

Factors contributing to the negation of therapeutic services by emerging adults in a South African university

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Dissertation submitted in fulfilment of the requirements for the degree *Magister Artium* in Psychology at the Potchefstroom Campus of the North-West University

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December 2013



ACKNOWLEDGEMENTS

Completing a project of this nature cannot be done without the input, assistance and support of others. I would hereby like to acknowledge the efforts and dedication of these organisations and individuals:

- To North-West University and its personnel for their support and hard work during this project. I would specifically like to thank the library services staff, the staff at Ingryp, as well as the house parents and house committee members of the residences. My sincerest appreciation to my study leader, Mrs I. Jacobs and co-study leader, Mrs S. Weideman: without you this study would not have been possible.
- To the participants who were the essential members of the research. Thank you for being the voices that emphasised the importance and relevance of this topic.
- To everyone who carried me through this process, you will never know the depth of my gratitude. Thank you very much!

DECLARATION

I hereby declare that this study, titled 'Factors influencing the negation of therapeutic services by emerging adults in a South African university' is my own work. All the references that have been used and quoted are indicated and recognised.

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PREFACE

The Harvard referencing style has been used as referencing method in this document. This document is presented in English although the focus groups for the study were conducted in Afrikaans. Direct phrases and verbatim quotes of the participants were translated from Afrikaans to English for the purpose of inclusion in this document.

SUMMARY OF THE STUDY

This study was informed by a phenomenon observed by a variety of members from the multidisciplinary team at an acute psychiatric facility, where the researcher works daily. It appeared to clinicians as if the individual between the ages of 18 and 25 years was reluctant to engage in therapeutic intervention. The researcher considered current literature and discovered that this phenomenon seems to be globally relevant and an issue in the field of mental health. Emerging adulthood is the developmental phase that occupies the transitional period between adolescence and adulthood. The life phase is an essential developmental phase where an identity is established and skills are acquired to equip the individual through his/her life process. Emerging adulthood is predominantly defined by the individual's progress to independence and autonomy and the establishment of a personal and societal identity. Developmental tasks include taking responsibility for him/herself, deciding on future career paths and re-evaluating introjected values to form an independent belief system.

Literature indicates that emerging adults' life phase can cause severe distress due to a variety of social and personal stressors. Emerging adults who are enrolled in university often face additional stressors with regards to adapting to campus life, academic pressure and a need to establish themselves within their new environments. A high prevalence and onset of mental health disorders is noted not only in the general emerging adult population, but also in the population of emerging adults who attend university. Despite the increase in stressful experiences the percentage of emerging adults who experience distress is not reflected in the percentage of emerging adults who actually seek and receive therapeutic intervention as a means to manage their distress. As therapeutic intervention is seen as an effective tool in managing distress, the fact that emerging adults negate the help is a clear area of concern. This urged the researcher to closely consider which factors might lead to negation of therapeutic services by the emerging adult.

The study was performed at a South African university where students residing in campus residences were approached to volunteer their participation. In total fifteen participants participated in one of three focus groups with the focus on understanding which factors contribute to the negation of therapeutic services by emerging adults. The data crystallised into eleven main themes with different

subthemes to support and describe the relevant main theme. The themes clearly emphasised the lack of awareness, pervasiveness of stigmatisation and the internalised beliefs emerging adults have about themselves and therapy that induce help negation. In addressing the issue of help negation in emerging adults this study suggests solutions and actions to the role players involved in the therapeutic intervention of emerging adults that would support the promotion of mental wellbeing and mental health awareness.

KEYWORDS

Distress; Emerging adults; Help negation; Help negation behaviour; Mental health; Therapeutic services

AFRIKAANSE TITEL

Faktore wat die negering van terapeutiese hulp by ontluikende volwassenes aan 'n Suid Afrikaanse universiteit beïnvloed

OPSOMMING VAN DIE STUDIE

Hierdie studie volg vanuit 'n waarneming van 'n multidissiplinêre span van die navorser se daaglikse kliniese omgewing, 'n akute psigiatriefasiliteit. Dit het geblyk dat individue tussen die ouderdom van 18 en 25 jaar huiwerig was om betrokke te raak by terapeutiese intervensie. 'n Literatuurstudie het bevestig dat soortgelyke waarnemings wêreldwyd gemaak is en ook as 'n bekommernis beskryf word in die veld van geestesgesondheid. Ontluikende volwassenheid word beskryf as die fase tussen adolessensie en volwassenheid. Die fase is nie net bloot 'n oorgangsperiode nie, maar ook 'n noodsaaklike en ingewikkelde lewensfase. In die fase vestig individue hulle identiteite en bekom vaardighede om hulle toe te rus vir volwassenheid. Die ontluikende volwassene strewe na onafhanklikheid en outonomie, asook die vestiging van 'n persoonlike en sosiale identiteit. Ontwikkeling vind plaas deur byvoorbeeld verantwoordelikheid te neem, om toekoms- en beroepsbesluite te neem, en om waardes te herevalueer om sodoende 'n onafhanklike lewensbeskouing te vorm.

Literatuur toon verder dat verskeie sosiale en persoonlike stressors emosionele nood in die ontluikende volwassene kan veroorsaak. Ontluikende volwassenes wat aan 'n universiteit studeer, word aan verskeie stressors blootgestel met betrekking tot die aanpassing by die universiteitslewe, akademiese druk en die behoefte om hulself in hul nuwe omgewing te vestig. 'n Hoë voorkoms van geestesgesondheidsversteurings is in ontluikende volwassenes opgemerk.

Ten spyte van die toename in stresvolle ervarings wat ontluikende volwassenes in hierdie lewensfase ervaar, word die getal ontluikende volwassenes wat emosionele nood ervaar nie in die getal ontluikende volwassenes weerspieël wat hulp soek om dit te bestuur nie. Die negering van terapeutiese hulp deur ontluikende volwassenes is rede tot kommer, aangesien terapeutiese hulp doeltreffend aangewend kan word in die bestuur van emosionele nood. Hierdie kwessie het die navorser gelei om die faktore wat hulpnegerende gedrag in ontluikende volwassenes veroorsaak in meer diepte te bestudeer.

Die studie is aan 'n Suid-Afrikaanse universiteit uitgevoer waar 15 koshuisstudente deelgeneem het aan drie fokusgroepe waartydens die fokus daarop geplaas is om hulpnegerende gedrag in ontluikende volwassenes te bespreek en te beskryf. Die

kristallasiedata-analisetegniek is gebruik. Resultate het elf (11) hoofemas met ondersteunende subtemas geïdentifiseer. Dit toon duidelik dat die gebrek aan bewustheid, die teenwoordigheid van stigma en geïnternaliseerde wanpersepsies oor terapie 'n negatiewe invloed op terapeutiese deelname het.

Om die kwessie van hulpnegerende gedrag te ondersoek, het die navorser voorstelle gemaak rakende watter oplossings en aksies geïmplementeer kan word om ontluikende volwassenes se deelname aan terapeutiese intervensie te bevorder, en sodoende bewustheid van geestesgesondheid en geestelike welsyn te kweek.

SLEUTELWOORDE

Emosionele nood; Ontluikende volwassenes: Hulpnegering; Hulpnegerende gedrag;
Geestesgesondheid; Therapeutiese dienste

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CHAPTER ONE

INTRODUCTION TO THE STUDY

1.1 INTRODUCTION

When sitting with a group of senior citizens, one often hears them recall the days of their youth and reminisce about that carefree time in their lives. In contemporary society, one also tends to associate youth with a sense of positivity, energy and strength (Larson, cited by Arnett, 2007a:24). Unfortunately, this is not the only association with youth. Adolescents and young adults are also seen as being overly emotional, promiscuous and in constant turmoil with themselves, their families and the world (Arnett, 2007a:23-24). These polarities regarding the generalised public impression of young adults lead to Arnett's (2007b:68). development of the concept of emerging adults in 2004 and the ensuing debate about who and what the emerging adult really is. It is the same ambiguities related to the developmental nature and behaviour of emerging adults, observed whilst working with emerging adults in a clinical practice, which sparked the researcher's interest in the emerging adult population. Although literature around the definition and theory of emerging adults is starting to increase (Arnett, 2007b:68), very little has been investigated around the therapeutic needs (Biering, 2010:65) and age-specific intervention options (Gowers & Cotgrove, 2003:479) for emerging adults. With the intention of starting to fill this gap in literature, the researcher proposed this applied study in order to gain clarity with regard to the emerging adult's perception of therapeutic services and seeking therapeutic help. Researchers such as Colton and Pistrang (2004:312) and Grossoehme and Gerbetz (2004:592) noticed a need to identify issues with regard to therapeutic services for the emerging adult population and questioned ways of retaining emerging adults in therapy. This study hopes to create an evidence-based platform to gain an understanding of the interactions between emerging adults and therapeutic services, as well as to inform action to improve this relationship.

1.2 PROBLEM STATEMENT

In clarifying the emerging adult concept, Arnett (2000:469) proposed this age group as a distinctive life phase, ranging between the ages of 18 and 25 and comprising clear

normative roles and tasks. This age group is characterised most by constant changes concerning work, relationships, living arrangements and beliefs (Arnett, 2000:474).

These changes often bring major instability to a person's life and there is thus a need for adjustment and the ability to learn new skills to cope with life (Lenz, 2001:300). According to Lenz (2001:301), it appears that most of the stress experienced in this phase is related to the difficulty of transitioning from adolescence to adulthood, which includes events such as losing old friends, facing the responsibility of independence, coping with new environments and establishing independent beliefs.

Vanheusden, van der Ende, Mulder, van Lenthe, Verhulst, & Mackenbach's study (2009:239) recognised that when a person is unable to manage these adaptations, stress and, eventually, mental health disorders can develop. It seems, however, that few emerging adults manage to adjust effectively to this developmental phase, as it is currently believed that the emerging adult group has the highest prevalence of depression when compared against all other age groups (Van Voorhees, Fogel, Houston, Cooper, Wang & Ford, 2006:746; Vanheusden, *et al.*, 2009:239).

A large number of emerging adults occupy themselves by furthering their education through attending a university. This implies that, in addition to the developmental transition from adolescent to adult, the emerging adult also has to cope with the demands of campus life (Petersen, Louw & Dumont, 2009:102). Petersen *et al.* (2009:102) elaborates on this finding by defining university demands as dealing with academic pressures, adjusting to a new social environment and managing one's personal affairs independently (Petersen, *et al.*, 2009:102). Bojuwoye (2002:278) also identifies these demanding elements and adds that this is often the first time that the emerging adults leave the security of their family homes and accept responsibility for themselves and their choices. Facing all these challenges can be a highly stressful experience and can be the cause of severe difficulty in adjusting to new life roles and environments (Bojuwoye, 2002:278; Mudhovozi, 2011:511).

In the South African context, Pillay and Ngcobo (2010:237) found that emerging adults have to deal with additional obstacles, as secondary schooling is often inadequate when it comes to preparing them for the academic demands of campus life. Some individuals who were schooled only within their own cultural and language medium now have to adapt to using an unfamiliar language as a teaching medium, as well as a diversely different socio-economic and cultural environment (Bojuwoye, 2002:287).

Mudhovozi (2011:511) also claims that more rural and disadvantaged campuses may lack the funds and resources required to provide teaching facilities and learning aids, which can produce additional academic pressure on a student. These aspects can increase the stress experienced by emerging adults who are furthering their education and lead to increased inability to function adequately (Mudhovozi, 2011:512).

Experiencing these high levels of stress can often lead to exhaustion and burnout (Pienaar & Sieberhagen, 2005:155). Mudhovozi (2011:512) and Pillay and Ngcobo (2010:234) mention that severe mental vulnerability and a sense of helplessness experienced by emerging South African adults have been found to lead to a high prevalence of mental health disorders. Across cultures, this often leads to an increased use of alcohol and substances to help cope with distress (Arnett, 2000:475; Gasquet, Chavance, Ledoux & Choquet, 1997:151). Various researchers (Gasquet, *et al.*, 1997:151; Pillay & Ngcobo, 2010:234; Wilson, Deane & Ciarrochi, 2005:1526) have also found a positive correlation between increased incidents of suicide ideation and attempts and the need to escape their experiences of distress in both adolescent and emerging adult populations.

In view of the high prevalence of distress and mental health-related issues in emerging adults, ways to address emotional issues, manage distress and assist a person in functioning effectively should be considered. In this instance, Haynes, Eivors and Crossley (2011:156) are of the belief that both informal support (family and friends) and formal support (professional intervention) can help an individual to better manage mental and emotional dysfunction. In considering formal intervention that consists of either psychotherapy or pharmacotherapy or combinations of both, studies by Gasquet *et al.* (1997:151), as well as Vanheusden *et al.* (2009:240), have proven formal intervention to be most effective in helping individuals to adjust to their new circumstances and, if prevalent, manage their mental health disorder.

A South African Stress and Health Study (cited by Tomlinson, Grimsrud, Stein, Williams & Myer, 2009:369) revealed that of those individuals who presented with a lifetime prevalence of depression, only 8.2% sought help from a psychiatrist. The study has further shown that 4.2% sought help from a psychologist or health professional and about 6% sought help from a medical officer, religious adviser or traditional healer (Tomlinson, *et al.*, 2009:369). These findings indicate that there are a large number of individuals who do not seek help when having to deal with depression.

Bradley, McGrath, Brannen and Bagnell (2010:248) further confirm that a significant percentage of individuals do not seek or receive help when facing other mental health disorders, noting that it occurs specifically in the emerging adult phase. Briddle, Gunnell, Sharp and Donovan (2004:248) added to these results by discovering that emerging adults neglect to seek help during an emotional life crisis, even though therapeutic services are available to them. This phenomenon, which is called help negation, was also noted by Rickwood, Deane, Wilson and Ciarrochi (2005:14) and refers to not seeking help or utilising therapeutic services, despite having access to these services.

Help negation behaviour of emerging adults was not just evident to the researcher who, at the time, was working at an inpatient acute psychiatric facility in Gauteng, South Africa, but also to her clinical colleagues (Smuts, 2011; Stols, 2011). It was, for instance, noticed that emerging adults were not as likely as adolescents or adults to utilise available therapeutic services. This was further supported by observations in a crisis mental health support service facility at a South African university where emerging adults utilised crisis intervention services but were resistant to being referred for long-term therapeutic intervention (Weideman, 2012). In this last instance, it was found that emerging adults who would require emergency mental health support would be orientated and referred to appropriate therapeutic services, but only made use of these services on limited occasions. According to Weideman (2013), it also often occurs that the same individual's later report for emergency support again, having negated the previous therapeutic help offered.

Current literature (Rickwood, *et al.*, 2005:16; Wilson, *et al.*, 2005:1526) indicates that negative beliefs and attitudes toward therapeutic services in general and previous negative therapeutic experiences may be a possible explanation for help negation. Rickwood, *et al.* (2005:13) also identify poor emotional insight as a potential obstacle in help seeking, whilst Jorm, Kelly, Wright, Parslow, Harris and McGorry (2006:60) recognise limited mental health insight and a belief that it is better to deal with depression on one's own as likely barriers.

Despite growing theoretical interest in the emerging adult phase, researchers (Biering, 2010:70; Rickwood, *et al.*, 2005:16; Wilson, *et al.*, 2005:1526) are of the opinion that research on the help negation phenomenon in emerging adults is still vague and lacking.

An issue of concern is that available research focuses mainly on American and European populations. No studies could be found concerning the engagement of the emerging adult population with therapeutic intervention in an African or South African context. The limited available research for this age group and for the South African context was confirmed in observations by the team who conducted the South African Stress and Health Study (commissioned by the World Health Organization as part of the World Mental Health 2000 Initiative) (Tomlinson, *et al.*, 2009:368).

The tendency of emerging adults to negate help, despite distressing adaptations (Asberg, Bowers, Renk & McKinney, 2008:482) and a high prevalence of mental health disorders in the population (Kessler & Walters, 1998:3; Vanheusden, *et al.*, 2009:239), is alarming. It is disconcerting to know that services to support wellbeing and promote coping strategies, although proven effective, are often not used by the emerging adult. Current research has not provided an answer as to why this phenomenon occurs, specifically with regard to qualitative information (Borge & Fagermoen, 2007:194). These behaviours brought the researcher to the provocative question that forms the focal point for this study: “Which factors contribute to the negation of therapeutic services by emerging adults in a South African university?”

1.3 AIM

The aim of this study is to explore and describe the factors that contribute to the negation of therapeutic services by emerging adults enrolled in a South African university and thereby build on the existing knowledge of this phenomenon.

1.4 KEY CONCEPTS

1.4.1 Emerging adults

The first theories on developmental phases indicated some sort of transition phase from childhood to adulthood (Sadock & Sadock, 2003:19). Erikson (cited by Sadock & Sadock, 2003:19) and Levinson (cited by Sadock & Sadock, 2003:20) both acknowledge a potential early adulthood or early adult transitioning phase. Erikson and Levinson believed that adulthood starts as adolescence ends (Sadock & Sadock, 2003:41).

It was, however, recognised that a phase of transition may exist between adolescence and adulthood, where the individual explores options of occupations and roles and establishes an identity based on these options (Sadock & Sadock, 2003:41). Theorists such as Colarusso and Gould (cited by Sadock & Sadock, 2003:42) described the developmental task in this transitioning period as getting married, becoming a parent, establishing oneself in a career and developing adult friends and interests. They indicated that adulthood started somewhere between 17 and 22 years of age, depending on the individual (Sadock & Sadock, 2003:42). As society became more modernised and researchers continued their enquiry, it was later proposed that there is more than just a transitioning period between adolescence and adulthood; that this early adult transitioning phase was indeed a distinctive developmental phase (Arnett, 2000:469). Erikson (cited by Sadock & Sadock, 2003:40) coined the phase “emerging adulthood” – a term later adopted by other theorists (Arnett, 2000:469).

In contemporary civilisation, individuals get married later (Arnett, 2000:469) and become parents later (Arnett, 2000:472) than was previously the case. They take longer to settle on a career and explore various academic and formal or informal work possibilities (Arnett, 2000:472). Lenz (2001:301) further mentions that the emerging adult is highly involved in establishing a sense of identity, exploring beliefs, creating a sense of meaning for themselves and investing in relationships and communities. The emerging adult also actively explores opportunities in work, relationships, self and community and is therefore open to adaptation and a variety of alternatives with regard to life (Lenz, 2001:302). It seems evident that the emerging adult developmental phase is focused on more than simply preparing for adulthood. It is a life phase that focuses on autonomy, personal and public growth and exploring beliefs and identity (Lenz, 2001:301-303).

Currently discrepancies still occur with regard to the term and the specific age limits of the emerging adult group, however “emerging adults” and individuals between the ages of 18 and 25 years of age appear to be the most common defining term and age grouping (Arnett, 2000:469). Defining emerging adulthood would thus be to see it as a distinct phase of any individual’s life cycle, with distinctive properties and roles that occupy that time span.

1.4.2 Distress

Distress is defined in the Merriam-Webster Online dictionary (2013) as ‘a state of danger or desperate need’, even ‘a painful situation’. Distress comprehensively refers to the negative aspects of stress where an individual experiences difficulties or is under strain due to events or circumstances (Merriam-Webster Online Dictionary, 2013). In the context of the emerging adult population, distress may be due to relationship disappointments, disillusionment about the world and personal beliefs, dissatisfaction at work or even failure (Arnett, 2000:474). Grosseohme and Gerbetz (2004:590) found that distress could also be attributed to environmental pressure or discomfort. Lenz (2001:300) explains that distress, in the emerging adult population, will lead to an inability to adapt to constant changes of the environment, unsuccessful transitioning to new life roles and often to mental health concerns.

1.4.3 Therapeutic services

In this study, therapeutic service is used to describe the various forms of support and treatment a person can receive when he or she experiences distress, specifically distress causing mental health difficulties. Therapeutic intervention (or services) refers to the provision of treatment for emotional suffering and mental health concerns that will bring about cure and wellbeing to those who receive it (Merriam-Webster Online Dictionary, 2013). Pillay and Ncgobo (2010:238) mention that therapeutic services also include preventative care through the promotion of mental wellbeing and mental health awareness for emerging adults. On an aspect of practicality pertaining to this study, therapeutic intervention includes any school of thought or method of counselling and therapy (Sadock & Sadock, 2003:950-973).

Sadock and Sadock (2003:923-949) explain that therapeutic services can be conducted in individual, group, couple or family settings. It includes long term, brief and supportive intervention and is conducted in both in- and out-patient settings (Sadock & Sadock, 2003:923-949). Therapeutic services can comprise a variety of different types of intervention, for example, psychoanalysis, cognitive behavioural therapy, psychosocial intervention, hypnotherapy, support group intervention, biofeedback models and various other methods of counselling and treatment (Sadock & Sadock, 2003:950-973). Timmerman (2011) provides a successful summary of these services by explaining that therapeutic services is an umbrella term that refers to the broad range of psychological

schools of thought which aim to intervene where distress upsets healthy living and disturbs successful adaptation.

1.4.4 Help negation behaviour

In order to comprehend fully the concept of help negation behaviour it is first necessary to gain a better understanding of the counterpoint concept of help-seeking behaviour. The latter, in the psychological context, refers to an individual's willingness to get help so that they can better cope in their current, often distressing, situation. Rickwood *et al.* (2005:4) notes that help-seeking behaviour more specifically describes the active steps toward seeking help. Vanheusden *et al.* (2009:242), who explains that the first step toward help seeking is having an awareness of one's current distress and the realisation that help will be needed to overcome it, support this. Following this, one should believe that support or intervention would help to overcome the relevant problem (Van Voorhees, *et al.*, 2006:751). It further includes a sense of readiness for change and a willingness to take steps and at times even trounce any existing stigma or fear in order to solve the current stressful situation (Bradley, *et al.*, 2010:243; Colton & Pistrang, 2004:311-312). These perceptions and beliefs will eventually lead to the active seeking of help through getting into contact with potential resources and, finally, engaging with others to find solutions to one's problems.

In opposition to help-seeking behaviour is the concept of help negation behaviour. This negative conduct refers to not utilising formal or informal help resources, even though these means are available to the individual (Rickwood, *et al.*, 2005:14). Help negation occurs when individuals are unable to mobilise themselves to make use of services to overcome their current distressing situations.

Existing knowledge found that help negation is, at present, a common tendency within the emerging adult population (Gasquet, *et al.*, 1997:151; Rickwood, *et al.*, 2005:4; Van Voorhees, *et al.*, 2006:751). At this stage, researchers believe that fear of social stigma (Bradley, *et al.*, 2010:243), personal beliefs and attitudes about mental health (Van Voorhees, *et al.*, 2006:751), a lack of emotional and mental health awareness (Vanheusden, *et al.*, 2009:240) and, possibly, first trying to deal with the problem themselves (Jorm, *et al.*, 2006:64) could be some of the reasons as to why individuals display help negation behaviour. Research on help negation is, however, scarce and often inconsistent (Rickwood, *et al.*, 2005:5), especially in the South African context (Tomlinson,

et al., 2009:368), thus this study will aim toward building a more sound scientific knowledge base.

1.5 RESEARCH METHODOLOGY

1.5.1 Research design

The researcher intends to explore and describe the help negation behaviour of emerging adults with regard to therapeutic intervention. Academic literature (Fouché & Schurink, 2011:308) and practical research studies (Madden-Derdich, Leonard & Gunnel, 2002:356; Manso, Rauktis & Boyd, 2008:59) indicate that a qualitative design will allow for in-depth data collection. Previous studies on emerging adults (Abraham, Lepisto & Schultz, 1995:72; Edelman & Remond, 2005:57; von Below, Werbart & Rehnberg, 2010:133) also suggest the use of a qualitative design as it is assumed that emerging adults will share more authentic and valuable information through dialogical interaction than by means of quantitative data-collection methods.

Applied research stems from observed incidents and a verbalised requirement, where clinicians wish for insight and action that either overcome or satisfy this need (Leedy & Ormrod, 2005:43). The research problem has been formulated from a current need of clinicians in two different therapeutic intervention settings (Smuts, 2011; Stols, 2011; Weideman, 2012) and is therefore classified as an applied research study.

The study will thus be approached as a case study design, as case study designs aim to gain an intimate understanding of the behaviours and thought processes of an encapsulated population concerning a singular occurrence (Fouché & Schurink, 2011:320). The need to undertake the study originates from a specifically-observed phenomenon within an explicit age group, which constitutes what Creswell (cited by Fouché & Schurink, 2011:321) calls a “bounded system”. The bounded system for the purpose of this study will be emerging adults enrolled in a South African university.

