



RESEARCH ARTICLE

Youth Perspectives on Seeking Psychotherapy: A Concurrent Mixed Methods Study

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Abstract

Objective: Psychotherapy is the recommended first line of treatment for depression among youth; however, few youth seek professional support. This study compares barriers and facilitators to seeking psychotherapy among both youth who have and have not seen a psychotherapist. The study further explores reasons youth discontinue psychotherapy.

Methods: A concurrent mixed methods study design was used. Eligible participants completed a survey (N=104) and a subset of participants completed a semi-structured interview (N=60). The survey and interview data were analyzed concurrently using a triangulation design. **Results:** Surveys were conducted among youth who had experienced psychotherapy (N=53) and youth who had not (N=51). The majority of participants were female. Common reasons for not seeking psychotherapy included wanting to handle their problems on their own (87.6%), thinking their problems would improve on its own (87.6%), and not knowing who to see (74.3%). Several barriers were common across the two groups, including stigma, concerns about the therapeutic relationship, and a preference for self-management. Common facilitators included improving coping skills and addressing functional impairment. There was some overlap between the barriers to seeking psychotherapy and the reasons for discontinuing, although aging out of youth-oriented service also constituted a termination factor. **Conclusions:** As this study highlights the multiple factors that influence youth's psychotherapy-seeking behavior, a widespread, multi-level approach is needed to address barriers and facilitators at the individual level, but also at the community, policy, and organizational levels. Strategies such as increasing service availability and quality are needed to increase service seeking and improve retention.

Key words: youth, mental health, depression, psychotherapy, health services accessibility

Résumé

Objectif: La psychothérapie est le traitement de première intention recommandé pour la dépression chez les jeunes, toutefois, peu de jeunes recherchent un soutien professionnel. La présente étude compare ce qui fait obstacle et ce qui facilite la recherche de psychothérapie chez les jeunes qui ont vu ou pas un psychothérapeute. L'étude explore en outre les raisons pour lesquelles les jeunes cessent la psychothérapie. **Méthodes:** Une étude concomitante à méthodes mixtes a

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été utilisée. Les participants admissibles ont rempli un sondage (N = 104) et un sous-ensemble de participants a répondu à une entrevue semi-structurée (N = 60). Les données du sondage et de l'entrevue ont été analysées simultanément à l'aide d'une méthode de triangulation. **Résultats:** Les sondages ont été menés auprès des jeunes qui avaient l'expérience de la psychothérapie (N = 53) et des jeunes qui ne l'avaient pas (N = 51). La majorité des participants était de sexe féminin. Les raisons communes de ne pas rechercher la psychothérapie étaient notamment vouloir régler leurs problèmes par eux-mêmes (87,6 %), croire que leurs problèmes allaient se régler d'eux-mêmes (87,6 %), et ne pas savoir qui consulter (74,3 %). Plusieurs obstacles étaient partagés par les deux groupes, dont les stigmates, des préoccupations quant à la relation thérapeutique, et une préférence pour la gestion autonome. Ce qui facilitait communément était notamment améliorer les compétences d'adaptation et remédier à la déficience fonctionnelle. Il y avait un chevauchement entre les obstacles à la recherche de psychothérapie et les raisons d'y mettre fin bien que le fait de vieillir hors de la zone des services pour les jeunes constitue un facteur d'abandon. **Conclusions:** Comme cette étude mentionne les multiples facteurs qui influencent la recherche de thérapie chez les jeunes, il faut une approche étendue multi-niveaux pour aborder obstacles et facilitateurs au niveau individuel, mais aussi à l'échelle communautaire, politique et organisationnelle. Des stratégies comme accroître la disponibilité et la qualité des services sont nécessaires pour hausser la recherche des services et améliorer le maintien en place.

Mots clés: *jeunes, santé mentale, dépression, psychothérapie, accessibilité des services de santé*

Introduction

Worldwide, the burden associated with depression is highest among youth between ages 20 and 24 (Whitford et al., 2013). In Canada, 7.1% of youth aged 15 to 24 years reported past-year depression in 2012 (Findlay, 2017)—higher than any other age group in Canada (Statistics Canada, n.d.). Adolescent depression can predict mental health and substance use (MHSU) disorders during early adulthood (Aalto-Setälä, Marttunen, Tuulio-Henriksson, Poikolainen, & Lönnqvist, 2002; Thapar, Collishaw, Pine, & Thapar, 2012). It can lead to early school dropout (Fletcher, 2010), negative effects on interpersonal relationships (Hammen, Brennan, & Le Brocq, 2011), and worsened physical health (Hasler et al., 2005). Adolescent depression is associated with increased healthcare service utilization and poorer work functioning in adulthood, both of which can worsen quality of life and increase costs to the health care system (Keenan-Miller, Hammen, & Brennan, 2007). Thus, early interventions for depression among youth are critical (Kieling et al., 2011; McGorry, Purcell, Goldstone, & Amminger, 2011).

