Attachment, Emerging Adult Narratives and Seeking Mental Health Care

by

Sarah Malashevsky

Bachelor of Arts (Hons) Psychology, University of New Brunswick, 2021

A Thesis Submitted in Partial Fulfillment
of the Requirements for the Degree of

Master of Arts

in the Graduate Academic Unit of Psychology

Supervisor: Enrico DiTommaso, PhD, Psychology

Examining Board: Jonathan Wilbiks, PhD, Psychology, Chair
Sean Roach, PhD, Psychology
Wendy Stewart, M.D., PhD., Department of Pediatrics, Dalhousie University
Tobin LeBlanc Haley, PhD, Sociology

This thesis is accepted by the Dean of Graduate Studies

THE UNIVERSITY OF NEW BRUNSWICK

April, 2024

© Sarah Malashevsky, 2024

Abstract

Despite research suggesting 15-25-year-olds require mental health care, they are challenging to reach. Attachment patterns impact adults' narratives, thoughts, beliefs, and behavioural expectations. Narrative-type development influences subjective experiences and one's willingness to seek help for struggles. Secure attachment predicts narrative type and help-seeking. Adverse childhood experiences influence identity and mental health help-seeking. Adversity in childhood influences attachment development throughout adulthood. The following study examined how narrative types affect mental health help-seeking among 19-30-year-olds. Attachment patterns and ACEs were also tested for MHHS prediction. One hundred and seventy emerging adults recruited from UNB and social media completed mental health help-seeking, attachment, and adverse childhood experiences measures. Adverse childhood experiences, narrative types (progressive, tragic, or redemptive), and attachment avoidance predicted mental health support avoidance. Applications, implications, and future directions are discussed.

Keywords: emerging adult, narrative, types of narratives, mental health, help-seeking

Dedication

This project is dedicated to the child within that always longed to understand why people behave the way they do. She is still learning how to answer the why questions. This project led to a great deal of personal insight and healing.

The completion of this degree is a major life and family achievement. Thanks to my children, Jean and Xander, for inspiring me to pursue my dreams. My desire to be an advocate, has helped me to be a better mother. I hope my example reminds you that perseverance will accomplish anything. Thanks to my best friend Rose Miller for drying tears, looking for materials, and proofreading for hours. She has been one of my biggest supporters, and without her, I may not have been able to be the first in my family to attend graduate school. I doubt I would be as confident in my work without Rose. I would not be where I am in this process without my boyfriend Cam Buckley's encouragement, technical support, and advice. He always reminds me why I started and his faith in me propels me forward. My dearest aunt Deb “Choch” inspires me every day to follow my dreams and never give up. I am grateful to be surrounded by people who motivate me to achieve my wildest dreams.

Finally, and most importantly, I dedicate this project to the youth I have worked with, who continue to struggle with overcoming obstacles they have never been equipped to overcome. They have taught me that no one falls through the cracks; these youth work hard each day to achieve independence and stability despite enormous adversity and push back. I plan to continue in my studies and advocacy work to help those youth and many to come in the future.

Acknowledgements

This project was only possible with the help of some people who are important to me. Several professors have made a difference in my professional life, and there are too many to mention. First, I could not have succeeded without the patient supervision of Dr. DiTommaso. Your wisdom and feedback will stay with me throughout my career. Thank you for seeing the potential I have. Dr. Wendy Stewart has given me many wonderful opportunities, and her faith in me has been inspiring. I am grateful for the opportunity to continue working with you in the future. I want to mention Dr. Moira Law's early support of my program. I am grateful for her mentorship. I am grateful to my peers Amy MacQuarrie and Krista Keller for their help with coding narrative data. I also want to thank Dr. Sean Roach and Dr. Tobin LeBlanc-Haley for their work on my examining committee. I appreciate and am grateful for the input, feedback, and time you invested.

While completing this project, I have also had the opportunity to learn so much from so many within the UNB community as well as those within the larger Saint John community.

Table of Contents

Abstract ii
Dedication iii
Acknowledgements iv
Table of Contents v
List of Tables viii
List of Figures ix
Attachment, Emerging Adult Narratives and Seeking Mental Health Care 1
  Introduction 1
  Youth and Mental Health 2
    Facilitators of Help-Seeking 5
    Barriers to Mental Health Help-Seeking 6
    Adverse Childhood Experiences 7
    Adverse Childhood Experiences and Mental Health Help-Seeking 9
  The Narrative 11
    Narrative Types 14
    Narrative Types and Mental Health Help-Seeking 15
  Embodied Attachment Theory of Development 18
    Embodied Attachment and Mental Health Help-Seeking 22
    Attachment, Narrative Type, ACEs, and Mental Health Help-Seeking 24
  Current Study 29
  Hypotheses 31
Method 32
  Participants 32
  Measures 33
    Emerging Adult Mental Health Narrative Questionnaire 33
    Narrative Type and Experiences of MHHS 33
    General Help-Seeking Scale 35
    Adverse Childhood Experiences Checklist 36
    Experiences in Close Relationships Short Form 37
  Procedure 38
Results 39

Data Preparation 39
Data Cleaning 39
Data Conditioning 39
Descriptive Statistics of Measures 40
Correlational Analyses 41
Dramaturgical Narrative Data Analysis 41
Overview of Narrative Analysis 42
Attitudes About Mental Health Help-Seeking 42
Narrative Themes About Mental Health Help-Seeking 48
Quantitative Analyses 53
Does Narrative Type Predict a preference of support in Mental Health Help-Seeking Intentions? 53
Does Narrative Type Predict Attachment Pattern? 55
Do Adverse Childhood Experiences Differ by Narrative Type? 56
Do Narrative Type, Adverse Childhood Experiences, and Attachment Pattern Predict Mental Health Help-Seeking Intentions? 57
Was Past Help-Seeking Related to Narrative Type? 65
Did Narrative Type Influence Perceived Helpfulness of the Help Sought? 65
Are there differences between gender, attachment anxiety, and intentions to seek help? 65
Discussion 66
Attachment 67
Adverse Childhood Experiences 68
Narrative type 70
Mental Health Accessibility and Trust in Others 73
Mental Health Help-Seeking 75
Emerging Adult Narratives About Mental Health Help-Seeking 76
The Role of Family 77
Mental Health Help-Seeking at School 78
No Intention to Seek Help 79
Internalized Stigma 79
Broadening and Building Attachment Security with Trust 80
Theoretical Implications 82

Mental Health Literacy and Reducing Stigma ... 84
Trauma-Focused Approaches ... 85
Clinical Implications ... 86
Clinical Interventions to Promote Mental Health Help-Seeking ... 87
Limitations and Future Directions of This Study ... 92
Demographics ... 92
Socioeconomic Status ... 92
Narrative Types ... 93
Future Directions for Consideration ... 94
Internalized Stigma and Mental Health Literacy ... 94
Conclusion ... 95
Bibliography ... 97
Appendix A ... 162
Appendix B ... 164
Appendix C ... 166
Appendix D ... 167
Appendix E ... 169
Appendix F ... 170
Appendix G ... 171
Appendix H ... 173
Appendix I ... 175
Appendix J ... 177
Curriculum Vitae

List of Tables

Table 1 ... 128
Table 2 ... 130
Table 3 ... 131
Table 4 ... 132
Table 5 ... 134
Table 6 ... 135
Table 7 ... 136
Table 8 ... 137
Table 9 ... 138
Table 10 ... 139
Table 11 ... 140
Table 12 ... 141
Table 13 ... 142
Table 14 ... 143
Table 15 ... 144
Table 16 ... 145
Table 17 ... 146
Table 18 ... 147
Table 19 ... 148
Table 20 ... 149
Table 21 ... 150
Table 22 ... 151
Table 23 ... 152
Table 24 ... 153
Table 25 ... 154
Table 26 ... 155

List of Figures

Figure 1 ... 44
Figure 2 ... 45
Figure 3 ... 47
Figure 4 ... 52
Figure 5 ... 91
Figure 6 ... 156
Figure 7 ... 157
Figure 8 ... 158
Figure 9 ... 159
Figure 10 ... 160
Figure 11 ... 161

Attachment, Emerging Adult Narratives and Seeking Mental Health Care

Introduction

For over three decades, researchers have struggled to explain why youth are less likely than children or adults to seek mental health treatment (Garland & Zigler, 1994; Office of New Brunswick Child and Youth Advocate, 2020). Youth are consistently among the most challenging demographics to reach, despite research indicating that youth aged 15-30 have a distinct need for mental health resources (Lee & Murphy, 2013; Office of New Brunswick Child and Youth Advocate, 2020). Struggles with mental health impact every area of life and understanding the experiences of youth can offer insight into their mental health needs. The steady decline of the reported mental health of Canadian youth has reached alarming lows whereby most youth currently self-report struggles with mental illness (Statistics Canada, February 2021). Additionally, the number of mood disorders in youth increased from 11% in 2020 to 12% in 2021 (Statistics Canada, 2022). Males (48.7%) in this age group tend to fare better than their female (32%) peers and are less likely to report experiencing suicidal thoughts (19.6% of females compared to 15.5% of males; Statistics Canada, February 2021). Notably, the prevalence of suicidal ideation in Canadian youth rose from 5% in 2019 to 8% in 2020 (Liu et al., 2022). This is especially concerning given that suicide is the second leading cause of death amongst youth in Canada (Office of the NB Child and Youth Advocate, 2020). As a result, many parents and advocates have lobbied to improve access to mental health services for youth in NB (Brown, 2021; Office of the NB Child and Youth Advocate, 2020).

This study evaluated emerging adults' narratives using narrative inquiry methodology. Narrative inquiry is a valuable tool for understanding the underlying attitudes and beliefs that guide behaviour (Clandinin & Connelly, 2000; Miller, 2011). A narrative is an internalized story connecting experiences and events. Narratives facilitate the transmission and maintenance of culture and contain thoughts, beliefs, goals, attitudes, and values (Granqvist, 2021; McLean et al., 2013; Miller, 2011; Pennbaker & Seagal, 1999). The following study examined the link between the narrative types that emerging adults develop and their subsequent mental health help-seeking behaviours. Furthermore, attachment patterns and adverse childhood experiences (ACEs[1]) were examined for their ability to predict mental health help-seeking (MHHS[2]).

Youth and Mental Health

Youth mental health is a topic of interest in studies exploring relationships between general help-seeking (Planey et al., 2019; Rickwood et al., 2005), psychological disorders (Planey et al., 2019), resilience-based interventions (Ross et al., 2020), and identity development (Kawamoto, 2016; Pennbaker & Seagal., 1999). Rates of self-reported mental wellness have steadily declined in those aged 15-30. For example, in 2003, 76% of Canadian youth reported excellent or very good mental health (Statistics Canada, February 2021). The report rate dropped to 73% in 2013-2014 and to 56% in 2019 (Statistics Canada, February 2021). This number increased slightly to 57% in 2020 (Statistics Canada, September 2021). In 2003, only 4% reported fair or poor mental

[1] ACEs = Adverse Childhood Experiences
[2] MHHS = Mental Health Help-Seeking

health which has increased to 14% in both 2019 and 2020 (Statistics Canada, September 2021; St. Pierre & Beland, 2004). In 2020, 25% of Canadian youth aged 18-34 reported the need for mental health support in the previous year (Statistics Canada, September 2021). However, this age group was the largest demographic to report seeking mental health support unsuccessfully (Statistics Canada, September 2021). Fifty-three percent of those who engaged in seeking mental health support, reported feeling their mental health needs had been partially unmet or unmet (Statistics Canada, September 2021). In Canada, the negative impact of the pandemic on mental health was highest among youth (Statistics Canada, September 2021). Youth were the group most likely to report negative impacts on their mental health following social distancing implementation, whereas seniors were the least likely to do so (Statistics Canada, September 2021). For example, during the summer of 2020, only 40% of youth reported very good to excellent mental health (Statistics Canada, February 2021). Another report found 42% of Canadian youth thought their mental health had deteriorated since the onset of the pandemic (Office of the New Brunswick Child and Youth Advocate, 2020).

Youth struggling with mental health tend to have comorbid mental health and substance use conditions/disorders, which lead to negative health outcomes and can impact willingness to seek support for their mental health. In 2019, rates of substance abuse showed that cannabis and alcohol use was higher amongst youth aged 15-34 than in older cohorts (Statistics Canada, February 2021). Individuals reporting fair or poor mental health were also more likely to report increases of cannabis and alcohol use during the pandemic (i.e., 11.6% and 18.7% reported increased use respectively; Statistics Canada, September 2021).

People expect a person to seek help or support when they are struggling, yet for many youths, this is not the case (Planey et al., 2019). The earlier an individual experiences symptoms of mental illness, the less likely they are to seek help; however, the longer they wait, the more likely symptom severity will increase, and symptoms will be harder to treat (Wang et al., 2007). In Switzerland, only 13% of youth in need of mental health services seek them out (Mauerhofer et al., 2009). The US National Comorbidity Survey of adolescents (aged 13-18) found that half of the adolescents never received services for mental disorders that caused severe impairment (Merikangas et al., 2011). Of those, less than one in five adolescents received services for eating disorders, anxiety, or substance use disorders (Merikangas et al., 2011). Service utilization was most prevalently reported in youth experiencing concurrent or severe disorders (Merikangas et al., 2011).

Current preventative measures to improve mental health in children and youth focus on resilience-building initiatives and require youths' participation (Khanlou & Wray, 2014). Each time youth engage in these programs, these experiences shape their view and, subsequently, their narrative about that experience and how it translates to other situations. Factors associated with narrative development and MHHS behaviours in youth include adverse life experiences (Filetti et al., 2019), satisfaction with life (Diener et al., 2017), parental influence (Hagstrom & Forinder, 2019; McLean et al., 2010), community involvement (Hasford et al., 2017), and social connection (Lee & Robbins, 1995).

MHHS could be considered a prosocial behaviour that promotes community well-being (Hasford et al., 2017). However, MHHS can be an intimidating and anxiety-

provoking experience for many youths or emerging adults due to the stigma associated with needing help (Community Stakeholder, Personal communication, March 5, 2021). Stigma is a commonly reported barrier to seeking mental health support (Corrigan, 2000; Hetrick et al., 2017; Mason-Jones et al., 2012). For example, in a systematic review, 92% of participants across 53 studies rated social stigma and embarrassment as a primary barrier to seeking help (Radez et al., 2021). Stigma is perceiving aspects of an individual as bad or unusual and using that perception to make generalized judgments about the individual's character (Goffman, 1963). Unsurprisingly internalized stigma about MHHS can contribute to feelings of shame and, therefore, hesitancy to seek professional support (Courtney & Makinen, 2016; Miller, 2011; Planey et al., 2019; Rickwood et al., 2005). It is possible to reduce the stigma by understanding the narrative types that youth have regarding MHHS and developing interventions to shift attitudes about MHHS (Miller, 2011; Rickwood et al., 2005).

Facilitators of Help-Seeking

Research suggests several facilitators for seeking mental health support that can offset common barriers. Psychoeducation about the MHHS process, improving mental health literacy, trust, familiarity, and therapeutic rapport promoted help-seeking behaviours (Rickwood et al., 2005, 2015; Stevens et al., 2006). A systematic review identified that facilitators to general help-seeking included activities away from unhelpful environments, availability of mentors, youth-friendly settings, support group options, community-based familiar settings, transport assistance, and provision of housing for those experiencing homelessness (Brown et al., 2015). Additionally, youth would benefit from opportunities to voice their needs, desired programming, and decision-making

involvement (Office of the New Brunswick Child and Youth Advocate, June 2022; May 2022; Ross et al., 2020). Following this thinking, it will be beneficial to ask emerging adults why they either do or do not access mental health care.

There are four types of MHHS that include instrumental help for direct problem-solving, tangible support for acquisition of necessities, informational support for knowledge and advice, and finally emotional support for reassurance, comfort, and emotion regulation (Corrigan, 2000). Support may come from formal (i.e., professionals) or informal supports (i.e., family and friends). If youth feel unsupported in their lives, they may adopt a negative view of the MHHS process (Rickwood et al., 2005). This attitude about MHHS is facilitated in part through developing the individual's life story, otherwise referred to as a narrative. Therefore, positive attitudes about MHHS, positive overall well-being and mental health in youth is important for reducing negative health outcomes in adulthood.

Barriers to Mental Health Help-Seeking

Common barriers to general help-seeking behaviours for youth from early grade school to emerging adulthood involve a lack of emotional competence, such as an inability to identify, describe, or understand emotions (Brown et al., 2015; Rickwood et al., 2005). Often, efforts to exercise autonomy lead to youth self-reliance and reliance on their peers for informal emotional support (Hetrick et al., 2017; Lee & Murphy, 2013; Norris et al., 2016; Sears, 2020). Their reliance on peers can be problematic as youth often cannot recognize when a mental health issue requires professional help (Planey et al., 2019). Second, youth may need help finding accessible services (Saunders et al., 1994; Srebnik et al., 1996). For example, 72.6% of youth in New Brunswick reported

they do not know where to access help in their community (Office of New Brunswick Child and Youth Advocate, June 2022).

Promoting the development of mental health literacy can address these commonly reported barriers. Mental health literacy encompasses emotional competence, awareness of mental illness, and knowing where to seek help. Individuals without this ability are more likely to lack access to sources of help or have been unsuccessful in help-seeking previously (Rickwood et al., 2005). Mental health literacy is an essential life skill due to growing service gaps (Office of the New Brunswick Child and Youth Advocate, September 2021, May 2022, June 2022; Planey et al., 2019; Rickwood et al., 2015; Ross et al., 2020). For example, recently identified gaps include long wait times, lack of transportation to attend appointments, or delayed referrals to mental health professionals and have contributed to youth suicide in New Brunswick (Brown, 2021; Office of the New Brunswick Child and Youth Advocate, September 2021, June 2022). Moreover, experiencing hopelessness predicts intentions not to seek help in general, which begins a cycle known as the help-negation effect (Rickwood et al., 2005). Additionally, attitudes relating to general help-seeking, particularly a sense of helplessness or invalidation during previous attempts, are predictors of failure to seek future help (Brown et al., 2015; Rickwood et al., 2005).

Adverse Childhood Experiences

One plausible reason youth may not seek help could be related to the influence of ACEs in their lives. Throughout general development, adversity is plausible and likely to occur at some point (Mate & Perry, 2022). ACEs, a determinant of health, are events occurring in childhood with lasting effects across the lifespan (Filetti et al., 2019; Mate &

Perry, 2022; Matlin et al., 2019). ACEs are painful or distressing to the individual, drain coping resources, and may disrupt attachment patterns (Sarma & Thomas, 2020). In their initial model of ACEs, Filetti and colleagues (2019) included physical abuse, emotional abuse, a mentally ill household member, witnessing domestic violence, a substance-using household member, an incarcerated household member, presence of one or no parents in the home, and emotional and physical neglect. Taylor and Weems (2009) expanded these to include witnessing violence in the community, subjective feelings of discrimination, unsafe neighborhoods, living in foster care, and experiences of bullying. These experiences and the presence or absence of mitigating influences can result in any number of outcomes because resilience may be present in some life areas but not others (Weems et al., 2021). What these experiences have in common is that most of them involve family members in the home. These experiences leave their mark on the individual as they progress into adulthood through developing attachment patterns. As a result, ACEs disrupt narrative construction (Bohn & Berntsen, 2008) and hinder individuals from seeking mental health support (Lee & Murphy, 2013; Turner et al., 2020).

ACEs impact families generationally through the behaviours parents acquire to cope with their own ACEs and the parenting practices they learn and continue using (Mate & Perry, 2022; Weems et al., 2019). Therefore, parents' behaviour also influences narrative development of youth (Weems et al., 2019). Regardless of the best parenting practices, youth are likely to experience adversity (Hays-Grudo & Morris, 2020; Mate & Perry, 2022). ACEs are strongly associated with behaviours or events related to negative health outcomes (Filetti et al., 2019). These outcomes include early initiation of sexual

activity, teenage pregnancy, later development of psychopathology, disrupted neurocognitive development, disease, disability, and potentially early death (Cronholm et al., 2015; Filetti et al., 2019; Weems et al., 2021). Each time the individual experiences trauma, beliefs are formed and reinforced by filtering the experience through the existing narrative to aid in interpretation and ascribing some meaning to the event (McAdams & Jones, 2017). By the time they graduate from high school, emerging adults are often capable of assessing their skills for employment and planning for further education or training (McAdams 2001b, 2008; Penuel & Wertsch, 1995). They also participate in groups and organizations and make decisions about their beliefs, and which causes they support (McAdams 2001b, 2008; Penuel & Wertsch, 1995). This review of life objectives and beliefs can be challenging for a youth in need of more guidance (Erikson, 1968).

Adverse Childhood Experiences and Mental Health Help-Seeking

The effects of ACEs over the lifespan are profoundly concerning, and seeking mental health support could enhance the overall quality of life in emerging adults. ACEs can deter MHHS or contribute to the lack of awareness of available professional support (Mate & Perry, 2022). If youth have supportive adults encouraging MHHS, youth are more likely to consider this coping strategy an option (Hays-Grudo et al., 2021). However, as new information integrates, negative experiences can impact perceived capabilities and self-worth (Hagstrom & Forinder, 2019). Some individuals no longer trust adults because adults abuse their trust (Hagstrom & Forinder, 2019; Mate & Perry, 2022). If ACEs occur at home, parents may be unable to offer healthy support. Realistically, the family unit serves as a primary means of support to individuals facing adversity (Saltzman et al., 2020); Meaning this could be an important reason for not

engaging in MHHS behaviour. Additional barriers to MHHS may include dropping out of school to work and help with household bills or the dread of confronting caregivers about substance abuse (Hagstrom & Forinder, 2019). Impressions of adults as uncaring and reliable (i.e., a negative view of others), together with subjective feelings of insignificance, fosters a narrative whereby seeking mental health support may appear futile (Hagstrom & Forinder, 2019).

MHHS is a suitable and desirable coping mechanism for individuals who are struggling. However, youth with ACEs may not have positive coping strategies, and they will use whatever strategies are available to them. Attempts to cope with ACEs can lead to smoking, a greater prevalence of STIs due to risky sexual behaviours, depression, drug use, alcoholism, and suicide attempts (Felitti et al., 2019), all of which are behaviours associated with unfavorable long-term health effects (Erikson, 1968). Individuals with ACEs may be more likely to engage in risky behaviour for the immediate satisfaction of needs and reduction of distress experienced (Hays-Grudo & Morris, 2020). Risky behaviour is an unhealthy coping mechanism linked to youth's underdeveloped problem-solving and decision-making brain regions (Filetti et al., 2019; McMahan & Thompson, 2015).

Additionally, for every subsequent ACE experience, youth are at risk of suicide rates of up to 1220% compared to the general population (Filetti et al., 2019). ACEs contribute to 80 percent of youth suicide attempts (Filetti et al., 2019). This finding means identifying strategies to mitigate adverse effects of ACEs, such as seeking mental health support, critical in improving emerging adults' quality of life. For instance, one key strategy is building a supportive social network, which is a primary feature of

attachment security (Bowlby, 1969). Another important consideration are the internalized views and expectations held within an individual's narrative or life story.

The Narrative

Cognitive scripts are schemas or shortcuts our brain uses to make decisions about future experiences faster (Reisberg, 2019). Interpersonal schemas are the internal working models or narratives people use to navigate circumstances in efforts to minimize harm and distress (Beckes et al., 2015). People are only sometimes aware that they use schemas (Reisberg, 2019). In this context, schemas are the stories or narratives that express who people are, where they came from, personal conflicts they have encountered, and their resolution (Clandinin & Connelly, 2000; Rosenthal, 1993). The act of storytelling is a fundamental part of the human experience (Pennbaker & Seagal, 1999) and is a theme in identity research (McAdams, 2001a; Rosenthal, 1993). A narrative is a conscious cognitive schema formed through event appraisal and reflection (McAdams, 2008). Narratives provide "explanation, justification, and rationalization" of experiences that normalize thoughts and habits necessary to derive meaning from our lives (Mate, 2022, p.417). Narratives are constructed to develop a sense of the meaning of past events by linking them to current events and the present self and are used to predict the expectations the individual has for the future (Erikson, 1968; Habermas & Bluck, 2000; McAdams, 2001a, 2008; McLean et al., 2010; Pennbaker & Seagal, 1999). Life narratives begin with explanatory themes in childhood and evolve through to integration of the meaning associated with the experience of a given event (Berntsen & Rubin, 2004; McLean et al., 2013; Schnitker et al., 2019). For example, when examining play

scenarios of childbirth, Day, and colleagues (2018) found that young females narrated experiences related to gender-specific roles of the mother, doctor, and nurses.

The motives and traits of an individual become internally organized within the self through the iterative use of the life narrative. For instance, cognitive abilities to solve problems, prioritize importance, and use working memory develop in concert with the narrative aiding decision-making (Beckes et al., 2015; Reisberg, 2019; Sarma & Thomas, 2020). Emotional interpretations of memories shape attitudes and opinions (Reisberg, 2019). For example, attachment theorists have shown that when children do not have someone to nurture their needs and provide comfort, they develop a lack of confidence in their caregiver to meet those needs and, subsequently, a preoccupation with getting their needs met (Bowlby, 1969, 1982). During the iterative process of integrating new experiences into existing narratives in any given life area, the individual learns to express and identify with the self (Day et al., 2018; Habermas & de Silveira, 2008; Hammack & Cohler, 2011; McLean et al., 2013). An integrated and logically connected narrative is associated with a strong sense of self and contributes to well-being (Habermas & de Silveira, 2008).

As emerging adults progress into adulthood, those who have found a sense of identity and have gained confidence in their beliefs and chosen causes to support will, in turn, gain fidelity (Erikson, 1968). Fidelity is a sense of faithfulness or loyalty to their beliefs, allowing them to build a sense of identity amongst the social expectations in their environment (Erikson, 1968). Fidelity prevents self-doubt and affords rebellion against authorities or societal norms (Erikson, 1968). This developmental progression is evidence of well-being and provides the individual with the emotional and social resources

necessary to progress to later stages of psychosocial development (Erikson, 1968; McAdams et al., 2001b). Narrative development is an iterative process resulting in a more coherent sense of identity with each iteration.

During personality development, narrative progression has three stages (McAdams, 1995). Individual traits first become attributed to generic individual temperament. Second, personal goals, life objectives, psychological defense mechanisms, coping methods, and values develop and integrate into temperament in childhood. The narrative, or inner story of self is the third tier. The first two tiers logically connect in an expressive language leading to a complete understanding of the inner story of the self. Narratives bridge the inner world with the external aiding the connection of self to events, thereby supporting a developing integrated sense of self (Hammack & Cohler, 2011; McLean & Pratt, 2006; Pasupathi et al., 2007).

Narrative revisions entail reflection, and behaviours, such as journaling, that integrate experiences from many life events into a pattern that leads to an individual's sense of meaning and purpose (Berntsen & Bohn, 2010; Bohn & Berntsen, 2008; Habermas & Bluck, 2000; Soucie et al., 2012). When confronted with negative ideas or values on a narrative topic, youth may struggle to integrate their experiences because they value the opinions of others in their lives. (Hammack & Cohler, 2011; Hammack et al., 2009). For example, parents may openly oppose youth experiences or the narrated sense of self (i.e., sexuality; Hammack & Cohler, 2011; Hammack et al., 2009). One controversial book for parents of adolescent girls named the first chapter referring to transgender teens as "The Contagion," suggesting alternative sexual identities to heterosexuality are pathological (Shrier, 2020). Titles like this show a cultural view of

youth sexuality, and this view leads to LGBT+ youth often facing shame, bullying, and exclusion (Hammack & Cohler, 2011; Hammack et al., 2009; Office of the New Brunswick Child and Youth Advocate, November 2020, September 2021, May 2022, June 2022). Essential adults in young people's lives play a meaningful role in the formation of attachment patterns which, in turn, contributes to narrative development. The messages received by youth from significant others may influence narratives about MHHS and the likelihood that they will access support when needed.

Narrative content in youth through into adulthood often includes stories of resilience (Khanlou & Wray, 2014), adverse childhood experiences (ACEs; Filetti et al., 2019), secure attachment patterns (Habermas & de Silveira, 2008; Sarma & Thomas, 2020), and coping strategies (Filetti et al., 2019; Pennbaker & Seagal, 1999). The pattern of narrative development is complex and continues to evolve in response to the environment (Strand et al., 2019). It is essential to understand the development of narrative type alongside attachment patterns because these patterns predict a variety of mental illnesses and social struggles (Mikulincer & Shaver, 2016; Strand et al., 2019).

Narrative Types

There are three types of narratives: progressive, redemptive, and tragic (Lieblich et al., 1998). Progressive narratives involve stories in which the individual's life events and attitudes continue forward in a consistently positive or neutral way with minor change. Redemptive narratives begin with a negative emotional tone (e.g., sadness or fear) and end with a positive tone. In other words, a transformation occurs whereby the negative changes to positive. For example, a person may experience something traumatic yet still learn to thrive. McAdams (2008) compares redemptive stories to the literary

structure of a hero in a novel. The hero faces obstacles but pushes forward with faith and hope in their abilities to find success. Redemptive stories can generally be considered adaptive; however, they could also be toxic positivity in disguise (Upadhyay et al., 2022). Toxic positivity is the tendency to minimize or suppress negative emotions instead of working through them to focus on only the positive (Upadhyay et al., 2022). Redemptive narrative types demonstrate a psychological capacity to create a positive gain from a negative obstacle and are evidence of resilience achieved by the narrator (McAdams & Jones, 2017). For example, in emerging adults reporting redemptive stories, 47% were also more likely to report psychological well-being and higher self-esteem (McAdams et al., 2001b). Specifically, reports of redemption imagery and increased agency were associated with well-being in similar studies (McAdams et al., 2001b; McAdams & Guo, 2015). Finally, tragic narratives have a downward direction or tone. Events or experiences are perceived negatively, and the narrative develops toward negative rather than positive outcomes. Tragic narratives are positively correlated with suicidality and negatively correlated with life satisfaction (Sandage, 2012).

Narrative Types and Mental Health Help-Seeking

Narrative theorists explore narrative identity types in three ways (Negele & Habermas, 2013). First, understanding how people link the past to the present and predict their future based on previous experiences. Second, narratives contribute to the sense of continuity of self, parallel to personality development. Third, investigating individual views by evaluating how lessons are integrated and how events lead to increases in insight contributes to a sense of self-continuity (McLean & Pratt, 2006; Negele & Habermas, 2013). In addition, ACES influence narrative development and attachment

patterns. However, it should be noted that narrative research has yet to explore the links between narrative-type classifications and instances of MHHS.