The study will fulfil a mainly exploratory purpose in order to describe a phenomenon, which will broaden and test existing knowledge, as well as establish new theoretical concepts (Fouché & Schurink, 2011:321). Calder (cited by Greeff, 2011:364) explains the suitability of focus groups in exploratory studies as they can support the explanation and production of theoretical insights. Focus groups will thus be considered to be a suitable means of data collection for the purpose of this study.

1.5.2 Setting

This study follows a method of target sampling, therefore certain aspects have been preselected in order to target a certain population. The study will be conducted at a South African University. The setting will be further refined to include university residences only; students who are members of a university residence will be approached to participate in the study. The targeted university has nine male residences (communal accommodation), 11 female residences (communal accommodation) and six day residences (mixed gender and private accommodation).

The researcher will first obtain permission to conduct the study from the management of the relevant university. Contact with the students will then be made through the house parents and the house committee members and the students will be invited through both written and verbal invitations. Students who volunteer will then be informed of the date, time and venue of the focus groups. Further arrangements will ensure that the venue will be neutral to all the university residences.

1.5.3 Participants

1.5.3.1 Sampling

Leedy and Ormrod (2005:204-205) define the population of a study as a group of individuals that possess certain similar characteristics that are of interest to the researcher. Strydom (2011c:223) further expands on this definition by explaining that the population sets the larger boundaries within which a study would be conducted. In this study, the population is identified as being all emerging adults who are receiving further education at a specific university in South Africa.

According to Strydom (2011c:223), the sample of a study refers to the narrower boundaries and more selected portion of the population that the researcher selects for study participation. In order to select a portion of the population, target sampling will be utilised. Target sampling (Strydom, 2011c:233) is chosen as it ensures that a group of individuals with specific traits in a specific environment are intended for participation in this study. Strydom (2011c:233) characterises this approach as flexible, which suits this study as individuals from the sampling group will be recruited and then asked to volunteer their time to participate in the study.

1.5.3.2 *Criteria for participation*

In order for an individual from the targeted population to participate in the study, the following criteria should be met:

- Participants need to be between the ages of 18 and 25;
- Participants should be enrolled at the university at the time of the study;
- Participants should be a member of a university residence;
- Participants should agree to participate voluntarily in the study in order to adhere to the ethical considerations of the study;
- Participants should be competent in speaking English, as this is the language in which the focus groups will be conducted; and
- Participants will not be excluded based on their individual ethnicity, religion or gender.

1.5.3.3 *Study size*

Grudens-Schuck, Allen and Larson (2004:2) suggest that multiple focus groups be conducted in order to get thorough and reliable information. This study will comprise three different focus groups of individuals from the same sample. Some literature suggests that between six and 12 members per group are ideal for a focus group (Del Rio-Roberts, 2011:312), whilst Grudens-Schuck *et al.* (2004:2) suggests either 10 to 12 participants and Greeff (2011:366) suggests six to 10. This study will aim to have between six and 10 participants per focus group.

Most of the literature suggests over recruiting so as to ensure that a sufficient number of participants attend the group (Del Rio-Roberts, 2011:313; Grudens-Schuck, *et al.*, 2004:2). Recruiting for this study is thus a crucial element for the success of the study.

1.5.3.4 *Recruiting procedures*

Recruitment is a systematic process to ensure that enough participants from the sample group attend the data collection session (Greeff, 2011:366). Initially, the house parents of each residence will be contacted in order to arrange a meeting with the residence members. The researcher will then present the study to the residence members, explaining the aims and nature of the study and inviting them to participate. Written information will be given to the house parents and house committee members to distribute amongst the students. The house committee members will also be asked to remind the

residence members of the study. The written information will include posters and information sheets containing a full description of the study and the data collection method (Refer to Appendix A & B). The study and focus group times will also be advertised on each residence's social media site.

Participation in the study will be motivated by the role that residence members can play in expanding the existing knowledge on a social phenomenon in their age group. Residence members will further be encouraged to participate in the focus groups, as this could be a valuable learning experience for them in the completion of their own studies.

1.5.4 Data collection

As was mentioned earlier (refer to 1.5.1), focus groups will be used to collect data, as this method will provide rich data on the perceptions of emerging adults with regard to formal help negation behaviour. Focus groups are specifically chosen as they do not only answer directly-asked questions, but also allow mind-sets, thoughts and feelings to emerge from the interaction between participants (Massey, 2011:21). Greeff (2011:371) further states that the environment in which the focus groups will be held should be a milieu where individuals feel safe and are comfortable to discuss the topic at hand. These elements will be considered when choosing a suitable venue for the focus groups.

It is recommended that a focus group last between one and two hours (Del Rio-Roberts, 2011:314). The researcher will be cautious of the time limit when conducting the focus groups. In order to adhere to the time limit (Del Rio-Roberts, 2011:314), to allow for comfortable, flowing conversation (Grudens-Schuck, *et al.*, 2004:3), to obtain prolific data (Massey, 2011:21) and to increase the reliability of the study (Del Rio-Roberts, 2011:314), an interview script and topic guide (refer to Appendix C) will be used to guide the questioning during the group.

The group facilitation team will consist of a facilitator and an assistant facilitator. Greeff (2011:368) clarifies that the role of the facilitator is to guide the conversation in a natural flow, which will deliver sufficient data from the content of the conversation. The facilitator should also be competent in getting individuals to offer their honest opinions and engage with each other around these opinions in order to allow an open-minded, comfortable and valuable conversation to take place (Greeff, 2011:369; Webb & Doman, 2008:54).

Webb and Doman (2008:57) explain that the assistant facilitator should act as the observer and recorder of the groups. The assistant will not be part of the formal group but

will observe the dynamics and interactions of the group. The assistant will also be responsible for the field notes taken during the interviewing process (Webb & Doman, 2008:57). In addition, the assistant facilitator will also play a role in dealing with distractions, should they arise, and in handling the recording equipment (Greeff, 2011:368). In this study, the researcher will act as facilitator and a competent assistant facilitator will be selected.

The focus groups will be recorded by means of a sound-recording device and later transcribed for data extraction. The focus groups will also be video recorded so as to afford the facilitators the opportunity to return to observe the finer nuances of group dynamics, which may have played out and might be deemed to be significant data for inclusion in the study. All participants will be informed of the recording procedures and will have to give informed consent (refer to Appendix D) regarding the process of data collection. Participants who feel uncomfortable with this will have the right to withdraw from the study at any time. Field notes will be taken during the group by the assistant facilitator. These can be used in later reflections and for a reconstruction of the interview, to support articulated and emergent data (Fouché & Schurink, 2011:316; Strydom, 2011b:328).

1.5.5 Data analysis

Schurink, Fouché and De Vos (2011:397) describe the analysis of data as the focal point in all research, as research aims to produce findings and, through these findings, broaden insight. Schwandt (cited by Schurink, *et al.*, 2011:397) adds that data analysis is the process of interpreting, conceptualising and understanding the data. In obtaining insightful and trustworthy results three types of data, as outlined by Massey (2011:23), will be used. These three types are:

- articulated data: direct responses to questions asked;
- attributional data: data that either supports or rejects possible prior hypotheses; and
- emergent data: data that is completely new and unexpected to the researcher (Massey, 2011:23).

Throughout this process, Creswell's data analysis spiral (cited by Leedy & Ormrod, 2005:150-151) will be incorporated. The spiral follows four steps, namely (1) organisation, (2) comprehension, (3) categorisation and (4) integration of data.

During organisation, data will be managed by using the long table method. In this method, comments and responses to answers will be identified and grouped correctly under the questions asked by the researcher (Massey, 2011:23).

Data collected through the long table method will thus constitute the articulated data component of the study, as this comprises the candid response and 'raw' information provided by the participants. The researcher will ensure that no data are interpreted at this stage, but will simply portray the raw information in a systematic, clear and understandable fashion (Schurink, *et al.*, 2011:405). Massey (2011:24) believes that attribution data should be collected through the thoughtful question development. Greeff (2011:369) adds that careful development of high quality questions will have a direct impact on the successful outcome of the study. The questions will thus be developed in such a way that current literature results, with regard to factors influencing the negation of formal help, will be investigated in the focus groups so as to determine in what way the emerging adult in the South African context can relate to these factors.

Massey (2011:25) explains that emergent data is the deepest layer of data as it refers to the unarticulated processes, meanings and insights of the group. Emergent data is completely new information to the researcher and often arises from underlying social impacts (Massey, 2011:25). During the data-capture process, making field notes and later listening and viewing of collected data, the researcher will make note of these 'invisible' assumptions for inclusion in the analysis step of data comprehension. Should these issues, however, arise in the interview, the researcher will, depending on time limits and relevance, encourage group participants to expand on the issue during the session (Massey, 2011:26).

After organising the data, a process of comprehension should then include some interpretation and understanding of the raw information available (Creswell, cited by Leedy & Ormrod, 2005:150-151). The researcher will then start to notice certain themes and recurring aspects that arise from the material. A process of coding information will occur whereby data is initially grouped with respect to comparable detail and then later coded in a more selective fashion in order to form larger concepts in a systematic manner (Trochim, 2001:160). Data will then be categorised (the third step in Creswell's spiral) according to these concepts, in a process to start "labelling phenomena" (Schurink, *et al.*, 2011:411).

Kreuger and Neuman (cited by Schurink, *et al.*, 2011:415) specifically mention that the researcher should at this stage be equally aware of information that does *not* occur in the data, in order to have a more comprehensive understanding of the significance of the data collected.

Through labelling the findings of the standings, the process of interpreting and thus integrating the data will start. At this stage of the process, the researcher will make sense of the data that is available and thereafter present it as the findings of the study (Schurink, *et al.*, 2011:416). Subsequently, the three types of data will be integrated in order to provide a comprehensive perspective on the opinions of the focus group participants (Massey, 2011:23).

In this study, however, data collection and analysis will occur simultaneously as this promotes consistency in the interpretation of data (Schurink, *et al.*, 2011:405). This will be done through reviewing the collected material and identifying possible themes, thus following the Creswell spiral (cited by Leedy & Ormrod, 2005:150-151), as soon after the interview as is possible. Greeff (2011:359), as well as Sheridan, Peterson and Rosen (2010:148), claim that by using both transcribed data and field notes to develop data interpretation, the trustworthiness of the study will be increased. The above-mentioned steps will be followed in order to increase the accuracy of the interpretations.

1.6 TRUSTWORTHINESS

Throughout the data collection and analysis stages, the researcher will keep a continuous awareness of the need to maintain the trustworthiness of the data. The aspects described below will be considered throughout the research procedure.

1.6.1 Ensuring authenticity

Ensuring authenticity refers to providing an accurate description of the participants' phenomenology (Schurink, *et al.*, 2011:420). In essence, this implies that the data captured should state the truth and be credible. To safeguard the study's trustworthiness, the researcher will present and portray the information in the exact manner that the participants revealed it and from their intended perspective. The researcher will also take responsibility with regard to recording the data in a systematic and authentic manner (Schurink, *et al.*, 2011:405), as well as regularly checking the data with the participants, in

order to ensure it is understood accurately (Greeff, 2012). The researcher will review the group's main perspective with the group participants. The researcher and the assistant facilitator will also review any pertinent perspectives and themes that presented themselves through the data collection process, directly after the focus group.

During the analysis process, transcribed data will be matched accurately to the audio material and actual phrases used by the participants will be used in the analysis and description of themes.

1.6.2 Maintaining transferability

It is important that information is representative of the sampling group, but can also be applied to another case or person within the population. Through achieving this, the data will be universal and applicable and the study would maintain transferability (Schurink, *et al.*, 2011:420). In order to achieve transferability, Greeff (2012) suggests that the researcher must ensure that rich and sufficient data are gathered to a point of saturation. In this study, transferability will also be established through the recruitment of participants from a fully-representative sample of the population. The setting of the study also allows for a diverse and representative sample of demographics, as university residences require diversity in their residing students. The recruitment parameters of this study will be aimed at the entire demographic population of the university.

1.6.3 Promoting dependability

Dependability refers to consistency of data collection and data analysis throughout the research process (Greeff, 2012). The researcher will take extreme caution in documenting the data in a logical and proper manner (Schurink, *et al.*, 2011:420) and will repeat the same step-by-step procedures in conducting the focus groups. During the data analysis process, themes and findings will be discussed and cross-checked by the research team, namely the researcher and the assistant facilitator.

1.6.4 Guaranteeing confirmability of the study

This aspect is one that requires attention both during and after the study. It initially requires that the researcher maintain complete objectivity toward the interpretation of data (Schurink, *et al.*, 2011:421). It is highly recommended that the researcher make use of 'bracketing' so as not to allow previous beliefs, frameworks or personal phenomenology to influence the findings of the study (Fouché & Schurink, 2011:316). According to Fairfield

(2004:345), bracketing refers to when the therapist or interviewer makes an active choice not to allow any interfering personal beliefs, biases or pre-established assumptions to cloud their unrestricted attention to the present phenomenon. Confirmability also refers to the manner in which the current research can confirm and support previous literature or be supported and confirmed by future literature (Schurink, *et al.*, 2011:421). This can only be achieved through accurate, uninfluenced and thorough data collection and analysis that the researcher will strive for at all times.

1.6.5 Safeguarding of data

All the recordings will be safeguarded and will be used only for the purpose of this study. Sound and video recordings will not be made public and will be listened to and viewed only by the research team. Recorded material will be stored on a hard drive and disk format and will then be safeguarded by the research team at the Centre for Child Youth and Family Studies of the North-West University, Potchefstroom Campus. The material will be destroyed five years after the completion of the study.

1.7 ETHICAL CONSIDERATIONS

Ethical considerations form a crucial part of a research study as they protect the participant against the possible harms of social experimentation (Trochim, 2001:24). The aspects described below is the outline that will be considered with regard to ensuring ethical practice during the execution of this study.

1.7.1 Voluntary participation

Trochim (2001:24) states that the foundation of good ethical practice in research is that participants are approached to participate in the study without a feeling of coercion. Leedy and Ormrod (2005:101) continue by saying that participants should be clearly informed that their participation is voluntary and that they have the right to withdraw from the study at any time. In this study, the participants will not be forced or coerced into participation, but will be recruited after volunteering their involvement.

1.7.2 Informed consent

Leedy and Ormrod (2005:101-102) explain that informed consent not only extends to a written agreement of participation, but includes the basic purpose, aims and procedures of the research. Information included in the informed consent should be clear, truthful,

understandable and comprehensive (Strydom, 2011a:117) and should include obtaining permission for the recording of the data (Greeff, 2011:359). As participants should be 18 years or older, they are able to provide consent, both independently and lawfully, to participate in this study.

Participants will be fully informed of the aims and purpose of the study as well as the voluntary nature of participation through a clearly descriptive document (refer to Appendix B) as well as during the orientation and introduction of the focus groups (refer to Appendix C). Informed consent will also include agreeing to the use of sound and video recording for data collection purposes. This permission should be confirmed by means of a signed informed consent form.

1.7.3 Confidentiality and anonymity

The right to privacy is a crucial ethical element in any research study, but even more so in a qualitative design. According to Leedy and Ormrod (2005:102), this includes confidentiality in terms of the content of the interview as well as the anonymity of the participant. Both Kitzinger (1995:300) and Webb and Doman (2008:56) emphasise that confidentiality in focus groups can be more challenging and should thus be given careful consideration. During this study, specific steps will be taken to ensure confidentiality and anonymity. During the orientation, the participant will be informed about the intended use of the information provided and informed concerning the confidentiality agreement of this study. As the study makes use of a focus group method, ground rules about confidentiality amongst group participants will be stated clearly and agreed upon. Confidentiality will include the boundaries of recording the interviews, safeguarding the recorded material and use of the recorded material during data analysis.

Participants will, however, be informed of any exceptions to confidentiality in terms of the harmful behaviour of others or themselves should these be revealed during the interview. To secure anonymity during the focus group process, participants will be allowed to use self-selected pseudonyms and thus not reveal their identity. As suggested by Strydom (2011a:120), the names and pseudonyms will be omitted during the data analysis process, so as to ensure continued anonymity. Strydom (2011a:119) further states that one of the rights of privacy involves the right to evaluate the information gathered during the interview. The researcher will therefore share the summary of the focus group with the participants and through this support privacy and confidentiality.

1.7.4 Avoidance of harm

Social science studies focus on people as the subject of their investigation and therefore the researcher should act with caution and sensitivity so as not to cause harm to the participants of the study (Leedy & Ormrod, 2005:101; Strydom, 2011a:115). This study will thus take specific precautions in this regard. Grudens-Schuck *et al.* (2004:3) proposes that good flow and comfort in a focus group will allow participants to be more relaxed and they would thus engage with greater ease in the conversation. Establishing cohesion and reducing anxiety to allow for natural conversation will be taken into account during the focus group. As excessively long interviews may lead to exhaustion and thus be seen as harmful to the participant (Greeff, 2011:344), the researcher will take caution against over-exertion and will adhere strictly to the time limits of the focus group. Grudens-Schuck *et al.* (2004:3), as well as Greeff (2011:343), warn against the possibilities of sensitive issues arising during the data collection process. The researcher will provide careful guidance and assistance should sensitive issues arise during the interview. Strydom (2011a:116) suggests that should the researcher become aware of certain questions leading to possible distress in the participants, the questioning and interview guide should be altered so as to allow for optimal comfort for the participants. The researcher will therefore be sensitive to questions that are overly provoking and will alter the interview guide if needed.

1.7.5 Debriefing of participants

An additional ethical action against harmful participation is to provide debriefing for the participants after the completion of the interview (Leedy & Ormrod, 2005:101). During this study the participants will be provided with the opportunity to reflect on the focus group, which will allow the participants to express emotions concerning the focus groups.

1.8 CLOSURE

Through reviewing this chapter and examining the basic elements of the problem statement, it is clear that this study is needed in order to fill the gap in theoretical and clinical knowledge concerning the phenomenon on emerging adult formal help negation behaviour. This will be achieved by successfully meeting the aims of the study, which the research design and methodology are constructed to accomplish. In order to embed the need for this study further, the next chapter will consist of a literature review to consider the current literature base as well as the presenting clinical problem.

CHAPTER TWO

CONCEPTUAL FRAMEWORK OF THE STUDY

2.1 INTRODUCTION

In contemporary society, the term “mid-life crisis” is widely understood and used as a term to describe the physical, emotional and psychological crisis or transition that individuals undergo during middle age, spanning from the ages of 45 to 60. (Sadock & Sadock, 2003:46-47). According to Sadock and Sadock (2003:35), it is a known fact that adolescents go through a similar transition from puberty to adulthood. Arnett’s (2007a:24) research builds on the foundational developmental-phase work of Erikson (cited by Sadock & Sadock, 2003:211) in the 1950s. He therefore uses Erikson’s term “emerging adults” to describe this life phase. Emerging adulthood describes the life demands and developmental roles, as well as the internal and external conflicts, that a person between the ages of 18–25 experiences. Although emerging adulthood has been considered as a developmental phase since the early stages of developmental theories, it has only recently received attention in the literature (Arnett, 2007b:68). With this research study, it is hoped to further contribute to the discussion on this developing life phase phenomenon.

De Vos, Strydom, Schulze and Patel (2011:26) are of the opinion that in order to inform existing research, clinicians need to use theoretical knowledge as underlying principles to their intervention. Clinicians are encouraged to observe gaps in the existing theoretical knowledge that hinders effective practical intervention in order for these observed gaps to inform the need for further research projects. Trochim (2001:27) builds from this statement to describe that a literature review’s importance lies in ensuring that a research project has a thorough grounding in both the practical field and existing theoretical knowledge. The literature review brings a broader understanding of the available knowledge on which the study hopes to build (Fouché & De Vos, 2011b:93), but also specifies the focus of a particular study (Trochim, 2001:27). With regard to this chapter, the literature review serves as an outline of the basic concepts of emerging adulthood as well as the needs and mental health concerns of the individuals in this phase.

The review will consider current definitions and developmental parameters for the emerging adult population and reflect on the emerging adult in the process of continuing their education, a common vocation of this particular life phase.

Thereafter, the distress of the emerging adult, specifically those in continuing education, will be highlighted, whilst the ensuing mental health needs will be explored in order to present the need for therapeutic intervention for individuals in the emerging adult life phase. The discussions in this chapter will include current trends in help negation behaviour in the emerging adulthood phase in order to create an understanding of the need to delve deeper into the factors that influence help negation behaviours of therapeutic services.

2.2 DEFINING EMERGING ADULTHOOD

In establishing a theoretical foundation as mentioned above, the following section will focus on establishing emerging adulthood as an independent life phase by separating it from adolescence and adulthood. It will aim to clarify confusions and contradictions in existing academic resources and, finally, provide a developmental outline of emerging adulthood in both age limits and life roles.

2.2.1 Emerging adulthood as independent life phase

Literature indicates that discrepancies exist with regard to the specific age and developmental norms of an early adult transitioning phase. It is, for instance, stated that adolescence extends to the end of age 20, after which adulthood then commences (Sadock & Sadock, 2003:42). This implies that the interim period between adolescence and adulthood is merely a short period of adjustment and transitioning (Sadock & Sadock, 2003:41).

Erikson (cited by Jacobsson, Tysklind & Werbart, 2011:282) was the first to refer to this transitioning life phase as “emerging adulthood”, whilst Levinson (cited by Sadock & Sadock, 2003:42) coined it the “early adulthood transition”. Elliot and Feldman (cited by Arnett, 2000:476) referred to the phase as “late adolescence”. In more contemporary and single-focused studies, Arnett (2000:471) adopts Erikson’s term of “emerging adulthood”. Current research (Arnett, 2000:469; Molgat, 2007:495), however, indicates that emerging adulthood is no longer merely a state of transition. With the shifts in developmental norms,

societal expectations and pressures, as well as living in a world with increased opportunities, emerging adulthood has become an independent life phase that is essential to the development of a successful and autonomous adult (Bynner, 2005:369).

As can be noted in the variety of terms given for this interim life phase, it is clear that there is not yet uniformity about the terminology of this age group. Likewise, the age limits of this group have not been established with any level of consistency. For example, Anderson and Lowen (2010:780) in their study refer to individuals between 15 and 25 years as young adults. Van Voorhees *et al.*, (2006:746) claims that young adults are 16 to 29 years of age, whilst Vanheusden *et al.*, (2009:241) defines the age limit of young adults as being 19 to 30 years of age.

Arnett (2000:471) brought an entirely new understanding to the emerging adult phase with his intensive research. He, for instance, claims that a specific age limit for this group cannot be defined successfully as it depends on the individual's perception of the life phase they are in, but that it commonly extends between 18 and 25 (Arnett, 2000:469). As Arnett's research is currently the most recent and extensive with regard to the emerging adult phase, the proposed age limit of 18 to 25 years and the term 'emerging adulthood' will be adopted for the purpose of this study.

2.2.2 The individual caught between adolescence and adulthood

It is not only the terminology and age limits of this group that should be demarcated for emerging adulthood, but attention should also be given to the person within this age group. This includes considering the individual's societal norms, developmental roles and age-related tasks, as well as how these roles and tasks have changed over the years.

To start, one can consider the age of marriage as an example of a discrepancy in roles for emerging adulthood. Arnett (2000:478) highlights the fact that before the industrialisation and westernisation of the world, marriage was seen as the transitioning event between childhood and adulthood – a so-called "rite of passage". Arnett (2000:478) noted that young girls exited childhood and almost immediately entered adulthood, as the age of marriage was commonly set between 15 and 18. As society developed and demands expanded, the age of marriage extended so that adolescence, and no longer childhood, became the period of transitioning and preparation for adulthood and for marriage (Lenz, 2001:301).

Societal norms, however, continue to change and transform at a rapid rate. In this regard, Arnett's (2000:469) and Bynner's (2005:372) research indicated that the median age of marriage increased over the past 25 years in the United States, Germany and Britain. Bynner (2005:373) continued by indicating that the percentage of individuals who had children at the age of 30 dropped significantly over the past 25 years. Bynner (2005:373) claims that men with children at the age of 30 declined with 60% and woman with children at the age of 30 declined with 30%.

It is clear from these statistics that sexual maturity, marriage and rites of passage cannot constitute the adolescent–adult transition any longer, as the age of transitioning has extended significantly.

