, and thinking help is for other people. Furthermore, seeking help from informal sources meant that the individual does not take on the mental illness label. In contrast, if the individual were to seek professional help, this would mean taking on the identity of someone with a mental illness. Thus, becoming a “help-seeker” would mean the individual is at risk of both self and social stigma. Not only would this act as a threat to the individual’s sense of self, it would also put them at risk of social disapproval.

Thus according to this model, dominant issues that contributed to non-help-seeking were attitudinal barriers, such as a belief that one should manage on one’s own (self-reliance) and the threat of stigma, both from the self and from others. In addition, a lack of mental health literacy contributes to non-help-seeking. Firstly, a lack of knowledge of the symptoms of mental disorder can contribute to an individual’s failure to acknowledge that they have a problem. Secondly, a lack of awareness about appropriate treatment of mental disorders can be a factor in choosing to self-manage. Thirdly, a lack of awareness about help options can also contribute to not seeking professional help. The findings from this study appeared to be consistent with literature that indicate that there is a gap between clinical categorisations of mental disorders that would point to a need for professional help and what that treatment should be, and public knowledge about the signs that somebody may need help and acceptable ways for them to cope (Jorm et al., 2006). For example, many of the participants in this study spoke about self-reliance and self-management of their distress. When asked what people might do to deal with distress, there was only one person who suggested seeking professional help.

The findings from this study, as described in the model, highlighted several barriers to help-seeking that may be active in the help-seeking process. Preceding a decision to consider e-help, the individual must first admit that they have a problem and

admit that they need help. They may at this point choose to deal with it on their own and self-manage their symptoms. Although there are several non-professional e-help methods—such as self-help web-based Interventions—participants in this study were not aware of them. When the individual decides to get help, they may choose informal sources of help, such as from family or friends. In this study it was found that if these trusted sources were to recommend e-help, then the individual may be more likely to use it. This would require that the family and friends had knowledge about e-help options and also that they had positive views about its use. The findings from this study indicate that for some people, this may not be the case.

Once a decision to seek professional help had been reached, the decision about whether or not to use e-help is subject to several issues. The findings from this study indicated that many participants had a general lack of awareness about what e-help options are available. Furthermore, many participants had negative attitudes toward the use of e-help. For example, some participants believed that e-help methods were too impersonal or an unsafe method of seeking help. There were also some participants who expressed doubt concerning the effectiveness of e-help methods, or that they were not as effective as face-to-face treatment methods. In addition, there were participants who were uncomfortable using mobile phones, telephones and the Internet. On the other hand, e-help methods would be considered by some participants as an option for assistance with mental health conditions: when a safe and secure environment could be guaranteed; when initial attempts at seeking help with friends and family had not been helpful; and when individuals perceived face-to-face services as confronting.

Theoretical Implications

This study makes several contributions to the body of knowledge. First, the findings from this study add to the general help-seeking literature. These findings provide an understanding of some of the processes and factors involved in help-seeking and non-help-seeking. Second, these findings also contribute to the e-help literature by adding to potential consumer perspectives. This study is unique in providing a “first glimpse” into community perspectives on e-help in general. An important finding was that the lack of visual cues in many modes of e-help can be an important advantage for people who may feel discomfort in face-to-face interactions. This study also indicated the importance of situating perceptions on e-help within the greater context of help-seeking; to isolate e-help from general help-seeking runs the risk of excluding some important factors that can hinder its use, such as the role of attitudinal barriers.

Practical Implications

The findings from this study indicate several implications for the provision of mental health services using electronic forms of communication. The first implication of these findings is that e-help may not be suitable for everyone. Consideration of its use depended on a person's level of comfort with the mode of communication. For those who did not like communicating electronically, using the telephone, mobile or Internet, e-help was not a preferred option for seeking help. Whereas e-help modes of help appeared to be an attractive option for people who felt uncomfortable with face-to-face interventions, or when preferred sources of help were unavailable. A second implication relates to the finding that people need to trust and feel safe in the environment in which they are seeking help. This indicates a need to provide services in a manner that ensures that help-seekers' information and disclosures are not at risk of getting into the hands of an unintended audience. This secure environment and the anonymity or confidentiality of the interaction can be stressed to the client to enable them to feel safe when seeking help in that environment.