By emerging adulthood, positive developmental outcomes typically include persistence, hopefulness, goal-directedness, healthy expectations, success orientation, a sense of purpose, coherence of self, and anticipation for the future (Damon, 2004). The narrative describes the accomplishment of these goals using themes, logic, sentences, word choices, and future orientation. Those with supportive adults offering practical support when they struggle with identity are likely to have a more positive narrative type overall (Hammack et al., 2009). Thereby narratives of those with attachment security should have a tone of positivity and redemption. Narrative-type development happens interactionally with subjective experiences and can influence or determine one's willingness to seek help for their struggles (Bohn & Berntsen, 2013).

A progressive narrative type involves a steady progression in life. Therefore, progressive narrative types may feel less need to engage in MHHS. Conversely, a redemptive narrative has ups and downs and encompasses a story of overcoming adversity, creating a positive sense of self (Lieblich et al., 1998). MHHS is a positive, active coping skill that aims to promote well-being by assisting individuals with overcoming adversity and addressing mental health concerns (Srebnik et al., 1996). Themes associated with redemptive narrative types include an early life advantage, sensitivity to suffering, moral steadfastness, redemptive sequences, and prosocial goals (McAdams & Guo, 2015). An example of an early advantage could include being born into a family of higher socioeconomic status. Those in lower socioeconomic statuses struggle with higher poverty rates, crime, and mental illness (Castillo, 1997). As a result,

individuals with advantages early on may have fewer reported ACEs which could result in a progressive narrative type.

Tragic narrative types, however, are distinguished by a sense of hopelessness when faced with adversity (Lieblich et al., 1998). MHHS is an adaptive skill when it successfully results in the provision of social support meant to assist in overcoming adversity and struggles with mental health (Kawamoto, 2016). Tragic narrative types have strong relationships to struggles with mental illness that result in suicidality (Sandage, 2012), indicating either a lack of MHHS or perceived inadequacy of the help sought and acquired.

A lack of life experience may lead those with an unstable sense of self to rely more on semantic knowledge about the possible personal outcomes of future events such as MHHS (Bohn & Berntsen, 2013). In other words, individuals with prior experience in seeking mental health support are more likely to base their future expectations of MHHS on the outcomes of those past experiences, in contrast to individuals who have not engaged in such behaviours before (Bohn & Berntsen, 2013). MHHS assists in resolving the problem identified and related emotions associated with the process (Planey et al., 2019; Rickwood et al., 2005). The development of the resulting narrative necessitates an assessment of the problem, its perceived impact on the individual, and knowledge of the options available to address the identified problem (Rickwood et al., 2005). The appraisal or assessment must then be translated into language by sharing with others about their experience (Rickwood et al., 2005). When seeking out another for support, the lack of available help may inhibit successful help-seeking. Unavailability of support can

contribute to the unwillingness to engage in MHHS and disclose the problem to the source of support (Rickwood et al., 2005).

Embodied Attachment Theory of Development

MHHS is a behaviour that requires the capacity for social connection, which as noted can be disrupted by ACEs (Brown et al., 2015). Attachment theory provides a framework of reference to better understand individual narratives and why some emerging adults may be more inclined to engage in MHHS than others. Attachment patterns have been linked with MHHS (Sandage, 2012), ACEs (Brown et al., 2015), and narrative development (Habermas & de Silveira, 2008). Emerging adults have four attachment styles (Bartholomew & Horowitz, 1991). Securely attached individuals enjoy closeness and autonomy where they have positive views of self and others. The preoccupied individual views themselves positively but others negatively, making relationships unstable. Dismissive individuals see themselves positively but others negatively and avoid personal interactions. Finally, fearfully attached individuals avoid close interactions and hold negative self- and other views. Attachment insecurity groups the preoccupied, dismissive, and anxious attachment tendencies (Fraley et al., 2015).

Attachment patterns develop due to social interactions with caregivers and other significant adults (Mikulincer & Shaver, 2016). Furthermore, attachment motivates behaviours that promote well-being and survival (Bowlby 1962, 1982). Attachment security can be earned through overcoming adversity which, for many, will result in a redemptive narrative type (McAdams, 2008). A redemptive narrative features overcoming adversity and turning the negative into a positive (McAdams, 2008). Conversely, experiencing negative events that erode attachment security can lead to

attachment insecurity and a possible tragic narrative type (Sandage, 2012). A tragic narrative features an inability to overcome adversity resulting in the reinforcement of negative emotions like helplessness (McAdams, 2008). Experiencing adverse events in childhood can disrupt the development of attachment security (Sarma & Thomas, 2020).

Consistent child-caregiver interactions build attachment security (Ainsworth et al., 1978). When their caregiver is physically and emotionally available, the child feels safe and secure (Ainsworth et al., 1978). However, inconsistent caregiver attentiveness leads to attachment insecurity and mistrust in caregivers (Ainsworth et al., 1978; Bowlby, 1969, 1982). ACEs in the family produce inconsistent caregiver behaviours, subsequently affecting attachment security (Mate & Perry, 2022; Sarma & Thomas, 2020; Weems et al., 2019). Notably, caregiver responsiveness causes neurological and physiological changes contributing to memory consolidation in children that sustain stable attachment patterns into adulthood (Ainsworth, 1982, 1989; Beckes et al., 2015).

Attachment theory suggests that caregivers respond to infant cues and vice versa to create a bond (Bowlby, 1969, 1982). Caregivers' responsiveness to infant cues contributes to developing cognitive frameworks or internal working models (Bowlby, 1969, 1982; De Wolff & van Ijzendoorn, 1997). Bowlby believed that consolidating the working model into memory was crucial to attachment patterns and their resistance to change over the lifespan (1969, 1982). Subconscious internal working models are triggered by environmental cues such as the perceived emotional state of others and impact metabolic resources, emotion regulation and social expectations (Beckes et al., 2015). Internal working models of self and others form the consciously constructed baseline narrative (Bartholomew & Shaver, 1998; Bowlby, 1969, 1982). Caregiver

responses reinforce relationship-based cognitive schemas through embodied neurological and physiological processes (Ainsworth, 1982, 1989; Beckes et al., 2015; Bowlby, 1969, 1982).

Attachment security is correlated with subjective well-being (Calvo et al., 2020; Mikulincer & Shaver, 2016; Rholes & Simpson, 2004), general help-seeking (Bachman & Bippus, 2005; Carr & Wilder, 2016; Guerrero & Jones, 2005), positive and supportive social networks (Bowlby, 1969; Guerrero & Jones, 2005; Mikulincer & Shaver, 2016), and neuro-cognitive structural and functional differences across cultures in youth (Beckes et al., 2015; Buckheim et al., 2017; Fitter et al., 2022; Heckendorf et al., 2016; Sarma & Tomas, 2020; Webb, 2021). By contrast, attachment insecurity increases emotional vulnerability (Webb, 2021). Insecurity is further exacerbated by emotional sensitivity, reactivity, and slow returns to baseline, which are associated with several personality disorders (Webb, 2021). Emotional reactivity occurs when a child cannot find comfort or protection (Bartholomew & Horowitz, 1991; Khalil et al., 2022). Failure to find comfort leads to preoccupation with social cues and over-reliance on others for comfort rather than learning to self-soothe (Khalil et al., 2022).

A hybrid embodied attachment theory examines environmental effects on neurological and physiological systems relative to cognitive and attachment pattern development (Beckes et al., 2015). Embodied approaches assert that interaction between information in the environment, sensory experiences, body features, and opportunities for behaviour serve to inform the process of attachment better than cognitive working models alone (Beckes et al., 2015). Embodied theories expand traditional attachment theory to integrate social elements of relationships beyond cognitive scripts by accounting for the

neurobiological processes of attachment (Beckes et al., 2015). Conscious cognitive scripts or mental representations thus form because of interactions between the brain, body, and environment (Beckes et al., 2015). The environment includes family composition, location, urban vs. rural community, individual vs. communal culture, cultural expectations, values, and beliefs. Cognitions adapt to environmental conditions, and bodily states serve as the mechanism of embodied attachment (Beckes et al., 2015).

Caregivers teach the child to identify others' desires or mental states and predict their behaviour within that environment (Heckendorf et al., 2016). This knowledge guides and comprises the attitudes, ideas, beliefs, and perceptions of appropriate behaviour held within the narrative (Granqvist, 2021). Furthermore, attachment influences the metabolic resources and brain development necessary for successful relationships (Beckes et al., 2015). Thus, caregiver sensitivity improves mental health and coping because attachment drives environmental survival behaviour arising from distress (Granqvist, 2021; Mikulincer & Shaver, 2016). A subconscious internal working model attributing comfort-seeking behaviours to unpredictable responsiveness, hyperactivates physiological systems, and drives proximity-seeking behaviours (Beckes et al., 2015). Conversely, physiological processes may defensively deactivate to prevent unsuccessful proximity-seeking (Beckes et al., 2015).

Attachment affects neurotransmitters and brain structures that govern emotions (i.e., serotonin; Buchheim et al., 2017; Fitter et al., 2022). For survival, attachment insecurity reactively increases amygdala activity (Beckes et al., 2015; Buchheim et al., 2017). These findings show that neurotransmitter pathways develop to match attachment patterns, lowering serotonin levels as attachment insecurity increases (Buchheim et al.,

2017). Attachment insecurity also affects several psychopathologies including depression (Buchheim et al., 2017; Webb, 2021). Thus, mental illness may impair executive functioning and maturity benchmarks like MHHS (Buchheim et al., 2017; Hammack & Cohler, 2011). Attachment insecurity makes a person feel unprepared to manage stress or solve problems, and they tend to blame unpleasant events on self-deficit (Moreira & Rodrigues Maia, 2021).

Perception of self-deficit becomes a theme in narrative content (Moreira & Rodrigues Maia, 2021). Narratives consist of memories associated with individual identity consistently revised in context with social experiences (Pasupathi & MacLean, 2013). The narrative becomes a mechanism of conscious identity development (Pasupathi & MacLean, 2013), through which attachment internal working models create a subconscious base narrative (Negele & Habermas, 2013). Both rely on memory, past experiences, the development of language, and information processing, to anticipate future expectations of themselves. This form of embodiment contributes to the resulting narrative type the individual forms about the self and others.

Embodied Attachment and Mental Health Help-Seeking

Social support is a maintenance mechanism of attachment security in adulthood, and attachment security positively correlates with active MHHS behaviours (Guerreros & Jones, 2005). Attachment security can be earned in relational contexts, and reduces internalized and observable behaviour, such as maladaptive coping, which strains bodily, psychological, and social domains (Hays-Grudo et al., 2021). There is an interplay between the attachment system, social interactions, and the resulting narratives that will

either foster protective development, promote MHHS or facilitate the likelihood of increased risk for psychopathology (Hays-Grudo et al., 2021).

Those with better resilience and positive coping abilities connected to attachment security, such as MHHS, embody secure attachment (Mikulincer & Shaver, 2016; Rholes & Simpson, 2004). When exposed to attachment-related stress, securely and avoidantly attached adolescents showed more heart-rate variability from baseline (Gander et al., 2022). Secure adolescents recover faster than avoidant adolescents, implying that avoidants may adapt coping strategies to avoid stressful circumstances but still struggle to manage their emotions. However, there was no statistically significant difference in heart-rate variability among anxious-attached adolescents, possibly due to the tendency to exaggerate distress cues in proximity-seeking interactions (Gander et al., 2022).

Many seek informal support before professional help (Rickwood et al., 2005). Avoidantly attached individuals are more likely to manage alone because they fear rejection and connection (Bachman & Bippus, 2005; Guerrero & Jones, 2005; Mikulincer & Shaver, 2016). In addition, attachment insecurity increases the likelihood of anxiety, depression, and negative coping skills and of holding negative social attributions (Thomson & Jaque, 2017). MHHS improves outcomes by actively seeking support from others (Rickwood et al., 2005). Simultaneously, interpersonal skills formed in tandem with attachment patterns are required to enable MHHS from others (Mikulincer & Shaver, 2016).

When an infant's needs are unmet, their attachment system activates, and they behave in an attempt to find comfort or protection (Bowlby, 1962, 1982). Ignoring symptoms of mental illness can increase emotion dysregulation, and everyday

functioning (e.g., social or communication skills) can decline, which is related to increases in suicidality (Chovil, 2004; Hetrick et al., 2017). These disparities are critical, considering that adolescents and emerging adults tend to have poor mental health service engagement (Hetrick et al., 2017).

Another barrier to seeking mental health support related to stigma and attachment concerns a lack of social connection (Chovil, 2004; Thakur & Jain, 2020). Social connection, an outcome of secure attachment, is known to reduce the risk of anxiety, depression, substance abuse, or other symptoms of various psychopathologies (Mate, 2008; Thakur & Jain, 2020). Furthermore, youth with low self-esteem, and self-worth, that belong to an ethnic minority, live in a family with low income, or have a death in the family have a heightened risk of developing post-traumatic stress or suicidality (Kun et al., 2009; Thakur & Jain, 2020). Most of the literature reviewed involved clinical or undergraduate samples, not the larger community. Therefore, it is crucial to understand why emerging adults in community settings choose not to engage in MHHS when they may need it most.

Attachment, Narrative Type, ACEs, and Mental Health Help-Seeking

Attachment patterns become embodied and influence social and physiological changes in identity development (Carr & Wilder, 2016; Fitter et al., 2022). A mother's attachment representations based on her subjective experiences are associated with biological changes in the child’s brain structure (Fitter et al., 2022). This change in brain structure impacts the child's ability to regulate emotions in concert with their developing attachment systems (Fitter et al., 2022). For instance, biological responses to emotions happen following the experience of thoughts and beliefs (Beckes et al., 2015). The

resulting behaviours influence the body's subsequent perception of physical or psychological threats (Lux et al., 2021). Attachment patterns are embodied through this biological reaction during times of distress yet are not active during calm times (Beckes et al., 2015). These physiological responses of both mother and child underlie the motivation for behaviour to the extent that they influence emotions that might cyclically elicit thoughts, beliefs, and behaviour (Lux et al., 2021). Some attitudes and beliefs correlate with resilient behaviours like MHHS (Beckes et al., 2015; Lux et al., 2021). For example, youth that have positive social supports tend to voluntarily seek support because they are likely to have been successful in general help-seeking previously (Rickwood et al., 2005). The LGBT community's perception of negative judgements from others would also serve as an example of beliefs that would limit the likelihood of MHHS (Hammack & Cohler, 2011). Attitudes and beliefs promote social learning and attachment patterns through the developing narrative (Beckes et al., 2015; Lux et al., 2021). Therefore, attachment security should contribute to MHHS and the contents of individual narratives.

ACEs have long-lasting effects on youth attachment orientations and willingness to engage in MHHS behaviours in youth (Larose & Bernier, 2001; Patel & MacKenzie, 2017). Instances of household dysfunction and sexual, physical, or emotional abuse can result in distrust of caregivers (Hagstrom & Forinder, 2019). Distrust in caregivers is also likely to contribute to a lack of trust in the process of seeking mental health support through attachment patterns (Hagstrom & Forinder, 2019). Following instances of traumatic experiences, individuals may incorporate beliefs such as "I am weak or incompetent," "the world is dangerous," or "it is my fault this happened" into their

narrative (Arikan et al., 2016). Reduced willingness to engage in MHHS behaviours due to a lack of trust in the process is associated with decreases in positive treatment outcomes following each subsequent ACE event (Thomson & Jaque, 2017). The experience of adversity can result in the pursuit of more social support for mental health struggles, though that support is most likely from friends or family members (Thomson & Jaque, 2017; Sears, 2020). Therefore, ACEs contribute to attachment insecurity and, in turn, will predict MHHS.

Caregiver sensitivity fosters attachment security (i.e., availability and responsiveness), whereby individuals learn emotion regulation and positive coping skills such as comfort in help-seeking (Bowlby, 1969, 1982; Dobson et al., 2022). Attachment security is strongly associated with positive social outcomes and more time spent reflecting on positive experiences, which leads to a more positive sense of self and others (Kawamoto, 2016). Narratives of securely attached individuals should thus also show more logical connection, and integration of MHHS events owing to more energy spent reflecting on their experiences. If emerging adults with attachment insecurity believe others are unable to help them, their narrative about MHHS would contain notions of futility concerning seeking mental health support. According to the evidence, attachment insecurity predicts psychopathology and a higher need for mental health support, but it does not predict MHHS behaviour specifically (Mikulincer & Shaver, 2012; Thomson & Jaque, 2017). Attachment insecurity relates to a lack of a consistent sense of self in their environment and personal feelings of worthlessness, hopelessness, unstable self-esteem, and distrust of others (Mikulincer & Shaver, 2012). Furthermore, attachment anxiety is directly related to low self-esteem and to imagining future events as negative (Goodall,

2015). These same features characterize negative elements within the contents of a redemptive narrative (Lieblich et al., 1998).

Redemptive stories feature overcoming obstacles and end positively (Lieblich et al., 1998). Similarly, having a sense of confidence in one's ability to overcome challenges, or having self-efficacy, is related to attachment security and capabilities to cope positively with adversity (Bender & Ingram, 2018; Carr & Wilder, 2016). Positive experiences influence positive development, whereas negative experiences affect identity development negatively because people tend to choose social environments that match the tone of their internal temperament (Kawamoto, 2016; Thomson & Jaque, 2017). However, repressing negative emotions to attempt a positive adaptation is toxic (Upadhyay et al., 2022). Consistent experience of positive or negative events both linearly and progressively characterize a progressive narrative (Lieblich et al., 1998). Attachment security moderates the influence that life experiences will have on personality development and, thus, narrative development (Garland & Zigler, 1994; Kawamoto, 2016). In addition, characteristics used to describe the self, implies the integration of experience into the narrative (Garland & Zigler, 1994). A childhood environment free of ACEs is categorized in a progressive narrative type. Therefore, they are less likely to sense the need for support because they do not perceive hardship. When anticipated negative events occur, they reinforce negative views of seeking mental health support (Kawamoto, 2016). This is best explained through behavioural conditioning (see Martin & Pear, 2019, for information about behavioural conditioning). This attitude surrounding MHHS should be found in tragic narrative types, wherein previous experiences, or a lack of access to services leads to a sense of pointlessness in seeking

mental health support. Attachment insecurity is strongly associated with high sensitivity to and the amplification of negative experiences, such as perceptions of being judged by others negatively (Carr & Wilder, 2016; Kawamoto, 2016; Thomson & Jaque, 2017). These negative beliefs and attitudes could develop as barriers to seeking mental health support.

Furthermore, intense efforts to deactivate the attachment system by avoiding social connections and, thereby, avoiding emotional vulnerability characterize attachment avoidance (Bender & Ingram, 2018). Avoiding emotional vulnerability can lead to an inflated sense of security whereby the individual is confident yet internally experiences unresolved distress that diminishes their coping abilities when experiencing adverse experiences (Mikulincer & Shaver, 2012). On the other hand, perceptions of personal worthlessness, inabilities to cope with adversity, and an unstable sense of self characterize a tragic narrative type (Lieblich et al., 1998). Therefore, a tragic narrative characterizes individuals with little hope for redemption from ACEs because they lack trust in seeking mental health support from others (Halpern et al., 2012). Similarly, attachment insecurity would relate to a story containing futility in seeking mental health support due to a lack of confidence in caregivers to meet their needs comprising a tragic or negatively progressing narrative type. The same is true of positive experiences that reinforce traits such as self-efficacy and a greater trust in the MHHS process (Kawamoto, 2016). Previous studies have examined how narratives develop (Day et al., 2018; McAdams, 2001a, 2008, 2015), how they progress to a more mature continuous way of identifying the self (Habermas & Bluck, 2000; Habermas & de Silveira, 2008; McLean et al., 2010; McLean & Pratt, 2006), and how those continuity differences are represented in

at-risk populations using case studies (Hagstrom & Forinder, 2019; Hammack & Cohler, 2011; McLean et al., 2013; Sandage, 2012).

Current Study

The primary purpose of this study was to determine the narrative type of emerging adults relating to willingness to engage in MHHS. MHHS is a positive coping skill and an intervention influenced by attachment pattern (Kawamoto, 2016). The consequence of ACEs might include struggles with achieving or maintaining mental health and unwillingness to engage in MHHS. Recovery from trauma associated with ACEs requires empowerment (Altmaier, 2017). Empowerment includes having a sense of self-efficacy and faith in one's ability to seek support when needed. In other words, MHHS is a positive active coping skill required for sustainable recovery from ACEs' effects on development (Rickwood et al., 2015).

Redemptive, progressive, or tragic narrative types develop subjectively (McAdams, 2008). Therefore, thematically analyzing the language and emotional content of the narrated experiences written by participants about their experiences of MHHS will afford a broader understanding of how they develop alongside attachment patterns (Sandage, 2012). Very little literature describes the relationship between narrative type and willingness to engage in MHHS behaviours. This study examined the narrative-type of participants by identifying general themes, attitudes, beliefs, and emotional tones from the narrative excerpts they provide. The knowledge obtained could potentially inform future interventions aimed at improving service engagement.

The current study incorporated written experiences about MHHS from emerging adults' perspectives. Given that emerging adults have had few opportunities to describe

their experiences with seeking mental health support specifically in previous studies, this study design addressed this limitation. Narratives are a valuable tool for understanding attitudes and behaviours, providing insight through personality traits described, strengths or weaknesses discussed, the setting of the event, and social context given by participants through written passages (McAdams, 1995; Miller, 2011). The meaning and beliefs attributed to an event are evident in the type of narrative that emerging adults develop (McAdams, 2001b, 2008). Additionally, this study aimed to investigate the relationship between attachment patterns and narrative type, which adds to the growing body of empirical narrative literature. Attachment security may be one explanation for the ability to frame ACEs positively within the narrative type developed by emerging adults (Felitti et al., 2019; Miller, 2011).

Furthermore, most research involves clinical or undergraduate samples limiting the overall understanding and generalizability of the findings in terms of general help-seeking. While this study sampled undergraduates, recruitment also occurred via social media within the larger community to address previous sampling limitations. This method helped engage those of sub-clinical and community populations through snowball sampling. None of the studies reviewed involved narratives relating to MHHS specifically. Weems et al.'s (2019) previous work noted that neurological effects on youth samples focused exclusively on exposure to traumatic stressors or childhood maltreatment. This study examined this from a slightly different perspective. Many experiences of ACEs' clinical outcomes on physical and psychological well-being overlap with the barriers and facilitators to help-seeking behaviours identified in the literature. The current study examined the relationship between ACEs and how they

relate to the narrative types developed by emerging adults. Additionally, this study aimed to determine what role attachment patterns play in narrative development and in prediction of MHHS.

Hypotheses

Based on the literature reviewed, the following hypotheses were generated:

1. ACEs would be positively correlated with attachment anxiety and avoidance.

2. ACEs would be negatively correlated with intentions to seek help.

3. Narrative type would predict MHHS of emerging adults. It was expected that those with redemptive narratives would be more likely to engage in MHHS than those with a tragic narrative type. Those with a progressive narrative type were expected to be less likely to MHHS due to either having never felt a need to do so.

4. Narrative type would predict attachment. Based on existing research, it was expected that those with redemptive narratives would have a more secure attachment (less avoidance and anxiety). It was unknown what attachment pattern those with progressive narrative types might have. Those with tragic narratives were expected to report greater anxious or avoidant attachment.

5. ACEs would differ by narrative type. Those with redemptive and tragic narrative types would report greater levels of ACEs compared to those with a progressive narrative type.

6. Narrative type, ACES, and attachment would predict MHHS.

Method

Participants

For the current study, English-speaking participants ages 19-30 were recruited online via SONA and social media (see Appendices A and B). Other studies looking at emerging adults have age ranges that vary from 18-22 (DiTommaso et al., 2003), 18-25 (Lippold et al., 2024; Walker et al., 2024), and 18-35 (Robinson et al., 2024). The 19-30 age range was selected because it accounts for the age of majority in New Brunswick (19) and will be comparable with Statistics Canada's age range for youth which is most commonly presented as ages 15-30 (Statistics Canada February 2021, September 2021). SONA is an online recruitment platform whereby students can engage in a list of available studies at the University of New Brunswick. An ad was also posted on the social media platform Facebook (www.facebook.com) to recruit emerging adults 19-30. Participants recruited through social media may be from differing regions, or healthcare systems which could influence their MHHS behaviours and experiences. Despite this, geographical location is not being examined to allow for exploratory efforts to understand connections between narratives and MHHS. A power analysis was performed to identify the minimum sample size required for the regression analyses (GPower 3.1.9.7; Faul et al., 2007, 2009). A minimum of 98 participants was required, assuming a medium effect size ($f^2 = 0.15$, $\alpha = 0.05$, power = 0.80).

A final sample of one-hundred and seventy participants were included in this study. Descriptive statistics for the demographics of the sample can be seen in Table 1. Participants' mean age was 22.3 (*SD* = 3.243). There were 53 participants who identified as male, 110 that identified as female, 5 identified as non-binary, 1 identified as

transgender male, and 1 preferred not to say. The majority of the sample (72.9%) identified as heterosexual.

Measures

Emerging Adult Mental Health Narrative Questionnaire

The Emerging Adult Mental Health Narrative Questionnaire (see Appendix C) was semi-structured and consisted of six items. Items included demographic information such as age, gender, and sexual orientation. There was also a two-part qualitative question. It asks participants to first describe an experience they have had with MHHS and then provide a brief explanation for why they may not have sought help if it was needed. Participants were asked to provide roughly half a page to two pages. The qualitative data collected allowed for the determination of narrative type (Lieblich et al., 1998; McAdams, 2008). Transcripts were analyzed to identify themes, objectives, conflicts or obstacles, strategies to manage them, attitudes, expressions of identity, perceptions, values, connections made between events, thoughts and feelings, and attributions made to the experience of MHHS (Braun & Clarke, 2019; DeCuir-Gunby et al., 2011; Nowell et al., 2017; Onwuegbuzie et al., 2016).

Narrative Type and Experiences of MHHS

To assess narrative type and develop the coding manual, transcripts were subject to an iterative process of analysis until sufficient data was achieved to account for any discrepancies (Malterud et al 2016). In other words, analysis was conducted in iterations until no new codes or themes were identified (Leese et al., 2021). Efforts to minimize the subjectivity of this type of analysis indicated qualitative codes are likely to reach the goal of sufficiency within 10-36 transcripts (Guest et al., 2016; Hennink et al., 2019; Malterud

et al 2016; Sim et al., 2018). Thus, a randomly selected sub-sample of 10-30 narratives was used to develop the coding manual (Hennink et al., 2019; Sim et al., 2018). Coding of narrative type was completed by the author and a fellow graduate student with interest in the study topic. The coding manual was developed alongside the research questions and was data-driven (DeCuir-Gunby et al., 2011). Codes were developed using Saldana's (2021) method of dramaturgical coding which specifically aims to describe inter- and intrapersonal participant experiences and additionally addressed questions relating to experiences of MHHS. Definition of the progressive narrative type was refined to ensure rater clarity. Progressive narratives were simplified to represent consistently neutral or positive life stories or attitudes with minor change. This process repeated until inter-rater agreement of 24 ratings reached $k = .82$. An objective third rater was consulted to reach %100 agreement for 6 narratives. Each theme code had an example, a definition, inclusion, and exclusion criteria, which evolved and became more refined with each iterative review of transcripts (DeCuir-Gunby et al., 2011). Transcripts were further evaluated by assigning codes to the beginning and ending emotional tones of narratives to determine narrative type.

Coding on a 5-point scale of the emotional tone of the beginning and the end of a narrative established categorization of narrative types (i.e., progressive, redemptive, tragic; Berntsen & Bohn, 2010; Lieblich et al., 1998; McAdams et al., 2001b). An extremely negative beginning/ ending was coded as '1,' a very unhappy story was coded as '2,' a slightly negative beginning/ending/generally unhappy story, or a mixed/neutral or indeterminate beginning/ending with a neither happy nor unhappy nor both stories coded as '3.' A positive beginning/ending, generally happy story, was coded as '4,' and a

very positive beginning/ending, extremely happy stories coded as ‘5.’ Inter-rater reliability was good for coding emotional tone at .84 (McAdams et al., 2001b). Once each transcript was coded for emotional tone of the beginning and ending, transcripts were assigned narrative codes for statistical analysis. For this study, inter-rater agreement was acceptable with a weighted kappa value of .80.

To be diligent in avoiding as much researcher bias as possible, a mixed methods approach was considered most appropriate in addition to assessing inter-rater reliability. Quantitative measures of ACEs, attachment, and MHHS assisted with drawing conclusions about narrative type that were grounded in the literature and theory that informed the research questions being explored. The qualitative portion of the study was critical in examining participants’ narratives, and also provided an opportunity for emerging adults to express their experiences about MHHS in a meaningful way.

General Help-Seeking Scale

Mental health help-seeking intentions were assessed using the General Help-Seeking Scale (GHHS; Wilson et al., 2005a, 2005b; see Appendix D), which includes 14 items assessing past, current, and future intentions to seek help. Items were rated on a 7-point Likert scale. The GHHS measured future intentions to seek help, past experiences with seeking help and perceived helpfulness of past help-seeking experiences (Rickwood et al., 2005). Higher scores indicate a greater likelihood of seeking help. Reliability in previous studies was good for the General Help-Seeking Scale with Cronbach alpha = .85, and test-retest reliability after three weeks was .92 (Rickwood et al., 2005). This study found acceptable reliability for the formal sources of support sub-scale with Cronbach alpha of .76. The overall scale and informal sub-scale did not have acceptable

internal reliability (Overall α = .53, Informal sub-scale α = .17). Therefore, for the main analyses outcome variables for MHHS included the formal sub-scale (α = .76) and individual items for partner, friend, family, and intention not to seek help from anyone.

Adverse Childhood Experiences Checklist

The Adverse Childhood Experiences Checklist (ACEs; Blosnich et al., 2021; Ford et al., 2014; see Appendix E) includes 22 items. For simplicity, this study excluded seven items focused on natural disasters and general witness of suffering as these items are additions to the already expanded ACEs checklist. This left a total of 15 items. The scale assessed experiences in childhood prior to age 18 associated with adverse outcomes in adulthood. Examples of items include "lacked money for food or housing," "parents/ caregivers separated/ divorced," "witnessed extreme physical violence between family members," and "emotionally abused by a parent, caregiver, or partner." Other items include experiences such as victimization by bullying, sexual assault, or unwanted sexual experiences. Questions were scored with 0 = "*no*" and 1 = "*yes*" (Filetti et al., 2019; Liu et al., 2020; Matlin et al., 2019; Woods-Jaeger et al., 2018). Higher scores indicated greater level of risk and subsequent need for interventions across the lifespan (Filetti et al., 2019).