According to high quality clinical practice guidelines (National Collaborating Centre for Mental Health, 2005), the first line of recommended treatment for youth depression is psychotherapy. Evidence-based psychotherapies include cognitive behavioral therapy, interpersonal psychotherapy, and family therapy (Hopkins, Crosland, Elliott, & Bewley, 2015; MacQueen et al., 2016). In Ontario, cognitive behavioral therapy, family therapy, social skills training, and solution-focused brief therapy are among the common forms of psychotherapy available to youth (Watson, Mehra, Hawke,

& Henderson, 2019). Despite guidelines and the availability of depression-specific treatments in service settings, only 53–56% of youth with past-year depression access professional supports in general (Cheung & Dewa, 2007).

Some barriers to service seeking among youth have already been identified. Common infrastructure barriers include high service costs, difficulty scheduling appointments at preferred times, and transportation difficulties (Gulliver, Griffiths, & Christensen, 2010; Sylwestrzak, Overholt, Ristau, & Coker, 2015). Both qualitative and quantitative studies have identified barriers such as stigma (Gulliver et al., 2010; Nearchou et al., 2018), concerns around the therapeutic relationship (Gulliver et al., 2010; Rickwood, Deane, & Wilson, 2007; Sylwestrzak et al., 2015), and a preference for managing their issues independently (Sylwestrzak et al., 2015). A lack of available, high quality, evidenced-based services is also a barrier (Watson et al., 2019).

Facilitators to service seeking among youth have been less studied (Mitchell, McMillan, & Hagan, 2017). A quantitative study identified facilitators, including the need for support in dealing with emotions and stress, and the need for sustainable solutions to undesirable behaviors (Sylwestrzak et al., 2015). A review found that youth are also more likely to seek services when they are encouraged by others, and when services are available (Rickwood et al., 2007). In addition, a systematic review of both qualitative and quantitative studies found that youth are more inclined to seek psychotherapy when they already have positive attitudes and experiences with services (Gulliver et al., 2010).

However, many youth discontinue services early—sometimes immediately after intake (Gonzalez, Weersing, Warnick, Scahill, & Woolston, 2011; Miller, Southam-Gerow, & Allin, 2008; National Collaborating Centre for Mental Health, 2005). Youth may terminate psychotherapy due to a desire to self-manage their mental health, a belief that their mental health issues will improve, or after experiencing mental health improvements (Sylwestrzak et al., 2015). Some of the barriers to seeking psychotherapy, such as stigma and access, may also contribute to service discontinuation (Sylwestrzak et al., 2015).

Given the possible overlap and interaction between facilitators and barriers to seeking, continuing, discontinuing, and restarting psychotherapy, it is important to closely examine these factors to better understand overlapping issues with access to services and service engagement. Although studies have explored barriers and facilitators to seeking psychotherapy, there have been calls to compare these factors between help seekers and non-help-seekers (Mitchell et al., 2017). Researchers have also highlighted the need to further understand barriers and facilitators among youth who do not access services (Mariu, Merry, Robinson, & Watson, 2012). Furthermore, there have been calls to use qualitative approaches to better understand subjective experiences (Bates, 2010; Coll & Chapman, 2000). Thus, this concurrent mixed methods study aims to understand the barriers and facilitators to seeking psychotherapy among youth who have experienced versus have not experienced psychotherapy.

Methods

2.0 Objective

What are the barriers and facilitators to seeking psychotherapy among youth who have experienced versus have not experienced psychotherapy and how do the experiences differ between groups?

2.1 Design

A concurrent mixed methods study was conducted. A concurrent triangulation design was employed; the timing of both qualitative and quantitative methods occurred simultaneously, with equal weight (Ivankova & Kawamura, 2010)). The convergence model of the triangulation design was used; here, both sources of data were combined to analyze the research question and the quantitative and qualitative data were merged during the interpretation stage to compare and contrast the findings (Creswell, 2005).

2.2 Participants

Purposive sampling was conducted among youth (aged 16–22 years) from a previous longitudinal study—the Research and Action for Teens study (RAFT)—who had consented to be contacted for future research (Henderson et al., 2019). The RAFT study is described in Henderson et al. (2019). Potential participants were selected based on the presence of internalizing mental health concerns on the Global Appraisal of Individual Needs – Short Screener (GAIN-SS) (Dennis, Chan, & Funk, 2006) or Centre for Epidemiologic Diseases Depression Scale–12 (CESD-12) (Poulin, Hand, & Boudreau, 2005). To be invited, potential participants had to have previously met either the moderate likelihood screening criteria for an internalizing disorder on the GAIN-SS (i.e., 1+) or the 12+ threshold for somewhat elevated depressive symptoms on the CESD-12 (Dennis et al., 2006; Poulin et al., 2005). These youth were invited to participate in an online survey (30–45 minutes), followed by a phone interview (60 minutes).