A third implication of these findings is the import role that psychoeducation can play in the help-seeking process. The majority of participants in this study indicated that they would be willing to use the Internet to seek information to help in the self-management and understanding of their symptoms, as well as to find options for professional help. This indicates that websites could be used to capture potential help-seekers at this point in their help-seeking process. Such websites could aim to increase people's mental health literacy, such as to aid the recognition of and appropriate courses of treatment to deal with symptoms of mental disorders. People could also be directed to suitable free-access self-help interventions, such as MoodGYM or *e-couch* (for depression and anxiety-related disorders). As some people have a preference for dealing with their symptoms alone, it is important that they be provided with effective interventions to do this. These types of self-help interventions could also stress the limitations of their use, and the point at which professional help should be sought. Psychoeducation is also important to help friends and family who may be searching for ways to help someone close to them. Recommendations from people who are trusted would increase the likelihood that people would use e-help and other professional mental health services. Thus, psychoeducation should also be directed at advising people about how they can help others and the appropriate types of treatment and services that are available.

Strengths and Limitations

One limitation of the present study was that it used three existing groups and may not be representative of the general community. However, the intention of the study was as an exploration and first look at the views of the general community on e-help. This study sampled from existing groups who were unlikely to be consumers of e-help. It would appear that the sampling strategy was successful in that respect. Some participants had used the Internet to search for mental health information, although there were no reports of using any other type of help. It is possible that participants who attended the group discussion may have differed from those who did not attend, and from people who do not attend groups. For instance, there were people who did not turn up to the groups who were scheduled to attend. One of these people, from the church group, told the researcher that she had decided not to attend because she feared that she may be committed [to an institution]. Although this was said in a joking manner, it appeared that she was suspicious of the research process and perhaps of the idea of psychology in general (as she knew that the researcher was studying psychology). It may also be the case that people who did not attend, or whose groups chose not to participate, may have more negative views on help-seeking and mental health issues. If this were the case then the findings reported here, even though they highlight a reluctance to seek help and preference for self-management, may represent more positive views compared to other people in the general community.

Another limitation of this study was that it looked at participants' hypothetical views on using e-help, in other words what they said they would think, feel or do if they were distressed and needed to seek help, and whether or not they would consider e-help. It was evident in the findings that the participants had limited knowledge about e-help options. Perhaps the findings may have been different if the study had presented a selection of different types to e-help options that are available, as well as their effectiveness and acceptability with people who have used them. Alternatively, the study could have investigated one e-help method, such as text-based Internet options. The participants in this current study did not have that direct experience or exposure to e-help, and therefore drew upon their shared knowledge about what help is like, which tended to be stories about bad help. For instance, studies have shown that exposure or experience to counselling, improved participants attitudes to e-help methods such as telephone counselling (Reese et al., 2006) and online counselling (Rochlen, Land, et al., 2004). On the other hand, the strength of having taken a general e-help approach means

that these findings are not specific to any one mode of e-help, and the findings may potentially be applied across different e-help methods.

Future Research

This was an exploratory study, therefore there is much to be gained from further investigation into the views of the general public about using e-help methods. Future research could be conducted using both quantitative and qualitative methods. As well as the need for more qualitative studies using other members of the general community, there is a need for a large representative population based quantitative study on community perspectives on using e-help methods. Future studies could also target specific populations such as rural communities, people with specific disorders (e.g., social phobia), and people with cognitive impairment (e.g., people who cannot speak but can communicate using a keyboard). In addition, research could be conducted in online communities where there is likely to be a greater comfort with electronic modes of communicating.

Conclusion

In conclusion, the current study offered an initial look at community perspectives on using electronic communication for the provision of mental health services. The IPA analysis of the focus group data identified three main themes with related subthemes. This study found that many factors that contribute to non-help-seeking for traditional forms of mental health services appeared to remain as barriers to using e-help. For instance, e-help methods may not be able to overcome attitudinal barriers such as self-reliance and self-stigma. In addition, there appeared to be a general lack of mental health literacy and a lack of awareness regarding the extent of e-help methods. If people do not know about e-help mental health services, it is unlikely that they will use them. However, psychoeducation holds great potential to delivery this knowledge and capture those in need of help as they go surfing the net. The findings from the current study also found individual differences in comfort with mode of communication and preferences for help. A surprising finding was that a lack of visual cues was seen as an advantage of text-based online treatment methods for those participants who anticipated discomfort with face-to-face interventions.

If e-help is to fulfil its promise in contributing to closing the gap between high prevalence rates of mental illness and low uptake of services, it will need to overcome some of the same barriers that face more traditional mental health modes of service

delivery. With almost two-thirds of people with mental health conditions not seeking help, it remains paramount to identify the specific ways in which e-help methods may be applied and the types of people and situations in which it may be most suited.

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Appendix A
Research Flyer

e-Help Research Focus Groups



Focus Groups

I want to know what you think:

Topics:

- What are the best ways of accessing help in times of psychological distress and despair?
- What do you think about using electronic methods of help?