The checklist has been used in various studies with good internal consistency demonstrated by an acceptable coefficient alpha of .74 (Howard et al., 2015). The checklist also demonstrates adequate internal consistency in another study, demonstrated by 96% of participants reporting four or more ACEs (Cronbach's alpha = .88; Murphy et al., 2014). Inter-factor correlations found moderate relationships between the three subscales ranging from .40 (household dysfunction and sexual abuse) to .56 (sexual abuse

and physical/emotional abuse), indicating acceptable construct and criterion validity (Ford et al., 2014). In this study, the ACE checklist demonstrated good internal consistency with a Cronbach alpha of .80. The ACE checklist sub-scales demonstrated acceptable reliability with Cronbach alphas of .77 for the abuse sub-scale and .60 for the household dysfunction sub-scale. Furthermore, inter-factor correlations in this study found excellent construct and criterion validity between the two subscales used ranging from .93 (sexual abuse and physical/emotional abuse), to .85 (household dysfunction and sexual abuse). However, for the purpose of this study, only the total score will be used in the main analyses.

Experiences in Close Relationships Short Form

Attachment patterns were assessed using the Experiences in Close Relationships Short Form (ECR-12; Lafontaine et al., 2016; see Appendix F). The scale consists of 12 items assessing adult global anxious (i.e., fear of rejection and abandonment) and avoidant (i.e., discomfort with closeness and dependence on others) attachment patterns. There are two dimensional subscales of attachment anxiety and avoidance. The anxiety subscale consists of six items (e.g., "I worry about being alone") and the avoidant subscale consists of six items (e.g., I don't feel comfortable opening up to others"). Participants rated their responses on a Likert scale, 1 = "*Strongly disagree*" to 7 = "*Strongly agree*." Scores for each subscale were averaged with higher means indicating higher levels of attachment anxiety or avoidance (Lafontaine et al., 2016). The ECR-12 is psychometrically sound and has shown to be a superior measure for global attachment compared to the ECR-Short form (Lafontaine et al., 2016). Internal consistency is good with Cronbach alphas .78 to .87 for the anxiety subscale and .74 to .83 for the avoidance

scale (Lafontaine et al., 2016). The scale has indicated good convergent, criterion, and construct validity across numerous validation studies (Lafontaine et al., 2016). In this study, reliability for the ECR-12 scale was good with Cronbach alpha of .75. Internal consistency for the ECR-12 in this study was found to be good with Cronbach alpha of .85 for the anxiety sub-scale and .78 for the avoidance sub-scale.

Procedure

Data was collected over the internet using Qualtrics survey software (https://www.qualtrics.com). Participants recruited through SONA and social media clicked on a link redirecting them to the informed consent page (see Appendices G and H). Participants who did consent to participate were redirected to complete the study. All questions were optional. Failing to respond to a question did not prevent the participant from moving forward in the study. Participants' responses are kept entirely confidential. Upon completing the questionnaire package, participants were then taken to a debriefing page (see Appendices I and J). Debrief forms explained the purpose of the study and were given to respondents, as well as an e-mail address where they could inquire about the results/conclusion of the study when completed.

Results

Data Preparation

Data Cleaning

The original dataset (*N* = 339) was cleaned and conditioned to ensure there were no data entry errors. Data was coded and adjusted as appropriate. Descriptive statistics were calculated and analyzed for out-of-range values, missing cases, univariate, and finally multivariate outliers. One hundred and thirty-eight participants were deleted due to completion time under 7 minutes (420 seconds) and ReCaptcha scores indicating bot activity, which would not provide meaningful responses. Thirteen participants were deleted due to missing data or bizarre text entries. After assessing attention screening questions four more participants were deleted. Finally, 15 participants were deleted for ages outside of the study criteria. This left a final *N* = 170.

Data Conditioning

To address univariate outliers, values were transformed into z-scores and histograms and were visualized to confirm discontinuous variables. The number of visits variable had two responses that were discontinuous from the dataset (*SD* = 15.96, skew = 5.029, kurtosis = 31.60). These were adjusted to match the distribution by changing the values to represent the maximum value in the range (*SD* = 13.04). This approach was also used for the GHHSmean variable which had one value discontinuous from the distribution of scores. Multivariate outliers were next assessed based on a discontinuity approach, and there were no variables found with a Mahalanobis distance of 5 or more points. This left a final continuous data set with *N* = 170. For clarity, participants' were then reassigned a new ID number. After conditioning the data, frequencies were re-run to

ensure absence of first univariate and second multivariate outliers. To re-assess for univariate outliers, frequencies were visualized on histograms, p-plots, and ZDependent and ZResidual plots to confirm homogeneity of variance and homoscedasticity. To re-assess for multivariate outliers, correlations and scattergrams were utilized to assess assumptions of normality, linearity, and absence of multicollinearity. There were no significant violations of the assumptions for the GLM required for the main analyses. All data analysis was completed using SPSS 29 software.

Descriptive Statistics of Measures

Descriptive statistics for the GHHS and its subscales can be found in Table 2. The mean score for overall future intentions to seek help sub-scale was 3.85 (N = 168, SD = 0.93), indicating neutral overall intentions to seek help in the future. Participants in this sample indicated higher mean intentions to seek help from informal sources, than from formal sources. To better understand which sources of informal or formal support may influence help-seeking decisions, individual sources were also examined and can be found in Table 3. Fifty-nine percent of the sample reported they had sought help previously and 40.6% had not. The mean number of previous visits to a mental health professional was 7.99 (SD = 13.04), while participants rated the helpfulness of previous visits with a mean of 3.40 (SD = 1.20). Participants identified the type of professional they had seen previously. Psychologists and school counsellors were identified most frequently (see Table 4).

For the overall ACE scale the mean score was 3.76 (N = 168, SD = 3.32) indicating an average ACE score of 3 for this sample. Descriptive statistics for the ACE checklist can be seen in Table 5.

The maximum rating for attachment avoidance and anxiety was 7. Attachment avoidance had a mean score of 3.39 ($N = 170$, $SD = 1.11$), indicating low avoidance in this sample. The mean score for attachment anxiety was 4.59 ($N = 169$, $SD = 1.30$; see Table 5) indicating moderate anxiety in this sample.

Correlational Analyses

Correlational analyses were conducted to determine the relationships between the ACE checklist, GHHS sources of support, and ECR-12 subscales (see Table 6). Within the GHHS intention to seek help from a partner was negatively correlated with attachment avoidance ($r = -.23$). Intentions to seek help from a friend were significantly positively correlated with intention to seek help from family ($r = .29$), whereas it was negatively related to help from a teacher ($r = -.184$), and attachment avoidance ($r = -.28$). Intentions to seek help from a family member were negatively correlated with the intention to not seek help from anyone ($r = -.21$), total ACE score ($r = -.29$), attachment anxiety ($r = -.23$), and avoidance ($r = -.33$). The intention to seek help from formal supports sub-scale was strongly positively correlated as expected with intentions to seek help from a mental health professional ($r = .74$), phone help line ($r = .82$, family doctor ($r = .74$), and teacher ($r = .75$). Finally, attachment anxiety ($r = .21$), and attachment avoidance ($r = .33$) were correlated with the total ACE score. Attachment avoidance was negatively related to intentions to seek formal help ($r = -.16$).

Dramaturgical Narrative Data Analysis

This study focuses on narrative types and their content. Since quantitative data was compared to narrative type, narrative analysis will be discussed first for clarity.

Overview of Narrative Analysis

Narratives collected were subject to dramaturgical coding to examine participant narratives about MHHS. Narratives were coded for categorization into narrative type. There were 45 progressive, 39 redemptive, and 68 tragic narratives. Eighteen narratives were missing and not included in the analysis. Narratives were also analyzed for barriers and strategies used to seek mental health support and attitudes about MHHS. Fifty-one participants have not sought help in the past for their mental health. A total of one hundred and nineteen participants sought some form of help for their mental health in the past. Participants outlined reasons for seeking mental health care related to symptoms of mental illness, relationship breakdowns, stress, somatic symptoms, addiction, work-related stress, and fears of becoming ill with COVID-19. Symptoms and mental illnesses discussed included depression, anxiety, eating disorders, bipolar disorder, feeling overwhelmed, and increased thoughts or intentions of suicide. Twelve participants discussed taking medication to improve their mental health. Barriers to seeking mental health care described by participants included a lack of trust in others, long wait times for referrals, inaccessibility of services, COVID-19 restrictions, and lack of financial resources. One participant also identified experiencing discrimination related to gender identity as a barrier that kept them from seeking mental health support. One participant disagreed with existing options for treatment and chose not to seek help.

Attitudes About Mental Health Help-Seeking

Attitudes about MHHS revealed in participant narratives were bleak (See Figure 1). Out of those who sought out help, 26 participants found the overall experience to be unhelpful. Two participants described attempting to access mental health helplines

unsuccessfully due to no one answering the phone. Five participants saw counselors they felt were not a good fit for them but could not change therapists; This led to disengagement. At least four participants were told: “others need help more than you,”(P.135[3]). This messaging was implied in six other participant narratives and they resolved not to talk with anyone for fear of stigma or discrimination. A sense of defeat became clear as one participant noted, “I won’t get the help anyways, so why bother asking?” (P.45). See Figure 2 for illustration. Two participants experienced suicidal thoughts, two developed suicide plans, and one attempted to carry out those plans. For example, one participant stated, “Nothing anyone can say will make me feel better” (P.2).

---

[3] P = Participant number

Figure 1

Negative Attitudes About Mental Health Help-Seeking

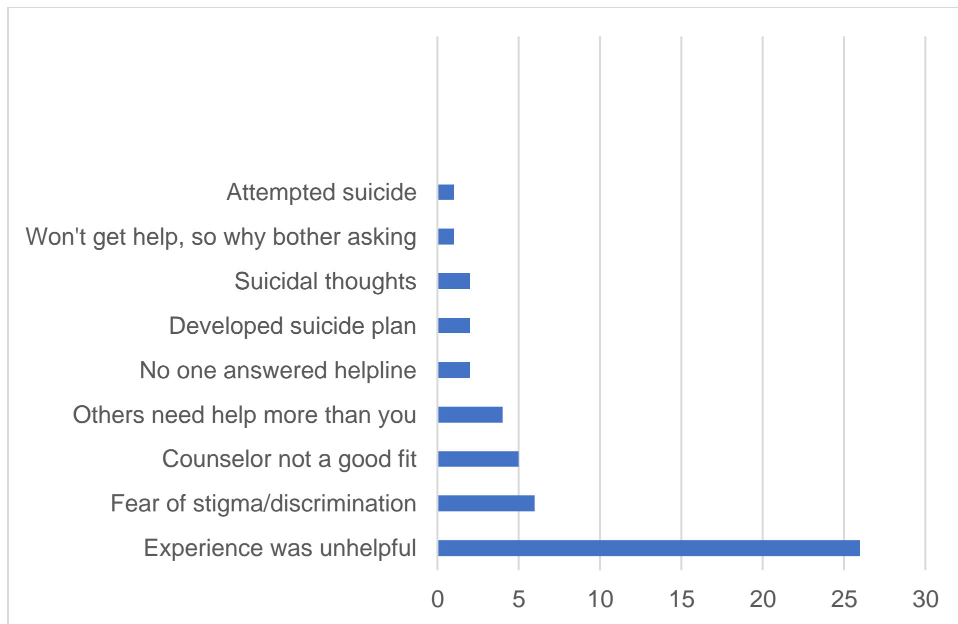
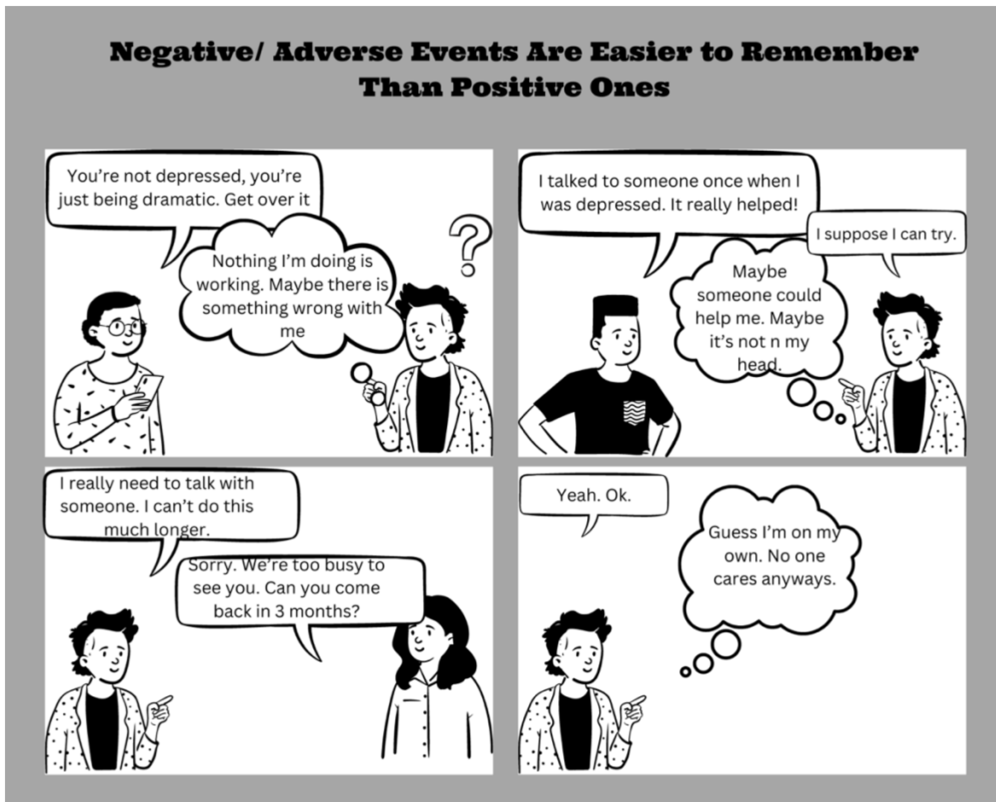


Figure 2

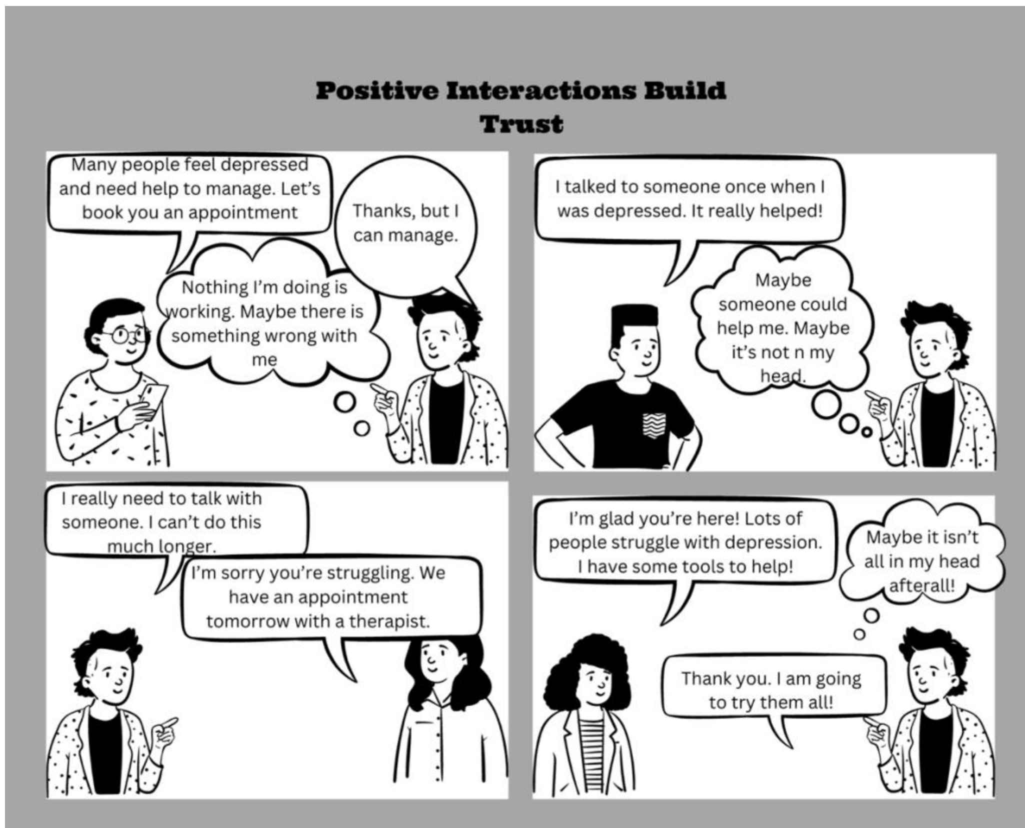
Illustration of negative help-seeking attitudes



Conversely, there were some positive attitudes about MHHS. Twenty-five participants stated that reaching out was "*beneficial*" (P.8) and that people would receive help it if they asked. They also described positive interactions with mental health care providers: "*My therapist saved me*" (P.148). For example, one participant discussed the ability of their therapist to shift their perspective stating, "*I had become savable all of a sudden, somehow*" (P.15). "*It felt like a waste of time for a while until it didn't*" (P.31). One participant identified "*therapy was crucial for my recovery*" (P.26); having a hard time in life was not attributed to character defects in these narratives but that "*asking for help makes you strong*" (P.28). Finally, many redemptive narratives reflected the belief that "*opening up about mental health is courageous and shows strength*" (P.29). See Figure 3 for illustration. Participants described a range of emotions relating to seeking mental health support (see Figure 4).

Figure 3

Illustration of positive help-seeking attitudes



Narrative Themes About Mental Health Help-Seeking

Both negative and positive attitudes were presented in the data regarding MHHS. There were five major themes contributing to help-seeking attitudes including role of family, mental health help-seeking at school, no intention to seek help, internalized stigma, and mental health support accessibility and trust in others. These themes are presented below.

The Role of Family. Many participants referenced the role their family has had in their help-seeking efforts. For example, ten participants' parents took them for mental health support while they were adolescents; when parents intervened without their input when they were minors, individuals felt "terrified and betrayed by my parents" (P.123), misunderstood, that their feelings did not matter and acknowledged "it was an awful experience for me" (P.101). Participants felt their responses to distress were normal reactions to their situation. It is evident that thoughts like "something is wrong with me" (P.47) can contribute to narratives containing low self-esteem or self-worth themes. Seventeen participants discussed feeling unsupported by family, friends, or coworkers for "making a mountain out of a molehill" (P.59) and were left thinking their feelings did not matter. One participant described using humor to deflect distress. If a friend, family member, or clinician offers help but is unavailable during a crisis, the narrative that "others are more important" (P.104), or that "the system does not have adequate support, therapists are not trained enough" (P.111) or "no one knows what to say" (P.21) may be reinforced.

Family serves as a source of support in seeking mental health care; however, one participant acknowledged the role family could play stating "*family members cause*

mental problems" (P.67). For example, while referencing a lack of familial support, one participant stated, "*I have made the decision to seek professional help when I am in a position where I no longer have to explain myself to them*" (P. 20). One participant had been made fun of for disclosing mental health struggles and stated "*No way*" would they seek help from friends again (P. 139). Another participant stated, "*The culture I'm from no one talks about mental health and they don't 'believe' in it*" (P.35). Two participants sought help and obtained an appropriate treatment plan, but their families disapproved. As a result of this disapproval, they abandoned the plan they had negotiated with their mental health professional or doctor.

Mental Health Help-Seeking at School. Even with institutional support, participant narratives described longer wait times: "I chose not to do this because of the known lack of mental health accessibility" (P.125) leaving many resigned to "deal with issues on their own" (P.2). In the university setting, being perceived as weak or that the "stigma of having mental illness means they won't cut it for a rigorous program" (P.22) kept at least two participants from seeking help. They felt that seeking mental health support would hinder their academic success, stating that "labels define a person" (P.47).

No Intention to Seek Help. Even though many participants said they wanted help with their mental health, many of them still said they would not pursue it. One participant stated, "My anxiety was just something I accepted about myself and I just dealt with the hardships it brought me until I finally had enough" (P. 54). The notion that "I'm a firm believer in the grind and was sure if I just powered through, I would bounce back" (P.27) speaks to this hyper-independent coping strategy and is featured in redemptive narrative

types of this sample. However, one of the main reasons mentioned not to seek help related to internalized stigma.

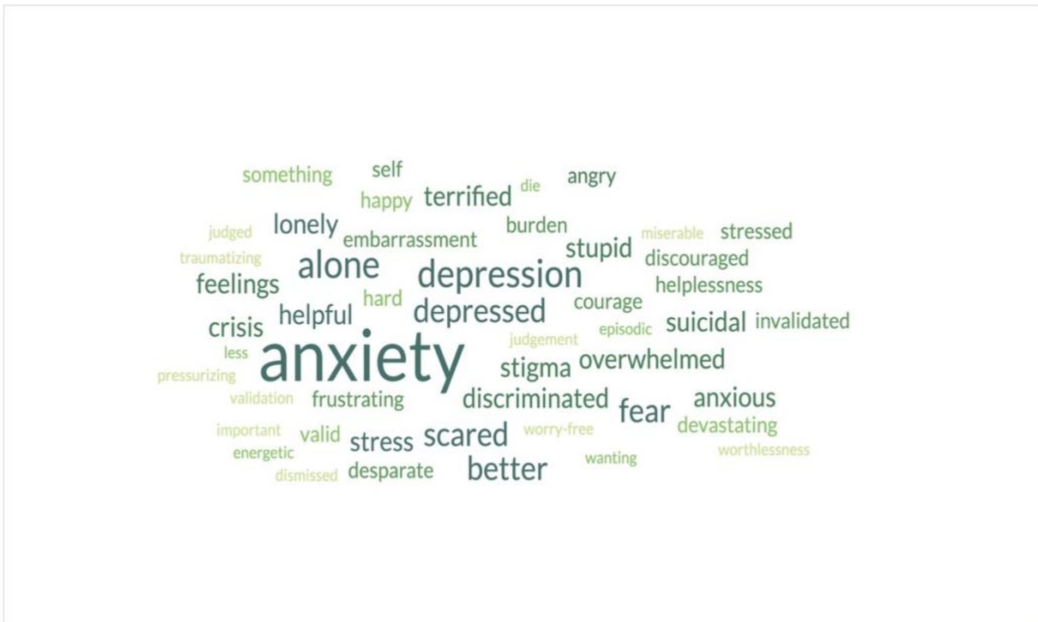
Internalized Stigma. Eleven participants with tragic and redemptive narrative types discussed fears of burdening others or feeling their issues were less important. Participant statements implied a lack of trust in the abilities of those meant to help them. They did not feel help that provides a safe space to be vulnerable would be available. Seeking help was discussed as a “last bastion” (P.15) because people would discriminate or judge them; “I felt judged and like I wasn’t important” (P.14). Another participant stated the concerns of those with addictions are often dismissed by healthcare professionals.: “People are denied mental health care because addiction is seen as an impairment in judgment and dismissed” (P.4). One participant stated, “I don’t think I would see out help because to me it seems weak” (P.98). While seeking help in the face of discrimination, ten emerging adults felt that people did not listen to them when they were minors and that “I learned why people don’t like to seek help, I fear feeling stupid or invalidated” (P.31). These participants discussed self-isolating to persevere through distress because they believed “accomplishment equals worthiness” (P.3).

Mental Health Support Accessibility and Trust in Others. Many participants sought help from school counselors, family, friends, or a psychologist in the past (see Table 4). However, referrals to psychiatrists and counselors resulted in long wait lists that led six participants to disengage and manage symptoms independently. This study indicated that at least forty-six emerging adults felt services were inaccessible and ten others felt that their needs were insignificant. For example, one participant disclosed "now two years later I still have not heard anything from anyone in regard to accessing these

services"(P.92). Another participant stated, “Mental health services I was looking for were unavailable, and I have not reached out since this happened” (P.45). Another participant stated the belief that “seeking help should not be this difficult” (P.19). This sentiment was also implied by eighteen others. Eight participants identified services are available for those with money: “I was still feeling poorly, but I had to stop going because my family could not afford it” (P.46).

Figure 4

Emotions of narratives relating to MHHS



Quantitative Analyses

Does Narrative Type Predict a preference of support in Mental Health Help-Seeking Intentions?

To test hypothesis 3 and analyze MHHS broadly by type support (i.e. partner, friend, family, formal, and no one) five multiple regression analyses were conducted. Due to the number of regression analyses being conducted for the main analyses, significance was determined at the .01 alpha level to avoid type 1 errors. This was the case for all remaining analyses.

Help From a Partner. The first regression examined narrative type's ability to predict intentions to seek help from a partner, while controlling for age and gender resulting in a two-step model (see Table 7). The overall model was not significant $F(4,137) = 0.78, R^2_{Total} = .22, p = .543.$ In step 1 control variables age and gender were entered and found to be not significant $R^2_{Change} = .01, F_{Change}(2,139) = 1.01, p = .367.$ In step 2, narrative type was entered and found to be not significant $R^2_{Change} = .01, F_{Change}(2,137) = 0.55, p = .580.$ Results indicate narrative type did not predict intentions to seek help from a partner.

Help From a Friend. For the second regression, narrative type was regressed onto intentions to seek help from a friend, while controlling for age and gender resulting in a two-step model (see Table 8). The overall model was not significant, $F(4,138) = 0.69, R^2_{Total} = .20, p = .600.$ In step 1 control variables were entered and found to be not significant, $R^2_{Change} = .02, F_{Change}(2,140) = 1.13, p = .326.$ In step 2, narrative type was regressed onto intentions to seek help from a friend and found to be

nonsignificant, $R^2_{Change} = .02, F_{Change}(2,138) = 0.26, p = .770.$ Results indicate narrative type did not predict intentions to seek help from a friend.

Help from Family. For the third regression, narrative type was regressed onto intentions to seek help from family, while controlling for age and gender resulting in a two-step model (see Table 9). The overall model was not significant, $\mathrm{F}(4,138) = 1.582, R^2_{Total} = .21, p = .182.$ In step 1 control variables were entered and found to be nonsignificant, $R^2_{Change} = .01, F_{Change}(2,140) = 0.84, p = .435.$ In step 2, narrative type was regressed onto intentions to seek help from family and found to be nonsignificant, $R^2_{Change} = .03, F_{Change}(2,138) = 2.31, p = .103.$ Results indicate narrative type did not predict intentions to seek help from family.

Help From Formal Supports. For the fourth regression, narrative type was regressed onto intentions to seek help from formal sources of support, while controlling for age and gender resulting in a two-step model (see Table 10). The overall model was significant, $\mathrm{F}(4,137) = 7.90, R^2_{Total} = .19, p < .001.$ In step 1 control variables were entered and found to account for 17.4% of variance in the model, $R^2_{Change} = .17, F_{Change}(2,139) = 14.64, p < .001.$ In step 2, narrative type was regressed onto intentions to seek formal help and found to be nonsignificant, $R^2_{Change} = .01, F_{Change}(2,137) = 1.13, p = .327.$ Results indicated that narrative type did not predict intentions to seek formal sources of support, however, age did significantly account for some formal help-seeking. As age increased so did the intention to seek formal help (β = .40, p <.001, *Sr* = .38). There was no significant difference with gender.

Help from No One. For the fifth regression narrative type (N = 143, Redemptive M = .27, SD = .44; Tragic M = .42, SD = .50) was regressed onto intentions to not seek help from anyone, while controlling for age and gender resulting in a two-step model (see Table 11). The overall model was significant, $F(4,138) = 6.76, R^2_{Total} = .16, p < .001.$ In step 1 control variables were entered and found to be not significant, $R^2_{Change} = .05, F_{Change}(2,140) = 3.40, p = .036.$ In step 2, narrative type was regressed onto intentions to not seek help from anyone and was found to be significant accounting for 11.8% of variance within the model, $R^2_{Change} = .122, F_{Change}(2,138) = 9.70, p < .001.$ Compared to progressive narrative type, tragic narrative type was more likely to choose not to seek help from anyone (β = .33, p <.001, *Sr* = .28). Finally, compared to redemptive narrative type, tragic narrative type remained less likely to seek help from anyone (β = .37, p <.001, *Sr* = .30; see Table 12). There was no difference found between redemptive and progressive narrative types (β = .04, p = .705).

Narrative type did not predict intentions to seek help from a preferred support including partner, friend, family member, or formal supports. As age increased, so did intentions to reach out to formal supports. Tragic narrative types were most likely to avoid seeking mental health support, followed by redemptive narrative types when compared to progressive narratives.

Does Narrative Type Predict Attachment Pattern?

To test hypothesis 4, multiple regression analyses were conducted.

Attachment Anxiety. The first regression examined narrative type ability to predict attachment anxiety, while controlling for age and gender resulting in a two-step model

(see Table 13). The overall model was significant accounting for 11.2% of variance within the model, $\mathrm{F}(4,137) = 4.34, R^2_{Total} = .11, p = .002.$ In step 1 control variables age and gender were entered and found to be significant accounting for 7.2% of variance in the model, $R^2_{Change} = .07, F_{Change}(2,139) = 5.42, p = .005.$ In step 2, narrative type was entered with progressive narrative type as the reference group and found to be not significant, $R^2_{Change} = .04, F_{Change}(2,137) = 3.08, p = .049.$ No significant results were found with redemptive narrative type as the reference group (see Table 14). Narrative type did not predict attachment anxiety.

Attachment Avoidance. The third regression examined narrative type ability to predict attachment avoidance, while controlling for age and gender resulting in a two-step model (see Table 15). The overall model was significant, $\mathrm{F}(4,138) = 1.17, R^2_{Total} = .03, p = .328.$ In step 1 control variables age and gender were entered and found to be not significant, $R^2_{Change} = .00, F_{Change}(2,140) = 0.05, p = .948.$ In step 2, narrative type was entered with progressive narrative type as the reference group and found to be not significant, $R^2_{Change} = .03, F_{Change}(2,138) = 2.28, p = .106.$ No significant results were found with redemptive narrative type as the reference group. Results indicate narrative type does not predict attachment avoidance.

Do Adverse Childhood Experiences Differ by Narrative Type?