Of 233 invited youth, 104 youth completed the survey. Among them, 53 youth had experienced psychotherapy and 51 youth had not (i.e., 53 youth endorsed having received counselling or psychotherapy at some point in their lives, while 51 reported that they had never received such services). Of the youth who had not experienced psychotherapy, 26 of them had considered it. For the semi-structured interviews, 60 youth from the survey sample were interviewed; 33 had experienced psychotherapy and 27 had not. Youth received \$30 and \$50 gift cards for the survey and interview, respectively. Informed consent was obtained for both components. Ethics approval was obtained from the Centre for Addiction and Mental Health Research Ethics Board.

2.3 Measures

The survey, hosted on a secure website using REDcap software (Harris et al., 2009), included a demographic questionnaire and the following scales:

MHSU scales. The GAIN-SS, validated among youth, assesses internalizing, externalizing, and substance use disorders, as well as crime and violence concerns (Dennis et al., 2006). It contains 20 items endorsed on a 0–3 scale (never [0] to past month [3]). Three or more items experienced in the past year signal a high probability of meeting diagnostic criteria in that domain. In the current study, Cronbach's alpha are .67 for internalizing, .63 for externalizing, .80 for substance use disorders, and .58 for crime and violence concerns (the latter having low variability in the current sample). The CESD–12, validated to assess depression among youth (Poulin et al., 2005), has twelve items with a 0–3 scale (never [0] to always [3]). A total score of 0–11

suggests minimal depression-related symptomatology, 12-20 suggests somewhat elevated, and 21-36 suggests very elevated symptomatology (Poulin et al., 2005); the current Cronbach's alpha is .83. From the validated Difficulties in Emotion Regulation Scale (DERS) (Neumann, van Lier, Gratz, & Koot, 2010; Perez, Venta, Garnaat, & Sharp, 2012), the Strategies subscale was administered to understand emotional regulation strategies (1-5 Likert scale, almost never (1) to almost always (5); current Cronbach's alpha = .81).

Psychotherapy-related questionnaires. A list of reasons for seeking, not seeking, and discontinuing psychotherapy was drawn, with permission, from Sylwestrzak et al. (2015). Reasons for seeking psychotherapy were asked of participants who had experienced or considered psychotherapy. All participants were asked reasons for not seeking psychotherapy. Reasons for discontinuing were asked of those who had discontinued. A service utilization questionnaire from the RAFT study (Henderson et al., 2019) was used to understand the past use of professional and informal supports for emotional issues.

2.4 Data Collection

For the quantitative component, youth received an email with a link to complete the survey. For the qualitative component, phone interviews were conducted using a semi-structured interview guide developed based on the literature, with feedback from the Youth Advisory Group (YAG) at the Centre for Addiction and Mental Health. The guide included open-ended questions about accessing psychotherapy, expectations about psychotherapy, and reasons for accessing and hesitating to access psychotherapy. Participants who had experienced psychotherapy were asked about their experiences and reasons for discontinuing. Interviews were audio-recorded and transcribed.

2.5 Data Analysis

Qualitative analyses. Interviews were thematically analyzed based on the Braun and Clarke (2006) framework. This framework includes six phases in order to identify patterns in the data, such as being familiarized with the data, generating initial codes, searching and reviewing themes, and defining themes (Braun & Clarke, 2006). Themes were identified at the semantic level, where the explicit meanings of the data were analyzed. Transcriptions were read repeatedly by two team members, who then independently coded 5 transcriptions of youth who had experienced psychotherapy and 5 of those who had not; the team members then discussed the coding to reach a consensus. The remaining 50 transcriptions were then coded NVivo 11 was used (Edhlund & McDougall, 2016).

The thematic analysis focused on barriers, facilitators, and reasons for discontinuing psychotherapy. In a mixed-methods context, the analytical process included a deductive approach leveraging the quantitative findings and an inductive approach seeking to identify new themes. Coding was completed separately for the two groups (experienced vs. did not experience psychotherapy) at the semantic level to reflect the explicit content of the data, and the themes were developed through multiple discussions. Quotes were extracted and themes refined. Themes were then confirmed by returning to the original transcripts to read the context of the youth's response and ensure that they were representative.