Lenz (2001:301) furthermore states that in the four years of extended transitioning from adolescence to adulthood, the sole focus of development is no longer only on preparing for marriage or even adulthood. One of the societal norms and tasks that is becoming increasingly important in contemporary society is education. Bynner (2005:369) states that society's need for educational achievement urges individuals to extend their period of education and occupation exploration. Bianchi and Spain (cited by Arnett, 2000:471), for instance, claim that approximately 60% of Americans attend higher education after high school. This education process is often combined with periods of working or regular changes in education paths; still the contemporary tendency is an increase in college attendance and often extended periods of education (Arnett, 2000:471). It is thus clear that the emerging adult is focused on personal development and not simply meeting a societal norm, namely, marriage before a certain age (Arnett, 2000:471).

Erikson (cited by von Below, *et al.*, 2010:129) describes the developmental crisis of the adolescent as being one of identity vs. role confusion, whilst the crisis for the transitioning adult is described as being one of intimacy vs. isolation. Van Voorhees *et al.*, (2006:746) argues that the emerging adult does not fall distinctly into one of these categories, but is rather in a continuous process between the elements of identity, role confusion, intimacy and isolation. It appears that the emerging adult has a clearer personal sense of self and is continuously involved in "finding" themselves more, but may still lack the skills and opportunities required to accept the tasks and responsibilities of an adult (Van Voorhees, *et al.*, 2006:746).

Evidently, emerging adulthood entails much more than just identity uncertainties or even a heterogenic set of demographics. It is a specific life phase with definite tasks, roles and purposes (Arnett, 2000:469) that is essential in the development and, eventually, the wellbeing of an individual (Rickwood, *et al.*, 2005:3). After concluding that emerging adulthood is indeed an independent life phase, defining characteristics and developmental norms of emerging adulthood can now be considered.

2.2.3 Emerging adulthood as developmental phase

Arnett (2000:469) describes this phase as one of profound change where, according to Perry (cited by Arnett, 2000:474), important worldviews regarding love, work and meaning are examined, explored and adopted. Lenz (2001:302) describes emerging adulthood as a period of identity stabilisation, where the individual is constantly involved in evolving and investing in themselves and others. The emerging adult is actively exploring the meaning of life and their individual purpose in life (Lenz, 2001:304).

Another largely defining characteristic is that individuals in this phase seek independence (Molgat, 2007:499). There was evidence in studies by Arnett (2000:473), Lenz (2001:300) and Rickwood *et al.* (2005:3) that tasks and commitments are focused on becoming self-sufficient with regard to making their own personal choices, being financially independent and resuming responsibility for their lives and health. Arnett (2000:473) emphasises that when adolescents make vocational and relationship choices it is based on the immediate moment and “having fun”, whereas emerging adults are more inclined to take responsibility for their lives. The choices emerging adults make consider their independence and future, which displays a sense of maturity and autonomy (Molgat, 2007:499).

Demographic heterogeneity is another strong identifying trait. Emerging adults may be involved in a variety of alternative vocations, academic processes, living arrangements and relationships. It also appears to be a tendency to change these aspects of life regularly in search of personal growth, meaning and success (Dyson & Renk, 2006:1231; Lenz, 2001:302). In summarising emerging adulthood, Arnett (2000:469) declares that emerging adulthood is a very specific experimental life phase, characterised by freedom, independence and exploration, accompanied by the acceptance of some responsibility. The entire life phase revolves around change, searching and originality.

2.3 DISTRESS IN EMERGING ADULthood

2.3.1 Stress and pressure

Despite the seemingly carefree and independent lifestyle of the emerging adult, it is not an exclusively pleasurable experience. Arnett (2000:474) notes that emerging adults often experience rejection with regard to love and childhood, experience disillusionment with regard to their beliefs and face disappointments concerning their work and career paths.

Both Jansen and Morch (cited by Arnett, 2000:474) state that emerging adults often have to experience these failures and frustrations alone. In addition, as all life phases are accompanied by a certain amount of change and instability, individuals often experience a period of adjustment before they settle into their new roles (Lenz, 2001:300).

The experience of this inability to adjust, accompanied by disappointment and disillusionment is often dependent on the individual's perception of this transition (Lenz, 2001:302) and can, in some individuals, lead to significant distress (Lenz, 2001:305). Grosseohme and Gerbetz (2004:590) accentuate the fact that environmental pressures and societal expectations can add to the individual's perceived inability to cope. Arnett (2000:475) noticed that specific high-risk behaviours, such as alcohol and substance use or sexual promiscuity, are commonly reported in the emerging adult population. These high-risk behaviours can contribute equally to an incapacity to perform normally or be a destructive coping skill in dealing with the transition adjustments (Arnett, 2000:475).

An inability to cope with life often brings forth significant dysfunction in all areas of life and can eventually lead to increased prevalence of mental health disorders (Vanheusden, *et al.*, 2009:239). In this regard, literature indicates genetics, changing environments (Grosseohme & Gerbetz, 2004:590) as well as emotional and developmental demands (Calton & Arcelus, 2003:293) as being factors that can lead to the decline of the functioning of certain individuals within this life phase. A global tendency, which indicates a higher prevalence of depression in emerging adults compared with other age groups, should therefore not come as a surprise (Bradley, *et al.*, 2010:242; Kessler & Walters, 1998:3; Voorhees, *et al.*, 2006:746). Wilson *et al.*, (2005:1525) states that a high rate of suicidal ideation is included in the category of depression. In addition, Gasquet *et al.*, (1997:151) found that emerging adults experience a higher level of self-rated emotional distress. In South Africa, it was discovered that the mean age of onset for depression is 26

for women and 25.6 for men, indicating the vulnerability that emerging adults display with regard to mental health problems in South Africa (Tomlinson, *et al.*, 2009:368).

The above-mentioned South African finding was supported in an article that compared accessibility of health services for youth worldwide. Anderson and Lowen (2010:780) discovered that individuals between the ages of 15 to 24 have the highest initial onset of mental health problems. In the same study, the emerging adult age group presented with a higher occurrence of mental health problems than did adults.

It was noted in Sweden that the prevalence of depressed individuals between the ages of 16 and 24 doubled during the years 1988 to 2001 (von Below, *et al.*, 2010:130).

2.3.2 Distress for the emerging adult as a student

As previously noted, emerging adults are often involved in a process of continuing their education through college or university courses (Arnett, 2000:471). In addition to the adjustment to life roles (Lenz, 2001:300) and developmental tasks that differ from adolescence, these individuals also have to adjust to the new environment and expectations of a tertiary education. Emerging adults are not only in a process of establishing their beliefs and identities (Arnett, 2000:474) and progressing to an independent sense of responsibility (Arnett, 2000:469), but have to do so in an unfamiliar, demanding and constantly-shifting context if they are enrolled to further their education. In South African studies by Mudhovozi (2011:511) and Pillay and Ngcobo (2010:234), it was determined that these challenges and changes can be overwhelming and can eventually lead to feelings of incompetence, vulnerability and hopelessness. Bojuwoye (2002:277) lists a variety of adjustments that emerging adults have to face in this environment such as the fact that the individual needs to leave the family home for the first time, cope with academic pressure, manage their own finances, develop a new social circle and grow in personal insight. Bojuwoye (2002:278) adds that the emerging adult also faces stressful decisions, not only regarding future career paths and course choices, but also with regard to difficult social choices such as substance use or sexual behaviour, as had previously been noted by Arnett (2000:475).

Although emerging adults might settle into this new phase and environment, new adjustments will arise as they progress toward the completion of their studies. These new adjustments, which are generally stressful challenges, involve searching for a job, attending interviews, even losing friendships and possibly relocating (Mudhovozi,

2011:513). This emphasises not only the ever-changing and demographic inconsistency of the emerging adult life phase (Arnett, 2000:477) but also the potential to experience distress.

The emerging adult's experience of distress has also been noted in statistics. The graduation rate in South African universities has dropped from 17% to 15% between 1993 and 2005. This decrease in graduation rate is attributed strongly to the difficulties in adjusting and coping with stress during university years (Petersen, *et al.*, 2009:99).

Pienaar and Sieberhagen (2005:155) encountered an increase in burnout and mental exhaustion in the student leaders of South African universities. Furthermore, in rural South African universities it was noted that an increase in the experience of distress often leads to deficient coping skills, suicide and violence (Mudhovozi, 2011:513). Naidoo (cited by Pillay & Ngcobo, 2010:234) reported that emerging adults often report for a range of mental health issues, including depression and suicidal tendencies, at university counselling centres.

Mudhovozi's (2011:520) study on analysis of stress and life satisfaction in universities indicated that emerging adults mostly use avoidance-oriented strategies, rather than emotion- or solution-focused techniques, in order to deal with distress. This is consistent with findings in both a global and local context where students increasingly use alcohol or substances as a coping strategy (Blomeyer, Buchmann, Schmidt, Jennen-Steinmetz, Schmidt, Banaschewski & Laucht, 2011:1143; Pillay & Ngcobo, 2010:234; Van Voorhees, *et al.*, 2006:746). It is evident that the emerging adult's increased experience of being overwhelmed can produce stress-related problems and results in a visibly-escalated prevalence of mental health disorders amongst this age group (Vanheusden, *et al.*, 2009:239).

2.4 THERAPEUTIC INTERVENTION FOR EMERGING ADULTS

2.4.1 Therapeutic intervention as terminology

In this study, 'therapeutic intervention' forms an umbrella term that refers to the broad range of psychological schools of thought, which aim to intervene where psychological disturbances upset healthy living (Timmerman, 2011). 'Therapeutic intervention' will also

refer to the helping services professionals offer so as to assist an individual in dealing with a variety of physical, emotional, practical and traumatic stressors.

Due to the ever-widening field of psychology, various forms of intervention exist. Intervention can be conducted in an individual, group, couple or family format; it includes long-term, brief and supportive intervention and can take place in both in- and outpatient settings (Sadock & Sadock, 2003:923-949). Therapeutic intervention can comprise a variety of techniques, for example psychoanalysis, cognitive therapy, behavioural therapy, psychosocial intervention, hypnotherapy, biofeedback models and various other methods of intervention (Sadock & Sadock, 2003:950-973).

Therapeutic intervention can also be performed by a range of trained health care professionals for example clinical or counselling psychologists, social workers or registered counsellors. Rickwood, *et al.* (2005:4) indicates that when an individual experiences distress it is a combination of their actual awareness of the problem, the realisation that they need help and their active seeking of help that would allow them to access therapeutic services as a helpful resource.

Despite the availability of a range of different therapeutic approaches, the collective aim for therapeutic intervention, namely ensuring or improving emotional and psychological wellbeing, is constant in all of these approaches. Borge and Hummelvoll (2008:366), as well as Lenz (2001:302), indicate that emerging adults strive specifically to gain a sense of purpose in their lives. Therapeutic approaches can address this need by helping the emerging adult to develop insight and skills in order to acquire a sense of meaning in their lives. Consequently, living a meaningful life will have a positive effect on how challenges and difficulties are managed (Borge & Hummelvoll, 2008:366-370). This aim can thus be achieved through the various schools of thought, forms and methods of intervention available.

2.4.2 The aim of therapeutic intervention

Mental health problems are clearly an ageless, universal problem that should be dealt with on a number of levels. Evidence, for instance, substantiates that both psychological and pharmacological intervention can alleviate both mental health problems and distress (Gasquet, *et al.*, 1997:151; Haynes, *et al.*, 2011:156; Vanheusden, *et al.*, 2009:240). With regard to the emerging adult, therapeutic intervention, according to Schumacher and Maleis (cited by Lenz, 2001:303), should be focused on relieving dysfunctional

interruptions, preparing for transitioning adjustments and supporting new relationships. Supporting emerging adults in the development of skills and the ability to deal with their problems through therapeutic intervention can lead them to develop insight into their identities, promote their self-confidence and help them reach their developmental goals in order to lead a healthier life (Jacobsson, *et al.*, 2011:288; von Below, *et al.*, 2010:132). Pillay and Ngcobo (2010:238) also suggest that therapeutic intervention should emphasise the effectiveness of treating distress and mental health issues in order to promote general mental and emotional wellbeing.

2.5 HELP NEGATION BEHAVIOUR

Help-seeking behaviour refers to the active process of identifying a need for professional help and then utilising resources in order to access this help (Rickwood, *et al.*, 2005:4). In contrast to this, help negation behaviour, according to Rickwood *et al.* (2005:14-16), refers to an individual *not* utilising therapeutic services, even though intervention is needed, available and accessible. Jorm *et al.*, (2006:59), as well as Kessler and Walters (1998:4), state that therapeutic intervention is often underutilised when distress or depression is experienced. Tomlinson *et al.* (2009:369) notes that this tendency is seen both globally and locally and also in a variety of age groups. In the emerging adult population, the underutilisation of therapeutic services is mostly attributed to the high prevalence of help negation behaviour (Rickwood, *et al.*, 2005:3; Vanheusden, *et al.*, 2009:239).

In a study done by Gasquet *et al.* (1997:151) on French emerging adults, only a third of the individuals who reported depression sought help to overcome it. Clinicians and literature both, however, claim that the reluctance to seek help or engage in therapeutic intervention is a common occurrence in the emerging adult population (Briddle, *et al.*, 2004:248; Smuts, 2011; Stols, 2011; Weideman, 2012). In the next section, findings from various resources on certain beliefs and attitudes that limit help-seeking behaviour will be explored.

2.5.1 Lack of readiness to change

In contemporary therapeutic frameworks, intervention is often collaborative between the client and the therapist. Borge and Hummelvoll (2008:366) established that the therapist plays a supportive role and contributes theoretical knowledge and guidance, whilst the client contributes with personal beliefs, experiences and solutions for problems. This

mutual relationship is further supported in findings by Borge and Fagermoen (2007:202), as well as Rickwood *et al.* (2005:19), who states that in order for intervention to be successful a trustful, authentic and committed relationship needs to exist between the therapist and the client. This relationship is, however, dependent on the willingness of the client to engage in therapeutic intervention, as well as the level of commitment and effort the client inserts in addressing their issues with the therapist so as to bring about change in their life. It might even be stated that the key to an individual's recovery is contingent on their own readiness to change and get well (Colton & Pistrang, 2004:311-312). Unfortunately, this phenomenon is often lacking in the emerging adult age group.

2.5.2 Negative attitude toward therapeutic intervention

In the opinion of Van Voorhees *et al.* (2006:752) and Wilson *et al.* (2005:1526), one of the most destructive beliefs that hinder the emerging adult is that professional assistance, whether medical or psychological, will not help them. Grosseohme and Gerbetz (2004:590) confirm this belief and add that this belief is often the cause of poor compliance or even early termination of therapeutic services. Vanheusden *et al.* (2009:244), focusing specifically on the emerging adult population, found that emerging adults do not believe that therapeutic intervention for mental health disorders can have a positive effect on aspects such as work, educational or relationship dysfunctions. In a study by Rickwood, *et al.* (2005:16) on the help-seeking behaviour of young men (aged 14–24) in New South Wales, Australia, it was also found that previous negative experiences of formal help created a belief that professional intervention is not helpful. Some participants even stated that intervention made their problems worse, specifically when they felt they did not overcome their problems or when they felt that they were not taken seriously (Rickwood, *et al.*, 2005:16).

This, as well as other factors, lead to another negative belief, namely that it is better to deal with mental health problems alone than to get formal or informal help for their problems (Rickwood, *et al.*, 2005:16; Vanheusden, *et al.*, 2009:240). This belief was conveyed repeatedly in various studies as noted by Jorm *et al.* (2006:60) in a literature review article. In a South African study amongst rural-based university students (Pillay & Ngcobo, 2010:238), a quarter of the participants believed that professional help would be ineffective and that they thus needed to deal with mental health issues on their own. It was also found that emerging adults believe that mental illnesses and distress are a personal

weakness and would therefore rather deal with these problems alone than admit to personal weakness (Jorm, *et al.*, 2006:64; Vanheusden, *et al.*, 2009:245).

2.5.3 Lack of insight and knowledge

Researchers almost uniformly believe that negative beliefs with regard to mental health stem from a lack of knowledge and insight on the part of the emerging adult (Jorm, *et al.*, 2006:60; Rickwood, *et al.*, 2005:16; Wilson *et al.*, 2005:1535). Vanheusden *et al.* (2009:240) and Van Voorhees *et al.* (2006:751) reported that limited knowledge on the causes and symptoms of mental health disorders, as well as poor knowledge on the severity of symptoms, often lead to a delay or ignorance in seeking help.

Vanheusden *et al.* (2009:240) concludes that having poor knowledge about mental health problems leads to poor identifying and labelling of the problem, therefore emerging adults often do not see the need for help and display help negation behaviour.

Equally, the inaccurate, sensationalised portrayal of mental health in the media and movies causes incorrect stereotypes, stigmatisation and often help negation (Rickwood, *et al.*, 2005:18). According to Jorm *et al.* (2006:60), very few strong and popular role models who have experienced mental health problems and received help are prepared to step forward to refute the inaccurate depiction of mental health problems.

Vanheusden *et al.* (2009:240) states that another potential reason for poor insight is that emerging adults might lack the emotional intelligence to realise that they are experiencing stress. This is supported by Van Voorhees *et al.* (2006:751), who report a low perceived need for help due to a lack of awareness of their emotional distress. In an undergraduate study on the emotional intelligence of students (Ugoji, 2012:105), it was proved that students with higher levels of emotional intelligence had increased success in managing their distress. Rickwood *et al.* (2005:13) is of the opinion that some emerging adults are still developing their own emotional intelligence, which may be why distressing emotions are not identified and managed.

2.5.4 Gender influences

Literature also shows a distinction between men and women when admitting to distressing emotions and engaging in therapeutic intervention. Men appear to either have less insight into the severity of symptoms or a stronger threshold in dealing with problems, but are definitely less likely to seek therapeutic assistance (Bridle, *et al.*, 2004:250-251). Jorm *et*

al. (2006:64) discovered that men also have beliefs that are more rigid in that they feel that it is better to deal with depression or mental health problems alone and therefore often negate available help.

2.5.5 Stigmatisation

Stigma regarding mental health problems are an ever-present obstacle in dealing with mental health issues (Bradley, *et al.*, 2010:243) and this seems to be particularly true for the emerging adult population (Vanheusden, *et al.*, 2009:240).

Emerging adults fear not only the rejection of their peers and society, but also hold on to a belief that medication may be addictive and they are therefore reluctant to seek professional help (Bradley, *et al.*, 2010:244). Both Borge and Fagermoen (2007:200) and Haynes *et al.* (2011:155) attain that the fear of potentially being hospitalised and being labelled as a 'patient' brings about feelings of embarrassment which Rickwood *et al.* (2005:17) explained increases the experience of stigmatisation and supports the belief that it is better to deal with depression alone. In this regard, a gender difference is once again noted in that men are particularly concerned about confidentiality and fear stigmatisation, despite the fact that private and discrete services are offered (Rickwood, *et al.*, 2005:17).

2.5.6 Help negation in suicidal tendencies

An area where fear of stigmatisation is especially noticeable is where symptoms include suicidal ideation (Rickwood, *et al.*, 2005:15). Rickwood *et al.* (2005:15), in their literature-reviewing article, summarises the fact that increased suicidal tendencies mostly restrict help seeking at informal sources of help. This tendency is emphasised by Wilson *et al.* (2005:1535) who found that emerging adults are reluctant to inform their families or friends of the gravity and hopelessness of their thoughts and the intent of their actions when experiencing suicidal tendencies. Denying or suppressing these tendencies in one environment, for example social networks, could lead to the denial or suppression of these tendencies in all areas and could thus cause an increase in help negation behaviour in general.

2.5.7 Service accessibility and availability

It is important not to neglect logistic barriers in a discussion concerning a lack of willingness to engage in therapeutic services. Accessing therapeutic services may be hindered by financial restrictions or even transportation problems (Vanheusden, *et al.*,

2009:240). In some areas, especially in developing countries such as South Africa, mental health services may not be available at all (Jorm, *et al.*, 2006:60). These factors may contribute to a lack of knowledge of mental health disorders and services. Although these factors are largely beyond the emerging adult's control, they still have the potential to influence the emerging adult's participation in therapeutic services.

2.5.8 Age-appropriate therapeutic services

Literature indicates that practising clinicians should also carry some responsibility for the poor engagement of emerging adults in therapeutic services. Clinicians should adapt their therapeutic style and techniques in order to deliver age-appropriate and client-centred intervention to an individual (Borge & Hummelvoll, 2008:365). Gowers and Cotgrove (2003:479) state that due to the specialised needs of emerging adults specialised therapeutic services should be developed to increase the efficacy of the treatment. Calton and Arcelus (2003:294), however, noticed that intervention is focused most on the child, adolescent and adult populations, thus regularly overlooking the emerging adult age group. Abraham *et al.*, (1995:75), as well as Gowers and Cotgrove (2003:479), postulate that the lack of age-appropriate intervention for emerging adults could be due to the limited information available on the type of intervention preferred by emerging adults. Briddle *et al.* (2004:253) hypothesises that a potential reason for emerging adults' help negation behaviour is that therapeutic intervention is not created, presented and marketed to suit the specific needs of the emerging adult population.

2.6 LITERATURE LIMITATIONS

The current researcher tends to agree with both Colton and Pistrang (2004:312) and Grossoehme and Gerbetz (2004:592) who mention that research studies often focus on children, adolescents and adults, thereby neglecting the emerging adult population. Available studies are often not fully representative of the cultural, gender and demographic diversities of the emerging adult population and lack uniformity of terminology and clear developmental concepts (Arnett, 2000:477; Kessler & Walters, 1998:12). In addition, studies reflected upon in this overview pertain only to a westernised context. There is a major lack of knowledge about the research regarding emerging adults in the African context, including South Africa. As cultural differences can have a significant impact on the outcomes of a study, conclusions from one cultural background cannot be assumed for

another (Fouché & De Vos, 2011b:84). It is necessary to conduct research to expand and support existing literature in a South African context in order to carry validity for the South African emerging adult population.

2.7 CLOSURE

It is undisputed that the emerging adult group fills an age and role gap that has been growing with the progression of modern society. This population is an actively-exploring, change-driven and transitional group of individuals focused on gaining life experience, becoming independent and being involved in their communities (Arnett, 2000:473; Lenz, 2001:301). They are not only taking responsibility for their own choices and lives, but also for their health and the decisions regarding their wellbeing (Lenz, 2001:301).

Making decisions regarding their health is often necessary as this group is exposed to various stressors, environmental and societal pressures and transition adjustments that leave them more vulnerable to mental health problems (Calton & Arcelus, 2003:293; Grosseohme & Gerbetz, 2004:590). The emerging adult currently continuing their education is faced with a number of transitions and challenges with regard to a novel, alien and stressful social and academic environment that often lead to severe difficulties in adjusting and coping with these changes and challenges (Bojuwoye, 2002:277; Mudhovozi, 2011:510). This explains the global and local increase in prevalence of mental health disorders for the emerging adult population (Tomlinson, *et al.*, 2009:368; Vanheusden, *et al.*, 2009:239). Despite this, various studies indicate that this age group is reluctant to seek help and to engage in therapeutic services (Gasquet, *et al.*, 1997:151; Rickwood, *et al.*, 2005:14).

Literature studies indicating possible reasons for this reluctance are scarce (Arnett, 2000:477) and often focus on either an older or younger population group (Arnett, 2000:473). Furthermore, literature on emerging adults is not representative of both the African and South African context (Tomlinson, *et al.*, 2009:368). If a wider foundation of theoretical knowledge were to exist with regard to this population group, specifically about their therapy-engaging behaviours and needs, clinicians will be able to adapt their therapeutic styles, milieus or marketing strategies in order to better retain emerging adults in therapeutic intervention. This will lead to improved help-seeking behaviours, willingness and compliance to engage in therapeutic interventions and, eventually, positive treatment

outcomes and increased client satisfaction (Abraham, *et al.*, 1995:75; Grosseohme & Gerbetz, 2004:590).

CHAPTER THREE

RESULTS AND FINDINGS OF THE STUDY

3.1 INTRODUCTION

This chapter will consider how the study was performed and how the methodology was implemented in order to achieve the aims of the study. The chapter will also include a presentation of the results of the study, initially reporting on the main themes and subthemes with supportive phrases from the data and thereafter integrating the data with current literature to deliver a full interpretation of the study's findings.

3.2 METHODOLOGY

3.2.1 Research design

The aim of the study was to explore and describe the factors that contribute to the negation of therapeutic services by emerging adults enrolled in a South African university. In order to achieve this aim and to build on existing knowledge of this phenomenon, a qualitative research design was implemented. Ivankova, Creswell and Plano Clark (2007:259) explain that a qualitative design allows the researcher to investigate multiple perspectives of the individual's worldview. Nieuwenhuis (2007:75) adds that a qualitative design can lead to a full and rounded comprehension of the unique interactions of a person or situation. This study aimed at both understanding and promoting insight with regard to the help negation behaviour regarding formal help of emerging adults and thus the qualitative design of this applied research study (Leedy & Ormrod, 2005:43) supported the aim sufficiently.