To test hypothesis 5, a one-way ANCOVA was conducted to determine the effect of narrative type on ACEs, controlling for age and gender. Results indicated that there was not a statistically significant difference in ACEs between progressive (M = 2.90), redemptive (M = 3.30), or tragic (M = 4.23) narrative type groups, $F(2, 137) = 2.26$, p =

.108. A supplemental one-way ANCOVA was conducted to determine the effect of positive narrative (i.e., progressive & redemptive) and negative narrative type (i.e., tragic) on total ACE score controlling for age and gender. The overall model was not significant, $F(3,138) = 4.23$, $p = .042$, indicating a difference in total ACE score for positive ($M = 3.08$) vs negative ($M = 4.22$) narrative type at the .05 α level.

Do Narrative Type, Adverse Childhood Experiences, and Attachment Pattern Predict Mental Health Help-Seeking Intentions?

The outcome of MHHS was assessed using individual items to determine more specifically if there was a preferred type of formal or informal support (i.e., partner, friend, family, mental health professional, phone help line, family doctor, teacher, no one, and formal sub-scale). To test hypothesis 6, ten multiple hierarchal regression analyses were conducted.

Help From a Partner. The first regression examined the ability of ACEs, attachment anxiety, avoidance, redemptive, and tragic narrative type, to predict intentions to seek help from a partner with progressive narrative type as the reference group, while controlling for age and gender, resulting in a 4-step model (see Table 16). The overall model was not significant, $\mathrm{F}(7, 132) = 1.34, R^2_{Total} = .07, p = .237$. In step 1 control variables age and gender were entered and found to be not significant, $R^2_{Change} = .02, F_{Change}(2,137) = 1.05, p = .353$. In step 2, total ACE score was added and found to be not significant, $R^2_{Change} = .00, F_{Change}(2,136) = 0.08, p = .784$. In step 3 attachment anxiety and attachment avoidance were entered and found to be not significant, $R^2_{Change} = .04, F_{Change}(2,134) = 2.84, p = .062$. Finally, narrative type was entered into step 4 and found to be not significant, $R^2_{Change} =$

$.01, F_{Change}(2,132) = 0.75, p = .475$. Therefore, intentions to seek help from a partner were not predicted by ACE, attachment pattern, or narrative type.

Help From a Friend. The second regression examined the ability of ACEs, attachment anxiety, avoidance, redemptive, and tragic narrative type, to predict intentions to seek help from a friend with progressive narrative type as the reference group, while controlling for age and gender, resulting in a 4-step model (see Table 17). The overall model was not significant, $F(7, 133) = 1.98, R^2_{Total} = .09, p = .062$. In step 1 control variables age and gender were entered and found to be not significant, $R^2_{Change} = .02, F_{Change}(2,138) = 1.09, p = .336$. In step 2, total ACE score was added and found to be not significant, $R^2_{Change} = .00, F_{Change}(2,137) = 0.14, p = .712$. In step 3 attachment anxiety and attachment avoidance were entered and found to be significant accounting for an additional 6.8% of variance within the model, $R^2_{Change} = .07, F_{Change}(2,135) = 4.99, p = .008$. Finally, narrative type was entered into step 4 and found to be not significant, $R^2_{Change} = .01, F_{Change}(2,132) = 0.75, p = .475$. Results indicated those with attachment avoidance (β = -.26, p = .003, *Sr* = -.25) were significantly less likely to seek support from a friend. Therefore, while attachment avoidance predicts intentions to avoid seeking help from a friend (see Figure 6), there were no significant differences between ACEs, attachment anxiety, narrative type, and intentions to seek help from a friend.

Help From Family. The third regression examined the ability of ACEs, attachment anxiety, and avoidance, redemptive, and tragic narrative type, to predict intentions to seek help from family with progressive narrative type as the reference group, while controlling

for age and gender, resulting in a 4-step model (see Table 18). The overall model was significant, $F(7, 133) = 3.98, R^2_{Total} = .17, p < .001.$ In step 1 control variables age and gender were entered and found to be not significant, $R^2_{Change} = .02, F_{Change}(2,138) = 1.02, p = .365.$ In step 2, total ACE score was added and found to be significant accounting for 6.1% of variance within the model, $R^2_{Change} = .06, F_{Change}(2,137) = 9.11, p = .003.$ In step 3 attachment anxiety and attachment avoidance were entered and found to be significant accounting for an additional 8.2% of variance within the model, $R^2_{Change} = .08, F_{Change}(2,135) = 6.55, p = .002.$ Finally, narrative type was entered into step 4 and found to be not significant, $R^2_{Change} = .02, F_{Change}(2,133) = 1.25, p = .289.$ Results indicated those with higher ACE scores would be significantly less likely to seek help from family (β = -.25, p = .003, *Sr* = -.25). Those with more attachment avoidance (β = -.24, p = .004, *Sr* = -.23) were less likely to seek help from family. Therefore, higher ACE scores and attachment avoidance predicted intentions to not seek help from family (see Figures 7 and 8). There was no significant difference found between attachment anxiety, narrative types, and intentions to seek help from family.

Help From a Mental Health Professional. The fourth regression examined the ability of ACEs, attachment anxiety, and avoidance, redemptive, and tragic narrative type, to predict intentions to seek help from a mental health professional with progressive narrative type as the reference group, while controlling for age and gender, resulting in a 4-step model (see Table 19). The overall model was significant, $F(7, 132) = 2.89, R^2_{Total} = .13, p = .008.$ In step 1 control variables age and gender were entered

and found to be significant accounting for 7% of variance within the model, $R^2_{Change} = .07, F_{Change}(2{,}137) = 5.19, p = .007$. In step 2, total ACE score was added and found to be not significant, $R^2_{Change} = .01, F_{Change}(1, 136) = 0.94, p = .335$. In step 3 attachment anxiety and attachment avoidance were entered and found to be not significant, $R^2_{Change} = .03, F_{Change}(2{,}134) = 2.49, p = .087$. Finally, narrative type was entered into step 4 and found to be not significant, $R^2_{Change} = .02, F_{Change}(2{,}132) = 1.75, p = .177$. Results indicated as age increased so did the intention to seek help from a mental health professional (β = .27, p = .002, *Sr* = .26). There were no significant differences between ACE score, attachment pattern, narrative types, and intentions to seek help from a mental health professional.

Help From a Phone Help Line. The fifth regression examined the ability of ACEs, attachment anxiety, and avoidance, redemptive, and tragic narrative type, to predict intentions to seek help from a phone help line with progressive narrative type as the reference group, while controlling for age and gender, resulting in a 4-step model (see Table 20). The overall model was significant, $F(7, 133) = 3.99, R^2_{Total} = .17, p < .001$. In step 1 control variables age and gender were entered and found to be significant accounting for 13.4% of variance within the model, $R^2_{Change} = .13, F_{Change}(2{,}138) = 10.70, p < .001$. In step 2, total ACE score was added and found to be not significant, $R^2_{Change} = .01,\ F_{Change}(1{,}137) = 1.79, p = .183$. In step 3 attachment anxiety and attachment avoidance were entered and found to be not significant, $R^2_{Change} = .02, F_{Change}(2{,}135) = 1.71, p = .185$. Finally, narrative type was entered into step 4 and found to be not significant, $R^2_{Change} = .01, F_{Change}(2{,}133) = 0.57, p = .570$.

Results indicated as age increased so did the intention to seek help from a phone help line (β = .31, p <.001, *Sr* = .30). However, there was no significant difference between gender and intentions to seek help from a phone help line. There were no significant differences between ACE score, attachment anxiety, narrative types, and intentions to seek help from a phone help line.

Help From a Family Doctor. The sixth regression examined the ability of ACEs, attachment anxiety, and avoidance, redemptive, and tragic narrative type, to predict intentions to seek help from a family doctor, while controlling for age and gender, resulting in a 4-step model (see Table 21). The overall model was not significant, $F(7, 133) = 1.74, R^2_{Total} = .08, p = .105.$ In step 1 control variables age and gender were entered and found to be significant accounting for 4.8% of variance within the model, $R^2_{Change} = .05, F_{Change}(2,138) = 3.47, p = .034.$ In step 2, total ACE score was added and found to be not significant, $R^2_{Change} = .01, F_{Change}(1,137) = 0.87, p = .353.$ In step 3 attachment anxiety and attachment avoidance were entered and found to be not significant, $R^2_{Change} = .03, F_{Change}(2,135) = 1.93, p = .149.$ Finally, narrative type was entered into step 4 and found to be not significant, $R^2_{Change} = .01, F_{Change}(2,133) = 0.27, p = .764.$ Results indicated as age increased so did the intention to seek help from a family doctor (β = .22, p = .013, *Sr* = .21). However, there was no significant difference between gender and intentions to seek help from a family doctor. There were no significant differences between ACE score, attachment pattern, or narrative type in predicting intentions to seek help from a family doctor.

Help From a Teacher. The seventh regression examined the ability of ACEs, attachment anxiety, and avoidance, redemptive, and tragic narrative type, to predict intentions to seek help from a teacher, while controlling for age and gender, resulting in a 4-step model (see Table 22). The overall model was significant, $\mathrm{F}(7, 133) = 5.62, R^2_{Total} = 23, p < .001.$ In step 1 control variables age and gender were entered and found to be significant accounting for 18.4% of variance within the model, $R^2_{Change} = .18, F_{Change}(2{,}138) = 15.59, p < .001.$ In step 2, total ACE score was added and found to be not significant, $R^2_{Change} = .00, F_{Change}(1{,}137) = 0.00, p = .980.$ In step 3 attachment anxiety and attachment avoidance were entered and found to be not significant, $R^2_{Change} = .01, F_{Change}(2{,}135) = 0.43, p = .649.$ Finally, narrative type was entered into step 4 with progressive narrative type as the reference group and found to be not significant, $R^2_{Change} = .04, F_{Change}(2{,}133) = 3.33, p = .039.$ No significant results were found with redemptive narrative type as the reference group (see Table 23). Results indicated as age increased so did the intention to seek help from a teacher (β = .41, p <.001, *Sr* = .39). However, there was no significant difference between gender and intentions to seek help from a teacher. There were no significant differences between ACE score, attachment anxiety, or narrative type in predicting intentions to seek help from a teacher.

Help From No One. The eighth regression examined the ability of ACEs, attachment anxiety, and avoidance, redemptive (M = .262, SD = .441, N = 141), and tragic narrative type (M = .418, SD = .495, N = 141), to predict intentions to not seek help from anyone with progressive narrative type as the reference group, while controlling for age and gender, resulting in a 4-step model (see Table 24). The overall model was significant,

$F(7, 133) = 8.54, R^2_{Total} = .23, p < .001$. In step 1 control variables age and gender were entered and found to be not significant, $R^2_{Change} = .04, F_{Change}(2,138) = 3.18, p = .05$. In step 2, total ACE score was added and found to be significant accounting for 6.8% of the variance in the model, $R^2_{Change} = .07, F_{Change}(1,137) = 10.54, p = .001$. In step 3 attachment anxiety and attachment avoidance were entered and found to be significant accounting for 12.4% of variance within the model, $R^2_{Change} = .12, F_{Change}(2,135) = 10.92, p < .001$. Finally, narrative type was entered into step 4 and found to be significant accounting for 7.4% of the variance in the model, $R^2_{Change} = .07, F_{Change}(2,135) = 7.16, p = .001$. Step 1 was not significant; however, it was explored to gain insight into possible significant single df effects. Interestingly, gender significantly influences the decision to avoid seeking help from anyone (β = -.21, p = .015, *Sr* = -.20). Results indicate as ACE score increases so does the likelihood of choosing not to seek help from anyone (β = .27, p = .001, *Sr* = .26; see Figure 9). Moreover, those with attachment avoidance (β = .36, p <.001, Sr = .35) are more likely to avoid seeking help from anyone (see Figure 10). Compared to those with progressive narrative types, those with tragic narratives are significantly more likely to avoid seeking help from anyone (β = .24, p = .009, Sr = .19). Additionally, compared to redemptive narrative type (see Table 25), tragic narrative types are significantly more likely to avoid seeking help from anyone (β = .32, p <.001, Sr = .26; see Figure 11).

Help From Formal Supports. The tenth and final regression examined the ability of ACEs, attachment anxiety, and avoidance, redemptive, and tragic narrative type, to predict intentions to seek help from formal sources of support, while controlling for age

and gender, resulting in a 4-step model (see Table 26). The overall model was significant and accounted for 22.9% of the variance, F$(7, 132) = 5.59, R^2_{Total} = .23, p < .001$. In step 1 control variables age and gender were entered and found to be significant accounting for 17.5% of variance within the model, $R^2_{Change} = .18, F_{Change}(2,137) = 14.49, p < .001$. In step 2, total ACE score was added and found to be not significant, $R^2_{Change} = .01, F_{Change}(1,136) = 0.01, p = .268$. In step 3 attachment anxiety and attachment avoidance were entered and found to be not significant, $R^2_{Change} = .03, F_{Change}(2,134) = 2.90, p = .058$. Finally, narrative type was entered into step 4 and found to be not significant, $R^2_{Change} = .01, F_{Change}(2,132) = 1.08, p = .344$. Results indicate as age increased so did the intention to seek help from formal sources of support (β = .41, p <.001, Sr = .39). However, there was no significant difference with gender. There were no significant differences between ACE score, attachment anxiety, or tragic narrative type in predicting intentions to seek help from formal sources of support.

ACEs, attachment avoidance, and narrative type predict intentions not to engage in MHHS. There were a number of nonsignificant results that indicated no particular preference for any one source of support. However, significant findings from the eleven regression analyses revealed that tragic narrative types predicted intentions to avoid seeking help from anyone. Also of significance, higher ACE scores and more attachment avoidance decreased the likelihood of seeking help from family. Additionally, ACE scores increased the likelihood of making the decision not to seek mental health support. Moreover, attachment avoidance significantly predicted intentions to avoid seeking help from anyone.

Was Past Help-Seeking Related to Narrative Type?

Follow-up analyses were conducted to determine differences between narrative type and those who have sought help in the past. Chi-Square tests indicate progressive narrative types were significantly less likely to have sought help in the past than redemptive or tragic narrative types, $X^2(2) = 17.73$, φ = .34, $p < .001$. However, there was no significant difference in having sought help in the past with positive (i.e., progressive, and redemptive) and negative (i.e., tragic) narrative types, $X^2(1) = 0.10$, φ = .03, $p = .750$.

Did Narrative Type Influence Perceived Helpfulness of the Help Sought?

To determine the relationship between narrative type and perceived helpfulness of help sought, a one-way ANOVA analysis was conducted. The overall model was not significant, $F(2, 124) = 3.32$, $p = .039$, $\eta^2 = 0.05$. These results indicate perceived helpfulness of past support was not related to narrative type.

Are there differences between gender, attachment anxiety, and intentions to seek help?

Follow-up *t*-tests were conducted to explore mean differences between gender and attachment anxiety and then intentions not to seek help. First, differences between gender and attachment anxiety were explored. On average females (*M* = 4.82, *SD* = 1.26) were significantly more likely than males (*M* = 4.09, *SD* = 1.27) to have more attachment anxiety, $t(102) = -3.42$, $p = <.001$, $d = -.58$. Second, differences between gender and intentions not to seek help from anyone were explored. On average, males (*M* = 3.72, *SD* = 1.79) were significantly more likely than females (*M* = 2.96, *SD* = 1.75) to have intentions not to seek help, $t(100) = 2.54$, $p_{one\text{-}tailed} = .006$, $d = .43$.

Discussion

Youth in Canada increasingly report struggles with mental health (Office of the New Brunswick Child and Youth Advocate, May 2022, June 2022; Statistics Canada, September 2021). Youth well-being is at risk without appropriate support to mitigate potential adverse outcomes. In this study the relationships between adverse childhood experiences (ACEs), attachment patterns, and narrative type were examined for their ability to predict mental health help-seeking (MHHS). It also included a narrative inquiry methodology to explore the attitudes, beliefs, and values held within the narratives of emerging adults about MHHS.

Hypothesis 1 stated that ACEs would be related to attachment anxiety and avoidance. This was supported. Experiencing more adversity in childhood is associated with higher attachment insecurity (i.e., anxiety and avoidance). Both attachment avoidance and attachment anxiety correlated with experiences of adversity. This finding is consistent with attachment theory. Attachment insecurity and the associated behaviours develop from inconsistent interactions with a caregiver. These interactions form one's view of self and others, and expectations about how others will behave or think develop from these views and belief systems. Those with attachment avoidance have narratives of self and others that result in distrust and withdrawal to protect themselves from distress, meaning they are likely to try to manage distress and conflicts independently (Mikulincer & Shaver, 2016). Conversely, those with attachment anxiety seek proximity to others when experiencing distress. When their attachment system is activated, those who are anxiously attached seek others out or exhibit 'clingy' behaviours to externally regulate their emotions (Brown & Elliott, 2016). In contrast, those with secure attachment patterns

are reassured when seeking comfort from others (Mikulincer & Shaver, 2016). Their proximity seeking in childhood was met responsively and with attentiveness, driving the belief that others will be there to support them when needed. The attachment patterns we form influence our paradigms about the world and people around us.

Attachment

Attachment patterns shape narrative type and childhood attachment patterns shape social connectedness. Most of this sample had low ACE scores, and overall low attachment anxiety and avoidance. The findings of this study support existing research relating to attachment avoidance. For instance, attachment avoidance predicted the avoidance of seeking mental health support when distressed. People with avoidant attachment tend to be hyper-independent and want to solve problems independently. For many of these individuals, this independence became a survival skill required to navigate the world (Gibson, 2015) and many avoidantly attached people 'suffer in silence' with mental illness (Brown & Elliott, 2016). Even when independent and appearing externally calm, those with avoidant attachment patterns have higher physiological distress and heightened emotions (Beckes et al., 2015). The assumption that 'I can do it on my own because I always have' may lead to illusory resolutions. For example, depressed people may attempt to cope independently and may feel shame if they cannot reduce distress (Fredrikson, 2001). When obligated or resigned to solve problems independently but cannot, people feel guilty and ashamed for not meeting social expectations (Gibson, 2015; Goffman, 1963). Shame is associated with inferiority, abnormality, and self-deficit (Goffman, 1963).

Shame is internalized and embodied physiologically, increasing attachment insecurity (Beckes et al., 2015; Fredrikson, 2001; Tops, 2014). As such, understanding the role of ACEs in narrative development is also valuable. Adverse events are easier to remember than positive ones, greatly influencing narrative-type development (Bohn & Berntsen, 2013).

Hypothesis 2 stated that ACEs would be negatively related to intentions to engage in MHHS. This was supported. Specifically, more adversity experienced resulted in fewer intentions to seek help from family and less intention to seek help from anyone. In other words, more adversity increases withdrawal from family and other supports. Consistently, ACEs influence the development of attachment patterns (Hays-Grudo & Morris, 2020), and attachment patterns inform decision-making relating to MHHS (Rickwood et al., 2005). ACEs occurring in the home can lead to the development of attachment anxiety towards caregivers, making children more likely to seek support outside the home (Brown et al., 2015). This is attributed to the need for proximity to others yet feeling unable to get help from family, highlighting the importance of informal social support networks.

Adverse Childhood Experiences

Consistent with the ACEs literature, weaknesses, and failures associated with seeking mental health support are learned from family and friends into adulthood (Hays-Grudo & Morris, 2020). Age was controlled for, yet results indicated that as one gets older, they are more likely to seek help from phone help lines, their family doctor, and teachers. This willingness suggests that as we age and feel more secure in our sense of self, we are not as deterred to seek help by potential stigma (Brown et al., 2016).

However, the opposite may also be true. As one ages, they may face compounded distress and exhausted coping skills to the degree that help is the only option for those with hyper independence or attachment avoidance (Brown et al., 2015; Ma et al., 2020). These findings demonstrated that individuals without life experience rely on others' knowledge of outcomes MHHS (Bohn & Berntsen, 2013). This could be evidence of attachment anxiety, where positive experiences can be dismissed when preoccupied with connection needs (Mikulincer & Shaver, 2022).

Those with higher ACE scores are more likely to face difficulty as adults, and those with tragic narratives are most likely to avoid seeking mental health support. This is problematic and may increase the risk of adverse outcomes. Long-term issues related to ACEs result from a persistent stress response, with elevated cortisol and epinephrine (Beckes et al., 2015). These consistently elevated levels lead to chronic health conditions such as diabetes, heart disease and obesity (Filetti et al., 2019) . Higher rates of serious health issues result the longer these hormones remain elevated. Thus, ignoring mental health issues may require physical intervention to address illnesses such as heart attacks, diabetes, or obesity (Filetti et al., 2019). Over time, mismanaged distress becomes harder to regulate (Wang et al., 2007). Due to the unmet demand for comfort and support, the fight or flight reaction causes persistent physiological distress. Increased risks to mental health resulting from an unmet need for support were reflected in participant narratives (Mate & Perry, 2022). Thus, neglecting symptoms of mental illness may increase emotional and physiological dysregulation, causing daily mental health disruptions (Chovil, 2004; Hetrick et al., 2017). This can lead to patterns of maladaptive coping that will likely exacerbate distress and illness long-term (Filetti et al., 2019). An effective

solution will require consideration of cultural beliefs (Castillo, 1997), family values (Gibson, 2015), and mental health literacy (Woods-Jaeger et al., 2018).

Hypothesis 3 stated that narrative type would predict MHHS in emerging adults. Redemptive narrative types were expected to be more likely to engage in MHHS than those with a tragic narrative type. Those with a progressive narrative type were expected to be less likely to seek help due to having never felt a need to do so. Narrative type was expected to shed light on preferred sources of support when seeking help for mental health. However, narrative type did not predict intentions to seek mental health support from a partner, friend, family, or formal support. This means that hypothesis 3 was not supported, and that narrative type did not predict intentions to seek mental health care. Instead, narrative type predicted intentions not to seek help at all. This finding was explored further in the final analysis. Notably, when controlling for age, increases in age predicted intentions to seek help from formal sources of support, indicating age does account for some formal mental health help-seeking.

Narrative type

Those with more social support rated MHHS experiences positively and were more likely to be categorized as redemptive. However, those with more attachment insecurity (avoidance and anxiety) sought less support. Social support is critical for narrative development, reducing distress and is often noted in redemptive narratives (McAdams, 2008). Early childhood attachment patterns influence narrative-type development through subconscious internal working models that become conscious narratives. Social connections allowed for narrative-type development based on degrees of attachment insecurity. For example, those with stronger attachment security and

excellent social support included these in their MHHS narratives. Emerging adults categorized as redemptive prioritize MHHS and make decisions using established narratives. These narratives include emotional language and nuanced perspectives supporting previous findings (Khanlou & Wray, 2014; Lux, 2021; McLean, 2013). Previous studies also found themes of hope for a more positive outcome in redemption narratives.

Those with redemptive narratives could depend on optimism, hope, and perseverance, all attachment security attributes, when experiencing hardship, consistent with the research of McAdams (2008) and Lieblich et al. (1998; Brown & Elliott, 2016; Mikulincer & Shaver, 2016). In the introduction, the possibility that redemptive narratives may be 'toxic positivity' in disguise was acknowledged, however, the narratives collected did not strongly represent 'toxic positivity'. A few participants said they ignored problems and waited for them to disappear and denial in attempts to 'be more positive' was common in these narratives (Upadhyay et al., 2022). Others believed they could resolve distress if they 'hung in there' and used the resources provided, even when struggling the most. However, strong social support networks eased participants' struggles; their struggle felt less futile alongside others, consistent with social attribution theory (Schnall et al., 2008; Stefanucci et al., 2005).

This study advances theoretical understanding of tragic narratives. Unfortunately, those with attachment insecurity, especially avoidance, reported feelings of futility with the mental healthcare system and in personal experience. This is evidence of the help-negation effect (Rickwood et al., 2005). Expecting hopelessness in seeking mental health support leads to intentions to avoid help-seeking (Price & Hollinsaid, 2022; Radez et al.,

2021). The individuals in this sample did not avoid help-seeking or express ambivalence about MHHS as in previous studies (Radez et al., 2021). Instead, they cited attitudes based on unsuccessful past help-seeking attempts. Tragic narratives showed skepticism of the system and mental health experts, supporting previous findings (Hagstrom & Forinder, 2019). However, some did indicate a total lack of help-seeking; those tragic narratives conveyed complete emotional isolation (Lieblich et al., 1998; Sandage, 2012). These distinctions stem from individual interactions with the culture of their community. Subsequent narrative-type development co-occurs between the individual and community, where the individual is a cultural participant influenced by voices of family, politics, peers, and teachers (Hammack & Toolis, 2019).

Hypothesis 4 stated that narrative type would predict attachment pattern. Based on existing research, it was expected that those with redemptive narratives would have more secure attachment (i.e., less avoidance or anxiety). It was unknown what attachment pattern those with progressive narratives might have. Those with tragic narratives were expected to report greater anxious or avoidant attachment. However, hypothesis 4 was not supported. Narrative type did not predict attachment anxiety or avoidance. Narrative type not predicting attachment insecurity indicates the possibility that there may be moderating variables responsible for the relationship between narrative type and attachment. Narrative analysis revealed differences in narrative types due to the influence of perceived social support, a sense of connection with others, and a sense of belonging. For example, redemptive narratives featured social support (i.e., supportive family or friends) that those with tragic narratives did not seem to have. Perhaps, how connected an

individual feels socially or one's sense of belonging mediates the relationship between developing narrative type and attachment pattern.

Mental Health Accessibility and Trust in Others

A potential mediating variable between attachment and MHHS conveyed by participants is the lack of trust in the mental health system and professionals meant to offer support. Results indicated that trust is crucial to seeking mental health support. Without trust in professionals, participants feared judgment or criticism from medical staff. People might avoid seeking help from friends, partners, family, or formal support if they don't feel emotionally supported (Garland & Zigler, 1994). Tragic narrative types conveyed a general sense of defeat and loneliness. Close informal relationships may have contributed to attachment avoidance. Relationships leading to attachment avoidance are unlikely to be sought for help by those struggling (Gibson, 2015; Mikulincer & Shaver, 2016). For instance, the tragic narratives in our sample reflected these beliefs.

Attachment theories recommend a broaden and build (B&B) approach to attachment security to promote trust and engagement (Kobak et al., 2015). Many emerging adults intend to avoid mental health help-seeking. This means that despite best efforts to improve existing services, emerging adults will not make it in the doors. Thus, increasing seeking mental health care requires creating trust in professionals, and the process before emerging adults will engage. Effectiveness of attempts to increase MHHS behaviour requires simultaneous efforts of both the individual and community. The B&B model establishes an interactional cycle of attachment security and connection (Kobak et al., 2015; Mikulincer & Shaver, 2016). Finding available and responsive care providers increases emotional regulation, social adaption, and close relationships, fostering

personal growth. The B&B approach promotes the development of a secure narrative and reassures individuals that care professionals will be available and will provide support thus reducing prolonged distress (Kobak et al., 2015; Mikulincer & Shaver, 2020).

Hypothesis 5 stated that ACEs would differ by narrative type. Those with redemptive and tragic narratives were expected to report more ACEs than those with a progressive narrative type. ACEs did not significantly differ by narrative type at the α = .01 level, indicating that hypothesis 5 was not supported. Based on these findings and those noted above, narrative type seems to be more influenced by attachment patterns than ACEs. Attachment insecurities are shaped by how individuals view others based on their ACEs, which can make individuals feel either connected or disconnected (Hays-Grudo & Morris, 2020; Mikulincer & Shaver, 2016). People who feel socially connected are more likely to have a redemptive narrative. As the number of ACEs increases, the likelihood of social disconnection and a tragic narrative also increases.

Hypothesis 6 stated that narrative type, ACEs, and attachment pattern would predict engagement in seeking mental health support. We examined each possible source of support with the expectation that redemptive types would seek out more formal supports, whereas tragic types were expected to seek informal or no support at all. However, this was not the case. Narrative type, ACEs, and attachment patterns predicted intentions to avoid engaging in MHHS. Therefore, hypothesis 6 was supported. Moreover, results indicate narrative type, ACEs, and attachment pattern did not predict seeking mental health support from a partner, friend, teacher, mental health professional, phone helpline, family doctor, or general formal support. Tragic narrative types were most likely to choose not to seek help from anyone as expected. Finally, more ACEs and

attachment avoidance predicted intentions to avoid seeking mental health support from family; however, narrative type did not. Consistent with attachment theory, those with attachment avoidance tended to avoid relying on others to protect themselves from being dismissed or rejected (Mikulincer & Shaver, 2016).

In the final test the analysis also showed gender to contribute to the decision to avoid seeking help. The results reiterate what we already know about attachment and help-seeking in general: women are more likely than men to have attachment anxiety and men are more likely than women not to get help at all (Sears, 2020). This indicates that stigma surrounding males vocalizing their struggles with mental health remains potentially significant.

Mental Health Help-Seeking

When it comes to seeking help, research suggests emerging adults prefer peer assistance (Rickwood et al., 2005). Due to stigma associated with speaking about struggles with mental health, results suggest emerging adults prefer to seek help from a romantic partner or close friend. There was no significant intent in this study by emerging adults to seek help from mental health professionals or a family doctor. This is concerning because participants would rarely seek first-line formal support suggesting a barrier before emerging adults have begun seeking mental health support.

Those with tragic narratives are least likely to seek mental health support. This expected result supports findings in the literature about narrative type (Delker et al., 2020; Hammack et al., 2009; McAdams, 2022). Those with tragic narratives stated that seeking mental health care was unsuccessful several times, reinforcing their belief that getting treatment is pointless. Our hypotheses were confirmed: progressive narrative

types sought help least often. Most progressive types reported never being distressed enough to seek mental health care. However, they intended to seek formal support if needed. Conversely, redemptive narrative types were more likely than progressive types to state past help-seeking was helpful, however this was not found to be statistically significant.

Themes of negative rapport emerged in the narratives of emerging adults. Successful support seeking for mental health requires rapport (Young, 2017). If emerging adults are unaware they may be developing symptoms of mental illness, they are not likely to perceive a need for help. This served to explain some perceptions of negative rapport; particularly for those who felt misunderstood as minors. For example, these individuals reported feeling there was not a problem at all, yet their parents had concern enough to take them to see a professional. The potential lack of mental health literacy in these youth led to an ambivalence that makes rapport challenging to create. Therefore, encouraging help-seeking as a proactive coping tool would improve mental health literacy and make subsequent rapport building with emerging adults that much easier. In other words, seeking help would no longer automatically be attributed to self-deficit within one's narrative meaning a person might be more willing to receive offers of help. There seems to be a need to build a sense of rapport with the process of mental health help-seeking and a need to build trust with the mental healthcare system. How this translates to practice must be explored.