Quantitative analyses. The grouping variable was a dichotomous indicator of whether participants had ever experienced psychotherapy or not. Demographic characteristics and GAIN-SS scores were compared using chi-square tests. For continuous CESD-12 and DERS scores, *t*-tests were conducted. Answers were required for all survey questions, with a "prefer not to answer" option, minimizing missing data. "Prefer not to answer" was only endorsed 0.4% of the time and did not in any case influence whether the participant met clinical cut-off scores. SPSS 24.0 (IBM Corp, 2016) was used. Based on the relevant data for various subgroups, quantitative results are provided for the full sample, as well as on an exploratory basis for sample subgroups: those who had experienced psychotherapy, those who had not, and those who had considered.

Results

The majority of survey participants were non-racialized and female. The mean age was 19.22 years ($SD = 1.39$). Youth who were non-racialized, female, and had one or more caregivers born in Canada were significantly more likely to have experienced psychotherapy (Table 1).

Participants who had experienced psychotherapy did not significantly differ in psychopathology compared to participants who did not (Table 2). Thirty-five (33.3%) participants had minimal depressive symptomatology, 51 (48.6%) had somewhat elevated symptomatology, and 19 (18.1%) had very elevated symptomatology; depression did not differ based on whether they had experienced psychotherapy, $\chi^2(2) = 2.56, p = .28$. GAIN-SS sub-screeners and emotional coping skills did not significantly differ across groups (see Table 2).

Themes and subthemes are described below. Tables 3, 4, and 5 include the quantitative analysis that reflect their respective themes. Themes are presented as the following: a) barriers to seeking psychotherapy (Table 3); b) facilitators to seeking psychotherapy (Table 4); and c) reasons for discontinuing psychotherapy.

Table 1. Demographic descriptive comparisons between youth who had experienced psychotherapy and those who had not

Demographic variable	Total	Had not experienced N = 51	Had experienced N = 53	t/ χ^2 (p)	Cohen's d ^a
Age (years) - Mean (SD)	19.22 (1.40)	19.31 (1.38)	19.13 (1.43)	0.66 (.51)	-0.13
Gender - n (%)				4.46 (.04)	-0.56
Boy/young man	29 (27.9)	19 (38.8)	10 (19.6)		
Girl/young woman	71 (68.3)	30 (61.2)	41 (80.4)		
Transgender or gender expansive ^b	4 (4.0)	1	1		
Ethnicity - n (%)				4.86 (.03)	-0.55
Non-racialized	68 (65.4)	28 (54.9)	40 (75.5)		
Racialized	36 (24.6)	23 (45.1)	13 (24.5)		
Currently in school - n (%)				0.04 (.84)	0.06
Yes	89 (85.6)	44 (86.3)	45 (84.9)		
No	15 (14.4)	7 (13.7)	8 (15.1)		
Currently employed - n (%)				1.11 (.29)	0.25
Yes	64 (61.5)	34 (66.7)	30 (56.6)		
No	40 (38.5)	17 (33.3)	23 (43.4)		
Lived in Canada all of their lives - n (%)				— ^c	-0.84
Yes	94 (90.4)	43 (84.3)	51 (96.2)		
No	10 (9.6)	8 (15.7)	2 (3.8)		
Caregiver(s) born in Canada - n (%)				7.66 (.01)	-0.68
Yes	63 (60.6)	24 (47.1)	39 (73.6)		
No	41 (39.4)	27 (52.9)	14 (26.4)		
Living with family - n (%)				0.68 (.41)	0.23
Yes	80 (76.9)	41 (80.4)	39 (73.6)		
No	24 (23.1)	10 (19.6)	14 (26.4)		

^aNegative Cohen's d indicates youth who had not experienced therapy had more characteristics that were problematic (e.g., not in school) or uncommon.
^b χ^2 analysis conducted only on boy/young man and girl/youngwoman cells due to small sample size.
^c χ^2 value not calculated because of low expected cell count in two cells.

3.1 Barriers to seeking psychotherapy

Access barriers. Attending school, pursuing work, and pursuing volunteer activities were reported as barriers to seeking psychotherapy by youth. Other barriers included scheduling appointments during their availability and transportation. One youth emphasized traveling as a barrier: "I guess the time commitment, just the travel and stuff. Plus trying to find a time that works when the clinic was open, was a bother." (P1, Experienced psychotherapy). Consistent with this finding, 64.8% of youth found the inconvenience and time-consuming aspect of psychotherapy a reason for not seeking it. Several youth also stressed that the cost of psychotherapy was a barrier. For instance, one youth stated: "Because I don't have money to pay a counsellor for their

work." (P2, Had not experienced psychotherapy). In agreement, 60.0% of youth were concerned about cost.

Youth mentioned that both the lack of awareness around service availability and the limited amount of services available were barriers to service use. Reflecting these results in the survey, youth reported not knowing who to see for treatment and were concerned about costs. Moreover, the majority of youth endorsed that psychotherapy was inconvenient and time consuming. Among youth in both groups, 87.6% also reported not knowing who to see for psychotherapy.