The research strategy most suited to investigating this study was a case study design. Welman, Kruger and Mitchell (2009:193) define the case study design as the understanding of the polarities and undercurrents of a single system or case, usually of a social nature. In this study, the researcher considered the entire developmental phase of the emerging adult population within the specific phenomenon of help negation behaviour, but focused closely on the help negation behaviour of emerging adults in a South African university.

3.2.2 Participants

For the purpose of this study, the study population was identified as being all the emerging adults that received further education at a specific tertiary institution in South Africa at the time of the study. Both Welman *et al.* (2009:210) and Ivankova *et al.* (2007:259) agree that the sample population for a case study design should be selected with purpose. The restricted boundaries stipulating the sample (Strydom, 2011c:222) compromised a set list of criteria. The set list of criteria helped the researcher to focus only on a selected group of individuals with homogenous traits within the population. All the participants of this study thus fulfilled the following set of criteria:

- All of the participants were between the ages of 18 and 25. The youngest participant was 18 years and 10 months and the oldest 23 years and 8 months at the time of the study. The mean age of participants was 20 years and 3 months.
- All participants were enrolled at a specific university at the time of the study. Most of the participants (seven) were enrolled in a psychology-focused degree, two were enrolled in a marketing and tourism degree, one in an education degree, one in a food science degree and four in a dietetics degree.
- All of the participants were members of a university residence or organisation. Ten participants were students residing in campus accommodation and five of the participants were day students involved in a campus organisation. Seven different residences or organisations were represented by the participants.
- All participants agreed to the ethical considerations and voluntary nature of the study.
- English competence was an initial criterion for participation. Although participants were competent with spoken English, they struggled to express themselves in a language that was not their mother tongue. As all the participants were Afrikaans speaking, an adaption was made and the focus groups were then conducted in Afrikaans.
- Participants of all ethnicities, religions and genders were included in the study. All the participants were, however, Caucasian and only one of the 15 participants was male.

Although the study made use of target sampling and recruitment focused on purposeful selection of participants, snowball sampling occurred spontaneously during the execution of the study.

Snowball sampling (also called chain referral sampling) occurs when participants who participate in the study inform others of the study and encourage them to participate in the study as well, should they meet the participation criteria (Nieuwenhuis, 2007:79). This unplanned occurrence of snowball sampling assisted in increasing the number of participants in the study. It did, however, also influence the heterogeneity and diverse representation of the participants as the participants encouraged friends with similar demographic identities to themselves to participate in the study, for example, those of the same culture or in the same course of study. A critical synopsis of the recruitment process yielded the following:

Recruitment started by gaining permission from the university management, following the stipulated recruitment procedures, a month in advance. Permission was granted by the Dean of students to recruit participants through the residence house parents. The respective house parents were contacted to gain permission to distribute pamphlets and present the study to the residence students at the weekly house meeting of each of the 26 residences. All house parents and committee members, as well as the student representative of the student council for current affairs, were informed about the study and asked to pass this information along to the students. A total of eight residences (four male and four female) were visited by the researcher, who gave a presentation and extended an invitation to participate in the study. The study was also advertised on the general social media sites of the university and multiple reminders and advertisements were placed on the social media sites of each residence. This process, although intricate and effective, seems to have focused on the routines and customs of a certain type of student, leading to over-recruitment of said type student, which did not fully adhere to the suggestion by Webb and Doman (2008:58) to over-recruit in order to ensure enough participants for a study. This phenomenon will be discussed in more detail in the section on limitations.

3.2.3 Data collection

Three focus groups were conducted in different time slots over a one-week period. This was done to accommodate students who could not attend a set time slot because of class

schedules. Fifteen participants took part in the study. With regard to the representation in the focus groups, two groups comprised six members and one group, three.

Although the number of participants leans to the minimum range of the suggested number of participants in a focus group (Del Rio-Roberts, 2011:312; Greeff, 2011:366), the groups provided rich information to be used as raw data on a topic about which they are deemed experts (Welman, *et al.*, 2009:209-210). The focus group method worked especially well in this study as the participants engaged eagerly in the discussion and what Nieuwenhuis (2007:90) describes as “building on each other’s ideas”. This allowed for an open discussion and honest sharing of emotions and insight. Massey (2011:21) states that such a conversation will elicit valuable and rich information from the group, meeting the previously stated need to gain more insight into the personal and collective outlook of the participants.

An interview guide (refer to Appendix C) was used as an outline and structure for the interview. A funnel structure was used in the formulation of questions and in the outline of the interview guide. Nieuwenhuis (2007:91) describes this structure as starting out with broad and generalised questions to assist participants in becoming comfortable with the format of the group and questions and then moving to more focused and specific questioning to elicit data and encourage conversation. In this study, gathering data through gaining rich content was also supported by asking a variety of questions. Welman *et al.* (2009:211) suggests starting an interview with main questions but then following up with leading, steering, testing and even emotional questions in order to elicit responses from participants. The researcher employed these types of questions during the focus group sessions.

In addition to the data gathered through the content of the interviews, focus groups can hold valuable data in the group dynamics and natural interactions of participants (Nieuwenhuis, 2007:91). During the study, the group dynamics were not only used to support comfort and flow in conversation, but also to reduce potential inhibitions and anxiety. This contributed to the participants being more forthright and open about their opinions. The group dynamics were also considered during the data analysis process by listening to finer nuances and silences in the audio-recorded material and by observing non-verbal dynamics and reactions in the video-recorded material.

The selection of a neutral setting as suggested by Greeff (2011:371) in order to engender a feeling of warmth, comfort and safety was not entirely successful as the focus groups took place in the offices of the crisis support centre at the university.

Some participants mentioned that they felt slightly uncomfortable entering the offices due to fear of being stigmatised for being at the centre. (This aspect will be discussed more fully under the section on the limitations of the study.)

The groups lasted for between 90 and 120 minutes. As participants were informed of the time span of the groups prior to participation, there were no disruptions with regard to a participant needing to leave early. The researcher was, however, sensitive to concentration and energy levels during the group sessions and managed this through allowing breaks as well as by changing the direction of conversation if a specific topic was not of interest to the group. As advised by various authors (Del-Rio Roberts, 2011:313; Greeff, 2011:368), the facilitation team consisted of the researcher, acting as the facilitator, and an assistant facilitator. This proved to be valuable in the group as it allowed the researcher to focus on the conversation and content of the discussion, whilst the assistant facilitator managed the recording of material and field notes and ensured that the researcher did not miss any questioning opportunities.

3.2.4 Data analysis

Schurink *et al.* (2011:405) states that data collection and analysis in qualitative research form an intertwined process. The writers (Schurink, *et al.*, 2011:403) refer to Creswell's familiar data analysis spiral, explaining that qualitative data analysis moves in a cyclic nature and are in an ever-evolving process until holistic integration is achieved. Greeff (2012) proposes that performing data collection and analysis as an almost simultaneous process will improve the dependability of the study. In this study the aim was thus to engage in data analysis in close proximity to the data collection and to allow a natural flow of integration between these two elements.

In fulfilling the process of organisation of Creswell's spiral, the researcher carefully compared the transcription documents and recorded material to ensure that the data was presented in an accurate manner. Schurink *et al.* (2011:402) states that the quality of transcribed material and thus the study's raw data are of crucial importance to the successful outcome of the study. The next step, according to Ivankova *et al.* (2007:259), which forms part of the organisation of the data, involves the coding of the text segments.

This was done whilst bearing in mind that, as recommended by Dyson and Brown (2006:150), the focus was placed on clear and concise data and that redundant details and haziness were rejected. During the coding process obvious themes emerged from the data.

The researcher gained insight into the broader content of the information and could then progress to the categorisation process. In the categorisation process, Massey's (2011:23) long table method of grouping data to questions was performed.

As suggested by Schurink *et al.* (2011:402), the researcher continuously revisited the research question to ensure confirmability and authenticity during data analysis. The long table method allowed for the identification of common themes, which could then be categorised into smaller, more specific subsets and themes. Again, Massey's (2011:23) analysis tool was implemented. He suggests that in focus groups analysis should focus on articulated data (the direct responses of participants to questions), attributional data (the testing of previous or current hypotheses with participants) and emergent data (new insights offered by participants) (Massey, 2011:23). This process contributed to a thorough examination of the data and not merely the obvious themes. The researcher managed to adhere to Schurink *et al.*'s (2011:402) encouragement to go beyond apparent understanding of the data, but also to investigate the deviations in patterns and finer nuances of meaning from the raw material. The research team reviewed the themes and subthemes in order to ensure an accurate portrayal of the data. Data were used from all collection resources: audio, video, field notes and summary notes in order to gain a comprehensive understanding during the comprehension and categorisation process.

Finally, the themes and subthemes were considered, taking into consideration additional research resources that included findings from current literature and an interview with student leaders at the university. As multiple resources were considered in the study the process of crystallisation permitted integrated and relevant findings to emerge from the study. Nieuwenhuis (2007:81) defines crystallisation as the emergence of data from the available resources. Crystallisation allows for a flexible and open process where interpretation emerges from the variety of techniques and resources used to collect the data. This was considered closely during the final process of resource integration (Nieuwenhuis, 2007:81). The researcher thus interpreted the patterns that materialised

from the collective fund of data rather than imposing personal views or biases on the results. The results and interpretations of the study are discussed below.

3.2.5 Trustworthiness

This study was planned and implemented with high regard for the trustworthiness of the information that was gained and the results that were delivered by this study. The steps set out in the preparation phase of this study were adhered to and will be discussed below.

Authenticity (Schurink, *et al.*, 2011:420) was firstly achieved during the interviewing process where inputs were reflected to participants to ensure that it was correctly understood. The researcher and the facilitator compared notes and clarified possible vagueness immediately after each focus group. This added to the correct and authentic interpretation of the data. Authenticity, however, was mostly maintained by ensuring that the content and intention of the participant's dialogue was authentically represented. During the analysis process data sources were crosschecked between the audio material, transcribed content and the verbatim phrases to ensure the accurate portrayal of information.

In order to ensure transferability (Schurink, *et al.*, 2011:420) of the study the researcher intended to recruit participants that were representative of the sampling group. Unfortunately, the participants who volunteered to participate in the study were of a specific demographic group and a fully representative group could therefore not be achieved. This could be considered as a limitation with regards to the transferability of the study to different ethnic and cultural groups. Within the specific demographic group that the participants represented, transferability was however achieved as the data collected reached a point of saturation, as suggested by Greeff (2012)

This study was executed in a logical and consistent fashion. The data gathered was also analysed systematically and regularly checked to ensure reliability. The study adhered to a high level of dependability (Greeff, 2012). Additionally steps were taken to guarantee the confirmability of the study (Schurink, *et al.*, 2011:421). As recommended by Fouché and Schurink (2011:316) the researcher made use of bracketing and remained objective throughout the data collection and analysis processes. The results of this study validate previous literature and can provide a solid foundation for further investigation relating this topic. This confirms the researcher's impartiality and unbiased interpretation of data. The trustworthiness of this study will continue through the safeguarding of the sound and video

recordings, as well as the safeguarding of the study itself. The raw data will be destroyed five years after the completion of the study.

3.2.6 Ethical considerations

Ethical considerations were highly regarded during this study in order to ensure ethical conduct during the implementation and interpretation of data. As suggested by Trochim (2001:24) participants were recruited on a voluntary base and were not coerced into participation. Participants were fully informed of the nature and the procedure of the study and were made aware of their rights during the participation of this study. According to the stipulations of Leedy and Ormrod (2005:101-102) the informed consent form included the purpose, aim and procedures of the study and was presented in comprehensible terms (See appendix B and C). The researcher was fully transparent about the recording of the focus groups, to which participants also had to give permission.

In order to ensure confidentiality and anonymity (Leedy & Ormrod, 2005:102) participants were allowed to choose pseudonyms, which some participants agreed to. The ground rules with regard to confidentiality were clearly communicated to the participants before the interviewing process of the focus group commenced. This included information of the recording of the sessions, as well as the safeguarding of the recorded material. During the analysis process, the researcher made use of codes to ensure the anonymity of the participants. The names and/or pseudonyms of the participants have not been made public through the research report, as suggested by Strydom (2011a:120). This study was conducted in a manner that ensured participant's privacy and maintained confidentiality.

The utmost caution was taken to avoid any harm to the participants during the focus group sessions (Strydom, 2011a:115). All the groups were a comfortable and safe space in which participants could share their opinions, which they did with ease. The groups had a good sense of cohesion and unity, especially as most participants agreed on the factors that contribute to the negation of therapeutic services by emerging adults. The facilitator allowed for a natural flow in the conversation, as proposed by Grudens-Schuck *et al.* (2004:3) and was sensitive to potentially distressing topics within the conversation. Although no severe incidents of concern arose for the participants. After the completion of the groups, the participants were invited to refreshments, which allowed the debriefing of participants to be informal and comfortable. Participants made use of this opportunity to ask questions and express emotions, where after the sessions were ended. Participants

verbalised that they enjoyed participating in the study and showed a keen interest in the research topic. Conclusively it can be stated that this study adhered to the planned ethical considerations.

3.3 DISCUSSION OF RESULTS

This section will give a detailed description and an interpretation of each of the themes and subthemes of this study. This study aimed to provide answers to the question: “What are the factors that influence the negation of therapeutic help by emerging adults at a South African university?” In answering this question, the following main themes were identified from the analysed data:

- Beliefs regarding the concept of therapy;
- Beliefs regarding participation in therapy;
- Fears with regard to therapy;
- Personal and developmental aspects;
- Familial influences;
- Societal factors;
- The style of the therapist;
- The therapeutic relationship;
- Financial barriers;
- Confusion with regard to the availability of specific therapeutic services and procedures; and
- Ineffective service promotion.

For each main theme, subthemes were identified that assisted in describing the theme. Each section will include a table to indicate the subthemes and verbatim quotes from participants that illuminate the theme. An additional column will affirm how the data integrates with the theoretical understanding gained through the literature review of this study as discussed in Chapter Two. Thereafter, an integrated discussion of the theme will follow, wherein the theme will be described and aligned to the existing knowledge on help negation behaviour.

3.3.1 Theme 1: Beliefs regarding the concept of therapy

As an introductory question to set off the focus group process, the researcher asked the participants what they thought therapy was. From the outset, it was clear that participants had only a very vague idea with regard to what therapy is and who can utilise therapeutic services. During the interviewing process, a clear theme emerged around certain beliefs held by the participants with regard to what therapy is and who should go for therapy.

Most of these beliefs are based on incorrect assumptions, previous negative experiences or general stigmatisation and play a big role in the rationale of the emerging adult when negating help.

Table 3.1: Theme 1 - Beliefs regarding the concept of therapy

| Theme | Subtheme | Example | Theoretical integration |
|--|---|--|--|
| Theme 1: Beliefs regarding the concept of therapy | <i>Subtheme 1.1: Therapy doesn't have an aim and isn't really helpful</i> | "Can that psychologist really help me?" | A. Negative attitude toward therapeutic intervention B. Lack of insight and knowledge |
| | | "I also don't believe that they are going to make me feel better." | |
| | | "I believe it is pointless." | |
| | | "I just do not see the purpose of it." | |
| | | "... It won't help to go to therapy ... because you remain in the situation and it doesn't go away." | |
| | <i>Subtheme 1.2: Therapy is only for people with</i> | "You have to go if you have real issues." | A. Negative attitude toward therapeutic |
| | | "It is not for a lot of small | |

| | | | |
|--|--|--|---|
| | <i>serious problems</i> | issues.” | intervention |
| | | “You don’t believe that ... is a serious enough problem to go for therapy.” | B. Lack of insight and knowledge C. Stigmatisation |
| | | “It is for crazy people and other extreme cases; they will get help from it.” | |
| | <i>Subtheme 1.3: Therapy is not seen as a priority</i> | “... it is difficult to make a commitment to go for therapy every week ... [i]t (therapy) is not part of a student’s routine.” | A. Lack of readiness for change B. Negative attitude toward therapeutic intervention |
| | | “Your priorities are different.” | |
| | | “I don’t think you can see the results [of therapy].” | |

3.3.1.1 Subtheme 1.1: Therapy doesn’t have an aim and isn’t really helpful

Participants were very clear in their belief that therapy does not have a well-defined aim and thus often stated the belief that going for therapy will not be helpful. They intertwine this belief with the belief that a person can get over a problem and that therapy is therefore not needed to help a person deal with their problems. Because participants believe that therapy is not a well-defined concept and the aims of therapy are very vague, they do not believe that therapy will be helpful. In the opinion of the participants, therapy can assist a person in gaining a new perspective on their problems, but will not necessarily help them overcome the problem. Participants felt that therapy is not an instant and transcendent solution to their problems; as a participant remarked, “Therapy is not magic.” It is therefore stated by the participants that if an individual is in a difficult situation that seems as if it will not change (e.g. domestic disputes), therapy will not help them, as it will not change the situation. Participants admitted that media and stereotyped perspectives on therapy also

influenced their beliefs. Rickwood *et al.* (2005:16) postulated that a current negative belief toward therapy could originate from a previous negative experience with therapeutic services. As only a very limited number of participants had previous therapeutic experience (three out of 15 participants), this statement could not be confirmed. Previous negative experiences in this focus group stemmed more from personal experience of friends or family who had received therapy previously. The fact that therapy was not always successful in the case of friends or family contributed to a general belief that therapy is not helpful or effective. Participants, however, were also of the opinion that therapy would be least helpful when the person going for therapy is not committed to the process. A study by Colton and Pistrang (2004:311) on emerging adults suffering from anorexia nervosa supported the fact that an individual should “play an active part” in their therapy in order for the therapy to achieve its aims. Despite realising that a sense of personal commitment is necessary in the therapeutic process, the generalised belief that therapy is not helpful has a large help negation effect. This subtheme supports the findings of Vanheusden *et al.* (2009:240) who similarly uncovered the belief that professional help is not beneficial in dealing with a problem.

3.3.1.2 Subtheme 1.2: Therapy is only for people with serious problems

Another significant barrier to seeking help is the belief that therapy is only for people who suffer from serious problems. One participant claimed, “You cannot just go and chat or talk about your stress, you have to go when there are real issues.” Participants believe that emerging adults not only struggle to admit that their problems may require therapeutic assistance, but they do not like to be associated with these serious issues and the people that have them. One participant stated that she at one point felt that she needed therapy, but because her idea of people that go for therapy was so far removed from her view of herself, she could not get herself to go. Participants stated that advertisements of therapeutic services often depict those who are struggling with psychosis or need an abortion as being individuals who need therapy. This promotes the association that therapeutic services are only for individuals with serious issues and thus discourages therapeutic participation in the generally distressed emerging adult. It is especially interesting to hear what participants view as “a serious problem”. It seems that participants consider only severe incidents as being serious problems. This is extended to singular life incidents including significant family problems, pregnancy and abortion, death of a loved one and suicidal tendencies. Although participants stated that they believe small everyday

life issues can build up and become even more disruptive than a singular life incident, this belief still does not seem to overcome the strongly held opinion that therapy is only for severe incidents.

In consulting student leadership on this study, Selo (2013), the student council member for current affairs, was also of the opinion that emerging adults have a perception that therapeutic services are only for serious issues, using the example of a serious incident such as contracting HIV. He believes that this perception largely contributes to help negation behaviour regarding formal help resources. Other studies (Bridle, *et al.*, 2004:248; Rickwood, *et al.*, 2005:15; Wilson, *et al.*, 2005:1535), however, stated that the extreme polarity of this theme is also a cause of help negation behaviour. According to these authors, emerging adults will also negate help when the problem is extremely severe and the individual tends to have suicidal ideation. This study could not, however, confirm this belief as participants were strongly of the belief that therapy is only for severe incidents.

3.3.1.3 Subtheme 1.3: Therapy is not seen as a priority

The belief that participants do not see therapy as a priority originates from two perspectives. Firstly, participants believed that therapy is not a typical student activity. According to the participants, emerging adults in general would consider spending time socialising, going to gym or doing a sport, or going out for coffee as being more important than going for a therapy session. On further probing, it was interesting to discover that participants actually realise that saying they are too busy and do not have time is merely an excuse and that therapy is simply not seen as being an activity of significance. Arnett (2000:469, 473) states that part of the developmental phase of emerging adults is to explore various activities and volitions and then exercise autonomy over deciding what they find to be meaningful engagement. As therapeutic services are not deemed significant and valuable, the emerging adult will thus rather choose to engage in other activities that they feel are more significant and valuable.

The second perspective that constitutes this theme could be considered a potential reason for why therapeutic services are not being viewed as a priority. In this regard, participants commented on the fact that therapeutic participation is not normally spoken about and as there are no clear and visible results of therapy, therapy is therefore not viewed as being beneficial and important. The participants believe that if one could speak about therapeutic

services and a “word of mouth reaction” could occur, it might contribute to a realisation that therapeutic sessions can deliver results and be valuable. As these discussions do not normally occur, the results of therapeutic services are unknown and therapy is thus not seen as a priority.

3.3.2 Theme 2: Beliefs regarding participation in therapy

Beliefs concerning therapy did not focus exclusively on the concept of therapy, but also included beliefs regarding participation in therapy. This theme explores how participants viewed others who participate in therapy and considers the characteristics of someone who would not need therapy. The theme will also look at the effect that participation in therapy will have on the individual’s sense of independence and how this influences an emerging adult’s participation in therapy. In view of this theme, it is clear that emerging adults have poor insight with regard to mental health issues and the benefits of therapy. It also emphasises the existence of stigmatisation in the emerging adult population.

Table 3.2: Theme 2 - Beliefs regarding participation in therapy

| Theme | Subtheme | Example | Theoretical integration |
|---|--|--|---|
| Theme 2: Beliefs regarding participation in therapy | <i>Subtheme 2.1:</i> <i>People often use therapy to seek attention or exaggerate their problems</i> | “...people who will go to therapy for the attention ... they do not really have a problem.” | A. Stigmatisation B. Lack of insight and knowledge |
| | | “I think there are people who would have liked their problems to be larger than what they really are.” | |
| | | “People go to a psychologist because they expect the worst and that is why they are there, but some people just need to be told: ‘Wake up; there is nothing wrong with | |

| | | | |
|--|---|--|---|
| | | you'." | |
| | <i>Subtheme 2.2: Going to therapy means that one is a weak person</i> | "...when they go to therapy they feel that they have given in and that they lose that sense of self belief that they are strong enough to do this, and then they become weak in a certain sense." | A. Stigmatisation B. Lack of insight and knowledge |
| | | "The fact that I have to ask for help makes me a weaker person." | |
| | | "... They will be seen as weaklings and they do not want to be seen that way." | |
| | | "It can be seen like that [to be a weakling], because you cannot deal with your problems yourself." | |
| | <i>Subtheme 2.3: 'Positive' people do not need therapy</i> | "Positive people can cope (with stress) and are fine [sic] where negative people struggle; they will need someone to talk to, to get them positive again and to help them get rid of the problem." | A. Stigmatisation B. Lack of insight and knowledge |
| | | "I am fine, I am positive, I will get over this, it's fine." | |
| | <i>Subtheme 2.4:</i> | "... Medication is being | A. Negative |

| | | | |
|--|--|---|---|
| | <i>One can become dependent on therapy or on the medication prescribed</i> | prescribed too quickly and too easily. It may be that you continue to drink the pills, because you firmly believe that you cannot cope without medication, even if you've learned new coping skills." | attitude toward therapeutic intervention B. Lack of insight and knowledge C. Stigmatisation |
| | | "I do not want to get up each morning and think that I will not be able to get through the day if I do not drink medication." | |
| | | "That medication becomes not only your crutch, but your legs." | |
| | | "I think that if you go to therapy you will be dependent on it and I think that is why a lot of people will not want to come to therapy." | |

3.3.2.1 Subtheme 2.1: People often use therapy to seek attention or exaggerate their problems

The belief that people who go for therapy only seek attention is created from a number of influences. The most influential factor is possibly previous experiences and perceptions of friends or family that, in the eyes of the participants, seemed to go for therapy to gain attention. Participants shared these experiences and claimed that some people thrive on always having problems and believing that they need help. Waters (2011:208), in a study on attention-seeking behaviour in the family dynamic, confirmed that presenting with distressing behaviour is often labelled by individuals as simply being a need to seek

attention. Participants are of the opinion that the issues that people in this situation present with are normally not serious enough to go for therapy, which links to the previously stated belief that one should only go for therapy for serious problems. Participants viewed situations like these as being a waste of a therapist's time and therapy resources that could rather have been used by someone who really needed them. Adding to this, they felt that therapy would not help these individuals, as sympathy would lead to more self-pity and the person would thus not take active steps to resolve their problems.