Investigation of Help-Seeking Methods for psychological distress and despair, and mental health issues using electronic forms of communication

What's in it for you?

- Get your voice heard on this topic
- Help influence the way people can get help when in need
- Share in group discussion
- Snacks and drinks
- Much gratitude for your opinions

What I need from you and your group:

- Your thoughts on this topic
- Your attendance at a focus group (duration: 45 to 90 minutes)
- Signed consent form

For more information or to volunteer to participate in this research, please contact: Jacquie Myles-Pallister

Tel: [REDACTED]

email: jmylespa@student.ecu.edu.au

Appendix B

Invitation to Participate

HUMAN RESEARCH ETHICS COMMITTEE

For all queries, please contact:
 Research Ethics Officer
 Edith Cowan University
 270 Joondalup Drive
 JOONDALUP WA 6027
 Phone: 6304 2170
 Fax: 6304 2661
 Email: research.ethics@ecu.edu.au



Invitation to Participate

Hello. I am inviting you to participate in a research project about using electronic forms of communication for seeking help (E-HELP). My name is Jacquie Myles-Pallister and I am currently completing my Honours in Psychology at Edith Cowan University. This research project is being undertaken as part of the requirements of my psychology degree. My research supervisor is Craig Harms, Faculty of Computing, Health and Science (School of Psychology and Social Sciences).

I thank you for your interest in this study - E-Help: Community Perspectives on Help-Seeking Using Electronic Forms of Communication. This project aims to find out what people think about getting help on the internet when they are feeling distressed.

I have been distributing leaflets about this project to groups around Perth, inviting people to participate. If you and the members of your group agree to participate, can you please contact Jacquie (details below). The focus groups are planned to take place at your usual group meeting venue; if that does not suit you, then another venue can be located. The focus group will take between 45 and 90 minutes; if you also agree, the focus groups will be audio recorded. Also, light refreshments will be served. The informed consent forms will be held separately to any data.

Since you will either already know the group participants or you will become known in the group during the process of the focus group, group participants will be asked to keep the information shared in the discussion confidential. If at any time during the discussion you would like to withdraw or be silent, that is quite acceptable. Should you become distressed in any way by your participation, you will be able to make contact with one of the services listed on the attached sheet.

Your views will be invaluable to help design services for people with mental health needs who currently do not use or drop-out of using mental health services. If you would like to participate, please inform your group co-ordinator and have them contact Jacquie directly on [REDACTED] jmylespa@student.ecu.edu.au. I will need you and the members of your group who agree to participate to fill in one of the attached informed consent forms. If you have any further queries about the project and how to get involved, do not hesitate to contact me or my supervisor Craig Harms: ph. 6304 5719 or c.harms@ecu.edu.au.

Information collected from the focus groups will be de-identified, that is your name will not be connected to any comments made in the group. This de-identified information will be analysed for themes and used to produce a research thesis and potentially an article for publication. Only the project team will have access to the project materials.

If you have any concerns or complaints about the research project and wish to talk to an independent person, you may contact: Dr Justine Dandy, Edith Cowan University, 270 Joondalup Drive, Joondalup WA 6027. Ph. 6304 5105, j.dandy@ecu.edu.au.

Thank you for your interest in this project.

Jacquie Myles-Pallister (ph. [REDACTED], jmylespa@student.ecu.edu.au).

Appendix C

Consent Form

HUMAN RESEARCH ETHICS COMMITTEE

For all queries, please contact:
 Research Ethics Officer
 Edith Cowan University
 270 Joondalup Drive
 JOONDALUP WA 6027
 Phone: 6304 2170
 Fax: 6304 2661
 Email: research.ethics@ecu.edu.au



Informed Consent

Title of the project

e-Help: Community Perspectives on Help-Seeking Using Electronic Forms of Communication

Researchers and Contact details

The researcher is Jacquie Myles-Pallister, ph. [REDACTED] or jmylespa@student.ecu.edu.au.
 My research project supervisor is Craig Harms, ph 6304 5719 or c.harms@ecu.edu.au – Faculty of Computing, Health and Science (School of Psychology and Social Science).

I agree that I have been given a copy of the Invitation to Participate, explaining the research project. I have read and understood the information provided and I have been given an opportunity to ask questions and have had my questions answered to my satisfaction. I am aware that if I have additional questions then I may contact the research team.

I understand the participation in the project will require me to participate in a focus group with others, for between 45 and 90 minutes. I am aware that a confidential note taker will be present.

