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ORIGINAL ARTICLE

Help-negation in suicidal youth living in Switzerland

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

Introduction

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

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

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

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

Methods

Procedure

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

Predictors

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

Outcome

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

Analytical sample

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

Statistical analysis

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

Table 1 Associations between socio-demographic characteristics and suicidality.

	Not suicidal *n* (%)	Low suicidality *n* (%)	Moderate suicidality *n* (%)	High suicidality *n* (%)	*p*-Value
Total sample	4419 (60.2)	1812 (24.7)	771 (10.5)	333 (4.5)	
Language region					
German	2462 (60.8)	1022 (25.2)	404 (10)	161 (4)	0.006
French	1429 (59.8)	550 (23.0)	283 (11.8)	128 (5.4)	
Italian	528 (58.9)	240 (26.8)	84 (9.4)	44 (4.9)	
Gender					
Male	2461 (65.1)	846 (22.4)	336 (8.9)	137 (3.6)	<.001
Female	1958 (55.1)	966 (27.2)	435 (12.2)	196 (5.5)	
Age					
16	552 (59.2)	241 (25.8)	93 (10)	47 (5)	0.235
17	1215 (59.8)	492 (24.2)	214 (10.5)	110 (5.4)	
18	1332 (60.5)	540 (24.5)	245 (11.1)	85 (3.9)	
19	863 (61.2)	355 (25.2)	127 (9)	64 (4.5)	
20	457 (60.1)	184 (24.2)	92 (12.1)	27 (3.6)	
Nationality					
Swiss	3770 (60.7)	1534 (24.7)	628 (10.1)	278 (4.5)	0.048
non-Swiss	649 (57.7)	278 (24.7)	143 (12.7)	55 (4.9)	
Academic track					
High school student	1455 (58.9)	663 (26.8)	266 (10.8)	87 (3.5)	0.001
Apprentice	2964 (60.9)	1149 (23.6)	505 (10.4)	246 (5.1)	

Results

Sample

Of the 7335 participants, 55.2% were from the German-, 32.6% from the French-, and 12.2% from the Italian-speaking regions. Altogether, 51.5% were males and 84.7% had Swiss nationality. The average age was 17.87 years ($SD = 1.17$).

Suicidality by socio-demographic characteristics

Associations between socio-demographic variables and suicidality are presented in Table 1. Language region was associated with suicidality. High suicidality was most common among people from the French- (5.4%), followed by Italian- (4.9%) and German-speaking regions (4%). More males than females were not suicidal (65.1% vs. 55.1%), whereas the reverse pattern was found for low (22.4% vs. 27.2%), moderate (8.9% vs. 12.2%) and high suicidality (3.6% vs. 5.5%). Age was not significantly associated with suicidality. Slightly more non-Swiss participants were moderately (12.7% vs. 10.1%) or highly suicidal (4.9% vs. 4.5%) relative to Swiss participants, whereas the reverse pattern was identified for the category ''not suicidal'' (57.7% vs. 60.7%). Lastly, academic track and suicidality were significantly associated, whereby more apprentices were highly suicidal relative to high school students (5.1% vs. 3.5%).

Not talking about mental health problems

The findings of the logistic regression analyses are shown in Table 2. People with increasing levels of depression and suicidality were more likely to report that they would generally talk with no one about mental health problems. Furthermore, French- (vs. German-speaking), males, Non-Swiss and apprentices (vs. students) were more likely to indicate that they would not talk about mental health problems. The effect sizes of the AORs were small to medium.[28] Age was not significantly associated with this outcome.

Discussion

The present study found positive associations between levels of suicidality and depression and *generally speaking with no one about mental health problems* in 16–20-year olds from Switzerland. This indicates help-negation among those most in need. Similarly, other studies have described help-negation in young people with mental health problems (including suicidality),[10–12,14] as well as in a Swiss sample of people aged 15–75+ years.[23]

The demonstrated help-negation might have been due to the adolescents' need for independence and their preference to rely on themselves.[12,18,29] Labouliere et al.[20] found that adolescents with extreme self-reliance – i.e. those who indicated that they solve problems on their own all the time – showed reduced help-seeking from informal sources traditionally favoured by young people (i.e. friends, parents) and were more likely to meet criteria for clinically-significant levels of depression and suicidal ideation. Among youth who had a heightened risk for suicide at baseline, extreme self-reliance predicted higher levels of suicidal ideation and depressive symptoms two years later, even after adjusting for baseline symptoms. The authors concluded that reducing extreme self-reliance in suicidal

Table 2 Logistic regression models predicting not talking about mental health problems.