One of the participants felt strongly about this and mentioned "sympathy would just make it worse as people who seek attention would continue to feel sorry for themselves and think themselves into a deeper hole". It is evident that the belief that people who only seek attention from therapy adds to the stigmatisation of therapeutic participation. This attitude and accompanying stigma can contribute to help negation behaviour when considering therapeutic services, as participants do not want to be seen as attention seeking and possibly weak.

3.3.2.2 Subtheme 2.2: Going for therapy means that one is a weak person

During the focus group process, the concept of being weak when one seeks help was one that often surfaced. "That would mean that I am a weak person" was a regular response during the focus group. One participant, for instance, responded to this aspect by saying "You need to have a hard shell. I shouldn't show that I need therapy". The concept of needing to present oneself with a tough exterior so as not to display personal weakness, as well as being weak when asking for help, appears to contribute to help negation. "Being weak" is conceptualised loosely by participants as "not being in control of myself and not being able to manage my own problems". This belief could possibly cause the emerging adult to try harder to cope on their own, even if their attempts are unsuccessful, and may even cause the emerging adult to deny the problem in the first place. As autonomy and self-actualisation (Arnett, 2000:473) is an important aspect of the developmental phase of the emerging adult, being or appearing weak will therefore directly counteract a sense of individual achievement. One participant used the metaphor of not wanting to start the journey of independent adult life with the use of a crutch. Participants also associated "being weak" with being negative and being too serious about life, which they identify as unwanted qualities. Similarly, being attention seeking and self-pitying were seen as great flaws and serve as frustration to the individual who can in a sense "get up", "carry on" and

deal with their own problems. Emerging adults are in search of their individualised identities (Haynes, *et al.*, 2011:154), but their identities are still, to an extent, dependent on positive feedback from peers (Asberg, *et al.*, 2008:483). It is therefore possible that the emerging adult's need for positive feedback by appearing to be in control and "strong" in front of peers can cause negation of therapy.

3.3.2.3 Subtheme 2.3: 'Positive' people do not need therapy

The belief that "positive' people do not need therapy" could be placed on the opposite end of the continuum from "going to therapy implies that you are weak". The belief that "positive' people do not need therapy" stems from a current reality: a set of characteristics that the emerging adults presume for themselves. Some phrases that participants used to describe a positive person are: "I am an open person"; "having a strong personality"; "having coped with things in the past" and "being an extrovert that can easily talk about their issues". The fact that they believe they possess these qualities makes it almost unthinkable that they would need therapy. The participants attributed a 'positive person' as being someone who is dynamic, spontaneous, often extroverted and easy going with a sense of perseverance and drive. Participants believed that if a person were a 'positive' person, the person would convey an optimistic attitude and not allow problems to overwhelm and disrupt them. Van Voorhees *et al.* (2006:751) postulated that this sense of character and strength has a direct influence on what they call a "lower perceived need for treatment", as the individual would then depend on their own skills and character to such an extent that they would not see the need to seek therapeutic support.

3.3.2.4 Subtheme 2.4: One can become dependent on therapy or on the medication prescribed

All the participants strongly held the belief that one might become dependent on medication or therapy. They believed without doubt, that utilising therapy or medication over a significant period would make a person dependent on them. Although some participants realised that medication was needed in the case of pathological disturbances, the belief that medication will eventually become addictive surfaced strongly. Bradley *et al.* (2010:244) also noted that the fear of medication becoming addictive would have a help negation effect. In contrast to this study, these authors found that emerging adults are mostly afraid of using medication because it would result in mockery and stigmatisation by their peers. In the opinion of the participants, emerging adults want to be autonomous and

independent. To them, the use of medication or therapy would jeopardise their sense of independence. Their opinion is consistent with findings from both Arnett (2000:473) and Lenz (2001:301) who present emerging adults as individuals craving to be independent and to take responsibility for themselves. Through participant responses, it was evident that the belief that therapy and medication can cause dependency stems from a lack of insight with regard to mental health disorders and treatment options. Despite these inaccuracies, participants felt that this belief would contribute largely to help negation of formal help.

3.3.3 Theme 3: Fears with regard to therapy

During the study, it became apparent that one of the most challenging barriers to help seeking in emerging adults is the fears that they have regarding therapy. They have specific uncertainties as to how therapy will be, how they will be treated during the therapeutic process, what the potential outcome of the therapy will be and how others will perceive them for attending therapeutic sessions. These fears also play a role in intensifying certain mistaken beliefs concerning therapy and can act as an aggravator for practical barriers.

Table 3.3: Theme 3 - Fears with regard to therapy

| Theme | Subtheme | Example | Theoretical integration |
|--|--|---|---|
| Theme 3: Fears with regard to therapy | <i>Subtheme 3.1: Fear of being diagnosed</i> | “This is becoming serious; there is something really wrong with me.” | A. Negative attitude toward therapeutic intervention |
| | | “So the idea that there is a possibility that I might be diagnosed is really too far removed from your idea on how people are when they are diagnosed.” | B. Lack of insight and knowledge C. Stigmatisation |
| | <i>Subtheme 3.2: Fear of being</i> | “I think that knowing you will be labelled is a big reason | A. Stigmatisation B. Negative |

| | | | |
|--|--|--|--|
| | <i>judged and stigmatised</i> | why we do not go for therapy.” | attitude toward therapeutic intervention |
| | | “They wonder: ‘Is he crazy?’; ‘What is wrong with him?’; ‘Why is he going to a psychologist?’” | |
| | | “The reason why you go to the therapy is maybe the reason why people judge you.” | |
| | | “I wondered what people were going to say when I walk into the crisis support centre.” | |
| | <i>Subtheme 3.3: Fear of being vulnerable and hurt</i> | “It is not a comfortable process to be confronted with every aspect of yourself.” | A. Negative attitude toward therapeutic intervention B. Lack of insight and knowledge |
| | | “What I realised now is that people are also scared of what will surface in therapy.” | |
| | | “Their questions can make these issues resurface or even suddenly exploding [sic] again.” | |
| | | “It is too hurtful to process these issues again.” | |

| | | | |
|--|--|---|--|
| | <i>Subtheme 3.4: Fear of being recognised and not being treated confidentially</i> | “I think you are especially scared here on campus that a therapist might talk to a physiotherapist or a receptionist.” | A. Age-appropriate therapeutic services B. Stigmatisation C. Negative attitude toward therapeutic intervention |
| | | “I think people are especially scared that confidentiality will be broken, because you are in a phase of your life where you want to establish your role in society.” | |
| | | “I want to see my therapist in therapy, not in another place.” | |

3.3.3.1 Subtheme 3.1: Fear of being diagnosed

Whilst discussing the concept of therapy and what it entails the possibility of being diagnosed when seeing a therapist (or psychologist) surfaced. As with the other subthemes of this theme, more probing was needed to get a clear understanding of what the participants implied when they mentioned this possibility. The underlying inference was that if there is a possibility of being diagnosed when going to therapy the emerging adult would rather not go to therapy, as they are too afraid of being stigmatised. One of the reasons for this fear coincides with the mistaken belief that going for therapy implies that a person is weak. Having mental health issues or even stress-related problems not only imply that a person is weak, but also that they are ‘crazy’. To the participants, this label is very undesirable and they would therefore not voluntarily attend a session where being “crazy” can be associated with them.

Although it is apparent that this fear stems from a lack of mental health awareness and stigmatisation, it also stems from a fear of associating oneself with a negative personality trait. According to Schwartz, Beyers, Luyckx, Soenens, Zamboanga, Forthun, Hardy,

Vazsonyi, Ham, Kim, Whitborne and Waterman (2011:854), emerging adults are in the process of establishing an individualised identity. It is believed that during the process of establishing one's identity, confusion and confluences can cause an emerging adult to over identify with certain identities or to adopt identities that are not necessarily authentic to them (Schwartz, *et al.*, 2011:840). It is distinctly noticeable in this study that participants do not want to associate themselves with certain negative characteristics such as being 'weak', 'negative or even 'introverted'.

Participants are afraid that their identities will be defined by these negative characteristics or even disorders. As one participant stated, "I think people would rather add that they are beautiful or successful to their list of characteristics, than adding that they suffer from depression". These negative characteristics are unfortunately associated with a person that requires therapy. Participants therefore verbalised their caution to admit to needing therapeutic services and felt that being associated with these characteristics can create an unwelcome conflict in their perception of who they are.

Lenz (2001:304) brought to attention the emerging adult's need for achievement and personal growth, whilst Bojuwoye (2010:287) and Pillay and Ngcobo (2010:237) noted that fear of failure is a trigger for stress in the emerging adult population. The participants indicated that being diagnosed would be like failing – an obvious barrier to the achievement of success. This opposes the normative instinct of the emerging adult and can consequently increase the fear of being diagnosed. Another mistaken belief that contributes to the fear of being diagnosed is the belief that therapy and medication can be addictive. Becoming dependent on medication or therapeutic support is seen as being a flaw and is in opposition to autonomy. The fear of being diagnosed thus includes the fear of being dependent, not being able to deal with problems by themselves and, ultimately, a fear that they will not be the strong and independent person that they strive to be.

3.3.3.2 Subtheme 3.2: Fear of being judged and stigmatised

Fear of stigmatisation as a barrier to help seeking is a widely reported phenomenon. It is reflected in findings on studies in most age populations (Borge & Fagermoen, 2007:200), but is also specifically noticed in the emerging adult population (Bradley, *et al.*, 2010:243; Vanheusden, *et al.*, 2009:240). Bradley *et al.* (2010:244) is of the opinion that this phenomenon is especially common in the emerging adult population as peer opinions and a need for acceptance are still important to the emerging adult. This theme could be

triangulated fully as the student leadership of the university (Selo, 2013) have also noted that fear of stigmatisation is a help negation factor. In feedback and observations by the student council, they became aware that students did not want to disclose certain issues or discuss their problems with counsellors or social workers due to the fear of stigmatisation. Both Selo (2013) and the participants of the focus group felt that the origin of distress is more linked to being judged and labelled than to the actual attendance of therapy. Participants explained that a person is labelled because of their diagnosis.

They fear that peers would wonder and gossip about why the person requires therapy and what their potential diagnosis is, more than the fact that they went for therapy. Selo (2013) was also of the opinion that students may be scared to enter the buildings where therapeutic services are offered, as they may potentially be criticised by peers when they are seen entering these buildings. This was confirmed by the participants who reported an actual experience of fear, despite only entering the building for the purpose of participating in the study. Furthermore, participants who had previous experiences of condemnation and lack of support from friends, families and institutions when they attended therapy claimed that these experiences increased their current experience of fear regarding judgement. The fear of stigmatisation indicates that there is still a lack of awareness and insight with regard to mental health and distress on university campuses (Pillay & Ngcobo, 2010:238).

3.3.3.3 Subtheme 3.3: Fear of being vulnerable and hurt

This subtheme offers what Massey (2011:23) labels as emergent data. This insight was unforeseen by the researcher and offers a novel perspective on the sentiments of the emerging adult population. When participants brought up the fear of being vulnerable and hurt it was accompanied by strong non-verbal responses that indicated the intensity of emotions that this fear elicits. The fact that therapy can potentially open up old wounds was shaded with strong negative associations. As one member articulated, “You store away everything that has happened to you; if you begin to talk it will all come back again”. In a counteraction, another member questioned the group by asking, “Have you really processed the issue if it is still traumatic and brings you such a lot of unsettled emotions?” Most participants, however, associated more with the first statement and felt that the fear of re-experiencing such hurt and vulnerability was an obstacle too immense to surmount. It can be that this fear may only be applicable in the case of emerging adults who had

experienced such hurt and vulnerability. Participants, however, agreed that the fear of having to re-experience trauma and feeling vulnerable and hurt would cause emerging adults to negate help even were it needed.

3.3.3.4 Subtheme 3.4: Fear of being recognised and not being treated confidentially

In a literature review study by Anderson and Lowen (2010:781) on mental health services provided to youth it was found that distrust regarding confidentiality is a significant barrier to accessing and utilising therapeutic services.

It appears that in the age-specific emerging adult population, concerns with regard to confidentiality were more due to the fear of stigmatisation and not because of the confidentiality itself (Rickwood, *et al.*, 2005:17). During the current study the issues concerning confidentiality and anonymity also surfaced as participants felt that the possibility of not being treated confidentially would have a help-negating effect on them. Participants acknowledged that their fear of judgement and stigmatisation would increase their need for confidentiality. This confirms the previous findings of Rickwood *et al.* (2005:17) that confidentiality is an area of concern because of fear of stigmatisation by others.

Participants indicated that this theme also considers their need for anonymity and thus an accompanying fear that they will be recognised or will have to face their therapist in a non-clinical setting. It may be that the setting of this study influenced this finding. The university and its main campus, where the study was performed, encourage a sense of community and thus familiarity. Because of this, it is implausible that a student will visit the same shops or churches as a therapist. In addition, participants were aware of the fact that the therapeutic services departments offer supervision opportunities or internships for final year students. Again, the possibility exists that the emerging adult will be recognised by someone that they know or that they may be confronted with seeing the same person in a non-clinical setting. The dreaded awkwardness, potential judgement and sense of personal embarrassment all contribute to the fear of being recognised and not treated confidentially. As this would potentially prevent participants from attending therapy, it is classified as a conceivable help negation factor.

3.3.4 Theme 4: Personal and developmental aspects

Researchers (Arnett, 2000:469; Molgat, 2007:495) often remark on the complexity of the emerging adult developmental phase. One of the reasons for this complexity is the critical

stage that an emerging adult faces with regard to their identity formations and transitions (Schwartz, *et al.*, 2011:839). Understanding that emerging adults are in an intense phase of identity clarification can cast a light on the reason for their help negation behaviour being influenced by personal and developmental aspects. Emerging adults' perception of themselves and themselves in society has a significant impact on them firstly admitting to distress and secondly seeking the help they need to manage it.

Table 3.4: Theme 4 - Personal and developmental aspects

| Theme | Subtheme | Example | Theoretical integration |
|---|--|---|---|
| Theme 4: Personal and developmental aspects | <i>Subtheme 4.1:</i> <i>Unawareness</i> | "You do not always realise what is really happening to you." | A. Lack of readiness to change B. Lack of insight and knowledge |
| | | "I think a lot of time you think that you are fine." | |
| | | "Maybe students do not realise that their methods are not working." | |
| | <i>Subtheme 4.2:</i> <i>Denial</i> | "You maybe don't want to admit it." | A. Lack of readiness to change B. Lack of insight and knowledge C. Stigmatisation |
| | | "The effect of these problems is not necessarily obvious, especially because you are also trying to hide it." | |
| | <i>Subtheme 4.3:</i> <i>Awareness, but need for</i> | "With or without help I will get over this." | A. Negative attitude toward therapeutic |
| "I can deal with my problems | | | |

| | | | |
|--|---|---|---|
| | <i>independence</i> | on my own.” | intervention B. Lack of readiness to change C. Stigmatisation |
| | | “I do not like the idea that someone else helps me, because I want to cope with my problems on my own.” | |
| | | “I think young adults do not want to be prescribed to and they do not want guidance. They just want to figure it out for themselves.” | |
| | | “I think that fact that people failed you is what makes you want to deal with problems on your own.” | |
| | <i>Subtheme 4.4: Gender differences</i> | “I think guys use different escapes.” | A. Gender influences |
| | | “I think that they just get over it by themselves.” | |
| | | “Girls are more comfortable to talk.” | |
| | <i>Subtheme 4.5: Individualism</i> | “Everyone has individual needs when it comes to therapy.” | A. Age-appropriate therapeutic services |
| | | “Every person is unique and you are going to react differently to what you need or what you want out of life.” | |

| | | | |
|--|--|--|--|
| | | “It’s my personal choice and opinion; it is the way I am.” | |
|--|--|--|--|

3.3.4.1 Subtheme 4.1: Unawareness

The lack of awareness with regard to stressful emotions or when one finds oneself in a distressing position is a substantial barrier to utilisation of therapeutic services in the emerging adult population. Rickwood *et al.* (2005:13) attributes this phenomenon to a lack of “emotional competence”, claiming that emerging adults do not have sufficient emotional insight to identify, understand and manage negative emotions. Vanheusden *et al.* (2009:240) also mentions lack of emotional competence as being a barrier, but also ascribe a lack of awareness to an inability to notice distressing symptoms due to a lack of mental health awareness. Although not as clearly articulated as in the research article by Vanheusden *et al.* (2009:240), the participants of this study felt that a lack of awareness is often because they do not realise that they are experiencing stress because the symptoms are not clearly visible to them.

The participants also claim that they often do not have time to process their emotions or the potentially stressful events that took place. With regard to this a participant commented, “You do not sit and think about, for example, that you were scared and why you were scared and what triggered it and what your reaction should have been.” Selo (2013) noted that this often happens to emerging adults in leadership positions as their schedules are so overloaded that there is little time to consider the effect of underlying stress on their mental and physical wellbeing. Some participants believed that a person might be implementing strategies to manage stressors but not realise that they are ineffective and are causing their problems and stress to increase and intensify. Vanheusden *et al.* (2009:243) also noted that emerging adults do not realise the effect that distress has on their daily ability to cope and function.

Participants also commented that it is often the small and seemingly insignificant daily issues that later combine to create severe distress and exhaustion. As a participant explained, “When something big happens you realise that you need help to overcome it, but you do not realise that when small things happen over and over again, it can also be a problem.” Emerging adults’ lack of awareness can thus be caused by a lack of mental

health awareness, poor emotional intelligence and insufficient time to focus on emotional wellbeing. These factors could all lead to an inability to notice distress and the individual would therefore not seek the help they need in order to overcome said distress.

3.3.4.2 Subtheme 4.2: Denial

The participants acknowledged that emerging adults are often aware that they are struggling and experiencing distress, but are most often in denial and do not want to admit it. They acknowledged that the denial could again stem from a fear of stigmatisation. Bojuwoye (2010:288), in a study on the experience of stress in South African universities, as well as a student leader (Selo, 2013), also acknowledged fear of stigmatisation as being a potential reason for denial by student leaders. Denial could stem further from a reluctance to face personal limitations. Participants viewed admitting to stress and needing therapeutic support as a weakness and felt that the person using therapy has a flawed personality. Denial, as an unconscious protection mechanism, protects the emerging adult against the reality and consequences of their distress. Whilst they are in the fragile and insecure stage of identity establishment in the emerging adult life phase, it appears that emerging adults are especially vulnerable to negative personal labels and judgements. Denial thus safeguards them against the actualisation of their negative beliefs with regard to therapy, as well as from believing that they are personally too weak to admit to their problems and use therapy. Unfortunately, the result of maintaining a position of denial will be the neglect of seeking and receiving which would allow one to manage difficult and stressful periods in one's life.

3.3.4.3 Subtheme 4.3: Awareness, but need for independence

Wanting to deal with mental health issues independently is possibly the most documented help negation factor, regarding formal help negation. Jorm *et al.* (2006:60) noticed this occurrence in adults whilst Rickwood *et al.* (2005:16), Vanheusden *et al.* (2009:240) and Van Voorhees, *et al.* (2006:751) noticed it in emerging adults. The need to deal independently with problems and stress-related issues can be due to the need for independence and personal responsibility that according to Arnett (2000:473), is a developmental attribute of the emerging adult population. Lenz (2001:300) elaborates that this need for independence includes the right to decide about their own health-related decisions and actions. Participants in this study felt very strongly that they have reached the developmental age where they want autonomy in their lives. This self-sufficiency

includes the right to deal with their problems independently. Participants explained that whilst growing up they did not experience autonomy and were always guided or supported in some way. Having now reached an age of increased independence they want to be fully autonomous, which includes accepting responsibility for their mental health. Previous studies by Rickwood *et al.* (2005:16) and Vanheusden *et al.* (2009:240) indicated that emerging adults feel that they are able to deal with their problems in an independent manner. In this study it is clear that emerging adults want to deal with their problems on their own, whether they are able to or not. This category thus considers both the personal aspect of capability with regard to dealing with problems and the developmental aspect of wanting autonomy during this life phase. Both contribute, quite persistently, to the help negation of therapeutic services by emerging adults.

According to Rickwood *et al.* (2005:16), the emerging adult's belief that therapy is not useful contributes to the fact that they would rather deal with their problems themselves. Participants were of the opinion that all that is needed when a problem arises is to change one's attitude and take actions toward resolving the problem. Therapy would therefore be pointless. A participant pronounced, "With or without help, I will manage. The psychologist is only a placebo effect to get me to where I want to be". Although this is true for some individuals, others might need the support and skills that can be offered through therapeutic intervention, specifically in cases of severe distress and an inability to cope.

Participants further mentioned that if a person is unable to deal independently with their problems they are viewed as a weakling. The embarrassment of having to admit that one is using therapeutic intervention would thus impose a sense of failure on the individual who used it. Therefore, the emerging adult would try to "hold out a little bit longer" or "try a different way", rather than bridging the need to appear in control and independent by asking for help.

Lastly, some participants felt that their previous disappointments in others and experiences where they were not helped sufficiently contributed to their help negation behaviour of formal help. Participants believed that emerging adults would have difficulty in trusting an individual, even if this were a health professional, after they have experienced a failed attempt of support previously. The participants felt that this often leads to a determination to deal independently with one's problems, despite realising the severity of their problem and knowing that there is help available.

3.3.4.4 Subtheme 4.4: Gender differences

The participants of this study felt that women would be more open to going to therapy and talking to someone than would men. There was also the general assumption that men would make more use of what Mudhovozi (2011:520) calls avoidance-oriented strategies, that is, strategies to block out the stress or the stressful trigger. Mudhovozi (2011:512) states that avoidance-oriented strategies can include alcohol or substance use and aggressive activities. It is interesting that participant felt that men would rather use these avoidance-oriented strategies than address their problems through therapy. It is, however, important to note that most participants were female and this is therefore a predominantly feminine perspective. A study by Rickwood *et al.* (2005:4), however, confirmed this view, indicating that it is more probable that women would ask for therapeutic support than men. In an earlier study by Rickwood and Braithwaite (1994:570), it was postulated that expressing emotions is a more feminine trait and thus to discuss distressing emotions does not necessarily affect the self-image or peer-image of a female. In contradiction to this, men are usually expected to be hard and tough and thus not express their emotions, which can contribute to a help-negating effect in males. Participants in this study agreed that men would refrain from talking about their emotions. It is thus clear that gender differences with regard to help negation factors do exist. This study cannot, however, conclusively pinpoint the exact differences as there was only one male participant and this was not the focus of the study.

3.3.4.5 Subtheme 4.5: Individualism

This subtheme continuously emerged from triangulated sources of data. As emerging adults are in a process of re-configuring their identities and world views, individualism is a quality that emerging adults strive for (Bynner, 2005:370; Molgat, 2007:499-500). In response to a question on emerging adults' needs in therapy a participant replied, "It depends on your age, on your level of development, on your level of maturity and your mannerisms and your coping strategies...". It is evident that emerging adults not only want to be independent in their actions and decisions, but that they also base their actions and decisions on their unique personalities, maturity and goals. They prefer to be treated based on their internal values and needs, rather than be subjected to uniformity and standardised methods. In a variety of themes, participants raised the issue that emerging adults have individualised needs and perceptions when it comes to therapy and

therapeutic approaches. Literature confirms this aspect when James (cited by Anderson & Lowen, 2010:781) states that youth services should be unique and separated from an adult-orientated approach to therapy. Similarly, Gowers and Cotgrove (2003:479) indicated the current evidence-based gap in the provision of specialised and age-appropriate intervention. In the emerging adult population, help negation would be prompted if services were not provided to suit the unique and individualised needs of the emerging adult age group or the specific needs of the individual.

3.3.5 Theme 5: Familial influences

Despite the emerging adult’s need to see themselves as individuals distinct from parents and family in order to gain independence, the influences of their childhood still have a distinctive effect on their thinking and acting (Molgat, 2007:497). In this theme, it is clear that emerging adults are not influenced directly by their families, but that beliefs, attitudes and behaviours that were cultivated in their upbringing can be present in an indirect manner in their current perceptions. In cases where these influences discourage emotional intelligence or the use of therapeutic services, childhood influences seem to influence the emerging adult’s current help negation behaviour when considering therapeutic services.