Emerging Adult Narratives About Mental Health Help-Seeking

Qualitative data was collected to add convergent validity and context to the quantitative data. There were a number of prominent themes relating to narrative

development and help-seeking which emerged from the data that warrant discussion. As noted previously, these include the role of family, mental health help-seeking at school, the intention not to seek help at all, internalized stigma and mental health support accessibility and trust in others. These themes are discussed more in depth below.

The Role of Family

Family was identified as both a strength and a weakness in narratives about MHHS. Parents influence attitudes about MHHS through their language and explanations about emotional experiences (Fivush et al., 2007). Individuals with secure attachment tend to have good social support networks. Supportive adults encourage seeking mental health support as a coping option for children and youth (Hays-Grudo et al., 2021). When family members support a person in seeking help for their mental health, that person is more likely to engage in MHHS behaviour and is more likely to benefit from that support (Bohn & Berntsen, 2013). For example, in this sample, parents' of participants in this sample took them for mental health support as adolescents. While some of these participants indicated that the help received was beneficial, two others struggled to understand why their families felt something was wrong with them. However, this does not diminish the frustration parents experience when trying to engage youth before they are ready. An explanation of this line of thought is beyond the focus of this study (see Radez et al., 2021 for more information about barriers to seeking mental health care identified by parents). The role of family can make trusting others difficult making it important to view barriers to seeking support from an attachment lens.

Some participants felt helpless when given a treatment plan without their input. These feelings are consistent with those conveyed by youth in other studies (Noble-Carr

et al., 2014). Alternative supports should be available to mitigate this and increase youths' sense of agency and community belonging (Ma et al., 2022). The B&B approach can be used with narrative therapy to externalize mental illnesses from the self and revise the narrative regarding seeking mental health support (Brown & Elliott, 2016; Howe, 2009).

Mental Health Help-Seeking at School

Teachers commonly provide front-line mental health support for students (Ma et al., 2022; Mason-Jones, 2012). In this study, narrative types did not predict seeking help from a teacher. This could be explained by the access emerging adults have to support through university student services; although, this may not be the case in youth of younger age groups. In the community, access to support is less readily available, and unsuccessfully trying to find resources came through strongly in the data.

University students are encouraged to seek support through student services for a number of issues including mental health (Abrams, 2022; Clements & Paramova, 2023). The diverse learning environments and promotion of mental health services for university students may make seeking help more acceptable (Clements & Paramova, 2023). Since campus mental health programs have shorter wait lists than community services, they may be more accessible. More students, in general, are using these resources, but funding for counselors has not kept pace, causing shortages of accessible counselors for students (Abrams, 2022). Some with redemptive narratives feared that seeking help for their mental health might hinder their academic progress, showing that there are still barriers relating to a willingness to seek help. This may also explain the intentions of redemptive narrative types not to seek help. Some participants felt that having to wait while in crisis

was dehumanizing and five considered suicide to end distress sooner. Each time an emerging adult seeks help is considered a success in terms of engagement because they reached out. However, despite their engagement with services, many emerging adults felt unsupported at critical times.

No Intention to Seek Help

Attachment avoidance, ACEs, and tragic narrative type predicted intentions to avoid seeking help. This finding is noteworthy and worth discussing. People are less inclined to seek help after experiencing high adversity. Narratives showed that individuals with more adversity felt seeking help for their mental health was meaningless and that while help was ideal, they could not find it. In some cases, this was due to long wait times; in others, it was due to unsuccessful, yet required referrals or being given the 'run-around' by service providers. Some participants reported being taught that seeking help for their mental health was a sign of weakness and failure. Other research on general help-seeking has found that seeking mental health care is typically seen as a weakness or failure (Goffman, 1963; Radez et al., 2021; Woods-Jaeger, 2018). Negative attitudes such as mental illness implying weakness of character are perfect exemplars of internalized stigma.

Internalized Stigma

Internalized stigma involves feeling weak because one cannot address distress independently, leading to shame and guilt for burdening others (Gibson, 2015; Ma et al., 2022; Torrey, 2006). The perception that seeking mental health support is a strength is subjective; thus, future studies should examine how youth describe strength in relation to seeking this type of support. The mental health system and the professionals working in

that system are responsible for assessing mental health and determining the course of individual treatment plans. However, allowing the individual to contribute to their network of care by choosing who is involved and what that involvement looks like can help emerging adults view seeking mental health support as a strength and enhance youth quality of life (McCabe et al., 2022). Redemptive narratives indicated that seeking mental health support had enhanced their ability to manage distress following various interventions. Growing up in a home that accepted and encouraged seeking mental health support reduced internalized stigma. Despite attempts to seek help that were unsuccessful, those with a redemptive narrative utilized other techniques to manage their distress to find a positive resolution. Strong social support networks enabled this skill in most situations confirming that strong social support networks facilitate seeking mental health support (Abreu et al., 2022; Planey, 2019).

Broadening and Building Attachment Security with Trust

Systemic flaws in the healthcare system relating to accessibility that hinder development of positive rapport must be addressed. Service disengagement and inaccessibility hinder healthy attachments to mental health practitioners and the process of seeking mental health support. Though beyond the scope of this study, these issues deserve brief discussion. Service providers must recognize that trust is essential to meaningfully engage 15-to 30-year-olds (Rickwood et al., 2015; Valenti, 2020). From an attachment perspective, no other work can be done if the individual feels unsafe and is unable to be vulnerable (Valenti et al., 2020). Thus, it becomes increasingly clear that services should only expect youth engagement with youth input and feedback in all aspects from program development to implementation (McCabe et al., 2022). Clinicians,

policymakers, and funders must recognize that building trust and relationships with youths takes time and that this time requirement must be incorporated into future program designs. Youth that have experienced higher rates of adversity struggle to trust others. As a result, youth with more adversity and attachment avoidance must build trust with clinicians, administration and agency staff, community partners, and the process of seeking mental health support (Community Stakeholder, August 20, 2023). Time to build trust is a necessary component of program design, but funding constraints typically overlook this. Logically, without trust, rapport will not develop in a positive direction (Lynch et al., 2021). Trust-building must be prioritized particularly in work with youth, to improve treatment outcomes and increase engagement in seeking mental health support. Various forms of media may additionally shape the community's narrative about seeking mental health support and experiences of mental illness (Brown et al., 2019).

Mental wellness is more than merely the absence of illness, as some might believe. Future goals must address the attribution of support-seeking to feelings of weakness and defeat. Like physical health, mental health involves flexibility, good adaption, and thriving. For example, physical health is important, and daily incorporating a nutritious diet and exercise can help people thrive into their senior years (Filetti et al., 2019). As discussion about mental health becomes normalized, the stigma of mental illness and seeking mental health support may decline resulting in a more adaptive general narrative about mental health. For some individuals, vocalizing their mental health struggles brings a sense of reality that some are not yet ready to face (Gibson, 2015). Some individuals wrestle with the idea that there may be something wrong with them, thus impacting their desire to seek supports and keep them isolated in their struggle

(Gibson, 2015; Mate & Perry, 2022). Strategies are therefore needed to build rapport before the individual decides to engage in seeking mental health support thereby preventing the need to struggle alone.

Theoretical Implications

The narrative methodology used in this study elicited experiences of participants in a rich and meaningful way. Narratives offered insight into the mentalization of experiences and choices directing decision-making represented in the quantitative findings (Bruner, 1990). Further, differentiation of narrative types was present. Each narrative type had specific characteristics noted in theories of narrative development (Lieblich et al., 1996; McAdams, 2008). Progressive narrative types had little need or experience of distress to warrant seeking help. Redemptive narratives featured obstacles such as mental health struggles, and disagreements with parents. They also contained feelings of achievement as participants felt they overcame the obstacles they faced. Tragic narrative types conveyed a general sense of hopelessness and futility. These types developed in tandem with life experiences integrating lessons learned with future expectations. The connections made between experiences, content of narratives, and future expectations that characterize each narrative type confirmed McAdams' (2008) three tiered theory of narrative development.

Emerging adults are distinctive in the community since they are no longer children but not yet fully adults. The narratives, triggered emotions, and subsequent decision-making of emerging adults in this study, confirms that individuals respond to environmental interactions supporting embodied theories of development (Beckes et al., 2015). Specifically, this study confirms the complex role attachment plays in narrative

development. Attachment security provides an individual the ability to comfortably interact with and trust others. Engagement in seeking mental health support requires youth-friendly, safe spaces that respect their agency, knowledge, and experiences (McCabe et al., 2022; Price & Hollinsaid, 2022). The decision not to seek help, as described in participant narratives, indicated that youth must be able to trust these services and professionals to foster engagement. Additionally, cultural, and environmental factors influence views about seeking mental health care and ultimately decisions to seek out support (Abreu et al., 2022; Castillo, 1997; Habermas & de Silviera, 2008). Narratives in this sample supported this; adolescents also need family or school support for seeking mental health support (e.g., consent; Radez et al., 2021). Similar findings have been found in studies examining general help-seeking of youth belonging to the LGBTQ+ community and racialized minorities (Abreu et al., 2022; Hammack & Cohler, 2011; Office of New Brunswick Child and Youth Advocate, November 2020, September 2021, May 2022, June 2022; Woods-Jaeger et al., 2018). Research on younger youth indicated that parental support was essential for effectiveness of seeking mental health support and fostering favorable attitudes about the help-seeking process (Beckes et al., 2015; Bohn & Berntsen, 2013). Mental health literacy helps parents recognize mental health issues and their influence on their children's mental health and MHHS narratives (Beckes et al., 2015; Bohn & Berntsen, 2013). Normalizing mental health issues, acknowledging that everyone needs support, and actively supporting their child in seeking mental health care may help children of any age develop positive attitudes about the process. Children will be less likely to express defeat and shame about their struggles as they emerge into adulthood (Rickwood et al., 2005).

The attachment-based B&B approach provides a safe emotional space to process distress. This emotional safety may improve mental health, life satisfaction, and mental health help-seeking beliefs. With time, therapeutic interactions help individuals manage distress and return to an emotional baseline quickly (Brown & Elliott, 2016). When the secure base narrative develops, individuals are more likely to take healthy risks, like seeking mental health support, and experiment with support options (Mikulincer & Shaver, 2020). The attachment system deactivates as distress subsides, making space for other tasks (Mikulincer & Shaver, 2020). The B&B cycle of attachment security occurs when individuals interact with caring others or community members, developing attachment security in varying relational contexts (Mikulincer & Shaver, 2020; Rickwood et al., 2015). Subsequently, the mental health of the individual improves by way of more positive views of self and others.

Mental Health Literacy and Reducing Stigma

Internalized stigma significantly contributes to intentions to seek mental health support (Ma et al., 2022; Vieira, 2023). Stigma is a known obstacle to seeking help, and this phenomenon continues in emerging adults (Corrigan, 2006; Price & Hollinsaid, 2022). Participants shared experiences of mental health stigma or discrimination while help-seeking. Stigma and discrimination caused feelings of dread, shame, and insignificance. These negative emotions were identified in redemptive and tragic narratives, leading to avoidance of help-seeking. These findings show that stigma and discrimination can harm individuals more than mental illness itself (Price & Hollinsaid, 2022; Thornicroft et al., 2015). In many narratives, seeking support for mental health was not an option because earlier experiences made the participant feel unheard or that their

problems were trivial. Thus, our results suggest that strategies to engage and validate the experiences of emerging adults in promoting seeking mental healthcare are still needed.

Long wait times, delayed mental health referrals, and healthcare system discrimination of addiction were reported as barriers in eleven participant narratives. Addiction discrimination in healthcare is well documented (Werder et al., 2022). Language like 'addict' is now unacceptable (Werder et al., 2022). Instead, language that does not dehumanize the individual (e.g., a substance use disorder patient) is advised (Werder et al., 2022). Studies have found that clinicians who perceive addiction as purely behavioural and due to choice report greater rates of addiction-related stigma (Rey et al., 2019; Werder, 2022). As a result, language reforms have been advocated as a public health priority (Rey et al., 2019; Werder, 2022). This strategy reframes narratives to retain a positive identity while identifying maladaptive coping techniques to improve seeking mental health care (Werder et al., 2022). Clinical discrimination emphasizes the need for trauma-informed mental health care and easy access to appropriate professionals.

Trauma-Focused Approaches

Trauma-informed literature increasingly views psychopathology as an environmental adaptation rather than a personal deficit (Mate & Perry, 2022). The narrative of adaptation challenges how mental illness, ACEs, and seeking mental health support are typically framed, referenced, and understood. Trauma-focused therapeutic rapport-building is key to success (Ovenstad et al., 2020). Consideration is given to the individual's adaptation while attending to the cascade of consequences ACEs leave in their wake. Trauma-informed approaches recognize the function of maladaptive coping.

For example, many people with substance use disorders feel a sense of community and connection with others who use substances. Another example of maladaptive functioning are those who feel isolated or angry and explode in response to their emotions and may not know how to communicate differently (Mate & Perry, 2022). Trauma-informed approaches aim to resolve the desire to mentally escape the circumstances or bodily discomfort resulting from ACEs (Mate & Perry, 2022). These approaches recognize that not all individuals have learned the same skill sets, and research on the efficacy of these approaches is growing. For example, while some youth were in school learning and achieving developmental milestones, others were enduring trauma or experiencing psychopathology and have had to learn how to cope with distress first (Mate & Perry, 2022). Some youths did not have accessible caregivers to assist in this process. As a result, B&B methods for creating connections should be considered in future mental health interventions.

Clinical Implications

This study has important clinical implications for emerging adult well-being. For instance, a looming question remains regarding how to engage emerging adults in seeking support for their mental health and building rapport before they enter into formal services for help. Available clinicians might use a B&B attachment security cycle by first building trust in their availability and responsiveness. Clinicians who can engage meaningfully with emerging adults will boost their hope and willingness to participate in seeking mental health support.

The B&B cycle is increasingly seen as more effective than cognitive behavioural therapies in improving mental health outcomes in those with depression, eating disorders,

and personality disorders (Mikulincer & Shaver, 2020). The B&B cycle enhances relationship quality, the capacity for resilience and broadens perspectives of self and others. On the other hand, attachment insecurity causes preoccupation with meeting the most fundamental desire for connection or avoiding others despite suffering. Those with redemptive narratives identified trust in the process of seeking mental health support and in mental health professionals. Successful interactions are marked by feelings of good rapport with the mental health professionals they have seen. This supports the evidence that positive therapeutic interactions require positive rapport (Abrams, 2022; DeAngelis, 2019). Belief in the benefit of seeking mental health support is also a predictor of successful therapeutic relationship building (Young, 2017).

Clinical Interventions to Promote Mental Health Help-Seeking

Knowledge translated into interventions for practice allows those in the field of mental health care to enhance the quality of service delivery. Evidence-based strategies to promote positive narratives about MHHS are discussed below and a summary of recommended clinical interventions can be found in Figure 5.

Some initiatives incorporate media about health, exercise, and nutrition (e.g., Canada's food guide) into school curriculum, or public service announcements. Movies, TV, and social media have depicted mental illness as dangerous and evoked fear (Brown et al., 2019). However, media can be a powerful instrument for redirecting community narratives to better reflect the human experience (Brown et al., 2015; Roeschley & Kim, 2019). Individual narratives and attachment insecurity are projected onto community narratives, reflecting similar narratives and insecurity within the community (Smith et al., 1999). For example, for decades many believed mental illness to be evidence of sin

(Dain, 1992). The narrative emerged in the general community that mental illness signaled character defects (Goffman, 1963). This study has shown that stigma influenced narrative type and decisions not to engage in seeking mental health support (Chovil, 2004; Edwards, 2017; Price & Hollinsaid, 2022). If individual narratives about MHHS can be improved, community narratives will follow. Individuals influence culture, and culture influences individuals (Habermas & de Silveira, 2008). Likewise, individual narratives affect cultural or community narratives and vice versa (McAdams & McLean, 2013). Furthermore, a change is required in the attitudes held within the general community about MHHS. Educating youth and their families about the collaborative psychotherapy process may help increase trust in mental health services and professionals (Brown & Elliott, 2016). Moreover, to better support the healthy development of mental health in their children, parents advocate for support to enhance their mental health literacy (e.g., how to help, or where to find it; Brown, 2021; Teagle, 2002).

Mental health literacy reduces stigma and increases youth engagement in seeking mental health support (Jorm, 2012; Koller et al., 2013). However, education must elicit a positive view of the benefits of seeking mental health care and provide information about support-options (Jorm, 2012). Community dialogue about seeking mental health care and mental health experiences can promote mental health literacy (Koller et al., 2013). A community strong in mental health literacy can dispel stigma and promote seeking help (Corrigan, 2006; Koller et al., 2013). Calgary's *Opening Minds* in High School project educated junior and high school students about mental health (Koller et al., 2013). Education sessions included those with lived experience of mental illness and recovery

experiences. The program successfully reduced misunderstandings and myths about mental health by 33% and, ultimately reduced stigma relating to mental illness.

A local example, the *Building Home* (www.BuildingHome.ca) project in Saint John, NB, emphasizes youth voice and experience (Community stakeholder, August 20, 2023). *Building Home* is a knowledge mobilization project that will engage the larger community and showcase youth experiences relating to homelessness, mental health, and their efforts to seek help through a large art installation. Projects such as these improve community mental health literacy and understanding of 'others' in the community, fostering a sense of belonging (Woodhall-Melnik et al., 2022). Such projects can dispel stereotypes and stigma and spark community discussions around seeking mental health support (Woodhall-Melnik et al., 2022). These opportunities for community belonging will embed a B&B approach into community capacity building.

Educational institutions offer several youth mental health interventions (Mason-Jones et al., 2012). Interventions have reduced the stigma of mental disorders but not internalized stigma or engagement in mental health services (Ma et al., 2022). School-based interventions should aim to reduce internalized stigma and include local mental health providers. Showcasing local agency services will aid relationship-building within schools and the community. Moreover, public education about mental health issues, where to seek help, and what each local agency offers should be combined with messages about the benefits of seeking mental health support. Contact interventions have also been shown to be beneficial (Allport, 1954; Denison et al., 2020; Evans-Lacko et al., 2012; Khenti et al., 2019; Martinez-Martinez et al., 2019). Contact interventions with individuals that have lived experience of mental illness and seeking mental health care

reduce anxiety about what to expect for those in need of support (Ma et al., 2022; Price & Hollinsaid, 2022). Promoting such programs while broadening and building attachment to care providers' institutions can boost the individual's sense of security with that institution (Granqvist, 2021).

Help-seeking pathways and processes should be voluntary and informed by emerging adults (McCabe et al., 2022). However, many services disengage punitively when youth (ages 15-25) are non-compliant, often at the expense of the working relationship (Noble-Carr et al., 2014). A B&B model suggests that disengaging youths who struggle with services is inappropriate, harmful, and counter-productive. Service disengagement fosters the belief that support is conditional and punitive, removing any sense of shared humanity and compassion (Community Stakeholder, August 20, 2023; Noble-Carr et al., 2014). Instead, service providers can pivot and build relationships with youth (Noble-Carr et al., 2014). If efforts are made to check in and maintain contact with youth not ready to engage in the formal process, youth will gain trust that service providers care about their well-being (McCabe et al., 2022). This will also build their sense of agency, self-worth, and value.

Figure 5

Summary of Recommended Clinical Interventions

Summary of Clinical Interventions	
	Utilization of the broaden and build cycle of attachment security to inform relational approaches to service delivery.
	Use of various media to redirect narratives to better reflect the human experience.
	Public and school-based education to reduce internalized stigma and promote mental health literacy (i.e., mental health issues, benefits of seeking help, process of theraputic interventions, and local support options and services).
	Knowledge mobilization and translation projects featuring youth voices and experience.
	Help-seeking pathways and processes should be voluntary and informed by emerging adults.

Limitations and Future Directions of This Study

This study is not without limitations. More specifically, limitations relating to study demographics, socioeconomic status, and narrative types are discussed below.

Demographics

The large number of undergraduates sampled was a limitation of narrative research this study tried to resolve. Undergraduates and clinical populations are over-represented in help-seeking research. However, only 12% of the sample were community members. Thus, this small number is unlikely to represent subclinical populations. Further data collection from the general community would allow for more robust conclusions from these findings.

Most of this study's sample identified seeking help from a psychologist or school counselor. This frequency could be due to emerging adults in post-secondary institutions having better access to school counselors than other emerging adults in the community. Future research should explore this with other demographics of youth for clarification.

Socioeconomic Status

This study did not collect SES data, but narrative data highlighted this theme. This study found narrative types specific to intentions to seek mental health support, providing novel insights. For example, redemptive narratives emphasized themes of agency and economic advantage illustrating the benefit of residing in a higher socioeconomic class where inaccessibility does not taint the hope of acquiring help.

Most of the participants were university undergraduates, therefore paid services may not always be possible. This study did not collect SES data, however several studies

link SES and mental health (Kern et al., 2020; Lowthian, 2021; Nagy-Penzes, 2020). Reduced SES increases mental illness, violence, and poverty, which inhibits help-seeking (Castillo, 1997; McAdams, 2008). Those belonging to lower-SES rely on publicly financed mental health care, which may be concerning. Waitlists for government health care services are long (Iyer et al., 2019; Office of the New Brunswick Child and Youth Advocate, Sept. 2021). For example, as mentioned, one person waited almost two years to see a psychiatrist. Longer delays in treating mental illness can lead to more severe symptoms and complex needs (Wang et al., 2007).

Narrative Types

Short and broad narrative excerpts were collected for this study. Shorter narratives may have necessitated redefining progressive narratives for code clarity. Initially, progressive narratives were noted to progress consistently, with the direction of emotional tone either up or down; however, while coding, it became evident that progressive and tragic narratives were indistinguishable from each other with this definition. To address this issue, progressive narratives were coded by positive or neutral emotional tone whereas tragic narratives had consistently negative emotional tones. In other words, progressive narratives were neutral, while tragic narratives were negative.

A small body of narrative research links decision-making, MHHS, and attachment. Future narrative type and MHHS research may use visuals of mental health care interactions and allow participants to write their interpretations (Rickwood et al., 2005). Interpretations will distinguish between tragic and progressive narratives through reflected attachment patterns and beliefs. This distinction can increase understanding of the applications and utility of the B&B approach to promoting attachment security.

Additionally, using biometric measurements like heart rate and galvanic skin response while writing narratives would lend further support to embodied attachment theories. Repeated-measures longitudinal narrative research could also distinguish narrative-type fluidity and change. To better distinguish narrative-type groups and attachment patterns, future studies might evaluate narrative-type coping strategies.

Future Directions for Consideration

Internalized Stigma and Mental Health Literacy

Future studies may want to explore ways to measure and explore internalized stigma in efforts to reduce the barrier it poses to MHHS. Standard educational approaches reduce mental illness stigma but not internalized stigma. Understanding how general and targeted messaging reduces internalized stigma is also important. This suggests mental health literacy interventions are still needed to promote engagement with services and reduce stigma-related barriers (Koller et al., 2013). Changing mental illness language is one strategy (Price & Hollinsaid, 2022; Werder et al., 2022). How universal interventions may blend attachment security (B&B) and evaluate internalized stigma in mental health support narratives is unknown.

There is currently a shortage of measures assessing mental health literacy, as noted by Ma et al. (2022). Additionally, the specific aspects of mental health literacy that are most beneficial to youth remain unidentified (Ma et al., 2022). Further research is required to pinpoint how interventions targeting the stigma associated with seeking mental health support among emerging adults can effectively address internalized stigma. Community education is essential to improve overall mental health literacy and clarify cultural misunderstandings about the process of seeking mental health support.

Conclusion

This study had complex results. Attachment insecurity increases with more ACEs; more specifically, attachment avoidance is more likely than attachment anxiety. Experiencing greater adversity reduced the likelihood of seeking help from family but did not predict narrative type. In particular, tragic narratives indicated no intention to seek mental health support. Notably, narrative type did not predict attachment and there was no preference for mental health services. The decision to avoid mental health help-seeking was predicted by narrative type, attachment avoidance, and ACEs.

This is one of many studies in a growing body of research on emerging adult narratives and MHHS. This study aimed to understand how narratives impact the decision to seek mental health support. Values expressed and contained in narratives guide behaviour and decisions (Schnitker et al., 2019). Values and attitudes develop in tandem with attachment patterns and corresponding narratives. Additionally, attachment patterns give context to the preferences of individuals when seeking help for mental health concerns. From a motivational perspective, individuals may be empowered to seek support when recognizing the value of ongoing efforts to improve their mental health, even when prioritizing their lives (Miller & Rollnick, 2013). It is, therefore, essential to engage emerging adults in developing programs and interventions to empower them as active agents in their lives.

Emerging adults in this study indicated little intention to seek help meaning existing services are perceived unfavorably and have yet to be trusted. Developing programs or interventions to engage youth better will require youth input and involvement moving forward. Engaging emerging adults in improving community mental

health literacy may take longer; however, the expected improvement in seeking mental health services is worth the effort. Our communities must normalize mental health and recovery-oriented beliefs, attending therapy, and requiring help both proactively and during distress (Vierthaler & Elliott, 2022). In conclusion, this study has shed light on the intricate link between narrative types developed by emerging adults and their subsequent mental health help-seeking behaviours using narrative inquiry methodology. By fostering a culture that encourages individuals to step out in bravery, courage, and pride, we can actively contribute to shaping more positive and constructive narratives surrounding the essential act of seeking mental health support.

Bibliography

Abrams, Z. (2022, October 12). Student mental health is in crisis. Campuses are rethinking their approach. *Monitor on Psychology, 53*(7). https://www.apa.org/monitor/2022/10/mental-health-campus-care

Abreu, R. L., Sostre, J. P., Gonzalez, K. A., Lockett, G. M., & Matsuno, E. (2022). "I am afraid for those kids who might find death preferable": parental figures' reactions and coping strategies to bans on gender affirming care for transgender and gender diverse youth. *Psychology of Sexual Orientation and Gender Diversity, 9*(4), 500-510. https://dx.doi.org/10.1037/sgd0000495

Altmaier, E. M. (2017). Meaning and connection after trauma. In E. M. Altmaier (Ed.), *Reconstructing meaning after trauma: Theory, research, and practice* (pp. 3-16). Elsevier Academic Press.

Arikan, G., Stopa, L., Carnelly, K. B., & Karl, A. (2016). The associations between adult attachment, posttraumatic symptoms, and posttraumatic growth. *Anxiety, Stress, & Coping, 1*, 1-20. https://dx.doi.org/10.1080/10615806.2015.1009833

Bachman, G. F., & Bippus, A. M. (2005). Evaluations of supportive messages provided by friends and romantic partners: An attachment theory approach. *Communication Reports, 18*(2), 85-94. https://dx.doi.org/10.1080/08934210500309975

Bartholomew, K., & Horowitz, L.M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of personality and Social Psychology, 61*(2), 226-244. https://dx.doi.org/10.1037/0022-3514.61.2.226

Bartholomew, K., & Shaver, P. R. (1998). Methods of assessing adult attachment. *Attachment theory and close relationships, 25-45.* http://moemesto.ru/rorschach_club/file/14257751/display/bartholomew98.pdf

Beckes, L., IJzerman, H., & Tops, M. (2015). Toward a radically embodied neuroscience of attachment and relationships. *Frontiers of Human Neuroscience, 9*, 1-18. https://10.3389/fnhum.2015.00266

Bender, A., Ingram, R. (2018). Connecting attachment style to resilience: Contributions of self-care and self-efficacy. *Personality and Individual Differences,* 130, 18-20. https://doi.org/10.1016/j.paid.2018.03.038

Berntsen, D. & Bohn, A. (2010). Remembering and forecasting: The relation between autobiographical memory and episodic future thinking. *Memory & Cognition, 38*(3), 265-278. https://dx.doi.org/10.3758/MC.38.3.265

Berntsen, D., & Rubin, D. C. (2004). Cultural life scripts structure recall from autobiographical memory. *Memory & Cognition, 32*(3), 427-442. https://dx.doi.org/10.3758/BF3195836

Blosnich, J. R., Garfin, D. R., Maguen, S., Vogt, D., Dichter, M. E., Hoffmire, C. A., Bernhard, P. A., & Schneiderman, A. (2021). Adverse childhood experiences checklist [Database record]. Retrieved from PsycTESTS. https://dx.doi.org/10.1037/t79495-000

Bohn, A., Berntsen, D. (2013). The future is bright and predictable: The development of prospective life stories across childhood and adolescence. *Developmental Psychology, 49*(7), 1232-1451. https://dx.doi.org/10.1037/a0030212

Bohn, A., & Berntsen, D. (2008). Life story development in childhood: The development of life story abilities and the acquisition of cultural life scripts from late middle childhood to adolescence. *Developmental Psychology, 44*(4), 1135-1147. https://dx.doi.org/10.1037/0012-1649.44.4.1135

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health, 11*(4), 589-597. https://doi.org/10.1080/2159676x.2019.1628806

Brown, L. (February 25, 2021). Lexi's legacy: Family fights for better mental health access after losing daughter to suicide. CTV News. https://atlantic.ctvnews.ca/lexi-s-legacy-family-fights-for-better-mental-health-access-after-losing-daughter-to-suicide-1.5324610

Brown, L. D., Berryhill, J. C., & Jones, E.C. (2019). Integrating journalism into health promotion: Creating and disseminating community narratives. *Health Promotion Practice, 20*(4), 513-519. https://dx.doi.org/10.1177/1524839918781334

Brown, D. P., & Elliott, D. S. (2016). *Attachment disturbances in adults: Treatment for comprehensive repair*. W. W. Norton & Company.

Brown, A., Rice, S., Rickwood, D.J., & Parker, A.G. (2015). Systemic review of barriers and facilitators to accessing and engaging with mental health care among at-risk young people. *Asia-Pacific Psychiatry, 8*, 3-22. https://doi.org/10.1111/appy.12199

Buckheim, A., George, C., Gundel, H., Viviani, R (Eds.) (2017). Neuroscience of human attachment. *Frontiers in Human Neuroscience.*

https://www.frontiersin.org/research-topics/3053/neuroscience-of-human-attachment

Calvo, V., D'Aquila, C., Rocco, D., & Carraro, E. (2020). Attachment and well-being: Mediatory roles of mindfulness, psychological flexibility, and resilience. *Current Psychology: A Journal for Diverse Perspectives on Diverse Psychological issues.* https://dx.doi.org/10.1007/s12144-020-00820-2

Carr, K., & Wilder, S. E. (2016). Attachment style and the risks of seeking social support: Variations between friends and siblings. *Southern Communication Journal, 81*(5), 316-329. https://dx.doi.org/10.1080/1041794X.2016.1208266

Castillo, R. J. (1997). *Culture and mental illness: A client centered approach.* Brooks/ Cole Cengage Learning.