Stigma. Youth reported experiences of self and social stigma. They were concerned about receiving a mental illness label, being treated differently, and being judged by the

Table 2. Comparisons of psychopathology between youth who had experienced psychotherapy and those who had not

Measure	Had not experienced N = 51	Had experienced N = 53	t- χ^2 (p)	Cohen's d ^b
CESD-12 ^c total, Mean (SD)	13.82 (6.52)	15.04 (6.07)	-0.98 (.33)	0.19
GAIN-SSd, n (%)				
Internalizing	32 (62.7)	41 (77.4)	2.65 (.10)	0.42
Externalizing	28 (54.9)	27 (50.9)	0.16 (.69)	-0.09
Substance use	8 (15.7)	8 (15.1)	0.01 (.93)	-0.03
Crime/violence	1 (2.0)	2 (3.8)	— ^a	0.30
DERS total, Mean (SD)	21.06 (7.45)	22.34 (7.40)	-0.88 (.38)	-0.17

^aChi-square value not calculated because of low expected cell count in two cells.
^bNegative Cohen's d means youth who did not experience therapy scored in the more problematic direction.
^cThe CESD-12 is the 12-Item Center for Epidemiologic Studies Depression Scale.
^dThe GAIN-SS is the Global Appraisal of Individual Needs—Short Screener.

therapist: “I didn’t want anyone to think that I was crazy or mentally unstable.” (P3, Experienced psychotherapy). Youth also described their perception of feeling weak: “That people would think that going to therapy may be considered, like, weak?” (P4, Had not experienced psychotherapy). Mirroring these sentiments, nearly two-thirds of participants (63.8%) from both groups reported fearing what others would think.

Self-management and informal support. Almost all youth interviewed—regardless of group—expressed trying to manage the issue by themselves. Youth described self-help techniques like journaling, exercising, taking breaks, and talking to friends or family:

“I tried (...) self-help methods, coping mechanisms, talking to friends and family, self-care days.” (P5, Experienced psychotherapy).

One of the most common survey reasons for not seeking psychotherapy was preferring self-management (Table 3). The most commonly used informal support for both groups were friends, followed by family members (Table 5):

“I usually rely mostly on my friends and my family for advice.” (P2, Had not experienced psychotherapy). Reflecting this, 87.6% of youth reported wanting to handle their problem on their own.

Disclosure hesitancy. The challenges of interacting with a therapist about personal and service issues was a predominant theme. Several participants experienced difficulty opening up to another person about sensitive mental health or substance use issues: “I feel like opening up in general to another person, like completely, would be something that

I would find pretty difficult.” (P7, Had not experienced psychotherapy). Youth expressed feelings of vulnerability in speaking about personal issues along with a lack of skills to do so. “I think it’s also because there’s like at big thing of vulnerability, like just telling someone like your deepest darkest stuff is kind of a daunting...” (P6, Experienced psychotherapy).

Lack of relationship with therapist. Youth value having a relationship with a therapist, but also feared not being able to have one. They expressed concerns about trusting and forming a connection with the therapist. They were concerned whether the therapist would be confidential, non-judgmental, and understanding. One youth expressed fears around not having a personable interaction:

“I was really worried that they’d just kind of be like a robot as opposed to an actual person. You know, when someone gets like doing a job and they only really focus on the job and not who they’re doing the job for.” (P6, Experienced psychotherapy)

Many youth mentioned anxiety about meeting a therapist for the first time and worried they would not feel comfortable enough to communicate with the therapist. “If I didn’t think I would be able to really have a relationship with my therapist when I needed it, then I don’t think that would be something I would seek (...).” (P8, Had not experienced psychotherapy).

Readiness for psychotherapy. Even with equivalent psychopathology scores (as shown in Table 2), youth who had not experienced psychotherapy expressed feeling that their issues were not serious enough to need psychotherapy. “The

Table 3. Reasons for not seeking treatment among youth who had experienced psychotherapy and those who had not (frequency, percent)