Table 3.5: Theme 5 - Familial influences

| Theme | Subtheme | Example | Theoretical integration |
|--|----------|---|--|
| Theme 5: Familial influences | – | “If your parents didn’t encourage emotions and maybe even punished you for showing emotions it [going to therapy] would have already been a problem.” | A. Negative attitude toward therapeutic intervention |
| | | “I mean all of our family members before us overcame these things by themselves; they didn’t have therapy.” | |

| | | | |
|--|--|--|--|
| | | <p>“You will now be less likely to seek help because you see adult interference as a threat to your autonomy.”</p> | |
|--|--|--|--|

Perry (cited by Arnett, 2000:474) explained that emerging adults are in a precarious position regarding their beliefs and opinions. They collected various introjected belief systems and behaviours throughout their development and are only now in a position where these views can be challenged and evaluated in order to develop their personal perspectives. The emerging adult is thus exploring their new beliefs, but is still, to a large extent, influenced by the beliefs and behaviours from their childhood. The participants of this study as well as student leadership (Selo, 2013) felt that certain familial aspects have a strong influence on help-seeking behaviour. For instance, if parents did not encourage the expression of emotions or the notion of therapeutic support it would make emerging adults less likely to consider and utilise therapeutic services in the present. In support of this a participant stated, “It’s not like we have been brought up in a home where everyone is OK with therapy or where you know that when you have problems you can go for therapy”.

The emerging adult’s upbringing also, to some degree, influences the belief that they should deal with stress independently and that going to therapy would be to display a weakness. Selo (2013) commented that specifically in the Afrikaans culture, there is a tendency to refrain from speaking about problems because of their conservative background and beliefs about needing to appear in control. These factors add to the emerging adult’s reluctance to engage in therapeutic services as they have been brought up to face and deal with their problems alone. Lastly, participants felt that the level of autonomy they experienced as children could cause them to cling to a newfound independence associated with the freedom of campus life and they would thus not want to go therapy where someone might engage with them from an authoritarian position. The need for autonomy extended to not wanting to be forced to go to therapy, especially by parents. Although emerging adults are purposefully exploring and expanding their personal views they are still influenced, to an extent, by their upbringing and their decision to engage in therapy might be hindered by certain familial influences.

3.3.6 Theme 6: Societal factors

Participants of this study felt quite strongly that their social support structures were adequate with regard to fulfilling their need for support and guidance. They added that the campus environment itself puts them in contact with ample opportunities to access social support. This theme explores the reasons for participants negating professional help in favour of informal help from friends and families. It further elaborates on other societal factors that can influence help negation behaviour.

Table 3.6: Theme 6 - Societal factors

| Theme | Subtheme | Example | Theoretical integration |
|-------------------------------------|---|--|--|
| Theme 6: Societal factors | <i>Subtheme 6.1:</i> <i>Societal lack of awareness and neglect of mental wellbeing</i> | “I think people should be educated to the goal and purpose of psychology.” | A. Lack of insight and knowledge |
| | | “Other things became more important than to care about others or to pay attention to your emotions.” | |
| | | “Emotions are seen as totally unimportant.” | |
| | <i>Subtheme 6.2:</i> <i>Using family and peer support</i> | “We have social support available to us.” | A. Negative attitude toward therapeutic intervention B. Lack of insight and knowledge |
| | | “It is easier for me to speak to someone I know.” | |
| | | “I think it is because of my support system, my parents were always with me.” | |

| | | | |
|--|--|---|---|
| | | “My friends are very mature and I feel that they give me good advice.” | |
| | <i>Subtheme 6.3: Depending on religion</i> | “In my opinion you receive your answers from God.” | – |
| | | “I feel that He reveals to me what I have to change and then the responsibility lies with me to do so.” | |

3.3.6.1 Subtheme 6.1: Societal lack of awareness and neglect of mental wellbeing

Studies by Jorm *et al.* (2006:60) and Vanheusden *et al.* (2009:240) noted that there is a general lack of mental health awareness. The lack of mental health awareness by society in general has, according to the participants, placed them in a position where they are uninformed about mental health and stress-related disorders. They also felt that the lack of time, energy and effort afforded to mental wellbeing by society causes them to neglect their mental health as well. It could therefore be said that poor insight with regard to mental health will cause poor seeking and engaging in therapy in the global population, but also in the emerging adult population.

3.3.6.2 Subtheme 6.2: Using family and peer support

Bynner (2005:368) and Vanheusden *et al.* (2009:239) state that emerging adults are in a developmental phase where establishing solid social relationships is of crucial importance. Participants indicated that these relationships are often their source of support and guidance. Parents, close family members, peers, even older friends, or community role models could give social support in times of distress. Participants, however, place great value on the importance of evaluating social support resources in order to determine whether the support system would be valuable and sufficient in helping a person deal with their problems. As explained by a participant, “I know them and what they stand for ... their integrity has been tested”. Concerning this, two aspects are considered when evaluating the worth of social support. Firstly, according to the participants, a person needs a “good”

social support structure, namely friends or family that are trustworthy and can give valuable advice. Secondly, a person needs enough support, thus having a sufficient number of individuals that they can go to for support. These aspects would be used to determine if a person has a solid support basis and if confirmed, therapy would often be deemed redundant. Rickwood *et al.* (2005:4) confirmed that getting help and support from parents or friends could increase help negation behaviour when it involves therapy, especially in women. Participants felt that women are more likely to use social support in dealing with their problems. Offer (cited by Rickwood, *et al.*, 2005:5), however, suggested that social support resources may not always provide sufficient support as the relevant person might lack the insight and training to provide help in severe situations.

Participants agreed with this hypothesis and one participant stated, "It's not always a good thing, because they [social support] do not always know what advice to give you and can give you wrong advice". Participants also mentioned that support resources could sometimes come from a friend who does not have a good social influence and that following this friend's advice can lead to more distress. They were, however, of the opinion that emerging adults normally have a variety of different support resources, which are available to them in different situations. For instance, when one simply needs to have a good time a specific friend might be available, whereas another might be available to discuss relationship issues with and yet another to discuss religious matters with. In the case where emerging adults have such a support base available to them, they would not consider therapy and would negate this help, even should therapy be needed or offered.

3.3.6.3 Subtheme 6.3: Depending on religion

Depending on religion, as with utilising social support, promotes help negation as participants felt that they would rather depend on their religion than go to therapy. This includes having an active relationship with God and experiencing his physical presence with regard to support and guidance during difficult times and depending on others who have an active relationship with God. It is of note that previous global literature on help-seeking behaviour did not raise religion as a basis for help negation. A vast number of students in the university population where this study took place, including the participants in the study, are known to have a strong religious foundation. It should be noted that the population demographic could have influenced this finding. A more diverse population is

needed in order to determine the transferability of a strong religious foundation as a help negation factor of formal help.

3.3.7 Theme 7: The style of the therapist

The theme of rapport and dynamics in therapy was unearthed by participants' explicit replies to the researcher's questions and is thus classified as articulated data by Massey's (2011:23). Yet, this theme also contributes some attributional data, whereby data either confirm or reject a current hypothesis. As mentioned before, the reason for the initial formulation of the current study was a concern raised in a clinical setting. Within this setting the researcher and clinical colleagues (Smuts, 2011; Stols, 2011) considered the possibility that certain characteristics of a therapist could have a help-negating effect, which was confirmed by the participants during the focus groups.

Table 3.7: Theme 7 - The style of the therapist

| Theme | Subtheme | Example | Theoretical integration |
|---|--|---|--|
| Theme 7: The style of the therapist | <i>Subtheme 7.1:</i> <i>Inexperience</i> | "They have studied, but they have not experienced it for themselves." | A. Negative attitude toward therapeutic intervention |
| | | "It is not that I second guess their knowledge, just their experience." | |
| | | "I also prefer someone younger, but I am just wondering if that person would have the necessary experience and knowledge to optimally help a person." | |
| | <i>Subtheme 7.2:</i> <i>Unprofessionalism</i> | "A lot of therapists are still feeble; they are not committed to being | A. Stigmatisation B. Negative attitude toward |

| | | | |
|---|--|---|---|
| | | professional.” | therapeutic intervention |
| | | “The issue that put me off was that you shouldn’t be late for a session, you should be there, pitch up!” | |
| | | “They treated me as if there was something wrong with me; they showed so much empathy that I thought: ‘OK, maybe not’ and I literally turned around and walked away.” | |
| <i>Subtheme 7.3: Divergent therapeutic traits</i> | | “Personally I wouldn’t like it if a therapist is always so dominating or if they interrupt me whilst I am talking.” | A. Age-appropriate therapeutic services B. Negative attitude toward therapeutic intervention |
| | | “It would be really bad if I had to try and explain myself throughout a session.” | |
| | | “Because then it is so morbid and it makes you even sadder about your situation.” | |
| | | “They pity you and I do not want to be pitied.” | |
| | | “I would prefer someone that still shares a bit of my life phase.” | |
| <i>Subtheme 7.4:</i> | | “I want someone to talk to me | – |

| | | | |
|--|------------------------------|--|--|
| | <i>Religious differences</i> | from my religious perspective.” | |
| | | “Someone with the same religious beliefs as me can give me a long-term solution.” | |
| | | “I would never go to a therapist that does not have the same religious beliefs that I have.” | |

3.3.7.1 Subtheme 7.1: Inexperience

The first aspect that would produce help negation regarding the therapist’s style would be if the therapist were inexperienced. Participants did not feel they had to question the theoretical knowledge of a therapist, but would be sceptical about going for therapy if they felt that the therapist was inexperienced. Participants were of the opinion that an inexperienced therapist would be less effective in their therapeutic engagement and the support that they can provide. In confirmation of this subtheme, a comparative study between experienced and inexperienced therapists by Willot (2007:41-42) claimed that inexperienced therapists often lack the self-awareness and confidence needed to engage positively with clients and would use disclosure of countertransference as a tool to achieve therapeutic results. Participants agreed that inexperience did not automatically imply the therapist’s years of experience but rather an inability on the part of the therapist to draw insight from personal experiences in order to guide their therapeutic interventions. In clarifying this statement, a participant, in view of an inexperienced therapist, declared, “Sometimes they do not have the personal wisdom and life experience that an older, more experienced therapist has”. Participants felt that if therapists simply based their interactions on their clinical knowledge, it would make them sceptical as to whether this person would really be of help.

3.3.7.2 Subtheme 7.2: Unprofessionalism

From the data, it was clear that unprofessional conduct would keep the participants from going to see a therapist. From the participants' viewpoint, unprofessionalism was seen as being over-sympathetic; implying that something is wrong with the person; not having mutual respect; not respecting appointments or the emerging adults' time; and not communicating about administrative aspects. Similar issues were identified in a study by Klinger, Ladany and Kulp (2012:568-569) on therapist's moments of embarrassment. These included aspects such as mistakes in scheduling, missing or being late for appointments and confusing clients with regard to administrative arrangements.

It was also found that, following incidents of unprofessionalism, a therapist's embarrassment could have a negative effect on the relationship equal to that of the incident itself (Klinger, *et al.*, 2012:555). Participants who had previous experiences of therapeutic unprofessionalism were more vocal about and opposed to unprofessionalism, but other participants in the group supported this sentiment eagerly.

When Clarkson (1989:144) defines professionalism from a Gestalt-oriented perspective, she claims that authenticity in personal experiences is crucial so as to not allow the therapeutic relationship to be construed in a negative light. Participants of this study confirmed that a lack of authenticity from therapists as well as support staff would cause them to question the professionalism of both the individual and the organisation. Clarkson (1989:69) also confirmed that a therapist should consider the whole of the client's personhood and not just their pathology. This endorses the need on the part of participants to be viewed as more than just "a problem to be fixed". Unprofessionalism as a help negation factor can also be linked to the previously discussed fear pertaining to being recognised in public and not being treated confidentially by an unprofessional therapist. In a study by Manso *et al.* (2008:62) on therapeutic alliance in a predominantly adolescent population, participants agreed that professionalism was an important quality in therapists. The study (Manso, *et al.*, 2008:62) claimed that the fundamental aspects of professional behaviour are trust, confidentiality and respectful conduct. Manso, *et al.* (2008:62) also found that if therapists did not conduct themselves responsibly their clients would not deem them professional. In describing unprofessionalism and how it affected the therapeutic relationship, a participant referred to a previous experience, "Then I found out

he was ill and it made me extremely angry ... I would have understood ... if he just told me.”

Lastly, it is important to note the participants' concerns with setting-specific occurrences. The internship offered at the therapeutic intervention centre in this setting contributed to the belief that the therapist might be unprofessional and inexperienced. Participants believed (whether correctly or incorrectly) that a person who is still in the process of an internship would not be sufficiently professional. Although neither the professionalism nor the experience of a therapist or intern therapist could be confirmed, the emerging adults' perspective that they *might* be unprofessional or inexperienced would still contribute to help negation.

3.3.7.3 Subtheme 7.3: Divergent therapeutic traits

Participants were very clear that certain characteristics of a therapist would put them off when considering therapy. Likewise, in the study by Manso *et al.* (2008:62) participants preferred a certain set of characteristics. In the younger population, these characteristics were of a more supportive nature and included being caring, having good judgement and being mature and being a keen listener (Manso, *et al.*, 2008:61). Participants in this study expressed that they do not want a therapist that is too domineering, superior and pushy. A clear rejection of an authoritarian therapeutic style was also expressed. They are also disinclined to engage with a therapist that is too calm, too serious and too morbid, preferring a lighter and more uplifting energy from a therapist. Participants claimed that they would prefer a therapist that has a collaborative style, rather than a nurturing or authoritarian one. Barnard and Kuehl (1995:167) acknowledge the fact that therapists should consider adapting themselves to suit the needs of their clients and holding a more authentic and mutual stance in therapeutic engagement.

Participants further appear to have an aversion to a therapist who is over-sympathetic and suggests or acts as if there is something wrong with them. As argued in previous themes, the emerging adult is reluctant to admit to personal weakness. It can be debated that this causes the emerging adult's rejection of an over-sympathetic approach, as it might feel that it is being implied that they are weak or not capable of dealing with their problems. Another therapeutic trait that would cause an emerging adult to negate the therapist's help is if the therapist makes assumptions, struggles to follow or understand what the person is saying and does not listen effectively. Participants also felt that it would be too difficult to

relate to someone much older than themselves. They felt that emerging adults would not relate to someone that did not share some of what they are currently going through in terms of developmental aspects, for example a person much older than them who is not necessarily up to date with younger trends or current with the needs of emerging adults. The participants felt that a therapist in their late twenties or early thirties would be ideal. As one participant stated, “The gap is not that big, therefore you can have a comfortable conversation”. Due to the traditional cultural norms of the participants, they were also hesitant to engage with an older individual that they had to refer to in culturally appropriate titles, such as ‘oom’ (uncle/sir) and ‘tannie’ (aunt/ma’am).

A participant explained, “You do not want to feel bad, because you are disrespectful when you talk about your problems”. The participants felt that they would immediately feel uncomfortable and inferior due to this hierarchical structure and would thus not want to commit to therapy. Some participants commented on the gender of a therapist that could also play a role in negating help from a therapist. Saturation of information in this regard was not, however, sufficient or conclusive.

Lastly, participants emphasised the importance of therapists identifying and adhering to the individual needs of a client. This seems to be an important aspect, as individualism is a crucial developmental goal for emerging adults (Lenz, 2001:302). Participants believed that each emerging adult would have their own individualised preferences with regard to a therapy style and therapist approach. Harpaz-Rotem and Blatt (2011) therefore suggest that it would be helpful for therapist to allow diversity in their relationships with clients based on the different needs and personalities of that client.

3.3.7.4 Subtheme 7.4: Religious differences

Participants felt that they would not want to see a therapist with different religious beliefs from themselves. Although they verbalised that religion would not have to be the focus of each session, they felt that they would rather engage with someone that has a religious basis and can interact from that perspective. Psychotherapeutic frameworks have always had contradicting views on the extent to which a therapist should allow their personal beliefs to influence the therapeutic interaction. The psychoanalytical movement expects complete refrain from intervening in a client’s process (Willot, 2007:5) whilst the Gestalt perspective is of the opinion that the therapist needs to be fully present with the client’s experience without losing their own perspective, in order to allow for authentic relational

contact (Hycner & Jacobs, 1995:48). In this study participants confirmed that the personal beliefs of a therapist with regard to religion, as well as their inclusion thereof in therapy, can be an essential element for successful intervention and would in fact draw emerging adults to both seek and retain therapeutic help.

3.3.8 Theme 8: The therapeutic relationship

This study also offered insight about preferences in the therapeutic relationship, which allows for an understanding of the aversion of emerging adults with regard to a therapist’s character traits. As research in the emerging adult population on partialities in the therapeutic relationship is limited, Biering (2010:65) indicated the need to investigate this further, especially to look at the requirements and needs of emerging adults with regard to the therapeutic relationship. The results of this theme therefore deliver a significant contribution to the current knowledge base of emerging adults and therapeutic interactions.

Table 3.8: Theme 8 - The therapeutic relationship

| Theme | Subtheme | Example | Theoretical integration |
|---|--|--|--|
| Theme 8: The therapeutic relationship | <i>Subtheme 8.1: Hierarchical relationship</i> | “He sits on his big nice leather chair; that would be very intimidating.” | A. Negative attitude toward therapeutic intervention B. Age-appropriate therapeutic services C. Stigmatisation |
| | | “He also has to share about himself, not excessively, but he shouldn’t be completely private.” | |
| | | “The sense that the therapist looks down on me.” | |
| | <i>Subtheme 8.2: Stereotyped therapeutic</i> | “In therapy you are constantly asked: ‘how do you feel about this?’” | A. Negative attitude toward therapeutic |

| | | | |
|--|---------------------|--|---|
| | <i>interactions</i> | “The psychologist sits and writes in his book and never looks up.” | intervention B. Age-appropriate therapeutic services |
|--|---------------------|--|---|

3.3.8.1 Subtheme 8.1: Hierarchical relationship

In a critical overview of psychodynamic counselling, Gross (2001:201) mentions that the key to efficient psychodynamic therapy is believed to be the one-sided and partial therapeutic relationship, which allows the therapist to be uninvolved in the client’s process. Gross (2001:215), however, questions whether this type of relationship is in fact ethical and beneficial. Brodley (1986) stated that, especially when incorporating the client-centred approach, a therapist should remove their professional mask and simply be a genuine human being, that is, themselves, within the relationship. Brodley (1986) claims that this would allow the client to experience “unconditional positive regard” and become the expert of their own situation and growth. This was especially important to the participants of this study, as one participant stated, “You want someone that has the knowledge to guide you in the right direction, so that you can actually analyse and help yourself”.

The participants of this study also verbalised that emerging adults are more inclined to a reciprocal working alliance. In considering a therapeutic alliance, a participant verbalised the following, “I do not want someone to tell me what to do; I want a mentor”. Barnard and Kuehl (1995:167) agree with this and encourage therapists to facilitate a non-hierarchical relationship that encourages a working relationship and the collaborative exploration of a client’s problems. As mentioned in the theme on divergent therapeutic traits, the emerging adult population does not prefer a therapist that is too authoritarian and serious. Similarly, the participants mentioned that a relationship with a therapist that is too formal, serious and didactic would prevent them from engaging in therapeutic intervention. To the participants, a vertical relationship included physical aspects such as sitting on an intimidating chair or very formally behind a desk and even dressing in an overly formal manner, as well as relational aspects, such as being too formal and private and being very stiff in conversation.

Rickwood *et al.* (2005:18) is of the opinion that stereotyped presentations of therapists in media and films could contribute to the lack of insight as to what therapeutic intervention really is. This sentiment seems to be obvious in the participant's discussions of their perception of the therapeutic relationship and venue. Although there is the possibility that these perceptions are based on incorrect assumptions, their key requirements of a therapeutic relationship would still be to have an open, comfortable and mutual relationship. Participants were of the opinion that they would either not go or not return to therapy in the case of having an uncomfortable and asymmetrical relationship with a therapist.

3.3.8.2 Subtheme 8.2: Stereotyped therapeutic interactions

Another stereotyped perspective as mentioned by both the participants and literature (Rickwood, *et al.*, 2005:18) is the way in which therapists speak. The phrase that is overly associated with therapists, namely, "How do you feel?" is believed to have an immediately preventative effect on the emerging adult with regard to engaging with a therapist. Other phrases that would cause negative reactions by emerging adults are, "things happen for a reason", "there is a bigger plan in this", or "you will understand all of this one day". This category relates closely to the previous category, wherein participants stated that a didactic and hierarchical therapeutic relationship would be a help negation factor.

Using stereotyped phrases would imply to the emerging adult that the therapist acts from a position of superiority where the emerging adult has to talk and the therapist has preconceived ideas, practised responses, as well as possible inauthenticity, because the therapist is not actively involved and present in a comfortable, reciprocal conversation. In a theoretical response to stereotyped therapeutic reactions, Brodley (1986) stated that a therapist should be cautious in the use of empathic responses and that the aim of these interactions is not to use these phrases, but to make the client feel understood. It is important to note that participants base their rejection of therapy due to stereotyped interactions on their *assumptions* of how a therapist would interact and not necessarily the *reality* of therapeutic engagement. Still, the perception that a therapist would engage with them in clichéd responses is sufficient to cause a help negation reaction in the emerging adult.

3.3.9 Theme 9: Financial barriers

Participants verbalised that the financial implications of attending therapy can produce help negation behaviour. The underlying causes for this barrier are investigated in this theme in order to gain an understanding of why financial factors cause a barrier to help seeking, when fees concerning therapeutic services on a university campus are often minimal or absent.

Table 3.9: Theme 9 - Financial barriers

| Theme | Subtheme | Example | Theoretical integration |
|--------------------------------|----------|--|---|
| Theme 9: Financial barriers | – | “People don’t know this, they are scared. Especially students are scared to pay.” | A. Service accessibility and availability |
| | | “There are other more tangible things that I want to spend my money on.” | |
| | | “Possible he has to independently look after himself. How would he then be able to pay for therapy?” | |

Although emerging adults in a university setting might still be financially dependent on parents, bursaries or organisations (Petersen, *et al.*, 2009:102), emerging adults are transitioning to making independent financial choices (Arnett, 2000:473). When choosing what to spend their money on, participants felt that therapeutic services would not be a priority. Despite the lack of awareness with regard to the affordability of therapeutic services offered to students, participants still reasoned that they would rather spend their money on something more tangible, practical and, in their opinion, valuable. One participant explained that the outcome of therapy is so difficult to weigh and compare with the immediate and quantifiable satisfaction of buying a piece of clothing or going out with friends. Participants also contemplated the fact that some students may have financial

difficulties and then, regardless of whether they need the therapy to help them manage their situation, they would be too scared that these sessions would cost money.

Concerning financial difficulties, studies by Mudhovozi (2011:510) as well as Pillay and Ngcobo (2010:237) confirmed that financial insecurity has a profoundly stressful impact on a South African university student. Because of significant financial difficulties, an emerging adult would refrain from spending that money on therapy. It is thus financial difficulties, the fear of expenditure concerning therapy and the lack of insight into the value of therapy in comparison with palpable materialistic spending that play a significant role in the help negation of therapeutic services by the emerging adult.

3.3.10 Theme 10: Confusion with regard to the availability of specific therapeutic services and procedures

Anderson and Lowen (2010:781) indicated that various studies considered availability of and access to services as being help negation factors. In the setting of this study therapeutic services are, however, both easily available and accessible. Participants expressed that they are often aware of the services available, but that their confusion about how and where to access these services can lead to a negation of help.

Table 3.10: Theme 10 - Confusion with regard to the availability of specific therapeutic services and procedures

| Theme | Subtheme | Example | Theoretical integration |
|---|----------|--|---|
| Theme 10: Confusion with regard to the availability of specific therapeutic services and procedures | – | “We all know the crisis support centre and even the number, but no-one has used it.” | A. Service accessibility and availability B. Lack of insight and knowledge |
| | | “No-one knows what services they offer.” | |
| | | “What must I do? How will the people be? Where are they located?” | |

| | | | |
|--|--|--|--|
| | | “We don’t really know how it works.” | |
| | | “I actually forgot that there is a service on campus.” | |

Participants very honestly admitted that they thought the crisis support centre would help them change a flat tyre or replace a lost student card. Even though they were all aware of the centre, its logo, number and even advertisements, they were not clear as to the actual purpose and procedures of the centre. They felt that some students might not even know about the option, but that it is more a case of not knowing exactly what the service entails that kept them from using it. This was also apparent in previous studies by Anderson and Lowen (2010:781) and Rickwood *et al.* (2005:18), in that emerging adults did not know where or how to go for help.