Chovil, I. (2004, August 1). Personal accounts: Help-seeking preferences of high school students: The impact of personal narratives. *Psychiatry Online.* Https://dx.doi.org/10.1176/appi.ps.55.8.863

Clandinin, D. J., & Connelly, F. M. (2000). *Narrative inquiry: Experience and story in qualitative research.* Jossey- Bass.

Clements, S., & Paramova, P. (2023). Institutional and psychological predictors of university students' mental health help-seeking intentions. *British Journal of Guidance & Counselling*. https://doi.org/10.1080/03069885.2023.2176823

Corrigan, P. W. (2000). Mental health stigma as social attribution: Implications for research methods and attitude change. *Clinical Psychology: Science and Practice, 7*(1), 48-67. https://dx.doi.org/10.1093/clipsy.7.1.48

Courtney, D. B., & Makinen, J. (2016). Impact of diagnosis disclosure on adolescents with borderline personality disorder. *Journal of the Academy for Child and Adolescent Psychiatry, 25*(3), 177-184.

Cronholm, P. F., Forke, C. M., Wade, R., Bair-Merritt, M. H., Davis, M., Harkins-Schwarz, M., Pachter, L. M., & Fein, J. A. (2015). Adverse childhood experiences: Expanding the concept of adversity. *American Journal of Preventative Medicine, 49*(3), 354-361. https://dx.doi.org/10.1016/j.amepre.2015.02.001

Damon, W. (2004). What is positive youth development? *The Annals of the American Academy, 591*, 13-24. https://dx.doi.org/10.1177/0002716203260092

Dain, N. (1992). Madness and the stigma of sin in American Christianity. In P. J. Fink & A. Tasman (Eds.), *Stigma and mental illness*. (pp.73-84). American Psychiatric Association.

Day, K.L., Smith, C.L., Neal, A., & Dunsmore, J.C. (2018). Private speech moderates the effects of effortful control on emotionality. *Early Education and Development, 29*(2), 161-177. https://doi.org/10.1080/1049289.2017.1379880

DeAngelis, T. (2019, November 1). Better relationships with patients lead to better outcomes. *Monitor on Psychology*, *50*(10). https://www.apa.org/monitor/2019/11/ce-corner-relationships

DeCuir-Gunby, J. uT., Marshall, P. L., McCulloch, A. W. (2011). Developing and using codebook for the analysis of interview data: An example from a professional

development project. *Field Methods, 23*(2), 136-155. https://dx.doi.org/10.1177/1525822X10388468

Denison, J. A., Burke, V. M., Miti, S., Nonyane, B. A. S., Frimpong, C., Merrill, K. G., Abrams, E. A., & Mwansa, J. K. (2020). Project YES! Youth Engaging for Success: A randomized controlled trial assessing the impact of a clinic-based peer mentoring program on viral suppression, adherence, and internalized stigma among HIV-positive youth (15-24 years) in Ndola, Zambia. *PLOS ONE*, *15*(4), e0230703. https://doi.org/10.1371/journal.pone.0230703

Diener, E., Heintzelman, S.J., Kushlev, K., Tay, L., Wirtz, D., Lutes, L.D., & Oishi, S. (2017). Findings all psychologists should know from the new science on subjective well-being. *Canadian Psychology/Psychologie Canadienne, 58*(2), 87-104. https://dx/doi.org/10.1037/cap0000063

DiTommaso, E., Brannen-McNulty, C., Ross, L., & Burgess, M. (2003). Attachment styles, social skills and loneliness in young adults. *Personality and Individual Differences*, *35*(2), 303–312. https://doi.org/10.1016/S0191-8869(02)00190-3

deWolff, M. S., & Ijzendoorn, M.H. (1997). Sensitivity and attachment: A meta-analysis on parental antecedents of infant attachment. *Child Development, 68*(4), 571-591. https://dx.doi.org/10.2307/1132107

Dobson, O., Price, E. L., & DiTommaso, E. (2022). Recollected caregiver sensitivity and adult attachment interact to predict mental health and coping. *Personality and Individual Differences, 187*. https://dx.doi.org/10.1016/j.paid.2021.111398

Edwards, L. (2017). The intrapersonal health determinants, assets, and character strengths of college students and their intentions to seek help for mental health problems [ProQuest Information & Learning]. In Dissertation Abstracts International: Section B: The Sciences and Engineering (Vol. 79, Issue 5-B(E)).

Erikson, E. (1968). *Identity: Youth and crisis*. Norton & Company Inc.

Evans-Lacko, S., London, J., Japhet, S., Rüsch, N., Flach, C., Corker, E., Henderson, C., & Thornicroft, G. (2012). Mass social contact interventions and their effect on mental health related stigma and intended discrimination. *BMC Public Health*, *12*(1), 489. https://doi.org/10.1186/1471-2458-12-489

Faul, F., Erdfelder, E., Lang, A.-G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioural, and biomedical sciences. *Behavior Research methods, 39*, 175-191. https://dx.doi.org/10.3758/BF03193146

Faul, F., Erdfelder, E., Buchner, A., & Lang, A.-G. (2009). Statistical power analyses using G*Power 3.1: Tests for correlation and regression analyses. *Behavior Research Methods*, *41*, 1149-1160. https://dx.doi.org/ 10.3758/BRM.41.4.1149

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P., & Marks, J.S. (2019). REPRINT OF: Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences study. *American Journal of Preventative Medicine, 56*(6), 774-786. https://doi.dox.org/10/1016/j.amepre.2019.04.001

Fitter, M. H., Stern, J. A., Straske, M. D., Allard, T., Cassidy, J., & Riggins, T. (2022). Mothers' attachment representations and children's brain structure. *Frontiers in Human Neuroscience, 16*, 1-18. https://dx.doi.org/10.3389/fnhum.2022.740195

Ford, D. C., Merrick, M. T., Parks, S. E., Breiding, M. J., Gilbert, L. K., Edwards, V. J., Dhingra, S. S., Barile, J. P., & Thompson, W. W. (2014). Examination of the factorial structure of adverse childhood experiences and recommendations for three subscale scores. *Psychology of Violence, 4*(4), 432-444. https://dx.doi.org/10.1037/a0037723

Fraley, R. C., Hudson, N. W., Heffernan, M.E., & Segal, N. (2015). Are adult attachment styles categorical or dimensional? A taxometric analysis of general and relationship specific attachment orientations. *Journal of Personality and Social Psychology, 109*(2), 354-368. https://dx.doi.org/10.1037/pspp0000027

Fredrickson, B. L. (2001). The role of positive emotions in positive psychology: The broaden-and-build theory of positive emotions. *American Psychologist*, *56*(3), 218–226. https://doi.org/10.1037/0003-066X.56.3.218

Gabriel, M.G., Brown, A., Leon, M., & Outley, C. (2020). Power and social control of youth during the COVID-19 pandemic. *Leisure Sciences*, *43*(1-2), 240-246. https://doi.org/10.1080/01490400.2020.1774008

Gaetz, S. (April 2014). https://www.rondpointdelitinerance.ca/blog/housing-first-can-work-young-people-lets-make-sure-we-get-it-right

Gander, M., Karabatsiakis, A., Nuderscher, K., Bernheim, D., Doyen-Waldecker, C., & Buchheim, A. (2022). Secure attachment representation in adolescence buffers

heart-rate reactivity in response to attachment-related stressors. *Frontiers in Human Neuroscience, 16*:806987. https://dx.doi.org/10.3389/fnhum.2022.806987

Garland, A.F. & Zigler, E.F. (1994). Psychological correlates of help-seeking attitudes among children and adolescents. *American Orthopsychiatric Association Inc., 64*(4), 586-593. https://dx.doi.org/10.1037/h0079573

Gibson, L. C. (2015). *Adult children of emotionally immature parents: How to heal from distant, rejecting, or self-involved parents.* New Harbinger Publications Inc.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Prentice-Hall Inc.

Goodall, K. (2015). Individual differences in the regulation of positive emotion: The role of attachment and self-esteem. *Personality and Individual Differences, 74*, 208-213. https://dx.doi.org/10.1016/j.paid.2014.10.033

Granqvist, P. (2021). Attachment, culture, and gene-culture coevolution: Expanding the evolutionary toolbox of attachment theory. *Attachment & Human Development, 23*(1), 90-113. https://dx.doi.org/10.1080/14616734.2019.1709086

Guerrero, L. K., & Jones, S. M. (2005). Differences in conversational skills as a function of attachment style: A follow-up study. *Communication Quarterly, 53*(3), 305-321. https://dx.doi.org/10.1080/01463370500101014

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods, 18*(1), 59-82. https://dx.doi.org/10.1177/1525822X05279903

Habermas, T., & de Silveira, C. (2008). The development of global coherence in life narratives across adolescence: Temporal, causal, and thematic aspects. *Developmental Psychology, 44*(3), 707-721. https://dx.doi.org/10.1037/0012-1649.44.3.707

Habermas, T., & Bluck, S. (2000). Getting a life: The emergence of the life story in adolescence. *Psychological Bulletin, 126*(5), 748-769. https://dx.doi.org/10.1037//0033-2909.126.5.748

Hagstrom, A.S., & Forinder, U. (2019). 'If I whistled in her ear she'd wake up': Children's narration about their experiences of growing up in alcoholic families. *Journal of Family Studies, XXXXXX.* https://doi.org/10.1080/13229400.2019.1699849

Halpern, J., Maunder, R.G., Schwartz, B., Gurevich, M. (2012). Attachment insecurity, responses to critical incident distress, and current emotional symptoms in ambulance workers. *Stress & Health,* 28, 51-60. https://dx.doi.org/10.1002/smi.1401

Hammack, P. L., & Cohler, B. J. (2011). Narrative, identity, and the politics of exclusion: Social change and the gay and lesbian life course. *Sexuality Research & Social Policy: A Journal of the NSRC, 8*(3), 162-182. https://dx.doi.org/10.1007/s13178-011-0060-3

Hammack, P. L., Thompson, E. M., & Pilecki, A. (2009). Configurations of identity among sexual minority youth: Context, desire, and narrative. *Journal of Youth and Adolescence, 38*, 867-883. https://dx.doi.org/10.1007/s10964-008-9342-3

Hammack, P. L., & Toolis, E. E. (2019). The dialogic development of personality: Narrative, culture, and the study of lives. In D. P. McAdams, R. L. Shiner, & J. L. Tackett (Eds.), *Handbook of personality development.*(pp. 465-486). The Guildford press.

Hasford, J., Abbott, K., Alisat, S., Pancer, S.M., & Pratt, M.W. (2017). Community involvement and narrative identity in emerging and young adulthood: A longitudinal analysis. *Identity, 17*(1), 40-54. https://doi.org/10.1080/15283488.2016.1268962

Hays-Grudo, J., Morris, A. S., Beasley, L., Ciciolla, L., Shreffler, K., & Croff, J. (2021). Integrating and synthesizing adversity and resilience knowledge and action: The ICARE model. *American Psychologist, 76*(2), 203-215. https://dx.doi.org/10.1037/amp0000766

Hays-Grudo, J., & Morris, A. S. (2020). *Adverse and protective childhood experiences: A developmental perspective*. American Psychological Association. https://dx.doi.org/10.1037/0000177-000

Heckendorf, E., Huffmeijer, R., Bakersman-Kranenburg, M. J., & van IJzendoorn, M. H. (2016). Neural processing of familiar and unfamiliar children's faces: Effects of experienced love withdrawal, but no effects of neutral and threatening priming. *Frontiers of Neuroscience.* https://dx.doi.org/10.3389/fnhum.2016.00231

Hennink, M. M., Kaiser, B. N. & Weber, M. B. (2019). What influences saturation? Estimating sample size in focus group research. *Qualitative Health Research, 29*(10), 1483-1496. https://dx.doi.org/10.1177/1049732318821692

Hetrick, S.E., Bailey, A.P., Smith, K.E., Malla, A., Mathias, S., Singh, S.P., O'Reilly, A., Verma, S.K., Benoit, L., Fleming, T.M., Moro, M.R., Rickwood, D.J., Duffy, J., Eriksen, T., Illback, R., Fisher, C.A., & McGorry, P.D. (2017). Integrated (one-stop-shop) youth health care: best available evidence and future directions. *The Medical Journal of Australia, 207*(S10), S5-S18. https://dx.doi.org/10.5694/mja17.00694

Howard, A.R.H., Parris, S., Hall, J., S., Call, C.D., Razuri, E.B., Purvis, K.B., & Cross, D.R. (2015). An examination of the relationships between professional quality of life, adverse childhood experiences, resilience, and work environment in a sample of service providers. *Children and Youth Services Review, 57*, 141-148. http://dx.doi.org/10.1016/j.childyouth.2015.08.003

Howe, D. (2009). *A brief introduction to social work theory.* Palgrave MacMillan.

Iyer, S. N., Shah, J., Boksa, P., Lai, S., Joober, R., Andersson, N., Fuhrer, R., Abdel-Baki, A., Beaton, A. M., Reaume-Zimmer, P., Hutt-MacLeod, D., Levasseur, M. A., Chandrasena, R., Rousseau, C., Torrie, J., Etter, M., Valliantos, H., Abba-Aji, A., Bighead, S., MacKinnon, A., & Malla, A. K. (2019). A minimum evaluation protocol and stepped-wedge cluster randomized trial of ACCESS Open Minds, a large Canadian youth mental health services transformation project. *BMC Psychiatry, 19.* https://10.1186/s12888-019-2232-2

Jorm, A. F. (2012). Mental Health Literacy: Empowering the Community to Take Action for Better Mental Health. *American Psychologist*, *67*(3), 231–243. https://doi.org/10.1037/a0025957

Kawamoto, T. (2016). Personality change from life experiences: Moderation effects of attachment security. *Japanese Psychological Research, 58*(2), 218-231. https://dx.doi.org/10.1111/jpr.12110

Kern, M. R., Duinhof, E. L., Walsh, S. D., Cosma, A., Moreno-Maldonado, C., Molcho, M., Currie, C., & Stevens, G. W. J. M. (2020). Intersectionality and Adolescent Mental Well-being: A Cross-Nationally Comparative Analysis of the Interplay Between Immigration Background, Socioeconomic Status and Gender. *Journal of Adolescent Health*, *66*(6, Supplement), S12–S20. https://doi.org/10.1016/j.jadohealth.2020.02.013

Khalil, M., Hollander, P., Raucher-Chene, D., Lepage, M., & Lavigne, K. M. (2022). Structural brain correlates of cognitive function in Schizophrenia: A meta-analysis. *Neuroscience and Biobehavioral Reviews, 132*, 37-49. https://dx.doi.org/10.1016/j.neubiorev.2021.11.034

Khanlou, N., & Wray, R. (2014). A whole community approach toward child and youth resilience promotion: A review of resilience literature. *International Journal of Mental Health and Addiction,12*, 64-79. https://dx.doi.org/10.1007/s11469-013-9470-1

Khenti, A., Bobbili, S. J., & Sapag, J. C. (2019). Evaluation of a pilot intervention to reduce mental health and addiction stigma in primary care settings. *Journal of Community Health: The Publication for Health Promotion and Disease Prevention*, *44*(6), 1204–1213. https://doi.org/10.1007/s10900-019-00706-w

Koller, M., Chen, S-P., Lamantia, A., & Stuart, H. (2013, October). *Opening minds in high school: Results of a contact-based anti-stigma intervention.* Mental health Commission of Canada. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/Stigma_OM_in_High_School_Results_of_a_Contact_based_Anti-stigma_Intervention_Beautiful_Minds_ENG_0.pdf

Kun, P., Han, S., Chen, X., & Yao, L. (2009). Prevalence and risk factors for posttraumatic stress disorder: A cross-sectional study among survivors of the Wenchuan 2008 Earthquake in China. *Depression and Anxiety, 26*, 1134-1140. https://dx.doi.org/10.1002/da.20612

Lafontaine, M. -F., Brassard, A., Lussier, Y., Valois, P., Shaver, P. R., & Johnson, S. M. (2015). Selecting the best items for a short-form of the Experiences in Close Relationships questionnaire. *European Journal of Psychological Assessment*. Advance online publication. https://dx.doi.org/10.1027/1015-5759/a000243

Larose, S., & Bernier, A. (2001). Social support processes: Mediators of attachment state of mind and adjustment in late adolescence. *Attachment & Human Development, 3*(1), 96-120. https://dx.doi.org/10.1080/14616730010024762

Lee, V. W. W., & Murphy, B. P. (2013). Broadening the early intervention paradigm: a one stop shop for youth. *Early Intervention in Psychiatry, 7*, 437-441. https://dx.doi.org/10.1111/eip.12055

Lee, R. M., & Robbins, S. B. (1995). Measuring belongingness: The Social Connectedness and the Social Assurance Scales. *Journal of Counseling Psychology, 42*(2), 232-241. https://dx.doi.org/10.1037/0022-0167.42.2.232

Leese, J., Townsend, A., Li, L., & Backman, C. L. (2021). Moving beyond 'until saturation was reached': Critically examining how saturation is used and reported in qualitative research. *Arthritis Care & Research*, *73*(9), 1225-1227. https://dx.doi.org/10.1002/ACR.24600

Lieblich, A., Tuval-Mashiach, R., & Zilber, T. (1998). *Narrative research: Reading, analysis, and interpretation*. Sage Publications.

Lippold, M. A., Jensen, M., Chase, G. E., Wyman, K., Jenkins, M. R., Mohanty, S., & Bodenmann, G. (2024). Parent strategies to help emerging adults manage stress are associated with their mental health: A dyadic coping perspective. *Family Process*, 00, 1–18. https://dx.doi.org/10.1111/famp.12991

Liu, S.R., Kia-Keating, M., Nylund-Gibson, K., & Barnett, M.L. (2020). Co-occurring youth profiles of adverse childhood experiences and protective factors: Associations with health, resilience, and racial disparities. *American Journal of Community Psychology, 65*, 173-186. https://dx.doi.org/10.1002/ajcp.12387

Liu, L., Pollock, N. J., Contreras, G., Tonmyr, L., & Thompson, W. (2022). Prevalence of suicidal ideation among adults in Canada: Results of the second survey on COVID-19 and mental health [Catalogue no. 82-003-X]. *Statistics Canada Health Reports, 33* (5). https://dx.doi.org/10.25318/82-003-x202200500002-eng

Lux, V., Non, A. L., Pexman, P. M., Stadler, W., Weber, L. A. E., & Kruger, M. (2021). A developmental framework for embodiment research: The next step toward integrating concepts and methods. *Frontiers in Systems Neuroscience, 15*. https://dx.doi.org/10.3389/fnsys.2021.67240

Lynch, L., Moorhead, A., Long, M., & Hawthorne-Steele, I. (2021). What Type of Helping Relationship Do Young People Need? Engaging and Maintaining Young People in Mental Health Care—A Narrative Review. *Youth & Society*, *53*(8), 1376–1399. https://doi.org/10.1177/0044118X20902786

McAdams, D. P., Logan, R. L., & Reischer, H. N. (2022). Beyond the redemptive self: Narratives of acceptance in later life (and in other contexts). *Journal of Research in Personality*, *100*, 1–8. https://doi.org/10.1016/j.jrp.2022.104286

McAdams, D. P., & Jones, B. K. (2017). Making meaning in the wake of trauma: Resilience and redemption. In E. M. Altmaier (Ed.), *Reconstructing meaning after trauma: Theory, research, and practice.* (pp. 3-16). Elsevier Academic Press. https://dx.doi.org/10.1016/B978-0-12-803015-8.00001-2

McAdams, D. P., & Guo, J. (2015). Narrating the generative life. *Psychological science*, *26*(4), 475-483.

McAdams, D. P., & McLean, K. C. (2013). Narrative identity. *Current Directions in Psychological Science*, *22*(3), 233–238. https://doi.org/10.1177/0963721413475622

McAdams, D.P. (2008). Personal narratives and the life story. In John, Robins, & Pervin (Eds.), *Handbook of personality: Theory and research* (3rd ed., pp. 242-262). Guildford Press.

McAdams, D.P. (2001a). The psychology of life stories. *Review of General Psychology, 5*(2), 100-122. https://dx.doi.org/10.1037//1089-2680.5.2.100

McAdams, D. P., Reynolds, J., Lewis, M., Patten, A. H., & Bowman, P. J. (2001b). When bad things turn good and good things turn bad: Sequences of redemption and contamination in life narrative and their relation to psychosocial adaptation in midlife adults and in students. *Personality and Social Psychology Bulletin, 27*(4), 474-485.

McCabe, E., Amarbayan, M. (Megan), Rabi, S., Mendoza, J., Naqvi, S. F., Thapa Bajgain, K., Zwicker, J. D., & Santana, M. (2022). Youth engagement in mental health research: A systematic review. *Health Expectations : An International Journal of Public Participation in Health Care and Health Policy*, *26*(1), 30–50. https://doi.org/10.1111/hex.13650

McLean, K.C., Wood, B., & Breen, A.V. (2013). Reflecting a difficult life: narrative construction in vulnerable adolescents. *Journal of Adolescent Research, 28*(4), 431-452. https://dx.doi.org/10.1177/0743558413484355

McLean, K. C., Breen, A. V., & Fournier, M. A. (2010). Constructing the self in early, middle, and late adolescent boys: Narrative identity, individuation, and well-being. *Journal of Research on Adolescence, 20*(1), 166-187. https://dx.doi.org/10.111/j.1532-7795.2009.00633.x

McLean, K. C., & Pratt, M. W. (2006). Life's little (and big) lessons: Identity statuses and meaning-making in the turning point narratives of emerging adults. *Developmental Psychology, 42*(4), 714-722. https://dx.doi.org/10.1037/0012-1649.42.4.714

McMahan, I., Thompson, S. (2015). *Adolescence.* Pearson.

Ma, K. K. Y., Burn, A.-M., & Anderson, J. K. (2023). Review: School-based mental health literacy interventions to promote help-seeking – a systematic review. *Child and Adolescent Mental Health*, *28*(3), 408–424. https://doi.org/10.1111/camh.12609

Malterud, K., Siersma, V., & Guassora, A. D. (2015). Sample Size in Qualitative Interview Studies: Guided by Information Power. *Qualitative Health Research*, *1*. https://doi.org/10.1177/1049732315617444

Martin, G., & Pear, J. (2019). *Behavior modification: What it is and how to do it*. Routledge.

Martínez-Martínez, C., Sánchez-Martínez, V., Sales-Orts, R., Dinca, A., Richart-Martínez, M., & Ramos-Pichardo, J. D. (2019). Effectiveness of direct contact intervention with people with mental illness to reduce stigma in nursing students. *International Journal of Mental Health Nursing*, *28*(3), 735–743. https://doi.org/10.1111/inm.12578

Mason-Jones, A.J., Crisp, C., Momberg, M., Koech, J., Koker, P.D., & Mathews, C. (2012). A systematic review of the role of school-based healthcare in adolescent sexual, reproductive, and mental health. *Systematic Reviews, 1*(49), 1-12. https://www.systematicreviewsjournal.com/content/1/1/49

Mate, G., & Perry, B. (2022, October 13). *Healing the wounds of trauma* [Conference session]. PESI Institute, Online, Saint John, NB. https://catalog.psychotherapynetworker.org/showtime/16228256?ClassroomTab=courseSchedule_15983880_12_0

Mate, G. (2008). *In the realm of hungry ghosts: Close encounters with addiction.* Vintage Canada.

Matlin, S. L., Champine, R. B., Strambler, M. J., O'Brien, C., Hoffman, E., Whitson, M., Kolka, L., & Tebes, J. K. (2019). A community's response to adverse childhood experiences: Building a resilient, trauma-informed community. *American Journal of Community Psychology, 64*, 451-466. https://dx.doi.org/10.1002/acjp.12386

Mauerhofer, A., Berchtold, A., Michaud, P. A., & Suris, J. C. (2009). GPs' role in the detection of psychological problems of young people: a population-based study. *British journal of general practice*, *59*(566), e308-e314.

Merikangas, K. R., He, J., Burstein, M., Swendsen, J., Avenevoli, S., Case, B., Georgiades, K., Heaton, L., Swanson, S., & Olfson, M. (2011). Service utilization for lifetime mental disorders in US adolescents: Results of the National Comorbidity Survey- Adolescent Supplement (NCSA). *Journal of the American Academy of Child & Adolescent Psychiatry, 50*(1), 32-45. https://dx.doi.org/10.1016/j.jaac.2010.10.006

Mikulincer, M., & Shaver, P. R. (2022). Enhancing the "broaden and build" cycle of attachment security as a means of overcoming prejudice, discrimination, and racism. *Attachment & Human Development, 24*(3), 260-273. https://dx.doi.org/10.1080/14616734.2021.1976921

Mikulincer, M., & R. Shaver, P. (2020). Enhancing the "Broaden and Build" Cycle of Attachment Security in Adulthood: From the Laboratory to Relational Contexts

and Societal Systems. *International Journal of Environmental Research and Public Health*, *17*(6), Article 6. https://doi.org/10.3390/ijerph17062054

Mikulincer, M., & Shaver, P. R. (2016). *Attachment in adulthood: structure, dynamics, and change* (2nd ed.). New York, NY: Guilford Press.

Mikulincer, M., & Shaver, P. R. (2012). An attachment perspective on psychopathology. *World Psychiatry, 11*, 11-15. https://dx.doi.org/10.1016/j.wpsyc.2012.01.003

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change (3rd ed.).* The Guildford Press.

Miller, D. L. (2011). Being called to account understanding adolescents' narrative identity construction in institutional contexts. *Qualitative Social Work, 10*(3), 311-328. https://dx.doi.org/10.1177/1473325011409479

Moreira, H., & Rodrigues Maia, B. (2021). Self-critical rumination as a mediator between attachment orientations and perceived stress: Evidence from a cross-cultural validation of the self-critical rumination scale. *Current Psychology, 40,* 1071-1082. https://dx.doi.org/10.1007/s12144-018-0025-2

Murphy, A., Steele, M., Dube, S. R., Bate, J., Bonuck, K., Meissner, P., Goldman, H., & Steele, H. (2014). Adverse childhood experiences (ACEs) questionnaire and adult attachment interview (AAI): Implications for parent child relationships. *Child Abuse & Neglect, 38*, 224-233. https://dx.doi.org/10.1016/j.chiabu.2013.09.004

Nagy-Pénzes, G., Vincze, F., & Bíró, É. (2020). Contributing Factors in Adolescents' Mental Well-Being—The Role of Socioeconomic Status, Social Support, and

Health Behavior. *Sustainability*, *12*(22), Article 22. https://doi.org/10.3390/su12229597

Negele. A., & Habermas. T. (2013). Self-continuity across developmental change in and of repeated life narratives. In K. C. McLean & M. Pasupathi (Eds.) *Narrative development in adolescence: Creating the storied self* (pp. 1-21). *In Advancing Responsible Adolescent Development series*. Springer.

Noble-Carr, D., Barker, J., McArthur, M., & Woodman, E. (2014). Improving practice: The importance of connections in establishing positive identity and meaning in the lives of vulnerable young people. *Children and Youth Services Review*, *47*, 389–396. https://doi.org/10.1016/j.childyouth.2014.10.017

Norris, S., Norris, M. L., Sibbald, E., Aubry, T., Harrison, M. E., Lafontaine, G., & Ghandi, J. (2016). Demographic characteristics associated with pregnant and postpartum youth referred for mental health services in a community outreach center. *Journal of the Canadian Academy of Child and Adolescent Psychiatry/ Journal de l'Académie Canadienne de Psychiatrie de l'enfant et de l'adolescent, 25*(3), 152-158

Nowell, L.S., Norris, J.M., White, D.E., & Moules, N.J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International journal of Qualitative Methods, 16,* 1-13. https://dx.doi.org/10.1177/1609406917733847

Office of the Child and Youth Advocate. (June 2022). *State of the Child 2022*. ISBN: 978-1-4605-3145-7

Office of the Child and Youth Advocate. (May 2022). *Through their eyes*. ISBN: 978-1-4605-3107-5

Office of the Child and Youth Advocate. (September, 2021). *The best we have to offer*. Final report on the youth suicide prevention and mental health services review. https://static1.squarespace.com/static/60340d12be1db058065cdc10/t/6141d16324d76514ebbe80ba/1631703401535/The+Best+We+Have+to+Offer.pdf

Office of the Child and Youth Advocate. (November 2020). *State of the child report 2020*. ISBN: 978-1-4605-2679-8

Onwuegbuzie, A. J., Frels, R. K., & Hwang, E. (2016). Mapping Saldana's coding methods onto the literature review process. *Journal of Educational Issues, 2*(1), 130-150. https://files.eric.ed.gov/fulltext/EJ1127478.pdf

Ovenstad, K. S., Ormhaug, S. M., Shirk, S. R., & Jensen, T. K. (2020). Therapists' behaviors and youths' therapeutic alliance during trauma-focused cognitive behavioral therapy. *Journal of Consulting and Clinical Psychology, 88*(4, 350-361. https://dx.doi.org/10.1037/ccp0000465

Pasupathi, M., & MacLean, K. C. (2013). Self-continuity across developmental change in and of repeated life narratives. In K. C. McLean & M. Pasupathi (Eds.) *Narrative development in adolescence: Creating the storied self* (pp. xix-xxxii). *In Advancing Responsible Adolescent Development series*. Springer.

Pasupathi, M., Mansour, E., & Brubaker, J. R. (2007). Developing a life story: Constructing relations between self and experience in autobiographical

narratives. *Human Development*, *50*(2-3), 85-110. https://dx.doi.org/10.1159/000100939

Patel, R., & MacKenzie, M. (October 19, 2017). *Finding hope in the opioid crisis* [Conference session]. Mental Health Promotion Committee of Southern Alberta, Lethbridge, Alberta, Canada.

Pennbaker, J.W., & Seagal, J.D. (1999). Forming a story: The health benefits of narrative. *Journal of Clinical Psychology, 55*(10), 1243-1254. https://doi.org/10.1002/(SICI)1097-4679(199910)55:10<1243::AID-JCLP6>3.0.CO;2-N

Penuel, W.R., & Wertsch, J.V. (1995). Vygotsky and identity formation: A sociocultural approach. *Educational Psychologist, 30*(2), 83-92. https://doi.org/10.1207/s15326985ep3002_5

Planey, A. M., Smith, S. M., Moore, S., & Walker, T. D. (2019). Barriers and facilitators to mental health help-seeking among African American youth and their families: A systematic review study. *Children and Youth Services Review,101,*190-200. https://dx.doi.org/10.1016/j.childyouth.2019.04.001

Price, M. A., & Hollinsaid, N. L. (2022). Future directions in mental health treatment with stigmatized youth. *Journal of Clinical Child and Adolescent Psychology*, *51*(5), 810–825. https://doi.org/10.1080/15374416.2022.2109652

Radez, J., Reardon, T., Creswell, C., Lawrence, P. J., Evdoka-Burton, G., & Waite, P. (2021). Why do children and adolescents (not) seek and access professional help for their mental health problems? A systematic review of quantitative and

quantitative studies. *European Child & Adolescent Psychiatry, 30*, 183-211. https://dx.doi.org/10.1007/s00787-019-01469-4

Reisberg, D. (2019). *Cognition: Exploring the science of the mind* (7th ed.). Norton & Company.