I understand that what happens in the focus group is to be kept confidential and that my identity will not be disclosed in any documentation related to the project group or any audio recording. I understand that the data collected from this focus group will only be used for the purposes of this research project. I further understand that the project will result in a thesis and publication and that I can withdraw at any time, either by leaving the group or by remaining silent. I may withdraw without penalty of any kind.

PARTICIPANT CONSENT:

I consent to my participation in a focus group YES ☐ NO ☐
 I also consent to the focus group being audio recorded YES ☐ NO ☐

Name: _____

Address: _____

Year of Birth: _____ Signature: _____

PARENTAL CONSENT:

I consent to my child participating in a focus group YES ☐ NO ☐
 I consent to my child being audio recorded YES ☐ NO ☐

Name: _____

Address: _____

Year of Birth: _____ Signature: _____

Appendix D
Focus Group Discussion Guide

Q1. What kinds of electronic communication do you use?

(prompts: landline phone, mobile phone, internet)

Q2. What sorts of things do you use electronic communication for?

(probe: What do you think about using it to access health information?)

(probe: How about for accessing mental health information?)

Q3. How do you feel about using electronic methods for communicating?

(probe: How do you feel about communicating using say your phones or the internet?)

(Probe: What do you like about it?

What don't you like about it?)

(Prompt: How do you feel about communicating electronically compared to talking to someone in person?)

Q4. What kinds of words or phrases come to mind when you hear the word 'distress'?

(prompts: What words would you use to describe feeling 'distressed')

(prompt: When you hear the words 'mental health' – what do you think of?)

When you hear the words 'mental illness' – what kinds of words or phrases come to mind?)

(Probe: what sorts of things do people do to deal with feeling distressed?)

(Prompt: How would you know if you or someone else needed help?)

Q5. If you or someone else you knew were feeling that way, (or substitute the words they've told me to describe being distressed), what do you think are the options for seeking help?

(Prompt: What do you think about getting help electronically?)

(Probe: Do you know of any electronic help methods that are available?

For example on the internet? Any sites? How about using the phone?)

Q6. What do you think is involved in somebody deciding whether or not to seek help using say their phone, internet or ...?

(probe: What do you think would prompt you to use it?

What do you think would stop you from using it?)

(prompt: What do you think about electronic forms of help if you could see the person? E.g., skype or video conferencing)

Q7. Let's imagine that sometime in the future IF you were to become distressed and needed to seek help, what would make electronic ways of receiving help an option for you? What would need to happen for you to want to use it?

Appendix E
Demographic and Evaluative Questionnaire

*** Note: please to not write your name on this form.**

Age: _____

Sex: (please circle) MALE / FEMALE

Q1. Do you have a landline phone at home? Please circle YES / NO

If yes, On average, how often do you use your phone? (Please tick the box)

- ☐ less than every 7 days
- ☐ less than every 2 days
- ☐ once a day
- ☐ twice a day
- ☐ up to five times a day
- ☐ 10 or more times a day

Q2. Do you own a mobile phone? Please circle YES / NO

If yes, How often do you use your mobile phone? (Please tick the box)

- ☐ less than every 7 days
- ☐ less than every 2 days
- ☐ once a day
- ☐ twice a day
- ☐ up to five times a day
- ☐ 10 or more times a day

Q3. Do you have access to the internet? Please circle YES / NO

(If yes, please circle - you can circle more than one option):

AT HOME / AT WORK / OTHER (please specify)

How frequently do you use the internet? usage in hours.

- ☐ less than 30 minutes per day
- ☐ 30 minutes - 1 hour per day
- ☐ 1 to 5 hours per day
- ☐ 5 to 10 hours per day
- ☐ over 10 hours per day

Q4. What do you use the internet for? *(If you need more room, please use the back of this page)*

Q5. Do you have any **additional thoughts** about the discussion that you did not want to share with the group? *If yes, please specify*

(If you need more room, please use the back of this page)

Q 6. How comfortable did you feel talking about the topics in this group discussion?

Please circle the appropriate option below:

1	2	3	4	5	6	7
extremely uncomfortable	very uncomfortable	slightly uncomfortable		slightly comfortable	very comfortable	extremely comfortable

Q 4. Are there any additional comments or feedback you would like to give on your experience of participating in the focus group discussion?

Thank you for your valuable time, effort and cooperation. Your participation and your views are important to us and have been greatly appreciated.

Appendix F List of Counselling Services

The following list of services is a copy of recommended services made by the Government of Western Australia, Department of Health

(source: http://www.health.wa.gov.au/mentalhealth/getting_help/gh_emergency.cfm)

Emergency services and help lines

For immediate assistance – ALL HOURS contact

- Call ambulance / police / fire on 000

For confidential mental health emergency assessment, support and referral services:

- Mental Health Emergency Response Line
Metro callers Phone 1300 555 788
Peel callers Freecall 1800 676 822

If you require urgent medical care, you can also visit your nearest public hospital Emergency Department.