The current study indicates that emerging adults might be aware of the service, but if they do not have a sense of the procedures and a level of security regarding what will happen at the therapeutic centre, they are also inclined to negate the help. This even included uncertainty as to the exact location of the services. A potential hypothesis for this occurrence, postulated by the participants, was that students are informed of the existence of therapeutic services during their first week as students. This is often a very busy and overwhelming week for students and therefore the transfer of information can easily go astray. Participants specifically attributed this to the fact that they are so overwhelmed by the magnitude of information during the first week that they later forget that therapeutic services are available. In addition, it might be that the marketing of therapeutic services is not efficient or striking enough and thus emerging adults do not pay attention to the content of the advertisement.

Another potential explanation for this confusion that became evident through this study is that an emerging adult needs to muster up a sufficient amount of courage to surmount fears, mistaken beliefs and potential stigmatisation in order to attend therapy and get the help they need. Leite and Kuiper (2008:55) stated that individuals with low levels of self-esteem could be particularly sensitive with regard to the uncertainty of a therapeutic process. In using Prochaska’s model of change, Leite and Kuiper (2008:55) discovered

that confusion and uncertainty could keep an individual stuck in the contemplative stage of change, without ever progressing to action. It is therefore a possibility that even the slightest insecurity about the procedure and location would decrease the emerging adult's courage radically and serve as an extensive help negation factor.

3.3.11 Theme 11: Ineffective service promotion

It appears from the findings of this study that ineffective service promotion can lead directly to a negation of help. Services that are not advertised in a clear, desensitised and age-appropriate way increased the emerging adult's negative beliefs and feelings of fear when considering therapeutic intervention.

Table 3.11: Theme 11 - Ineffective service promotion

| Theme | Subtheme | Example | Theoretical integration |
|---|--|--|--|
| Theme 11: Ineffective service promotion | <i>Subtheme 11.1: Marketing reinforces the belief that therapy is only for severe issues</i> | "They market it in such a way that it seems that you need to experience a serious crisis." | A. Negative attitude toward therapeutic intervention B. Lack of insight and knowledge |
| | | "Without making it look so serious as if I am about to go over the edge." | |
| | | "An advertisement that is just normal and just appears simple." | |
| | <i>Subtheme 11.2: Marketing doesn't explain the aims or benefits of</i> | "The way it is advertised makes it appear aimless." | A. Service accessibility and availability B. Lack of insight |
| "I think the goals of therapy should be clarified." | | | |

| | | | |
|--|--|--|--|
| | <i>therapy and doesn't clarify the procedures to access therapeutic services</i> | "You only know what the media or the television show you." | and knowledge C. Age-appropriate therapeutic services |
| | <i>Subtheme 11.3: Marketing neglects senior students</i> | "The first and last time that I heard about the crisis support centre was in orientation week last year." "There isn't anything like that for seniors." | A. Age-appropriate therapeutic services B. Service accessibility and availability |

3.3.11.1 Subtheme 11.1: Marketing reinforces the belief that therapy is only for severe issues

Participants perceived the marketing tools and advertisement of the therapeutic services on their campus to focus on the severe cases of mental health issues, such as abortion, death of a loved one or psychosis. As they do not find themselves in any of these scenarios, the advertisements only added to the perception that therapy is only for severe cases. In addition, these advertisements often strengthen stigmatisation as the participants claimed that students laughed and enjoyed the advertisements, but in honesty admitted that they thought that they were glad that they were not referring to them. Marketing that reinforces mistaken beliefs with regard to therapy, fear of diagnoses and fear of stigmatisation fortifies help negation behaviour in the emerging adult. With regard to this, one participant stated, "I am not one of those people who see little ducks everywhere, like the person in the advertisement; so I'd rather not go to therapy". It is clear that what is being advertised is simply too far removed from her perception of her own distress.

According to Rochlen and Hoyer (2005:676), a foundational element of mental health marketing is to understand the generalised personality traits, beliefs and needs of the targeted population. In this regard, the researcher believes that the complexity of the

emerging adult's developmental characteristics and needs are not fully considered in the marketing of therapeutic services. Service providers thus not only miss the opportunity to encourage emerging adults to engage in therapeutic services, but often cause emerging adults to feel more fearful of stigmatisation and a potential diagnosis through the presented advertisements.

3.3.11.2 Subtheme 11.2: Marketing doesn't explain the aims or benefits of therapy and doesn't clarify the procedures to access therapeutic services

Participants were of the opinion that the marketing strategies behind therapeutic services do not give a clear presentation of the aims, benefits and procedures of therapy and the various therapeutic services. Participants felt that emerging adults needed a more thorough and accurate, but still simplistic, explanation of therapeutic services and how they can assist any student. Emerging adults negate therapeutic help because of the incorrect and insufficient information they receive through marketing.

3.3.11.3 Subtheme 11.3: Marketing neglects senior students

In the opinion of the participants, therapeutic services are not marketed to senior students. The participants felt that senior students were not as exposed to marketing opportunities as first-year students. It appears that therapeutic services are often marketed during the orientation week of first-year students, but that marketing strategies are not sustained throughout the various student year groups. Both first-year and senior students felt that they only heard about therapeutic services in that week and that they, due to the overstimulation during that first week, would often later forget that therapeutic services were an option. It can, however, be that this is a phenomenon that simply occurs at the particular setting of this study. Conducting similar studies in other universities would be necessary in order to achieve transferability with regard to this result. Both the participants and student leadership (Selo, 2013) had suggestions regarding how to improve marketing of services to the entire campus that would be user-friendly and more amenable to the emerging adult population.

3.4 CLOSURE

In gaining an overview of the themes and subthemes, the following table presents a summary of the results:

Table 3.12: Overview of themes and subthemes

| Theme | Subthemes |
|--|---|
| Theme 1: Beliefs regarding the concept of therapy | Subtheme 1.1: Therapy doesn't have an aim and isn't really helpful |
| | Subtheme 1.2: Therapy is only for people with serious problems |
| | Subtheme 1.3: Therapy is not seen as a priority |
| Theme 2: Beliefs regarding participation in therapy | Subtheme 2.1: People often use therapy to seek attention or exaggerate their problems |
| | Subtheme 2.2: Going to therapy means that one is a weak person |
| | Subtheme 2.3: 'Positive' people do not need therapy |
| | Subtheme 2.4: One can become dependent on therapy or on the medication prescribed |
| Theme 3: Fears with regard to therapy | Subtheme 3.1: Fear of being diagnosed |
| | Subtheme 3.2: Fear of being judged and stigmatised |
| | Subtheme 3.3: Fear of being vulnerable and hurt |
| | Subtheme 3.4: Fear of being recognised and not being treated confidentially |
| Theme 4: Personal and developmental aspects | Subtheme 4.1: Unawareness |
| | Subtheme 4.2: Denial |
| | Subtheme 4.3: Awareness, but need for independence |
| | Subtheme 4.4: Gender differences |

| | |
|--|--|
| | Subtheme 4.5: Individualism |
| Theme 5: Familial influences | – |
| Theme 6: Societal factors | Subtheme 6.1: Societal lack of awareness and neglect of mental wellbeing |
| | Subtheme 6.2: Using family and peer support |
| | Subtheme 6.3: Depending on religion |
| Theme 7: The style of the therapist | Subtheme 7.1: Inexperience |
| | Subtheme 7.2: Unprofessionalism |
| | Subtheme 7.3: Divergent therapeutic traits |
| | Subtheme 7.4: Religious differences |
| Theme 8: The therapeutic relationship | Subtheme 8.1: Hierarchical relationship |
| | Subtheme 8.2: Stereotyped therapeutic interactions |
| Theme 9: Financial barriers | – |
| Theme 10: Confusion with regard to the availability of specific therapeutic services and procedures | – |
| Theme 11: Ineffective service promotion | Subtheme 11.1: Marketing reinforces the belief that therapy is only for severe issues |
| | Subtheme 11.2: Marketing doesn't explain the aims or benefits of therapy and doesn't clarify the procedures to access therapeutic services |
| | Subtheme 11.3: Marketing neglects senior students |

Considering the above-mentioned themes and subthemes it is clear that this study fulfilled its aim of gaining a better understanding of the factors that contribute to the negation of therapeutic services by the emerging adult in a South African university. The results, however, included far more than simply stating the basic factors of help negation behaviour, but also highlight concerns with regard to the perceptions and insight of emerging adults regarding mental health and therapeutic intervention. By careful integration and summarising of the above-mentioned findings, conclusions and recommendations can be considered which would not only decrease help negation behaviour, but could also devise strategies to promote mental health awareness and mental wellbeing in the emerging adult population.

CHAPTER FOUR

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

This chapter will include a summary of the findings, the conclusions, limitations and recommendations of the study and, lastly, a final comment from the researcher. As mentioned by Strydom and Delpont (2011:289), this chapter should focus on the implications of the study and on integration of these findings in the practical field. With regard to this study, integrating findings in the practical field will allow the study results to be grounded in the everyday clinical field, as well as in the lives of emerging adults and would thus become a part of evidence-based practice.

4.2 SUMMARY OF FINDINGS

The research question formulated for this study was as follows: 'Which factors contribute to the negation of therapeutic services by emerging adults in a South African university?' In order to answer this question the researcher employed a qualitative research design and method. The researcher is of the opinion that this study contributes to the existing knowledge with regard to emerging adults' help negation behaviour and thus answers the research question. In summary, the findings clearly indicate that certain factors play a major role in the help negation behaviour of emerging adults and can thus be the cause for the poor seeking and attendance of therapeutic services within this population. The themes have been grouped and summarised below.

4.2.1 Beliefs regarding the concept of therapy

Mistaken beliefs with regard to therapy as a concept play a significant role in the help negation behaviour of emerging adults. Emerging adults' belief that therapy is not helpful and is not seen as a priority makes them question the need for attending therapy. In addition, emerging adults seem to believe that therapy is only for individuals with serious problems. Emerging adults who do not experience these 'serious problems' often do not see the need or benefit of therapy for themselves, as their problems are not severe enough to justify therapeutic participation. A general lack of awareness with regard to

mental health issues contributes to emerging adult's beliefs that people often use therapy to seek help, often exaggerate their problems and are weak if they attend therapy.

4.2.2 Beliefs regarding participation in therapy

One of the emerging adult's beliefs is that therapy and medication can become addictive. As the emerging adult practices developmental goals of autonomy and independence, potentially becoming dependent on a therapist or medication is highly undesirable in the population. Emerging adults are also very aware of their personal identity and how they appear to others. Their perception that 'positive' people do not need therapy and that therapy implies that one is weak stems from a need to appear in control and 'strong' rather than weak and incapable of dealing with one's own problems. These mistaken beliefs are not only independent help negating factors, but are also influential in a variety of other help negating areas.

4.2.3 Fears with regard to therapy

As mentioned above the mistaken beliefs held by emerging adults accentuate their fears when considering seeking help. Emerging adults have specific fears with regard to therapy that instigate a tendency to negate help. Emerging adults have a fear of being diagnosed and stigmatised. These fears link in with the belief that people who attend therapy are weak and something is wrong. Emerging adults fear these 'labels' as they believe that they will be judged for them. The fear of stigmatisation has an intense help-negating effect. Emerging adults also fear being vulnerable and hurt when old traumas or negative experiences are discussed in therapy. Because they do not want to re-experience these painful events or emotions, they would rather negate therapeutic help.

Lastly, emerging adults are fearful of being recognised and of not being treated confidentially. Confidential agreements with therapists are viewed with scepticism in the face of potential accidents or slips regarding confidentiality. Because of the close-knit community of the campus, emerging adults of this study feared being recognised when entering the therapeutic building and being confronted with a therapist in a non-clinical setting. Participants of this study verbalised the immense courage it would take to overcome these fears in order to receive the help they may need. The emerging adult is in a sensitive life phase of defining their individual identity, whilst at the same time establishing an identity and role for themselves in their larger community. As the opinion of themselves and their peers is of utmost importance, these fears often stem from a need to

appear stable, adequate and strong rather than weak, feeble and dependent. Certain therapeutic elements, including some marketing strategies and particular ways in which therapists can use or present themselves, can intensify the sense of fear in the emerging adult.

4.2.4 Personal and developmental aspects

A number of bio-psychosocial factors contribute to mistaken beliefs and fears surrounding therapy, but also act independently as help negation factors. Personal and developmental factors can cause a severe reluctance to engage in therapy as emerging adults often lack the insight into their emotional state and the characteristics of mental health. This study indicated that emerging adults who are unaware of their distress or who are aware but in denial of their stress would refrain from seeking therapeutic assistance. The personal need for independence when dealing with distress is potentially the most influential of the help negation factors. The emerging adult's need for individualism is a developmental aspect that surfaced continuously during the analysis of the data. In the emerging adult life phase, emerging adults want their individuality and autonomy to be respected. Services and therapists that do not consider individuality would cause emerging adults to negate the help offered.

4.2.5 Familial influences

Other factors that cause help negation in the emerging adult population include the individual's upbringing, which could have caused certain attitudes of hesitancy about therapeutic participation. In the case where parents were reluctant to discuss emotion or consider therapy, help negation was more evident. In this particular setting, the emerging adult also introjected the attitude to the extent that they felt they ought to deal with their problems independently from their parents. This in effect led to emerging adults having the attitude that they should deal with their problems independently.

4.2.6 Societal factors

In considering societal influences on help negation behaviour, it is clear within this group of emerging adults that asking for help is associated with being weak and incapable. Therefore, emerging adults are reluctant to seek and accept help even though they might struggle to solve their problems on their own. Societal factors that cause help negation behaviour in the emerging adult population are the general lack of awareness of mental health issues of the society as well as a lifestyle that neglects mental wellbeing.

Because of the reluctance of society to support emotional awareness and mental wellbeing, emerging adults struggle to see the need to focus on these areas of their lives. Rather than seeking professional therapeutic help, emerging adults are also more likely to depend on social support from friends and family. Emerging adults believe that if they have a valuable and sufficient social support structure, therapy should be redundant. Emerging adults who are religiously inclined would also rather depend on their religious beliefs than engage in professional therapeutic support.

4.2.7 The style of the therapist

The theme regarding therapists' preferred traits in therapy had little prior research to support the findings in the emerging adult population. The results of this study, however, clearly indicate that the type of therapeutic relationship, dynamics between the therapist and client and the therapist's personal style of therapy can all have an effect on the emerging adult's willingness to engage in therapy. Emerging adults are hesitant to engage with a therapist who is inexperienced, has certain divergent therapeutic traits and is of a different religious background to themselves. Emerging adults are further resistant to unprofessionalism, specifically with regard to maintaining confidentiality and respectful conduct.

4.2.8 The therapeutic relationship

The therapeutic relationship can also influence help negation behaviour. A therapeutic relationship that is not reciprocal or authentic, as well as a therapist that utilises stereotypical therapeutic interaction, would cause a negative association with therapy for the emerging adult. Emerging adults prefer to be engaged in a work alliance where the therapist and client are seen as equal, which allows the sessions to be comfortable and interactive.

4.2.9 Financial barriers

Emerging adults are cautious about the financial implications of therapy and would rather spend their money on more tangible items. This then causes financial factors to be an obstacle in their seeking and acceptance of therapeutic help. Participants in this study were further aware that some emerging adults may not be able to afford therapeutic services because of their difficult socio-economic status and may negate help out of fear that these sessions will have an adverse financial implication.

4.2.10 Confusion with regard to the availability of specific therapeutic services and procedures

Confusion with regard to the availability and procedures of therapeutic services causes a sense of insecurity, which could have a direct influence on the already fearful emerging adult's decision against seeking help. Confusion also stems from the fact that emerging adults are too overwhelmed in their first week of orientation to digest the volumes of information regarding the forms of therapeutic support available to them on campus. It is possible that the general ineffective promotion of services can also lead to confusion with regard to the availability and objective of therapeutic services. During the focus group discussions, it appeared that participants would not be eager to exert additional effort to clarify their confusion in order to access the help that they might need.

4.2.11 Ineffective service promotion

Ineffective marketing strategies contribute to the sense of insecurity as they often endorse the perception that therapeutic services are for individuals with severe problems. In addition, advertisements and marketing strategies do not necessarily clearly depict the aims, benefits and procedures of therapy. This contributes to confusion on the part of emerging adults as to what services are available and how to access them. In this setting, it was evident that the promotion of therapeutic services focused on first-year students and that the neglect of senior students can contribute to help negation. Ineffective promotion of therapeutic services to the emerging adult population seems to have a devastating effect on the general image of mental health and therapeutic services and the emerging adult's willingness to engage with therapy.

4.2.12 Conclusion of summary

The results of this study offer insight into a variety of factors that contribute to the help negation behaviour of emerging adults. These insights can be used to draw effective conclusions from this study, as well as to suggest recommendations that adhere to the applied nature of this study. This study was not, however, able to furnish conclusive confirmation of the outcomes of other studies (Rickwood, *et al.*, 2005:15; Wilson, *et al.*, 2005:1535) regarding the relationship between help negation behaviour and suicidal tendencies. In addition, very little evidence was found regarding the use of adverse coping strategies, such as the use of alcohol and substances or engaging in promiscuous behaviour, as was suggested by Arnett (2000:475) and Lenz (2001:305).

4.3 CONCLUSIONS OF THE STUDY

The current study contributes significantly to the existing theoretical base on help negation behavior in emerging adults. A comprehensive literature review revealed the contributions previously made to the relatively understudied developmental phase of emerging adulthood and allowed for this literature to be integrated with the rich data uncovered during this study. This process allowed the discovery of valuable insights into the different beliefs and attitudes that influence in the negation of therapeutic services by emerging adults. In addition to highlighting the fact that this phenomenon is an area of concern in the field of mental health, the conclusions of this study contribute significantly to the existing theoretical base on this phenomenon. Interpretation of the findings led the current researcher to formulate conclusions that provide awareness regarding where intervention is needed in addressing these issues in daily clinical practice. The conclusions that follow are the most prominent to emerge from this study.

4.3.1 The effect of emerging adulthood

It is clear that emerging adulthood is a unique and critical developmental phase in the course of any individual's life. The perceptions and actions that are modulated during this life phase can have a direct influence on the values and behaviour on which an individual's entire life is based. In this study, it is evident that the need for autonomy, as well as the desire to be independent, is essential developmental qualities for emerging adults. This study emphasised the emerging adult's need to have a positive social image and regard from their peers. In addition, emerging adults appear to value a strong sense of personal identity, both in themselves and in others. This study accentuates the significant impact that the developmental norms and needs have on the emerging adult's willingness to engage in therapeutic interaction. It can be stated that the very fact that these individuals are currently in a phase of emerging adulthood can cause them to negate therapeutic help. A need to establish oneself as strong, capable and independent does not coincide with asking for help or going for therapy. The emerging adult would therefore negate help based purely on the importance of their current developmental issues.

Furthermore, emerging adults have very specific requirements regarding therapeutic intervention and, specifically, therapists. This is possibly influenced by the developmental attributes and norms of the emerging adulthood phase. Help negation would be more evident in the case where mental health service providers do not cater for the specific

needs of the emerging adult. It appears that current therapeutic services do not take sufficient steps to cater to the specific needs of this developmental phase, which exacerbates the negation of formal help by the emerging adult.

4.3.2 Negative attitudes and mistaken beliefs

During this study, the most prominent factor in help negation behaviour in the emerging adult population was their attitudes toward and beliefs regarding therapeutic participation. It is evident that the lack of awareness of symptomology and therapeutic procedures causes emerging adults to have an incorrect perception of what therapeutic support is, when it is needed and what the benefits would be. Mistaken beliefs mostly originate from introjected family beliefs, previous negative therapeutic experiences, misconceptions about mental health as portrayed in the media and stigmatisation. In addition, beliefs that are cultivated and supported by the larger society, pertaining to dealing with problems alone and being weak when one needs therapy, contribute significantly to negative perceptions regarding therapeutic intervention. These negative attitudes and mistaken beliefs create a sense of doubt, insecurity and fear in the emerging adult when they consider therapeutic intervention. The effect of these beliefs with regard to the negative emotions is so powerful that it creates a help negation effect. Addressing the issue of help negation would be ineffective if attention and change are not brought to bear on the negative beliefs and attitudes that emerging adults have toward therapeutic services.

4.3.3 Stigmatisation

Despite mental health and wellbeing becoming more popularised concepts in society, stigmatisation is still an active agent of help negation in the emerging adult population. It might be believed that the current emerging adult population is the 'youth of the future' and should thus have forward-thinking notions about most aspects of life, including their mental wellbeing and managements of stress. Unfortunately, fears with regard to mental illness and needing or using therapeutic intervention are preventing emerging adults from accessing the help that they need. Stigmatisation extends to others who make use of therapeutic intervention, those with severe mental health disorders and the therapeutic service itself. Stigmatisation, however, also includes a fear of being personally associated with therapy and the need thereof.

Emerging adults' fear of appearing weak, of being vulnerable and of being labeled are the most prominent elements in instigating a fear of stigmatisation. It is again clear that the lack of awareness with regard to mental health disorders and the actual needs for and benefits of therapeutic intervention is poor. The emerging adult's lack of awareness and internalised negative beliefs about therapeutic participation cause stigmatisation to be a profound help negation factor.

4.3.4 The presentation of therapeutic services

It can further be concluded that therapeutic services themselves can contribute in a large way to help negation in emerging adults. The manner in which services are presented, the location and look of the therapeutic venue and the style of the therapist have a definitive impact on the way emerging adults perceive therapeutic intervention. If an emerging adult, who is already anxious about admitting his or her problems and is slightly cautious of therapy, is faced with a challenging obstacle concerning the access of therapeutic services, it would cause them to, in their words, "turn around and leave". Emerging adults are adamant that overly sympathetic staff and a domineering therapist would cause them to question the overall benefits of going for therapy. In this regard, an unsatisfactory therapeutic milieu and asymmetrical relationship with a therapist can cause an emerging adult either to not attend therapy or to not return after an initial session. The image that is created of therapy through the marketing of services is equally accountable for the negation of help by emerging adults. Emerging adults believe that they cannot associate themselves with the concept of therapy as portrayed in the advertisements and that they therefore do not need therapy. The fact that the first encounter with therapeutic services, through therapeutic service promotion, contributes to the negative attitudes and mistaken beliefs about therapy, is an area of great concern and should be attended to.

In addition, one should consider the impact of setting-specific aspects as help negation factors. In this study, for example, student interns assisted at the therapeutic centre, which caused emerging adults to be more wary of the therapists and fearful that their confidentiality would be compromised. Therapeutic centres that neglect to evaluate critically all aspects of their operation, including marketing, initial contact with a client, the procedures of making an appointment and the location of their venues, risk the potential increase of help negation amongst their client base.

It appears that programmes, procedures and therapeutic approaches are not adapted sufficiently so as to be user-friendly, age-appropriate and flexible in meeting the specific needs of the emerging adult population. Emerging adults are, in general, sceptical of therapy and distrusting of therapeutic services. Service providers who do not go above and beyond to instill a sense of hope and possibility through their services will assist in advancing help negation behaviour.

4.3.5 Therapeutic services as agent of growth

When considering emerging adults it is apparent that they are influenced by their past, through families and childhood beliefs, focused on the present in terms of what they want to establish and achieve, but also pondering the future and what the consequences of their current actions will be. The emerging adult is not simply floating in limbo between the transition of adolescence and adulthood. They are engaging in life as they see fit, in order to secure a better life for themselves and their communities. During this study it was unmistakably noted that emerging adults would consider therapy and realise that there might be benefits to engaging in some sort of emotional support and therapeutic guidance. Unfortunately, the sense of insecurity and disregard for therapy that help negation factors create causes a discord between what emerging adults need and the concrete steps needed to actualise that need. Help negation factors are clearly denying emerging adults the opportunity to understand and manage their distress and emotions, or to gain personal insight and grow into the best version of themselves. It is crucial that the professionals revisit their strategies and approaches in order to overcome negation of formal help and create a more understandable, approachable and effective therapeutic service to emerging adults.

4.4 LIMITATIONS OF THE STUDY

The following aspects were considered to be limitations of the study:

- Participants were only representative of a single culture in terms of both language and race. This influences the ability to transfer the findings of the study to emerging adults of other cultures.
- Participants were mostly female, which could contribute to a feminine-oriented perspective concerning help negation factors in the emerging adult population.

- The recruitment procedures of the study allowed for voluntary participation and could have been the reason for participants representing a limited demographic. In addition, it appeared that emerging adults who are already active in their participation in campus activities were more inclined to volunteer their participation in this study. Recruitment procedures did not attract a sufficiently diverse population of both active and inactive emerging adults from the sample group.
- The participants mentioned that entering the therapeutic building for the purpose of the focus groups made them slightly nervous and afraid of stigmatisation. Although the venue was initially thought to be neutral, the results of the study indicated that it could have contributed to some anxiety in the participants before their participation in the group. It could also potentially have caused reluctance in other emerging adults from the sample group to participate in the study.