Rholes, W. S., & Simpson, J. A. (2004). Attachment theory: Basic concepts and contemporary questions. In W.S. Rholes and J. A. Simpson (Eds.) *Adult Attachment: Theory, Research, and Clinical Implications* (1st Ed., 3-14). New York, NY: Guildford.

Rickwood, D. J., Mazzer, K. R., & Telford, N. R. (2015). Social influences on seeking help from mental health services, in- person and online, during adolescence and young adulthood. *BMC Psychiatry, 15*(40). https://dx.doi.org/10.1186/s12888-015-0429-6

Rickwood, D., Deane, F. P., Wilson, C. J., & Ciarrochi, J. (2005). Young people's help-seeking for mental health problems. *AeJAMH (Australian e-Journal for the Advancement of Mental Health), 4*(3). https://dx.doi.org/10.5172/jamh.4.3.218

Roeschley, A., & Kim, J. (2019). "Something that feels like a community": The role of personal stories in building community-based participatory archives. *Archival Science*, *19*(1), 27–49. https://doi.org/10.1007/s10502-019-09302-2

Rosenthal, G. (1993). Reconstruction of life stories: Principles of selection in generating stories for narrative biographical interviews. *The narrative study of lives*, *1*(1), 59-91.

Ross, D. A., Hinton, R., Melles-Brewer, M., Engel, D., Zeck, W., Fagan, L., Herat, J., Phaladi, G., Imbago-Jacome, D., Anyona, P., Sanchez, A., Damji, N., Terki, F., Baltag, V., Patton, G., Silverman, A., Fogstad, H., Banerjee, A., Mohan, A. M. (2020). Adolescent well-being: A definition and conceptual framework. *Journal of Adolescent Health, 67*, 472-476. https://dx.doi.org/10.1016/j.jadohealth.2020.06.042

Saldana, J. (2021). *The coding manual for qualitative researchers* (4th ed.). Thousand Oaks, CA: Sage.

Saltzman, L.Y., Hansel, T.C., & Bordnick, P.S. (2020). Loneliness, isolation, and social support factors in post-covid-19 mental health. *Psychological Trauma: Theory, Research, Practice, and Policy, 12,* S55-S57. http://dx.doi.org/10.1037/tra0000703

Sandage, S. J. (2012). The tragic-ironic self: A qualitative case study of suicide. *Psychoanalytic Psychology, 29*(1), 17-33. https://dx.doi.org/10.1037/a0024897

Sarma, U.A., & Thomas, T.M. (2020). Breaking the limits of executive functions: Towards a sociocultural perspective. *Culture & Psychology, 26*(3), 358-368. https://dx.doi.org/10.1177/1354067X19898673

Saunders, S.M., Resnick, M.D., Hoberman, H.M., & Blum, R.W. (1994). Formal help-seeking behavior of adolescents identifying themselves as having mental health problems. *Journal of the Academy of Child and Adolescent Psychiatry, 33*(5), 718-728. https://dx.doi.org/10.1097/00004583-199406000-00013

Schnitker, S.A., King, P.E., & Houltberg, B. (2019). Religion, spirituality, and thriving: Transcendent narrative, virtue, and telos. *Journal of Research on Adolescence, 29*(2), 276-290. https://dx.doi.org/10.1111/jora.12443

Schnall, S., Harber, K. D., Stefanucci, J. K., & Proffitt, D. R. (2008). Social support and the perception of geographical slant. *Journal of Experimental Social Psychology*, *44*(5), 1246–1255. https://doi.org/10.1016/j.jesp.2008.04.011

Sears, H. A. (2020). Adolescents' first choice for help: Distinguishing characteristics of youth who select a friend, a parent, or no one. *J Youth Adolescence, 49*, 1731-1746. https://dx.doi.org/10.1007/s10964-020-01241-x

Shrier, A. (2020). *Irreversible damage: The transgender craze seducing our daughters.* Regnery Publishing. (5), 619-634. https://dx.doi.org/10.1080/13645579.2018.1454643

Sim, J., Saunders, B., Waterfield, J., & Kingstone, T. (2018). Can sample size in qualitative research be determined a priori? *International Journal of Social Research Methodology, 21*(5), 619-634. https://dx.doi.org/10.1080/13645579.2018.1454643

Smith, E. R., Murphy, J., & Coats, S. (1999). Attachment to groups: Theory and management. *Journal of Personality and Social Psychology*, *77*(1), 94–110. https://doi.org/10.1037/0022-3514.77.1.94

Stefanucci, J. K., Proffitt, D. R., Banton, T., & Epstein, W. (2005). Distances appear different on hills. *Perception & Psychophysics*, *67*(6), 1052–1060. https://doi.org/10.3758/BF03193631

Soucie, K.M., Lawford, H., & Pratt, M.W. (2012). Personal stories of empathy in adolescence and emerging adulthood. *Merrill-Palmer Quarterly, 58*(2), 141-158. https://dx.doi.org/10.1353/mpq.2012.0010

Srebnik, D., Cauce, A.M., & Baydar, N. (1996). Help-seeking pathways for children and adolescents. *Journal of Emotional and Behavioral Disorders, 4*(4), 210-220. https://dx.doi.org/10.1177/106342669600400202

Statistics Canada. (2022). Table 13-10-0096-18 Mood disorders, by age group. https://dx.doi.org/10.25318/1310009601-eng

Statistics Canada. (2021, September 8). Self-perceived mental health and mental health care needs during the COVID-19 pandemic [Catalogue no. 45-28-001]. https://www150.statcan.gc.ca/n1/en/pub/45-28-0001/2021001/article/00031-eng.pdf?st=s9rOpU1o

Statistics Canada. (2021, February 1). *Health of Youth in Canada* [Press Release]. https://www150.statcan.gc.ca/n1/daily-quotidien/210201/dq210201b-eng.htm

St-Pierre, M. & Beland, Y. (2004). Mode effects in the Canadian community health survey: A comparison of CAPI and CATI. *2004 Proceedings of the American Statistical Association Meeting, Survey Research Methods, Toronto Canada: American Statistical Association.*

Stevens, J., Kelleher, K.J., Ward-Estes, J., & Hayes, J. (2006). Perceived barriers to treatment and psychotherapy attendance in child community mental health centers. *Community Mental Health Journal, 42*(5). https://dx.doi.org/10.1007/s10597-006-9048-5

Strand, P. S., Vossen, J. J., & Savage, E. (2019). Culture and child attachment patterns: A behavioural systems synthesis. *Perspectives on Behavior Science, 42*, 835-850. https://dx.doi.org/10.1007/s40614-019-00220-3

Taylor, L. K., & Weems, C. F. (2009). What do youth report as a traumatic event? Toward a developmentally informed classification of traumatic stressors. *Psychological trauma: Theory, Research, Practice, and Policy, 1*(2), 91-106. https://dx.doi.org/10.1037/a0016012

Teagle, S. E. (2002). Parental problem recognition and child mental health service use. *Mental Health Services Research, 4*(4), 257-266. https://dx.doi.org/10.1023/A:1020981019342

Thakur, V., & Jain, A. (2020). COVID 2019- suicides: A global psychological pandemic. *Brain, Behaviour, and Immunity, 88*952-953. https://dx.doi.org/10.1016/j.bbi.2020.04.062

Thomson, P., & Jaque, S.V. (2017). Adverse childhood experiences (ACE) and adult attachment interview (AAI) in a non-clinical population. *Child Abuse & Neglect, 70*, 255-263. https://dx.doi.org/ 10.1016/j.chiabu.2017.06.001

Tops, M., Boksen, M. A. S., Quirin, M., IJzerman, H., & Koole, S. L. (2014). Internally directed cognition and mindfulness: An integrative perspective derived from predictive and reactive control systems theory. *Frontiers in Psychology, 5*, 121. https://dx.doi.org/10.3389/fpsyg.2014.00429

Torrey, E. F. (2006). *Surviving schizophrenia: A manual for families, patients, and providers*. Collins.

Turner, H. A., Finkelhor, D., Mitchell, K. J., Jones, L. M., & Henly, M. (2020). Strengthening the predictive power of screening for adverse childhood experiences (ACEs) in younger and older children: Child Abuse & Neglect. *Child Abuse & Neglect*, *107*. https://doi.org/10.1016/j.chiabu.2020.104522

Upadhyay, I. S., Srivatsa, KV. A., Mamidi, R. (2022). Towards toxic positivity detection. In *Proceedings of the Tenth International Workshop on Natural Language Processing for Social Media* (pp. 75-82).

Valenti, M., Celedonia, K. L., Wall-Parker, A., & Strickler, A. (2020). Trust is essential: Identifying trust building techniques from youth providers across the service array. *Children and Youth Services Review*, *117*, 105295. https://doi.org/10.1016/j.childyouth.2020.105295

Vieira, M., Silva, B. F., & Ribeiro, J. S. (2023). Internalized stigma – how we view our mental illness. *European Psychiatry*, *66*(S1), S1032–S1032. https://doi.org/10.1192/j.eurpsy.2023.2190

Vierthaler, J. M., & Elliott, E. C. (2022). A shared lived experience of a psychologist battling a mental health crisis. *Psychological Services, 19*(1), 46-48. https://dx.doi.org/10.1037/ser0000489

Walker, C. J., Williams, C. D., Hood, K. B., & Lozada, F. T. (2024). Narrative Review: Examining the Associations Between Ethnic-Racial Identity and Mental Health Outcomes Among African American Emerging Adults and Adults. *Identity*, *0*(0), 1–21. https://doi.org/10.1080/15283488.2024.2320431

Wang, P. S., Angermeyer, M., Borges, G., Bruffaerts, R., Chiu, W. T., De Girolamo, G., ... & Uestuen, T. B. (2007). Delay and failure in treatment seeking after first onset of mental disorders in the World Health Organization's World Mental Health Survey Initiative. *World psychiatry*, *6*(3), 177.

Webb, E. (2021, September 9). *Managing suicidality with high-crisis DBT clients*. [Conference Session]. PESI, Saint John, NB, online.

Weems, C. F., Russel, J. D., Herringa, R. J., & Carrion, V. G. (2021). Translating the neuroscience of adverse childhood experiences to inform policy and foster population-level resilience. *American Psychologist, 76*(2), 188-202. https://dx.doi.org/10.1037/amp0000780

Weems, C. F., Russel, J. D., Neill, E. L., & McCurdy, B. H. (2019). Annual research review: Pediatric posttraumatic stress disorder from a neurodevelopmental network perspective. *Journal of Child Psychology and Psychiatry, 60*(4), 395-408. https://dx.doi.org/10.1111/jcpp.12996

Wilson, C. J., Deane, F. P., Ciarrochi, J., & Rickwood, D. (2005a). General Help Seeking Questionnaire [Database Record]. Retrieved from PsycTESTS. https://dx.doi.org/10.1037/t42876-000

Wilson, C J., Deane, F. P., Ciarrochi, J., & Rickwood, D. (2005b). Measuring help-seeking intentions: Properties of the General Help-Seeking Questionnaire. *Canadian Journal of Counselling, 39*(1), 15-28.

Woodhall-Melnik, J., Hamilton-Wright, S., Hamilton-Wright, E., Guilcher, S. J. T., & Matheson, F. I. (2022). Getting help: Findings from Two World Cafes with Youth

who experience homelessness. *Canadian Journal of Family and Youth/ Le Journal Canadien de Famille et de la Juenesse, 14*(3), 52-77.

Woods-Jaeger, B. A., Cho, B., Sexton, C. C., Slagel, L., & Goggin, K. (2018). Promoting resilience: Breaking the intergenerational cycle of adverse childhood experiences. *Health Education and Behavior, 45*(5), 772-780. https://dx.doi.org/10.1177/1090198117752785

Young, M. (2017). *Learning the Art of Helping: Building blocks and Techniques (6th ed.)*. Pearson.

Table 1

Descriptive statistics of demographics of study sample

	N	*M*	*Mdn*	*SD*	*Min*	*Max*	*f*	%
Age	166	22.31	21	3.24	19	31		
Gender	170							
Male							53	31.20
Female							110	64.70
Non-Binary							5	2.90
Prefer not to say							1	0.60
Transgender male							1	0.60
Sexual Orientation	170							
Heterosexual							124	72.90
Lesbian							7	4.10
Gay							3	1.80
Bisexual							21	12.40
Questioning/Unsure							3	1.80
Asexual							6	3.50
Pansexual							1	0.60
Prefer not to say							5	2.90
Previously sought help from mental health professional	170							
Yes							101	59.40
No							69	40.60

Number of previous visits	135	7.99	15.96	0	100
Helpfulness rating of previous visits	151	3.40	1.20	1	5

Table 2

Descriptive statistics for General Help-Seeking Scale

Variable	*N*	*M*	*SD*	Min	Max
GHHSMean	168	3.85	0.93	1.86	7
GHHSINF	169	4.75	1.13	1.33	7
GHHSFOR	169	3.16	1.36	1	7

Note. GHHSMean = Total Score for future help-seeking intentions, GHHSINF = Informal help-seeking Intentions, GHHSFOR = Formal help-seeking intentions

Table 3

Descriptive Statistics for individual items of the GHHS

Source of support	*N*	*M*	*SD*	Min	Max
Partner	169	5.07	1.99	1	7
Friend	170	4.84	1.60	1	7
Family	170	4.30	1.87	1	7
Mental Health Professional	169	3.83	1.84	1	7
Phone Help Line	170	2.54	1.77	1	7
Family Doctor	170	3.53	1.75	1	7
Teacher	170	2.73	1.80	1	7
No One	170	3.19	1.82	1	7

Note. GHHS= General Help-Seeking Scale

Table 4

Type of professionals seen by participants when seeking help

Type of Professional	*f*	%
Counsellor	5	2.90
Family doctor	1	0.60
University Counsellor	1	0.60
Therapist	5	2.90
Psychologist	32	18.80
Psychiatrist	6	3.50
School Counsellor	23	13.50
Unsure	2	1.20
School Counsellor & Psychiatrist	2	1.20
Psychiatrist & Psychologist	1	0.60
Psychologist & Therapist	2	1.20
Addiction Counsellor & Therapist	1	0.60
Counsellor & Psychiatrist	1	0.60
Counsellor & Therapist	1	0.60
Doctor & Counselor	1	0.60
School Counselor & Psychologist	8	4.70
School Counselor & Therapist	2	1.20

Marriage & Family counselor	1	0.60
Psychiatrist & Psychologist & Counsellor	2	1.20
Psychologist & Psychiatrist & Therapist	2	1.20
Child psychiatrist & School Counselor & Therapist	1	0.60
Counselor & Therapist & Social Worker	1	0.60
Counselor & Psychologist & Psychiatrist & Neurologist	1	0.60
Doctor & Therapist & Psychiatrist & Guidance Counselor	1	0.60

Table 5

Descriptive statistics for Adverse Childhood Experiences Checklist, Experiences in Close Relationships 12- item Scale

Variable	*N*	*M*	*SD*	Min	Max
ACE checklist					
ACETOTAL	168	3.76	3.32	0	14
ECR-12					
Anxiety	169	4.59	1.30	1	6.83
Avoid	170	3.39	1.11	1.17	7

Note. ACETOTAL = Total ACE Score

Table 6

Correlation matrix of relationships between individual items of the GHHS, ACE, and ECR-12 sub-scales

	Variable	1	2	3	4	5	6	7	8	9	10	11	12
1	Partner	1											
2	Friend	.10	1										
3	Family	-.09	.29**	1									
4	MHP	.13	-.06	.00	1								
5	PHL	-.06	.00	.11	.45**	1							
6	Family Dr	.04	.08	.09	.40**	.49**	1						
7	Teacher	.02	-.18*	.11	.36**	.54**	.37**	1					
8	No One	-.08	-.13	-.21**	-.09	.07	.02	-.04	1				
9	GHHSFOR	.05	-.05	.09	.74**	.82**	.74**	.75**	-.02	1			
10	ACETOT	-.01	-.07	-.29**	.11	.14	.05	.03	.25**	.11	1		
11	Anxiety	.15	-.06	-.23**	.15	.01	.06	.02	.06	.09	.21**	1	
12	Avoid	-.23**	-.28**	-.33**	-.11	-.10	-.18*	-.11	.42**	-.16*	.33**	.02	1

Note. MHP = mental health professional, PHL = Phone help line, ACETOT = Total ACE score, Anxiety = ECR-12 Anxiety sub-scale, Avoid = ECR-12 Avoidance sub-scale, GHHSFOR = Formal sources of support

N ranged from 133-170.

*p<.05. **p<.01

Table 7

Multiple regression of narrative type predicting intention to seek help from a partner

Predictor	*B*	*Std. error*	*β*	*t*	*Sig.*	R^2	R^2_{change}	F_{Change}	F_{Change} *Sig*
Step 1						.01	.01	1.01	.367
Age	-0.04	0.05	-.06	-0.69	.491				
Gender	0.36	0.37	.09	0.96	.340				
Step 2						.02	.01	0.55	.580
Redemptive	-0.39	0.43	-.09	-0.91	.362				
Tragic	-0.02	0.39	-.01	-0.05	.963				

Note. Narrative type dummy coded; Reference category = Progressive narrative type.

Table 8

Multiple regression with the ability of narrative type on predicting intention to seek help from a friend

Predictor	*B*	*Std. error*	*β*	*t*	*Sig.*	R^2	R^2 *change*	F_{Change}	F_{Change} *Sig*
Step 1						.02	.02	1.13	.336
Age	-0.01	0.04	-.01	-0.10	.917				
Gender	0.43	0.31	.12	1.40	.165				
Step 2						.02	.00	0.26	.770
Redemptive	0.26	0.36	.07	0.72	.475				
Tragic	0.16	0.33	.05	0.47	.637				

Note. Narrative type dummy coded; Reference category = Progressive narrative type

Table 9

Multiple regression of narrative type predicting intention to seek help from family

Predictor	*B*	*Std. error*	*β*	*t*	*Sig.*	R^2	R^2_{change}	F_{Change}	F_{Change} *Sig*
Step 1						.01	.01	0.84	.435
Age	-0.00	0.05	-.00	-0.02	.983				
Gender	-0.45	0.36	-.11	-1.24	.218				
Step 2						.21	.03	2.31	.103
Redemptive	0.11	0.42	.03	0.25	.801				
Tragic	-0.64	0.38	-.17	-1.68	.095				

Note. Narrative type dummy coded; Reference category = Progressive narrative type

Table 10

Multiple regression of narrative type predicting intention to seek help from formal sources of support

Predictor	*B*	*Std. error*	*β*	*t*	*Sig.*	R^2	R^2_{change}	F_{Change}	F_{Change} *Sig*
Step 1						.17	.17	14.64	<.001
Age	0.17	0.03	.40	4.98	<.001				
Gender	-0.12	0.23	-.04	-0.52	.605				
Step 2						.19	.01	1.13	.327
Redemptive	-0.23	0.27	-.08	-0.85	.399				
Tragic	-0.34	0.25	-.14	-1.50	.136				

Note. Narrative type dummy coded; Reference category = Progressive narrative type

Table 11

Multiple regression of narrative type predicting intention to not seek help from anyone

Predictor	*B*	*Std. error*	*β*	*t*	*Sig.*	R^2	R^2_{change}	F_{Change}	F_{Change} *Sig*
Step 1						.05	.05	3.39	.036
Age	0.01	0.05	.02	0.18	.858				
Gender	0.87	0.34	.22	2.53	.013				
Step 2						.16	.12	9.70	<.001
Redemptive	0.14	0.38	.04	0.38	.705				
Tragic	-1.22	0.34	-.33	-3.53	<.001				

Note. Narrative type dummy coded; Reference category = Progressive narrative type

Table 12

Multiple regression of narrative type predicting intention to not seek help from anyone

Predictor	B	*Std. error*	β	t	*Sig.*	R^2	R^2_{change}	F_{Change}	F_{Change} *Sig*
Step 1						.05	.05	3.39	.036
Age	0.01	0.05	.02	0.18	.858				
Gender	0.87	0.34	.22	2.53	.013				
Step 2						.16	.12	9.70	<.001
Progressive	0.14	0.38	-.04	-0.38	.705				
Tragic	-1.36	0.35	-.37	-3.85	<.001				

Note. Narrative type dummy coded; Reference category = Redemptive narrative type

Table 13

Multiple regression of narrative type predicting attachment anxiety

Predictor	*B*	*Std. error*	*β*	*t*	*Sig.*	R^2	R^2_{change}	F_{Change}	F_{Change} *Sig*
Step 1						.07	.07	5.42	.005
Age	0.02	0.03	.06	0.66	.513				
Gender	0.78	0.24	.28	3.27	.001				
Step 2						.11	.04	3.08	.049
Redemptive	0.49	0.27	.17	1.78	.077				
Tragic	0.60	0.25	.23	2.41	.017				

Note. Narrative type dummy coded; Reference category = Progressive narrative type

Table 14

Multiple regression of narrative type predicting attachment anxiety

Predictor	*B*	*Std. error*	*β*	*t*	*Sig.*	R^2	R^2_{change}	F_{Change}	F_{Change} *Sig*
Step 1						.07	.07	5.42	.005
Age	0.02	0.03	.06	0.66	.513				
Gender	0.78	0.24	.28	3.27	.001				
Step 2						.11	.04	3.08	.049
Progressive	-0.49	0.27	-.18	-1.78	.077				
Tragic	0.11	0.26	.04	0.44	.659				

Note. Narrative type dummy coded; Reference category = Redemptive narrative type

Table 15

Multiple regression of narrative type predicting attachment avoidance

Predictor	*B*	*Std. error*	*β*	*t*	*Sig.*	R^2	R^2_{change}	F_{Change}	F_{Change} *Sig*
Step 1						.00	.00	0.05	.948
Age	-0.01	0.03	-.02	-0.19	.848				
Gender	-0.06	0.20	-.03	-0.31	.758				
Step 2						.03	.03	2.28	.106
Redemptive	0.26	0.24	.11	1.11	.269				
Tragic	0.46	0.22	.21	2.14	.034				

Note. Narrative type dummy coded; Reference category = Progressive narrative type

Table 16

Hierarchal multiple regression of narrative type, ACEs, and attachment pattern predicting intentions to seek help from a partner

Predictor	*B*	*Std. error*	*β*	*t*	*Sig.*	R^2	R^2_{change}	F_{Change}	F_{Change} *Sig*
Step 1						.02	.02	1.05	.353
Age	-0.04	0.05	-.06	-0.70	.485				
Gender	0.37	0.38	.09	0.98	.327				
Step 2						.02	.00	2.84	.784
ACETOT	-.01	0.05	-.02	-0.28	.784				
Step 3						.06	.04	2.84	.062
Anxiety	0.15	0.14	.10	1.10	.274				
Avoid	-0.34	0.16	-.18	-2.11	.037				
Step 4						.07	.01	0.75	.475
Redemptive	-0.41	0.44	-.09	-0.94	.351				
Tragic	0.07	0.41	.02	0.17	.866				

Note. Narrative type dummy coded; Reference category = Progressive narrative type

Table 17

Hierarchal multiple regression of narrative type, ACEs, and attachment pattern predicting intentions to seek help from a friend

Predictor	*B*	*Std. error*	*β*	*t*	*Sig.*	R^2	R^2_{change}	F_{Change}	F_{Change} *Sig*
Step 1						.02	.02	1.10	.336
Age	-0.00	0.04	-.01	-0.10	.925				
Gender	0.43	0.31	.12	1.38	.169				
Step 2						.02	.00	1.36	.712
ACETOT	-0.02	0.04	-.03	-0.37	.712				
Step 3						.08	.07	4.99	.008
Anxiety	-0.12	0.11	-.09	0.68	.497				
Avoid	-0.40	0.13	-.26	-2.98	.003				
Step 4						.09	.01	0.74	.479
Redemptive	0.37	0.36	.10	1.03	.303				
Tragic	0.37	0.03	.11	1.09	.276				

Note. Narrative type dummy coded; Reference category = Progressive narrative type

Table 18

Hierarchal multiple regression of narrative type, ACEs, and attachment pattern predicting intentions to seek help from family

Predictor	*B*	*Std. error*	*β*	*t*	*Sig.*	R^2	R^2 *change*	F_{Change}	F_{Change} *Sig*
Step 1						.02	.02	1.02	.365
Age	-0.00	0.05	-.00	-0.02	.981				
Gender	-0.50	0.36	-.12	-1.37	.174				
Step2						.08	.06	9.12	.003
ACETOT	-0.15	0.05	-.25	-3.02	.003				
Step 3						.16	.08	6.55	.002
Anxiety	-0.26	0.13	-.18	-2.07	.041				
Avoid	-0.44	0.15	-.24	-2.96	.004				
Step 4						.17	.02	1.25	.289
Redemptive	0.42	0.40	.10	1.03	.304				
Tragic	-0.17	0.37	-.05	-0.47	.643				

Note. Narrative type dummy coded; Reference category = Progressive narrative type

Table 19

Hierarchal multiple regression of narrative type, ACEs, and attachment pattern predicting intentions to seek help from a mental health professional

Predictor	*B*	*Std. error*	*β*	*t*	*Sig.*	R^2	R^2_{change}	F_{Change}	F_{Change} *Sig*
Step 1						.07	.07	5.19	.007
Age	0.16	0.05	.27	3.16	.002				
Gender	0.12	0.35	.03	0.35	.729				
Step 2						.08	.01	0.94	.335
ACETOT	0.05	0.05	.08	0.97	.335				
Step 3						.11	.03	2.49	.087
Anxiety	0.10	0.13	.07	0.77	.442				
Avoid	-0.31	0.15	-.18	-2.09	.039				
Step 4						.13	.02	1.75	.177
Redemptive	0.31	0.41	.07	.766	.445				
Tragic	-0.39	0.38	-.10	-1.04	.300				

Note. Narrative type dummy coded; Reference category = Progressive narrative type.