Predictor Total: *n* (%)	Would not talk about mental health problems 440 (6)	Crude OR (95%)	AOR (95% CI)
Suicidality			
Not suicidal: *n* (%)	210 (4.8)	1	1
Low suicidality: *n* (%)	101 (5.6)	1.18 (0.93–1.51)	1.11 (0.85–1.44)
Moderate suicidality: *n* (%)	69 (8.9)	1.97 (1.48–2.62)***	1.57 (1.12–2.19)**
High suicidality: *n* (%)	60 (18.0)	4.41 (3.23–6.02)***	2.87 (1.87–4.39)***
Depression: mean (SD)	6.42 (5.53)	1.56 (1.39–1.74)***	1.41 (1.20–1.65)***
Language region			
German: *n* (%)	218 (5.4)	1	1
French: *n* (%)	178 (7.4)	1.41 (1.15–1.74)***	1.26 (1.02–1.56)*
Italian: *n* (%)	44 (4.9)	0.91 (0.65–1.27)	0.77 (0.55–1.09)
Sex			
Male: *n* (%)	323 (8.5)	1	1
Female: *n* (%)	117 (3.3)	0.36 (0.29–0.45)***	0.30 (0.24–0.38)***
Age: mean (SD)	17.85 (1.11)	0.98 (0.91–1.07)	0.96 (0.88–1.05)
Nationality			
Swiss: *n* (%)	339 (5.5)	1	1
Non-Swiss: *n* (%)	101 (9)	1.71 (1.36–2.15)***	1.48 (1.16–1.89)**
Academic track			
High school student: *n* (%)	103 (4.2)	1	1
Apprentice: *n* (%)	337 (6.9)	1.71 (1.37–2.15)***	1.40 (1.11–1.77)**

Note: OR = odds ratio; AOR = adjusted odds ratio.
* $p \leq 0.05$.
** $p \leq 0.01$.
*** $p \leq 0.001$.

adolescents may increase the likelihood of appropriate help-seeking behaviour, whereby mental health problems could be reduced. In-line with this, Wilson et al.[12] proposed that mental health promotion programmes should convey the message that a person should be able to recognize when a problem is so severe that help and support is needed and then act accordingly.

Carlton and Deane[7] suggested that help-negation might be explained by problem-solving deficits of suicidal people, that is, a passive or avoidant problem-solving orientation, a lack of divergent thinking and a restricted ability to generate alternative or new solutions for existing problems. Hence, improving problem-solving strategies might also contribute to a reduction of help-negation. Accordingly, the *Youth Aware of Mental Health Program* (*YAM*) has been shown to be associated with a significant reduction of incident suicide attempts and severe suicide ideation, possibly because of an improvement in young people's coping skills in relation to adverse life events and stressors that might provoke suicidal behaviour.[30] Furthermore, the programme might have led to positive outcomes, since it provided young people with the opportunity to think, verbalize and discuss issues related to mental health with peers, which might counteract the tendency of suicidal people to suppress their emotion and their difficulties in identifying their own feelings.[30] Lastly, it has also been suggested that help-negation might possibly be reduced by informing young people about this effect[12] and by reducing factors that might contribute to help-negation, such as negative attitudes towards and beliefs about help-seeking.[7,12]

Regarding the utilization of professional mental health services of suicidal adolescents, it must be considered that they are often compelled by others to get formal treatment. Parents, for instance, play an important role in the process of professional help-seeking.[31] Hence, adolescents who indicate that they would generally not talk about mental health problems, possibly because they prefer to rely on themselves, might be in treatment, but still feel reluctant to accept help and to engage in the therapeutic process, whereby the effectiveness of treatment would be limited.[20] Hence, help-negation among suicidal youth should not only be considered in preventive interventions such as the above-mentioned *YAM*, but also in the therapeutical process.

The present study also identified some socio-demographic groups that require special attention: non-Swiss youth and apprentices were not only more likely to be moderately or highly suicidal, but also to report that they would generally not talk about mental health problems – a combination that might lead to adverse outcomes (not seeking help despite a high need might lead to a worsening of mental health problems, including suicidality). The results regarding non-Swiss youth are in line with previously described findings that more non-Swiss vs. Swiss 15–75+-year olds were experiencing suicidality with the highest frequency and that non-Swiss women were less likely to be currently in treatment for depression.[23] Subsequent studies

should address the reasons for the described differences in more detail. In doing so, it would be essential not only to consider the relatively heterogeneous group of non-Swiss people, but more fine-graded subgroups. In regard to apprentices, it must be considered that they not only have to navigate in the school context, but also in a working environment. The associated challenges might, in some cases, negatively affect the mental health of a young person. Furthermore, apprentices might be less likely to talk about mental health problems because they are, in contrast to high school students, not necessarily surrounded by peers during their working days and therefore have fewer opportunities to seek informal help from these generally preferred helping resources.

Males also seemed to be more likely to show help-negation, which confirms previous research.[19,23,32,33] This might be due to males feeling more pressured to react in a *''stoic, controlled and independent way''* to psychological symptoms relative to females.[34] Another explanation is that females are less likely to negate help because they have higher mental health literacy relative to males.[35–37] Hence, the pronounced help-negation among males might, among other things, be reduced by improving their mental health literacy, which includes the knowledge of when and where to get appropriate help for mental health problems.[38]

The following limitations of the study must be considered. Firstly, data were not available on some factors that might have influenced a person's willingness to talk about mental health problems, such as attitudes towards and beliefs about help-seeking.[7,12] Secondly, a relatively large number of participants had to be excluded due to missing data. Thirdly, we used data from a cross-sectional survey, which limits causal inferences.

In conclusion, help-negation was found in a sample of young adolescents living in Switzerland, an effect that was particularly pronounced in some socio-demographic groups. By reducing this reluctance to access or accept help, premature death due to suicide might be reduced.

Conflict of interest

The authors declare that they have no conflicts of interest.

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