4.5 RECOMMENDATIONS OF THE STUDY

In response to the results and conclusions of the study, the following recommendations will allow this study to be applied successfully in practice. Recommendations are relevant to the general mental health community, the university therapeutic team and clinicians that work with emerging adults. Recommendations for future research projects are made in order to support and expand the results from this study.

4.5.1 Recommendations to the mental health community

- It is recommended that the larger mental health community re-evaluate the image of mental health and therapy in society. An attempt should be made to provide a positive and correct portrayal of therapy, as well as to rectify incorrect perceptions with regard to the mental health field. In addition, information should focus on mental health awareness, in order to improve understanding about symptoms and intervention options. Psycho-education can be incorporated in magazine articles and publicity opportunities, but can also be presented in regular road shows to universities or colleges. Electronic media and social networks can also be used to reach the emerging adult population in an effective manner.
- It is recommended further that celebrities and sporting heroes suffering from mental health illnesses or stress-related disorders should be approached to be spokespersons for mental wellbeing and therapeutic intervention. Emerging adults

would acknowledge these individuals as role models, which would assist in decreasing the stigma and fear around therapeutic participation.

- Rickwood, *et al.* (2005:19) suggested that the mental health community make use of gatekeepers. This study endorses this suggestion. As emerging adults feel more comfortable using social support structures rather than formal support from clinicians, trusted role models in the community should be trained and educated with regard to mental health conditions and basic counseling services. These gatekeepers should then act as a referral pathway for emerging adults to receive the professional help they need. Gatekeepers can be peers, student leaders, church leaders or respected individuals of the community. A bond between the gatekeepers and the professional team should be maintained through regular interaction.

4.5.2 Recommendations for therapeutic centres

- Therapeutic centres should reconsider their marketing strategies. The marketing method should provide clear and simple information on the aim and benefits of therapy. It should also provide an easy-to-follow and step-by-step layout of the procedures involved in seeking therapeutic help. This should also include information concerning the financial aspects of therapy. Advertisements should be considered with caution so as not to induce stigmatisation and to include students who do not experience pathological disorders. Therapeutic centres should also take care to focus marketing strategies not only on the orientation of first years, but to market therapeutic services constantly to students of all courses and year groups.
- The participants of this study recommended that technology be used more effectively in both marketing and service delivery. Email pop-ups, links to You Tube videos and utilising the official university application or social networks can be very effective marketing tools. Participants also suggested the use of Whatsapp messages or email correspondence as a means of making an appointment or even interacting with a therapist.
- Marketing strategies for emerging adults should include an informal and fun element. The participants suggested a 'therapy centre mascot' that could walk around on campus giving smiles or hugs. Participants also emphasised the value of reaching emerging adults through playful but memorable interactions. They

suggested that these types of events or days could be presented in collaboration with the student council's portfolio for current affairs.

- Strategies to desensitise emerging adults to therapeutic intervention and to increase emotional awareness should be offered through alternative, more age-appropriate methods. Sessions that make use of movement, such as yoga or Zumba, or sessions that make use of expressive arts, such as creative writing, storytelling and projective arts, could expose emerging adults to a more informal and user-friendly format of therapeutic intervention. This will not only assist the participants of these sessions to gain emotional insight, but also promote therapeutic services. Therapeutic centres can liaise with the local gym, library or even restaurants in order to actualise such events.
- Therapeutic centres should liaise with community role models and student leaders to establish a gatekeeper system and to promote mental health awareness in individuals.
- It is recommended that therapeutic centres place continuous emphasis on the importance of confidentiality and anonymity of clients in the centre. This can be done through regular in-service training sessions and discussions on confidentiality amongst clinicians and support staff. Providing guidance and support through supervision, especially to student interns or junior staff members, can potentially decrease unprofessional behaviour in the form of inappropriate debriefing or talking about a client.
- Participants suggested billing therapy sessions to their student accounts. Some students might, however, object to this, as it would let their parents know that they were seeing a therapist. It is recommended that therapeutic centres offer some options to students regarding payment for therapeutic services. This can include billing their student account, per-session payments or even lump-sum payments. A student who engages in therapy can then choose which payment option best suits them.

4.5.3 Recommendations for clinicians

- Clinicians should be mindful with regard to maintaining an informal, open and reciprocal relationship with clients when working with emerging adults. The therapeutic relationship should be a partnership where mental wellbeing and personal growth are explored reciprocally.

- Clinicians should continuously re-evaluate their method of therapeutic intervention when working with emerging adults. Clinicians should be aware of character traits such as authoritarianism, over-sympathising and advice giving, which have the potential to put emerging adults off therapy. Clinicians should also be cautious with regard to the excessive use of clichéd remarks, especially, “How do you feel?” It is recommended that regular group discussion on therapeutic techniques for emerging adults are encouraged between clinicians. Furthermore, clinicians should discuss their styles of therapy when working with emerging adults in their personal supervision sessions, in order for them to enhance their continuing professional development in this regard.
- Clinicians should consider reframing themselves as mentors or life coaches to make the sessions appear less serious to emerging adults. This would potentially reduce fear in the emerging adult and facilitate a more collaborative and symmetrical relationship.
- Clinicians should provide a proper orientation session to emerging adults who engage with therapeutic services for the first time. This session should not only be used to establish a therapeutic rapport, but also to address any fears or insecurities the emerging adult might have. A clear overview of the process and benefits should be given. Emerging adults should also be reassured that their individual needs are considered and that ongoing therapy would be based on their individualised process. Clinicians can reassure emerging adults of their right to confidentiality during the suggested orientation session. It could also be valuable to discuss potential incidents such as seeing each other in a non-clinical setting and agreeing on an acceptable protocol for interaction in such an event.
- Wood (2006) investigated a therapeutic resource that can potentially assist in clarifying the therapeutic process to individual contemplating therapeutic intervention. He suggested that the use of a “consumer education resource” could help in supporting a new client to engage in therapy (Wood, 2006). The resource consists of an introduction to therapy and then guides the client through the process of why they need therapy. It can, for example, include a symptom checklist, then a goals or aims checklist and then include a brief synopsis of different therapist or therapeutic approaches. It can also include a list of interview questions that the therapist might ask the client. A therapist can use such a resource as a tool in an

orientation session or therapeutic centres could develop such a resource in order to assist clients in feeling more at ease and more informed when they start the therapeutic process. Developing a resource of this kind in a format that would be attractive and user-friendly to the emerging adult population can assist in counteracting help negation behaviour.

4.5.4 Recommendations for future research

- In considering the limitations of this study, the researcher would recommend that alternative strategies for recruitment be considered in the case of any replication of this study in order to ensure a more diverse and heterogeneous sample and an increased number of participants. A comparison between junior and senior students, residence-based or day students and even students enrolled in different courses would allow a more comprehensive view of the help negation phenomenon.
- Similar studies should be considered in other South African universities and colleges. This would provide an opportunity for insight on emerging adults' help negation behaviour on a national scale that would assist clinicians in understanding the common tendencies and beliefs of emerging adults in the South African context.
- A study to determine what emerging adults view as "serious" in terms of distress, as well as what symptomology would cause them to seek help, would create more insight with regard to help-seeking and -negating behaviour. This would also assist clinicians and therapeutic centres with regard to better promotion of therapeutic services.
- As there is a gap in the literature with regard to the preferences of emerging adults regarding therapeutic styles, frameworks and therapeutic relationships, it is suggested that researchers continue to investigate these aspects. These therapeutic aspects can be investigated in order to determine which therapeutic styles and frameworks would result in the best therapeutic outcomes, whilst allowing optimal levels of client satisfaction. A longitudinal study where groups of emerging adults receive intervention using different styles and techniques could be considered with the aim of performing a comparative investigation in this field of study.
- The relationship between religious backgrounds and beliefs and help negation behaviour in emerging adults requires further investigation. In the context of this study, it was clear that the potential relationship between an emerging adult's

religious belief and therapeutic participation should not be ignored. Gaining an understanding as to the specific nature of this relationship and the transferability of the phenomenon to other contextual settings could potentially improve the match between therapist and client, the therapeutic relationship and, therefore, therapeutic outcomes in general.

- More information is needed concerning the views and perspectives of emerging adults about their life phase. Qualitative studies should investigate emerging adults' perceptions of independence, autonomy, internal characteristics that contribute to success or failure and the degree of responsibility they accept for their own lives.

4.6 FINAL COMMENTS

The researcher is of the opinion that this study has contributed to the knowledge base regarding emerging adults and help negation behaviour. The researcher also, however, believes that insight about the emerging adult population, their perceptions and their preferences is still in the early stages of investigation. Continued research, specifically qualitative research, will create a foundation of knowledge and should lead to a better understanding of this life phase with its complex transitions, identity development and propensity to mental health issues. Through this knowledge base, clinicians, organisations and the global mental health community will be able to address crucial mental health issues in emerging adults that will result in more emotionally stable transitions to adulthood and thus a healthier and happier community at large.

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APPENDIX A – INFORMATION POSTER

Ever heard about therapy... Ever wondered about therapy...

Let's talk about therapy...

Participate in a research study

We would like to find out why students do not make use of therapeutic services when they need them



What do we need...

Your inputs and opinions on why students and young adults do not make use of therapeutic services

Because...

If we understand what keeps students from therapy, we will also understand what will make students use them when they really need it.

Who...

Any-one willing to join in this conversation

You do not have to need therapy or experience distress

We want to chat to **STUDENTS** between the ages of 18 & 25. As long as you are willing and want to volunteer your participation we would love to hear your opinion

How...

Focus groups, a small group, 6 to 8 people, will sit together and discuss the topic. This is about your perspectives and opinions; you will not have to share anything personal about your life.

When and Where...

Ingryp offices – conference room

Wednesday @ 16:00

Thursday @ 16:00

Friday @ 16:00

You can just pitch up at one of these sessions or give your name to a HC member or the researcher when they visit the residence.

APPENDIX B – PARTICIPANT INFORMATION SHEET

Factors contributing to the negation of therapeutic services by emerging adults in a South African university

Study Information

Thank you for your interest in participating in this study. This document hopes to answer some of your questions regarding the study and your potential participation in it.

WHAT IS THE PURPOSE OF THIS STUDY?

As a practising clinician, the researcher realised that a group of individuals, between the ages of 18 and 25, was often reluctant to engage in therapeutic services or support. On closer investigation, it seemed that other researchers also noted this reluctance in their studies. It appeared as though this phenomenon is common in the emerging adults life phase. The literature available on help negation behaviour in emerging adults was unfortunately very limited and mostly in a European context. With this study, the researcher will aim to describe what factors cause the help negation behaviour of emerging adults, more specifically of the emerging adults in South Africa. Understanding these factors will help clinicians and centres to better understand the clients they service and what can cause emerging adults to not make use of therapeutic services. Eventually, this will help professionals to find ways to provide therapeutic services to the emerging adult that are custom-made to the needs of this specific age group.

Emerging adults...

is the term used to describe individuals that are not adolescents anymore, but have to still take on the full responsibilities of adulthood, these individuals are between the ages of 18 and 25.

Therapeutic services...

The professional help that is available to individuals who find themselves in stressful situations or feeling unable to cope with life. Therapeutic services aim to improve self-awareness and life skills to overcome distress so that a person can lead a healthy, happy life.

Help negation behaviour...

Describes when individuals need therapeutic help, but do not try to access or use these services, even if they are available.

HOW WILL THIS STUDY BE PERFORMED?

To collect the data for this study, focus groups will be used. Focus groups are specifically chosen as they are a comfortable, open discussion with the potential to get rich information from the participants. The researcher will conduct three focus groups of students who attend psychology modules, one for each year group. There will be between six to 12 participants in the group. Participants can be of any race, ethnicity, sex or gender. The focus groups will be conducted in English. The focus group will last between an hour and a half and two hours. Members from the same residence will be divided equally into different focus groups.

The researcher will facilitate these focus groups with the help of an assistant facilitator. The interviews will be recorded with a sound-recording device and with a video camera. All the recordings will be safeguarded and will only be used for the purpose of this study. The recordings will not be made public and will only be viewed by the research team.

WHERE DO I FIT IN?

You are asked to participate in this study as you fall within the population of this study. The study population includes all students residing in the institution residences. The participants of any study are the most crucial element as it is their insights that the researcher want to explore and understand. In order to participate in this study you need to meet the study criteria:

- You should be between the ages of 18 and 25.
- You need to be enrolled and residing at the tertiary institution.
- You should be aware of reality and being able to interact appropriately.
- You should be proficient in English as a verbal medium.

- You can be of any ethnicity, religion, sex or gender.
- You have to voluntarily agree to participate in the study and understand the ethical

considerations of the study as well as carry knowledge that you may withdraw from the study at any given point.

WHAT WILL BE THE BENEFIT TO ME?

Although this study has no remuneration or incentives participating in a study can be a great learning experience. You will be able to interact with fellow students on a very significant and relevant topic. By participating in this study you will greatly assist in bringing insight about this topic and this insight may lead to positive change for the entire population. By participating in this study you will also be exposed to the research process and have an opportunity to experience personally the process of a focus group. Not only is this an excellent learning experience, but it can also benefit you in the completion of your own research projects through the course of your studies.

WILL I BE EXPOSED, VULNERABLE OR EMBARRASSED?

The focus groups will be facilitated with the utmost sensitivity. The researcher is skilled in assisting individuals to engage comfortably around a topic and to feel at ease to voice your opinion. The aim of the focus group is not to make you feel vulnerable or exposed but to simply understand your viewpoint on why individuals negate therapeutic help. All the participants will be signing confidentiality agreements and the study is also conducted with a strict confidentiality policy. You are allowed to choose a pseudonym if this will make you feel more at ease. Material and data will only be used for the purpose of completing this research. You will be asked to sign an informed consent form that explains all the aspects of the study. This form also indicates that you have the right to withdraw from the study at any given time during the study.

WHAT IS THE PROCESS FROM HERE ON?

If you are willing to participate in the study, please add your name and contact details to the participation list. You will be informed of the time, date and venue for when the focus group will take place. You will be reminded by text message of the sessions and will then be required to attend the session punctually.

During the focus group you will be informed of the purpose and process of the study, as well as how the focus group will be conducted. During the focus group process you are encouraged to raise questions related to the study purpose and procedure. The researcher will then ask a series of questions and will facilitate a discussion between the participants of the group. Toward the end of the study the researcher will summarise the data gathered. Refreshments will be served directly after the focus group.

WHAT WILL HAPPEN AFTER THE FOCUS GROUP?

After the focus group session the data will be transcribed and analysed to reach the aims of the study. This study is conducted toward fulfilling the requirements of a Master's degree in psychology and will also be submitted for publication. The researcher will also provide feedback and recommendations to the university on how to counteract help negation behaviour on campus in the future.

THANK YOU AGAIN FOR YOUR WILLINGNESS AND TIME TO CONSIDER THIS STUDY.

Date and times of focus groups (pick one)

Wednesday, 4 September @ 16:00

Thursday, 5 September @ 16:00

Friday, 6 September @ 09:00

Venue of focus group

Ingryp office –
conference room

(next to the health care
building)

APPENDIX C – FOCUS GROUP INTERVIEW GUIDE

Focus group interview guide

Proposed by M van den Berg in obtaining M(Psych); 2013

Factors contributing to the negation of therapeutic services by emerging adults in a South African university

INTRODUCTION

Afrikaans or English

Good day, my name is Marlene and I am a postgraduate student at NWU. In order to complete my Master's degree in psychology (play therapy), I am researching the factors that contribute to the help negation behaviour of emerging adults. I started this study when I realised that there are often therapeutic services available for individuals who experience stress, but that they do not always use these services. This is why I invited you to help me explore and understand why emerging adults, individuals between 18 and 25, do not use help if they need it. I would really like to thank you for your willingness in participating in this study.

I will act as the facilitator of the group, whilst Karen will be the assistant facilitator. My role is to direct the questions and help us create a comfortably, flowing conversation, whilst Karen will assist me in helping with the technical devices. She will also observe the group, make notes and help us to stay on track with our conversation.

INFORMED CONSENT

As you know, this is a voluntary study, which means that it is your choice to participate in it. To make sure that you are aware of your rights with regard to participating in this study. Let us review the informed consent form together:

- The purpose
- The participation criteria (*ensure all meet the criteria*)
- The data collection method (*ensure all give permission to the sound and video recording of the interview*)
- The risks of the study (*not therapy but research*)
- The cost and financial risks of the study
- The benefits and compensation
- The voluntary nature of the study (*emphasise the right to withdraw at any stage*)
- Confidentiality (*ensure all understand and agree to this clause*)
- The procedure of the study
- Feedback after the study

Are there any questions? (*Ensure all have signed and handed in the informed consent form*)

THE PROCEDURE OF THE FOCUS GROUP

This group will take about an hour and a half to two hours. I will ensure that we do not take longer than two hours. Please make sure that you are comfortable during the process. If you need to stand up to stretch your legs, you are more than welcome to do so.

The interview will be sound recorded to collect the content of the conversation, as well as video recorded to collect our interactions and non-verbal communication. They are set up there and there (indicate where set up).

The recorded data will only be used for the study and will not be viewed by anyone other than the research team. Everything you say will be confidential and anonymous. Still, if you would like to choose a pseudonym for the interview, you can do so. (Ensure everyone has a nametag).

The only exception to confidentiality is when information is shared about hurting yourself or others, which I would be obliged to report.

I will ask a question, which we will then discuss. I encourage you to be comfortable and open in your opinion as the aim of the study is to get a broad understanding on this topic. To be courteous, I will allow one person to speak at a time. Please feel free to interact with each other as well as interacting with me.

I will be making some notes during our conversation to help me in later analysing the data, but will check them with you during the summary after the group.

After the group, you are more than welcome to stay and enjoy some refreshments.

Do you have any questions before we begin? Can we make sure all of our cell phones are on silent before we begin?

RESEARCH QUESTIONS (ARTICULATED DATA)

What is your understanding of therapy? *Are you aware of the therapeutic services at the university?*

Why do you think people go to (or need) therapy?

What do you think would keep someone from going to therapy (what are the barriers in participating in therapy)?

What reasons would prevent you from attending these services?

Which factors will encourage you to make use of therapeutic services?

TESTING CURRENT LITERATURE HYPOTHESES (ATTRIBUTIONAL DATA)

In the case of these items not being raised during the previous discussion the researcher will invite the participants to comment on findings by previous research studies:

- Belief that family or friends can be more helpful than professionals
(Rickwood, et al., 2005)
- Beliefs that it is better to deal with stress and emotional problems on your own
(Jorm, et al., 2006; Van Voorhees, et al., 2006; Vanheusden, et al., 2009)
- Fear of confidentiality
(Rickwood, et al., 2005)
- Fear of medication and fear of possible addictive medication
(Bradley, et al., 2010)

- Fear of stigma
(Bradley, et al., 2010; Vanheusden, et al., 2009)
- Financial barriers
(Vanheusden, et al., 2009)
- Gender differences – females more likely to seek help
(Rickwood, et al., 2005)
- Higher levels of hopelessness and suicide ideation, less likely to seek help
(Rickwood, et al., 2005; Wilson, et al., 2005)
- Intensity of distress or illness symptoms
(Van Voorhees, et al., 2006)
- Lack of emotional intelligence
(Vanheusden, et al., 2009)
- Lack skills to seek help
(Rickwood, et al., 2005)
- Personal characteristics (distress is a weakness)
(Jorm, et al., 2006; Van Voorhees, et al., 2006)
- Poor insight into mental health, lack of seeing the signs of distress
(Jorm, et al., 2006; Rickwood, et al., 2005; Vanheusden, et al., 2009)
- Poor referral pathways
(Vanheusden, et al., 2009)
- Services availability and accessibility
(Jorm, et al., 2006)

CONFIRMING EMERGENT DATA

Reviewing notes to check for unasked questions with relation to comments, non-verbal reactions or group dynamics.

Are there any other comments or opinions that any of you want to make?

CONCLUSION OF INTERVIEW

Summarising of interview.

Thank you for your participation. I truly appreciate your willingness and courage in sharing your opinions with me.

DEBRIEFING OF GROUP

How did you experience this group and process?

Which emotions did the group discussions trigger in you?

Do you need to take any action to help ground yourself after this session?

Would you be open to me contacting you should I later have questions about our interview? (If participant agrees, make a note of this)

Thank you again for the time that you have spent in this interview and for the valuable information, you have given me.

APPENDIX D – INFORMED CONSENT FORM

Informed consent to participate in research study

Proposed by M van den Berg in obtaining M(Psych); 2013

Factors contributing to the negation of therapeutic services by emerging adults in a South African university

Thank you for your willingness and effort to contribute to this study.

THE PURPOSE OF THIS STUDY

The research aims to describe the help negation behaviour of emerging adults. It thus wants to understand why individuals, between the ages of 18 and 25 (emerging adults), do not make use of therapeutic support services that are available to them (help negation). The purpose of the study is to use this information to broaden the current information we have on this topic, but also to make this information more specific for your age group and for a person living in South Africa. The information will help clinicians and centres to better understand why services are not used and what should be focused on to help individuals use therapeutic services.

THE PARTICIPATION CRITERIA

- You should be between the ages of 18 and 25.
- You need to be a student, currently enrolled North West University.
- You need to stay currently in an NWU residence.
- You should be aware of reality and being able to interact appropriately.
- You can speak either Afrikaans or English.
- You will not be excluded due to your ethnicity, religion, beliefs, sex or gender.
- You voluntarily agreed to participate in the study and understand the ethical considerations of the study as well as carry knowledge that you may withdraw from the study at any given point.

DATA COLLECTION METHOD

Focused groups will be used to collect data for this study. You will thus be required to join a group of students in discussing concepts around help negation behaviour in emerging adults. The researcher will facilitate the focus

group sessions. The interviews will be recorded with a sound-recording device and with a video camera. All the recordings will be safeguarded and will only be used for the purpose of this study. The recordings will not be made public and will only be viewed by the research team.

RISKS OF THE STUDY

A possible risk of participation in this study is the possibility of being confronted with sensitive issues during the interview process. The researcher will attempt to make you feel secure at all times during the interview and will aim to minimise any discomfort. Should you, however, during the process, feel the need to withdraw from the study it is within your rights to do so at any time.

COST AND FINANCIAL RISKS

There are no financial costs directly associated with participation in this project.

BENEFITS AND COMPENSATION

This study does not include compensation and you will therefore not gain financially from your participation in this study. The study aims to describe a phenomenon observed in a group of individuals and it is therefore not guaranteed that you will benefit directly from participating in this study. Refreshments will be served after the focus group.

VOLUNTARY NATURE OF STUDY

This research is a voluntary study and therefore it is within your prerogative to choose to participate or to not participate. You may also withdraw at any stage during the study.

CONFIDENTIALITY

By signing this consent form all participants of the focus group adhere to the

confidentiality of the identity of participants and the content of the discussion. The utmost steps will be taken to ensure confidentiality of the information gained from the focus group. The strict confidentiality policy safeguards your identity, which will not be made known through any publication. Exceptions to confidentiality will only extend to court orders or law requirements.

PROCEDURE OF THE STUDY

Students who stay in an NWU residence will be informed of this study through written and verbal communication. Students will be invited to sign up voluntarily to attend the focus group sessions. You will be informed of the time, date and venue for when the focus group will take place. There will be a focus group for each year group. You will be reminded by text message of the sessions and will then be required to attend the session punctually.

During the focus group you will be informed of the purpose and process of the study, as well as how the focus group will be conducted. The researcher will then ask a series of questions and will facilitate a discussion between the participants of the group.

By signing below, you are indicating that you have read and understood the consent form and that you agree to participate in this research study.

Participant's signature

Researcher's signature

Toward the end of the study the researcher will summarise the data gathered. Refreshments will be served directly after the focus group.

During the focus group process you are encouraged to raise questions related to the study purpose and procedure. After the focus group session the data will be transcribed and analysed to reach the aims of the study. This study is conducted towards fulfilling the requirements of a Master's degree in psychology and will also be submitted for publication.

FEEDBACK

Feedback will be given in written form after the completion of the study. Feedback will be sent as a general summary report of the findings of the study. This report will be forwarded to you electronically.

DISCLAIMER/WITHDRAWAL

It is important to remember that your participation in this study is voluntary. You have the right to withdraw from the study at any given time.

Date

Date