Business hours

See your GP or attend your nearest GP after-hours clinic.

Contact your local mental health service, listed in the White Pages, or phone HealthInfo on 1300 135 030 to find your nearest health service.

Help lines (external links)

Lifeline

Phone 13 11 14

Men's Line Australia

Phone 1300 78 99 78

Kids Help Line

Counselling and support provided for young people (to 24 years old) who are feeling depressed, sad, or lonely – or just need someone to talk to

Phone 1800 55 18 00

The Samaritans

Careline Phone 9381 5555

Country callers Freecall 1800 198 313

Youthline Phone 9388 2500

Mental health online

Mental health education, support and treatment delivered via the internet have been found to be effective in reducing symptoms of depression. The internet offers anonymity for people who, due to the stigma often associated with mental illness, may feel uncomfortable seeking help. It also gives people living in rural and remote areas access to mental health information and help.

Please note that the information given in this handout or located anywhere on these sites is not intended as a substitute for professional advice. You should see a qualified health provider if you have any concerns.

General

beyondblue (www.beyondblue.org.au) is Australia's national organisation devoted to increasing awareness and understanding of depression in the community. Contains resources (including people's personal experiences) and information on depression and anxiety.

Black Dog Institute (www.blackdoginstitute.org.au) is an educational, research, clinical and community-oriented website dedicated to improve the understanding and diagnosis and treatment of mood disorders.

BlueBoard (<http://blueboard.anu.edu.au/>) is an online discussion forum for people suffering from depression and anxiety disorders, their friends and carers.

depressioNet (www.depressionet.com.au) offers peer support as well as comprehensive information and resources focused on all aspects of depression. The message board and chat functions allow people living with depression to share experiences and give and receive support and encouragement.

HealthInsite (www.healthinsite.gov.au) provides quality information on a wide range of health topics, including mental health.

InfraPsych Australia (www.infrapsych.com) offers online support to people with a mental illness, their carers and health professionals.

Lifeline Australia (www.lifeline.org.au/find_help/info_service/toolkits) has a number of self-help tool kits designed by mental health professionals that offer information and advice on a range of mental health and help seeking topics.

Moodgym (www.moodgym.anu.edu.au) is an online behaviour therapy tool designed to prevent depression.

Children and young people

headspace (www.headspace.org.au) is Australia's national youth mental health foundation for young people aged 12–25. The website contains information on mental health and drug and alcohol issues, getting help, what to expect, personal stories and MySpace and Facebook pages.

Kids Help Line (www.kidshelp.com.au) offers information and support for young people aged between 5 and 18 years as well as online counselling.

Itsallright (www.itsallright.org) contains diaries of four fictional teenagers touched by mental illness. There are fact sheets on mental illness including schizophrenia, bipolar disorder, depression and anxiety disorders.

Reach Out! (www.reachout.com.au) is specially designed for young people, aimed at improving their mental health. It provides support, information and referrals.

YBblue (www.youthbeyondblue.com) is beyondblue's website to help young people aged 18–25 years deal with depression.

Appendix G
Participants' Electronic Communication Access and Usage

	Focus Group 1	Focus Group 2	Focus Group 3
<i>Landline phone</i>	5/5 (100%)	7/7 (100%)	2/5 (40%)
No phone	-	-	3/5 (60%)
≤ once day	1/5 (20%)	6/7 (86%)	2/2 (100%)
Twice/day	3/5 (60%)	-	-
≤ 5 times/ day	1/5 (20%)	1/7 (14%)	-
<i>Mobile phone</i>	5/5 (100%)	6/7 (86%)	4/5 (80%)
No mobile	-	1/7 (14%)	1/5 (20%)
≤ once/ day	3/5 (60%)	3/6 (50%)	-
Twice/day	-	1/6 (17%)	-
≤ 5 times/ day	2/5 (40%)	2/6 (33%)	1/3 (33%)
≥ 10 times/ day	-	-	2/3 (67%)
<i>Internet access</i>	5/5 (100%)	7/7 (100%)	3/5 (60%)
No access	-	-	2/5 (40%)
Home	5/5 (100%)	6/7 (86%)	3/3 (100%)
Work	3/5 (60%)	4/7 (57%)	1/3 (33%)
Other	-	2/7 (29%)	-
≤ 1 hr/day	4/5 (80%)	5/7 (71%)	2/3 (67%)
1-5 hrs/day	1/5 (20%)	2/7 (29%)	1/3 (33%)