	Full Sample N = 104	Had not experienced N = 51	Had experienced N= 53		
Reasons for not seeking ^a	n (%)	n (%)	n (%)	χ^2	p
Wanted to handle problem on my own	92 (87.6)	44 (86.3)	47 (88.7)	0.18	0.71
Thought problem would improve on its own	92 (87.6)	45 (88.2)	46 (88.5)	0.001	0.97
Did not know who to see	78 (74.3)	39 (76.5)	38 (73.1)	0.16	0.7
Problem did not bother me much at first	77 (73.3)	38 (74.5)	38 (73.1)	0.03	0.87
Inconvenient/time-consuming	68 (64.8)	33 (64.7)	34 (65.4)	0.01	0.94
Feared what people would think	67 (63.8)	33 (64.7)	33 (63.5)	0.02	0.9
Did not think treatment would work	64 (61.0)	24 (49.0)	39 (73.6)	6.53	0.01
Concerned about cost	63 (60.0)	30 (58.8)	33 (62.3)	0.13	0.72
Transportation/schedule difficulties	46 (43.8)	22 (44.0)	24 (45.3)	0.02	0.9
Health insurance would not cover treatment	32 (30.5)	13 (26.5)	19 (38.0)	1.49	0.22
Prior treatment did not work ^b	30 (28.6)	3 (5.9)	27 (51.9)	n/a ^c	
Not satisfied with available services	30 (28.6)	11 (22.4)	19 (36.5)	2.4	0.12
Feared involuntary hospitalization	27 (26.7)	8 (15.7)	19 (35.8)	5.5	0.02
Could not get an appointment	27 (25.7)	8 (16.0)	19 (37.3)	5.82	0.02

^a Items used with permission from Sylwestrzak et al. (2015)

^bTreatment type (i.e., “psychotherapy”) was not specified in the question.

^cChi-square value not calculated because of low expected cell count.

Table 4. Reasons for seeking psychotherapy among youth who had considered psychotherapy but had not experienced it, versus youth who had experienced psychotherapy

	Full sample N = 79	Had considered N = 26	Had experienced N = 53		
Reasons for seeking ^a	n (%)	n (%)	n (%)	χ^2	p
Help with emotions (e.g., sadness, anger)	68 (86.08)	20 (76.9)	48 (90.6)	2.71	0.1
Cope with ongoing stress (e.g., stress at home)	65 (82.28)	20 (76.9)	45 (84.9)	0.76	0.38
Come to terms with your past (e.g., feelings about childhood)	50 (63.29)	17 (65.4)	33 (62.3)	0.07	0.79
Cope with recent stressful events (e.g., divorce of parents)	49 (62.03)	16 (61.5)	33 (63.5)	0.03	0.87
Deal with general body complaints (e.g., headaches)	38 (48.10)	16 (61.5)	22 (41.5)	2.8	0.09
Help make a life decision (e.g., to quit school)	35 (44.30)	14 (53.8)	21 (39.6)	1.43	0.23
Other reasons	25 (31.65)	8 (33.3)	17 (33.3)	0	1
Control problem behaviors (e.g., drinking problems)	22 (27.85)	9 (34.6)	13 (24.5)	0.88	0.35

^a Items used with permission from Sylwestrzak et al. (2015)

Table 5. Sources of support utilized by youth for emotional concerns, compared between youth who had experienced psychotherapy and those who had not

Source of support	Had not experienced	Had experienced	χ^2	p	Cohen's d ^c
	N = 51	N = 53			
	n (%)	n (%)			
Friends	38 (74.5)	45 (84.9)	1.74	0.19	-0.38
Family	21 (41.2)	40 (75.5)	12.61	<.001	-0.88
School staff ^a	8 (15.7)	13 (24.5)	1.26	0.26	-0.32
Religious leader	1 (2.0)	2 (3.8)	— ^b	-	-0.32
Family doctor	3 (5.9)	27 (50.9)	— ^b	-	-1.62

^aSchool staff does not include school mental health counsellor.
^bChi-square is not reported due to low cell counts.
^cNegative Cohen's d indicates youth who had not experienced psychotherapy scored in the more problematic direction (i.e., reported relatively less support).

problem that I had was not feeling that what I was going through was serious enough to warrant help.” (P9, Had not experienced psychotherapy). Youth who had experienced psychotherapy expressed that accepting they needed help and making the decision to seek it was a very difficult step. Some described undergoing a process of denial to acceptance before seeking professional help:

“Well, for a long time, I was really hard-headed and I was in denial that I need help. (...) But as soon as I had admitted it to myself that I need help, I can't do this on my own, it became a reason to accept help from other people.” (P5, Experienced psychotherapy)

In addition to describing a process of denial, 87.6% of youth thought their problem would improve on its own.

Fear of therapy failure. Youth who had experienced psychotherapy recalled having doubts about whether therapy would be successful before eventually seeking treatment. “Probably, that it wouldn't work or that I wouldn't gain or benefit anything from it.” (P10-Experienced psychotherapy). Some youth worried they would not be able to achieve change through psychotherapy, whereas some feared that talking about their issues would make their situation worse. This concern was much less frequently raised by youth who had not experienced psychotherapy. Reflecting this sentiment, 73.6% of youth who had not experience psychotherapy did not think treatment would work. This was felt only among 49.0% of youth who had experienced psychotherapy—a statistically significant difference between groups.

3.2 Facilitators to seeking psychotherapy

Improve coping skills. Youth from both groups expressed the need to learn skills to cope with stressful situations and to pursue self-improvement, for example: “It would be to learn, like, coping methods, because I don't have any. So, definitely they stand in the way.” (P12, Had not experienced psychotherapy). Another youth reported needing psychotherapy as a form of self-improvement: “Being able to get past things that troubled me... I guess to know in my head that I was being active and trying to better myself.” (P11, Experienced psychotherapy). The majority of youth endorsed several such facilitators, including coping with stress (82.28%) and coping with recent stressors (62.03%).

Improve functioning. Among youth who had experienced psychotherapy, several mentioned seeking psychotherapy once their MHSU issues started affecting their school functioning or interpersonal relationships. For instance:

“It was taking a (...) toll on my performance in school, so that was the primary reason that I went. I wanted to be able to perform at my highest potential at school and that was holding me back.” (P5, Experienced psychotherapy)

A few youth who had not experienced psychotherapy mentioned that if the issue started affecting their lives, they would seek therapy. “I just feel like [if it was] something that was always affecting my life, then I would definitely want to go to counseling.” (P13, Had not experienced psychotherapy). In terms of physical functioning, 48.10% of youth identified dealing with general body complaints as a reason for seeking psychotherapy.

Unsuccessful self-management or informal support. Several youth who had experienced psychotherapy stated that they sought psychotherapy because the self-management techniques they used were not effective.

“After spending a lot of time just, like, trying to deal with it myself and it not working and getting worse, you just become more open to other ways of helping. So, seeing someone else is just like plan B.” (P14, Experienced psychotherapy)

Similarly, youth who had not experienced psychotherapy reported that if self-management techniques failed, they would seek professional help: “I think once you’ve tried to get help from the people that are closest to you, and this problem is still crippling your life and hurting you, then you should go to a counsellor.” (P2, Had not experienced psychotherapy). Youth further identified psychotherapy as a means to control problem behaviors (27.85%) and to help with emotions (86.08%) (Table 4).

Encouragement from others. Only youth who had experienced psychotherapy recalled being encouraged by others to seek therapy. Several youth mentioned that family members, friends, teachers, or doctors acted as catalysts in helping them access services. “Probably my parents, for convincing me to actually go through with it, is why I actually went.” (P15, Experienced psychotherapy). In the survey (Table 5), although both groups of youth reported having sought help from informal sources, a significantly higher proportion of youth who had experienced psychotherapy had sought help from family members.

3.3 Reasons for discontinuing psychotherapy

Access barriers. Several youth who had experienced psychotherapy mentioned that time, cost, scheduling, and transportation difficulties were not only barriers to accessing psychotherapy, but also played a role in discontinuing. One youth expressed time constraints as a reason for discontinuation: “If I had made the effort to schedule more of these sessions with her, it would have taken me from my classroom time. (...) Missing class wasn’t something I did.” (P16, Experienced psychotherapy). Another youth stressed the cost of services: “If I were to keep going, I’d have to pay — her fees were like \$120 or like \$100 per session or something like that.” (P10, Experienced psychotherapy). Some of the most common access barriers associated with discontinuing service included having difficulty scheduling appointments (45.7%) and an excessive time commitment (43.5%).

Aging out of services. Many youth reported accessing services that were directed towards youth only (e.g., up to the age of 18), which contributed to terminating their therapy prematurely. “I was part of the youth program and because I was going off to college in the next year or so, they pretty much told me, ‘Oh, there’s resources on campus. You can go there.’” (P17, Experienced psychotherapy). Some youth noted transitional support services may have been helpful in addressing services discontinuity.

Unsatisfactory experience with psychotherapy. Several youth who had experienced psychotherapy reported being unsatisfied with services. In some cases, youth had not formed a working alliance with the therapist. They did not feel comfortable enough to talk to the therapist or did not receive satisfactory strategies to address their issues: “I just couldn’t relate to her and I didn’t feel comfortable and I couldn’t open up to her, and so I didn’t want to waste my time and her time.” (P3, Experienced psychotherapy). Youth indicated discontinuing because past treatment did not help (41.3%), because they thought treatment would fail (39.1%), and because they were not satisfied with the available services (32.6%).

Satisfied with their treatment. In contrast, some youth mentioned terminating their therapy because they felt better: “I was feeling very at ease, I wasn’t having troubles or anxiety anymore. So I was quite comfortable finishing.” (P18-Experienced psychotherapy). Youth further expressed receiving the help they needed, such as coping skills that they could use whenever a stressful situation arose. They also reported terminating their therapy because they had a better understanding of what they were experiencing and wanted to handle their remaining issues on their own. This is consistent with the survey data, where almost half of youth (47.8%) endorsed discontinuing psychotherapy because the problem went away, and two-thirds (65.2%) discontinued because they wanted to handle the problem on their own.

Discussion

The present study examined barriers and facilitators to seeking psychotherapy among youth with MHSU challenges who seek psychotherapy and those who do not, as well as reasons for discontinuing. While many barriers and facilitators were common across the two groups, the unique findings in this study were the differences between them, including readiness to change, fear of therapy failure and encouragement from others to seek psychotherapy. Consistency between the barriers to seeking psychotherapy and the reasons for discontinuing psychotherapy was also found.

Several barriers to seeking psychotherapy that were similar among youth who had experienced and had not experienced

psychotherapy are consistent with the literature: access, stigma, self-management preference, disclosure hesitancy and concerns about the therapeutic relationship (Del Mauro & Williams, 2013; Gulliver et al., 2010; Nearchou et al., 2018; Rickwood et al., 2007; Rickwood, Deane, Wilson, & Ciarrochi, 2005; Sylwestrzak et al., 2015). The lack of availability of therapists at convenient times was also identified as a barrier in this study. A greater availability of psychotherapy services is needed outside of school hours to address this barrier.

Common facilitators reflected in the literature include the improvement of coping skills and functional impairment (Gould, Munfakh, Lubell, Kleinman, & Parker, 2002; Sylwestrzak et al., 2015). Self-management preference has been found to be a crucial service-seeking barrier in several studies (Del Mauro & Williams, 2013; Rickwood et al., 2007; Sylwestrzak et al., 2015); however, the present study suggests that once self-management ceases to be helpful, youth may access professional support. Given the expressed preference for self-management, it is important to optimize the availability of and access to evidence-based self-help tools for youth, while also raising awareness of the availability of professional services (Wright, McGorry, Harris, Jorm, & Pennell, 2006).

In addition to the similar barriers and facilitators, it is also important to consider factors that differentiate the two groups. Youth who had experienced psychotherapy reported greater readiness to change, which is consistent with the Stages of Change model as youth mentioned progressing from pre-contemplation (not perceiving that they need help) to action (seeking professional help) (Norcross, Krebs, & Prochaska, 2011). Youth who had experienced psychotherapy also reported being encouraged to do so by others, while those who had not sought psychotherapy had not. These disparate factors may be providing the impetus for youth to seek psychotherapy, irrespective of other barriers and facilitators. Prevention and promotion activities to improve awareness of mental health issues—not only among youth, but among those who may encourage them to seek needed services—while fostering readiness to change (Norcross et al., 2011) may stimulate youth service access.

As reflected in previous research, reasons for discontinuing therapy included access barriers, unsatisfactory psychotherapy experiences, and satisfactory outcomes (Sylwestrzak et al., 2015). In addition, youth who age out of youth-oriented services find it difficult to transition to adult services, which may contribute to premature psychotherapy termination (Mandarino, 2014). Strategies to improve transitions to adult services include introducing policies to improve transitions, identifying transitional youth and their

needs, planning, and facilitating the transition (Cleverley, Rowland, Bennett, Jeffs, & Gore, 2018). System optimization to ensure youth have positive psychotherapy experiences—ensuring accessible, developmentally appropriate, integrated, effective services in a youth-friendly manner (Hawke et al., 2019; Henderson et al., 2017; Hetrick et al., 2017)—may affect not only therapy engagement and completion, but also future therapy-seeking behaviors (Gulliver et al., 2010).

There are several study limitations to keep in mind. The surveys were anonymized and unlinked to the interviews due to ethical requirements; this prevented direct participant-level matching of qualitative and quantitative responses. A larger sample that is more diverse and representative from multiple jurisdictions would improve the generalizability of the findings. A concurrent mixed methods study design precludes confirmatory analysis of the result of either quantitative or qualitative data; however, using qualitative interviews concurrently with quantitative surveys enabled both participants and researchers to connect the survey and interview responses (Driscoll, Appiah-Yeboah, Salib, & Rupert, 2007). Lastly, it is possible that by highlighting specific barriers in the quantitative survey, participants may have been primed for discussions around predominantly these barriers in the qualitative component of the study.

Conclusion

Given the high prevalence of depression and MHSU challenges among youth in Canada, the availability of and access to psychotherapy services merits attention. This study found that irrespective of experiencing psychotherapy, access issues, stigma, preference for self-management, therapeutic relationship concerns were barriers to psychotherapy, whereas youth who had experienced psychotherapy reported a fear of therapy failure as a barrier. Among youth who experienced psychotherapy, encouragement from others was a major facilitator. Since multiple factors influence youth's decisions to seek and continue psychotherapy, there is a need for a widespread, multi-level approach to addressing barriers and facilitators. Efforts should include increasing mental health literacy, awareness and service availability and quality, with a goal of increasing service seeking, engagement, and completion.

Conflicts of Interest

The authors have no financial relationships to disclose.

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