Table 20

Hierarchal multiple regression of narrative type, ACEs, and attachment pattern predicting intentions to seek help from a phone help line

Predictor	*B*	*Std. error*	*β*	*t*	*Sig.*	R^2	R^2_{change}	F_{Change}	F_{Change} *Sig*
Step 1						.13	.13	10.70	<.001
Age	0.17	0.04	.31	3.77	<.001				
Gender	-0.44	0.31	-.12	-1.42	.157				
Step 2						.15	.01	1.79	.183
ACETOT	0.06	0.04	.11	1.34	.183				
Step 3						.17	.02	1.71	.185
Anxiety	0.04	0.12	.03	0.35	.730				
Avoid	-0.24	0.13	-.15	-1.82	.071				
Step 4						.17	.01	0.57	.570
Redemptive	-0.25	0.37	-.06	-0.68	.499				
Tragic	-0.36	0.34	-.10	-1.05	.294				

Note. Narrative type dummy coded; Reference category = Progressive narrative type

Table 21

Hierarchal multiple regression with the ability of narrative type, ACEs, and attachment pattern on predicting intentions to seek help from a family doctor

Predictor	*B*	*Std. error*	*β*	*t*	*Sig.*	R^2	R^2_{change}	F_{Change}	F_{Change} *Sig*
Step 1						.05	.05	3.47	.034
Age	0.12	0.05	.22	2.52	.013				
Gender	0.01	0.33	.00	0.03	.978				
Step 2						.05	.01	0.87	.353
ACETOT	0.04	0.05	.08	0.93	.353				
Step 3						.08	.03	1.93	.149
Anxiety	0.01	0.12	.00	0.04	.969				
Avoid	-0.28	0.14	-.17	-1.96	.052				
Step 4						.08	.00	0.27	.764
Redemptive	0.02	0.39	.01	0.06	.956				
Tragic	-0.22	0.36	-.06	-0.59	.556				

Note. Narrative type dummy coded; Reference category = Progressive narrative type

Table 22

Hierarchal multiple regression of narrative type, ACEs, and attachment pattern predicting intentions to seek help from a teacher

Predictor	*B*	*Std. error*	*β*	*t*	*Sig.*	R^2	R^2_{change}	F_{Change}	F_{Change} *Sig*
Step 1						.18	.18	15.59	<.001
Age	0.23	0.04	.41	5.08	<.001				
Gender	-0.22	0.31	-.06	-0.69	.492				
Step 2						.18	.00	0.00	.980
ACETOT	-0.00	0.04	-.00	-0.03	.980				
Step 3						.19	.01	0.43	.649
Anxiety	0.01	0.12	.01	0.10	.919				
Avoid	-0.03	0.14	-.07	-0.93	.356				
Step 4						.23	.04	3.33	.039
Redemptive	-0.95	0.37	-.23	-2.57	.011				
Tragic	-0.55	0.34	-.15	-1.59	.114				

Note. Narrative type dummy coded; Reference category = Progressive narrative type

Table 23

Hierarchal multiple regression of narrative type, ACEs, and attachment pattern predicting intentions to seek help from a teacher

Predictor	*B*	*Std. error*	*β*	*t*	*Sig.*	R^2	R^2_{change}	F_{Change}	F_{Change} *Sig*
Step 1						.18	.18	15.59	<.001
Age	0.23	0.04	.41	5.08	<.001				
Gender	-0.22	0.31	-.06	-0.69	.492				
Step 2						.18	.00	0.00	.980
ACETOT	-0.00	0.04	-.00	-0.03	.980				
Step 3						.19	.01	0.43	.649
Anxiety	0.01	0.12	.01	0.10	.919				
Avoid	-0.13	0.14	-.07	-0.93	.356				
Step 4						.23	.04	3.33	.039
Progressive	0.95	0.37	.25	2.57	.011				
Tragic	0.40	0.35	.11	1.16	.247				

Note. Narrative type dummy coded; Reference category = Redemptive narrative type

Table 24

Hierarchal multiple regression of narrative type, ACEs, and attachment pattern predicting intentions to not seek help from anyone

Predictor	*B*	*Std. error*	*β*	*t*	*Sig.*	R^2	R^2_{change}	F_{Change}	F_{Change} *Sig*
Step 1						.04	.04	3.18	.045
Age	-0.01	0.05	-.02	-0.19	.851				
Gender	-0.85	0.35	-.21	-2.46	.015				
Step 2						.11	.07	10.54	.001
ACETOT	0.15	0.05	.27	3.25	.001				
Step 3						.24	.12	10.92	<.001
Anxiety	0.05	0.12	.03	0.39	.700				
Avoid	0.64	0.14	.36	4.66	<.001				
Step 4						.31	.07	7.16	.001
Redemptive	-0.31	0.36	.07	-0.87	.388				
Tragic	0.88	0.33	.24	2.65	.009				

Note. Narrative type dummy coded; Reference category = Progressive narrative type

Table 25

Hierarchal multiple regression of narrative type, ACEs, and attachment pattern predicting intentions to not seek help from anyone

Predictor	*B*	*Std. error*	*β*	*t*	*Sig.*	R^2	R^2 *change*	F_{Change}	F_{Change} *Sig*
Step 1						.04	.04	3.18	.045
Age	-0.01	0.05	-.02	-0.19	.851				
Gender	-0.85	0.35	-.21	-2.46	.015				
Step 2						.11	.07	10.54	.001
ACETOT	0.15	0.05	.27	3.25	.001				
Step 3						.24	.12	10.92	<.001
Anxiety	0.05	0.12	.03	0.39	.700				
Avoid	0.64	0.14	.36	4.66	<.001				
Step 4						.31	.07	7.16	.001
Progressive	0.31	0.36	.08	0.87	.388				
Tragic	1.19	0.33	.32	3.57	<.001				

Note. Narrative type dummy coded; Reference category = Redemptive narrative type

Table 26

Hierarchal multiple regressions of narrative type, ACEs, and attachment pattern predicting intentions to seek help from formal sources of support

Predictor	*B*	*Std. error*	*β*	*t*	*Sig.*	R^2	R^2_{Change}	F_{Change}	F_{Change} *Sig*
Step 1						.18	.18	14.49	<.001
Age	0.17	0.03	.40	4.95	<.001				
Gender	-0.13	0.24	-.05	-0.55	.584				
Step 2						.18	.01	1.24	.268
ACETOT	0.04	0.03	.09	1.11	.268				
Step 3						.22	.03	2.90	.058
Anxiety	0.04	0.09	.04	0.47	.637				
Avoid	-0.24	0.10	-.19	-2.36	.020				
Step 4						.23	.01	1.08	.344
Redemptive	-0.22	0.28	-.07	-0.79	.430				
Tragic	-0.38	0.26	-.14	-1.47	.145				

Note. Narrative type dummy coded; Reference category = Progressive narrative type

Figure 6

Attachment avoidance predicting seeking help from a friend

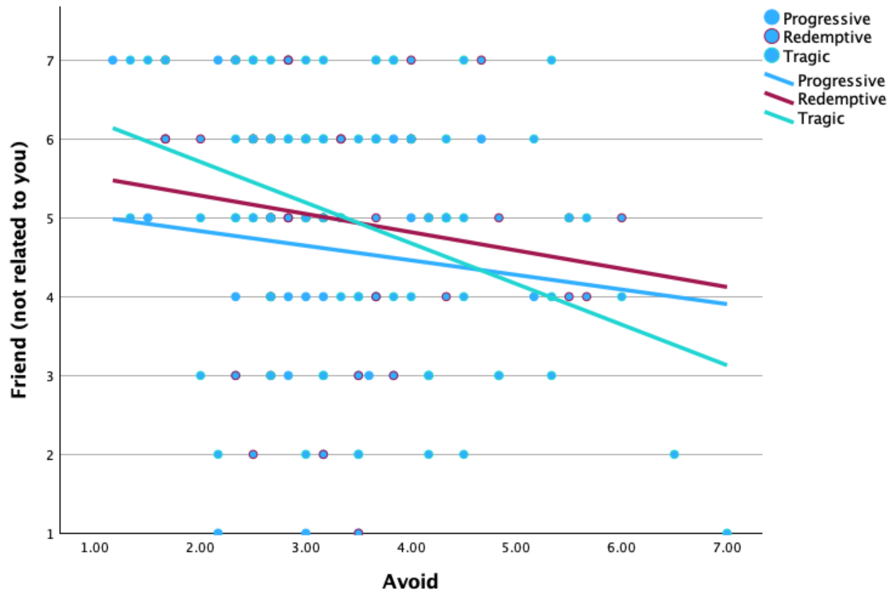


Figure 7

Adverse childhood experiences predicting seeking help from family

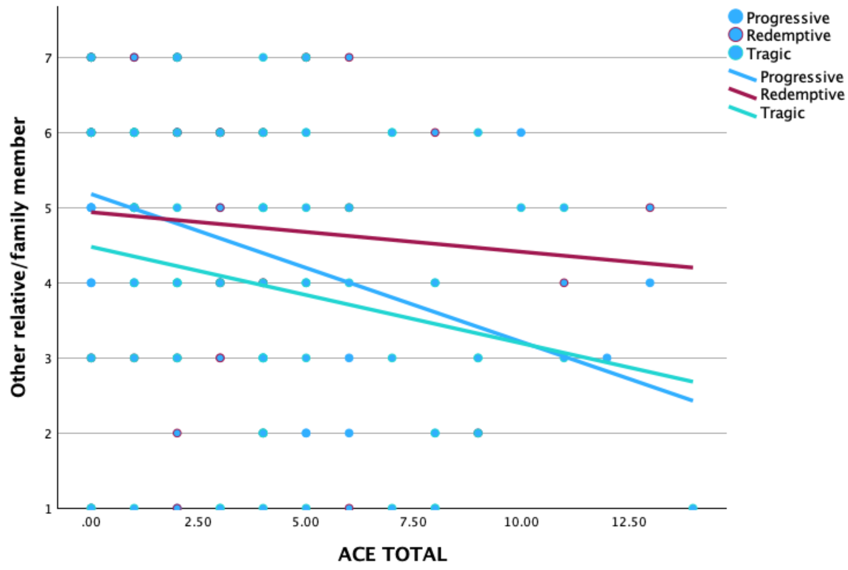


Figure 8

Attachment avoidance predicting seeking help from family

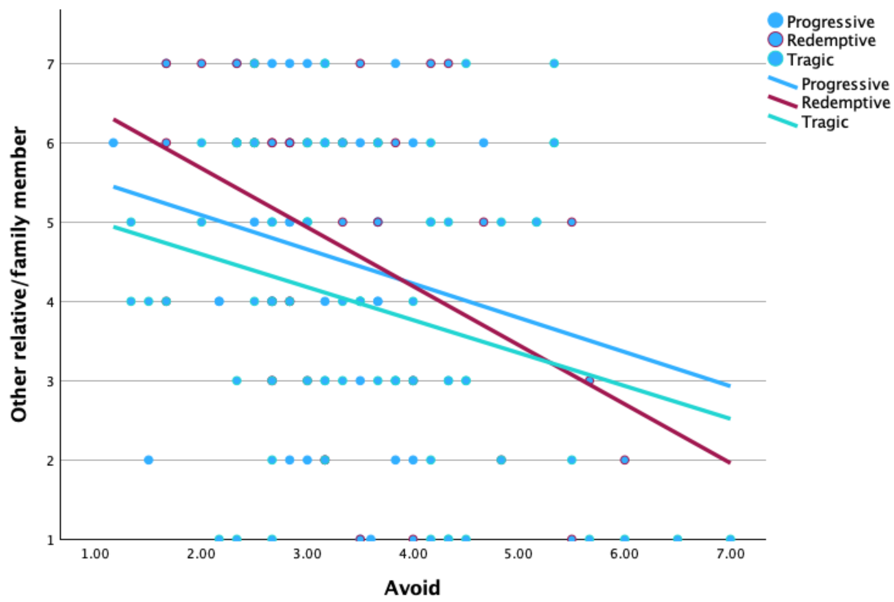


Figure 9

Adverse childhood experiences predicting not seeking help from anyone

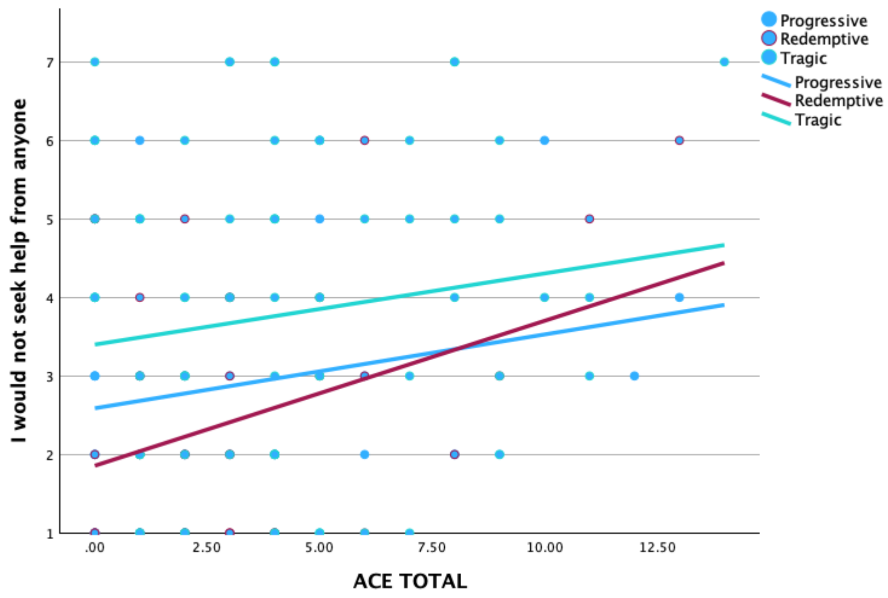


Figure 10

Attachment avoidance predicting not seeking help from anyone

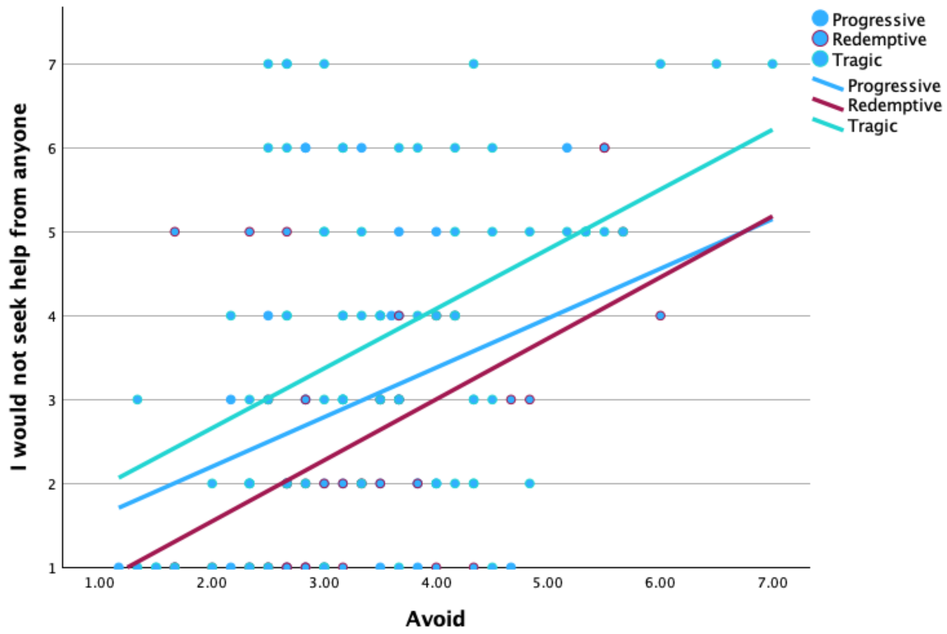
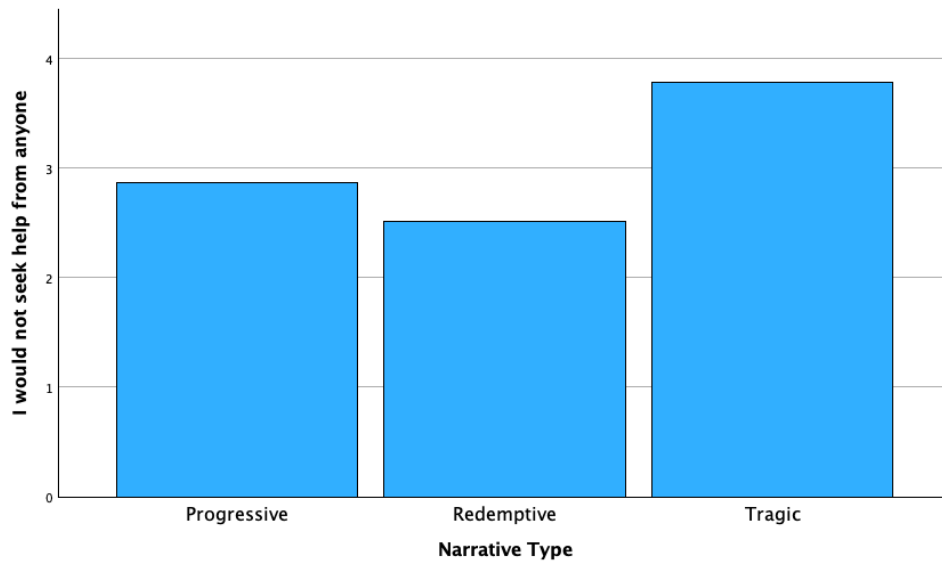


Figure 11

Narrative type predicting not seeking help from anyone



Appendix A

Recruitment Message: Undergraduates Appendix Title

My name is Sarah Malashevsky, and I am a master's student at UNB Saint John. I am working under the supervision of Dr. Enrico DiTommaso in the department of Psychology. I invite you to participate in my research study about what narrative types that emerging adults develop relating to their willingness to engage or not engage in seeking mental health care and how social factors may contribute to their decision. I am interested in learning more about why emerging adults seek or do not seek mental health care, allowing emerging adults to express their thoughts, attitudes, and needs. Research findings indicate emerging adults are often not given this voice in advocating for their mental healthcare and how decisions about their mental health care are made. In efforts to help improve mental health care in our community, I want to hear from emerging adults directly.

This study will include any emerging adults in the community ages 19-30. If you are interested in participating, please click the following link to be taken to a consent form. Once you consent by clicking "I agree," you will be redirected to the survey. The survey will take approximately 30 minutes, and your responses will be confidential. If you start the survey and decide you are not interested in participating further, you may stop at any time. You will still be eligible for compensation if you do not complete the entire questionnaire package. Thank you for your time and your input. Your voice is important.

This project has been reviewed by the Research Ethics Board at UNBSJ and is on file as REB File #2023-024. For your participation in this study, students of UNB will receive one bonus point in SONA for your chosen course. Students will also be able to earn bonus marks via an alternate option provided by their instructor.

Sincerely,

Sarah Malashevsky BA (Hons) *in Psychology,* $\textit{SW}_{\textit{Dip}}$
MA student in Experimental Psychology
UNB Saint John
sarah.malashevsky@unb.ca

Appendix B

Recruitment Message: Social Media Participants

My name is Sarah Malashevsky, and I am a master's student at UNB Saint John. I am working under the supervision of Dr. Enrico DiTommaso in the department of Psychology. I invite you to participate in my research study about what narrative types that emerging adults develop relating to their willingness to engage or not engage in seeking mental health care and how social factors may contribute to their decision. I am interested in learning more about why emerging adults seek or do not seek mental health care, allowing emerging adults to express their thoughts, attitudes, and needs. Research findings indicate emerging adults are often not given this voice in advocating for their mental healthcare and how decisions about their mental health care are made. In efforts to help improve mental health care in our community, I want to hear from emerging adults directly.

This study will include any emerging adults in the community ages 19-30. If you are interested in participating, please click the following link to be taken to a consent form. Once you consent by clicking "I agree," you will be redirected to the survey. The survey will take approximately 30 minutes, and your responses will be confidential. If you start the survey and decide you are not interested in participating further, you may stop at any time. You will still be eligible for compensation if you do not complete the entire questionnaire package. Thank you for your time and your input. Your voice is important.

This project has been reviewed by the Research Ethics Board at UNBSJ and is on file as REB File #2023-024. Those recruited via social media, will be eligible to have their name entered into a draw to win one of four $20 gift cards for Indigo books. Odds of winning a gift are approximately 4 in 200 (1:50). When prompted to enter your name, provide your email address.

Sincerely,

Sarah Malashevsky BA (Hons) *in Psychology, SW*$_{Dip}$

MA student in Experimental Psychology
UNB Saint John
sarah.malashevsky@unb.ca

Appendix C

The Emerging Adult Mental Health Narrative Questionnaire

Please complete the following questions to the best of your ability. Remember, you have the right to withdraw your consent to participate at any time by closing your browser window.

1. What is your age?
2. Are you a student?
3. Describe an experience you have had with seeking help for your mental health. (Consider **what happened**, **when** it happened, **who** was involved, what **you may have been thinking or feeling, why it was significant**, and what the experience may have **led you to believe about yourself**.) If you have chosen not to seek help for your mental health, please describe why.____
4. What is your gender? (Drop down menu)
    a. Female
    b. Male
    c. Transgender female
    d. Transgender male
    e. Agender
    f. Non-binary
    g. Other: please specify
    h. Prefer not to say
5. What is your sexual orientation?
    a. Lesbian
    b. Bisexual
    c. Heterosexual
    d. Queer
    e. Unsure/questioning
    f. Asexual
    g. Pansexual
    h. Other: please specify
    i. Prefer not to say

Appendix D

General Help Seeking Questionnaire

Below is a list of people who you might want to get help or advice from if you were having a personal or emotional problem. Please choose the number that shows how likely it is you would get help from each of these people for a personal or emotional problem in the next month.

	Extremely Unlikely						*Extremely Likely*
Partner (e.g., significant boyfriend or girlfriend)	1	2	3	4	5	6	7
Friend (not related to you)	1	2	3	4	5	6	7
Other relative/family member	1	2	3	4	5	6	7
Mental Health professional (e.g., school counsellor, psychologist, psychiatrist)	1	2	3	4	5	6	7
Phone help line (E.g., Mobile Mental Health, Kids Help Phone)	1	2	3	4	5	6	7
Family doctor/GP	1	2	3	4	5	6	7
Teacher (Homeroom or classroom teacher)	1	2	3	4	5	6	7
Someone else not listed above (Please	1	2	3	4	5	6	7

describe who this was)							
I would not seek help from anyone	1	2	3	4	5	6	7
Have you ever seen a mental health professional (e.g., school counsellor, psychologist, psychiatrist) to get help for personal problems?	Yes						No
How many visits did you have with the mental health professional?			_____ visits				
Do you know what type of mental health professionals you've seen? If so, please list their titles (e.g., school counsellor, psychologist, psychiatrist)	____						

	Extremely unhelpful				*Extremely helpful*
How helpful was the visit to the mental health professional?	1	2	3	4	5

Appendix E

Adverse Childhood Experiences Checklist

The following is a list of experiences that may or may have happened to you while growing up. Please answer if the following list happened to you based on experiences that happened before age 18.

Yes = 1 *No* = 0

1. Lacked money for food or housing
2. Lived in dangerous housing or neighborhood
3. Lived with someone with a severe physical, developmental, or mental disability or illness
4. Ever separated from your family for an extended period of time (lived with relatives or friends, in foster care or adopted)
5. Parent/caregivers separated or divorced while you were living with them
6. Experienced expected or non-sudden death of close family member or friend
7. Ever bullied (made fun of, threatened with harm)
8. Witnessed extreme physical violence between family members
9. Emotionally abused by a parent, caregiver, or partner
10. Physically abused by a parent, caregiver, or partner
11. Experienced sexual assault (rape, attempted rape, made to perform sexual act(s) through force or threat of harm)
12. Exposed to unwanted or uncomfortable sexual experiences other than assault
13. Experienced serious physical assault by someone close to you
14. Experienced serious physical assault by someone else
15. Witnessed sudden violent or accidental death or its aftermath

Appendix F

Experiences in Close Relationships - 12 (ECR- 12)

The following statements concern how you generally feel in your close relationships generally (e.g., with romantic partners, close friends, or family members). Please respond to each statement by indicating how much you agree or disagree. Mark your answer using the following rating scale.

1 = *Strongly disagree*

2 = *Disagree*

3 = *Somewhat disagree*

4 = *Undecided*

5 = *Somewhat agree*

6 = *Agree*

7 = *Strongly agree*

1. I feel comfortable depending on others.
2. I worry that others won’t care about me as much as I care about them.
3. I usually discuss my problems and concerns with close others.
4. I worry a fair amount about losing my close relationship partners.
5. I tell my close relationship partners just about everything.
6. I worry a lot about my relationships.
7. I don’t mind asking close others for comfort, advice, or help.
8. I worry about being alone.
9. I don’t feel comfortable opening up to others.
10. I need a lot of reassurance that close relationship partners really care about me.
11. I feel comfortable sharing my private thoughts and feelings with others.
12. If I can’t get a relationship partner to show interest in me, I get upset or angry.

Appendix G

Department of Psychology

University of New Brunswick, Saint John campus

Informed Consent Form for Undergraduates

This study is being conducted as part of a master's degree in the Experimental Psychology program for the Psychology department at the University of New Brunswick. The principal investigator (PI) is Sarah Malashevsky, and she is conducting thesis research under the supervision of Dr. Enrico DiTommaso.

Purpose of Research

This study will explore what socio-cultural factors influence the development of emerging adult narrative types relating to seeking mental health care. The study will require you to answer various questions about your experiences of mental health-seeking behaviours, attachment patterns, and adverse life experiences. This survey should take 30 minutes to complete.

Risks and Benefits

There are no known harms or benefits associated with participating in this survey. However, you may experience some distress while reflecting on personal experiences and emotions related to mental health help-seeking. Should you need to speak to someone about this distress, links to counselling supports will be provided at the end of the survey.

Confidentiality

All information collected will be kept completely anonymous. Except for your signed consent form, you will not be asked to include any information that will identify you personally. Responses will be collected through the online survey system Qualtrics, downloaded, and stored on password-protected computers for analyses. Although Qualtrics allows researchers to save IP addresses, we are not collecting IP addresses and thus, will have no identifying information about the participants. There will be no way that a person (or their location) can be identified through the platform. Qualtrics data is securely stored at a site in Toronto, Ontario and thus, is not subject to the US Homeland Security Act. No individuals will be singled out in this study. Electronic data will be password protected and stored on a USB stick that will remain in a locked cabinet in Dr. DiTommaso's office under his supervision. E-mail addresses collected for compensation purposes will be stored in a separate file on a separate USB stick and will not be connected in any way to the study data collected so responses remain anonymous. Data will only be described in aggregate form in published documents and presentations from

this research. The collected data will only be viewed by the PI, her supervisor Dr. Enrico DiTommaso, and others working in his labs.

Compensation

For your participation in this study, you will receive one bonus point in SONA for your chosen course. Students will also be able to earn bonus marks via an alternate option provided by their instructor. You will still be eligible for compensation if you do not complete the entire questionnaire package.

Contact

If you have any questions or concerns about the study or the procedures, you may contact the PI, Sarah Malashevsky, at sarah.malashevsky@unb.ca and her supervisor, Dr. Enrico DiTommaso at rico@unb.ca. This project has been reviewed by the Research Ethics Board at UNBSJ, and is on file as REB File #2023-024. If you have questions about the ethics of this study, you may contact Dr. Beth Keyes, Chair of the University of New Brunswick's Research Ethics Board, at REB@unbsj.ca; phone: 506-648-5994.

Participation

You must be aged 19-30 to participate in this survey. Participation in this study is completely voluntary and you can withdraw at any time by closing the survey window. Due to the anonymous nature of the survey, data cannot be withdrawn once submitted. You have the right to omit any question(s) you choose. This will not impact your eligibility for compensation. Your consent to participate in this study does not entail waiving any rights you have to legal recourse in the event of research-related harm.

By signing below or clicking "I agree," you consent to participate in the study. Remember that you may withdraw at any time during the survey if you no longer wish to participate. Once you click "I agree," you will be redirected to a link that will take you to the study.

I ______________________________ consent to participate in the study Emerging Adult Narrative Development in Seeking Mental Health Care signed this ________________ of 2023.

Appendix H

Department of Psychology

University of New Brunswick, Saint John campus

Informed Consent Form for Social Media Participants

This study is being conducted as part of a master's degree in the Experimental Psychology program for the Psychology department at the University of New Brunswick. The principal investigator (PI) is Sarah Malashevsky, and she is conducting thesis research under the supervision of Dr. Enrico DiTommaso.

Purpose of Research

This study will explore what socio-cultural factors influence the development of emerging adult narrative types relating to seeking mental health care. The study will require you to answer various questions about your experiences of mental health-seeking behaviours, attachment patterns, and adverse life experiences. This survey should take 30 minutes to complete.

Risks and Benefits

There are no known harms or benefits associated with participating in this survey. However, you may experience some distress while reflecting on personal experiences and emotions relating to mental health help-seeking. Should you need to speak to someone about this distress, links to counselling supports will be provided at the end of the survey.

Confidentiality

All information collected will be kept completely anonymous. Except for your signed consent form, you will not be asked to include any information that will identify you personally. Responses will be collected through the online survey system Qualtrics, downloaded, and stored on password-protected computers for analyses. Although Qualtrics allows researchers to save IP addresses, we are not collecting IP addresses and thus, will have no identifying information about the participants. There will be no way that a person (or their location) can be identified through the platform. Qualtrics data is securely stored at a site in Toronto, Ontario and thus, is not subject to the US Homeland Security Act. No individuals will be singled out in this study. Electronic data will be password protected and stored on a USB stick that will remain in a locked cabinet in Dr. DiTommaso's office under his supervision. E-mail addresses collected for compensation purposes will be stored in a separate file on a separate USB stick and will not be connected in any way to the study data collected so responses remain anonymous. Data will only be described in aggregate form in published documents and presentations from

this research. The collected data will only be viewed by the PI, her supervisor Dr. Enrico DiTommaso, and others working in his labs.

Compensation

For participating, your name will be entered into a draw to win one of four $20 gift cards for Indigo books. Odds of winning a gift are approximately 4 in 200. When prompted to enter your name, provide your email address. You will still be eligible for compensation if you do not complete the entire questionnaire package.

Contact

If you have any questions or concerns about the study or the procedures, you may contact the PI, Sarah Malashevsky, at sarah.malashevsky@unb.ca and her supervisor, Dr. Enrico DiTommaso at rico@unb.ca. This project has been reviewed by the Research Ethics Board at UNBSJ and is on file as REB File #2023-024. If you have questions about the ethics of this study, you may contact Dr. Beth Keyes, Chair of the University of New Brunswick's Research Ethics Board, at REB@unbsj.ca; phone:506- 648-5994.

Participation

You must be aged 19-30 to participate in this survey. Participation in this study is completely voluntary, and you can withdraw at any time by closing the survey window. Due to the anonymous nature of the survey, data cannot be withdrawn once submitted. You have the right to omit any question(s) you choose. This will not impact your eligibility for compensation. Your consent to participate in this study does not entail waiving any rights you have to legal recourse in the event of research-related harm.

By signing below or clicking "I agree," you consent to participate in the study. Remember that you may withdraw during the survey if you no longer wish to participate. Once you click "I agree," you will be redirected to a link that will take you to the study.

I ______________________________ consent to participate in the study Emerging Adult Narrative Development in Seeking Mental Health Care signed this _________________ of 2023.

Appendix I

Debriefing Form for Undergraduate Students

Thank you for taking part in this study!

We make sense of the world, our past, our present, and our hopes and dreams for the future through personal stories or narratives (Erikson, 1968). Narratives help people to connect with one another and with their own identities as they grow and change over time (McLean et al., 2010). The current study investigated sociocultural factors like previous experiences of mental health help-seeking, attachment to important others, and adverse childhood experiences. The data from this study will be used to learn more about how these sociocultural factors influence narrative development in emerging adults as well as future decisions about mental health help seeking. The information you have given us will be used to write a research paper about these topics. It is important to remember that your personal responses will remain confidential. Results from the information we collect will be shown together as a group; individual responses will not be shared or disclosed. Electronic data will be stored on a password protected USB stick in Dr. DiTommaso's office under his supervision. E-mail addresses collected for compensation purposes will be stored in a separate file on a separate USB stick and will not be connected in any way to the study data collected so responses remain anonymous. Only the primary investigator, her supervisor and others in his labs will see any of your responses.

If after completing the study you require mental health or substance use resources, please consult the resources below. **If you are in an emergency, call 911.** Students of UNB Saint John can contact Student Services if they would like to seek help from a counsellor (https://www.unb.ca/saintjohn/studentservices/health/index.html).

Other Resources:

Wellness Together Canada: https://wellnesstogether.ca/en-CA

If you are in distress, text WELLNESS to 741741

National Suicide Prevention Hotline: 1-800-273-8255

If you require referrals to services, dial 211.

Northwest Territories Helpline: 1-800-661-0844

Nunavut Kamatsiaqtut Help Line: 1-867-979-3333 or Toll-free at 1-800-265-3333 (24 hours).

Nunavut residents can also call the NWT Crisis/Helpline: 1-800-661-0844

Yukon Territorial Health Information Line: 8-1-1, or dial (604)-215-4700 if calling from a satellite phone.

Yukon Alcohol and Drug Services: 1-855-667-5777

British Columbia Crisis Intervention and Suicide Prevention Centre: Call 1-800-784-2433 (1-800-Suicide) or visit http://crisiscentre.bc.ca

British Columbia Mental Health and Substance Use Services: 310-6789 (310 Mental Health)

Alberta Mental Health Helpline: 1-877-303-2642

Alberta Addiction Services Helpline: 1-866-332-2322

Saskatchewan Mental Health & Addiction Services Directory (Select "Find Mental Health and Addictions Services in My Community"): https://www.saskatchewan.ca/residents/health/accessing-health-care-services/mental-health-and-addictions-support-services

Manitoba Suicide Prevention & Support Line: 1-877-435-7170 (1-877-HELP170)

Manitoba Addictions Helpline: 1-855-662-6605

Ontario Mental Health Helpline: 1-866-531-2600

Ontario Drug and Alcohol Helpline: 1-800-565-8603

Quebec Preventing Suicide: 1-866-277-3553

Quebec Health Resources: https://www.quebec.ca/en/health/health-issues/a-z/

Quebec Drugs Help and Referral: 1-800-265-2626

New Brunswick Suicide Prevention CHIMO Helpline: 1-800-667-5005

New Brunswick Regional Addiction Centers: https://www2.gnb.ca/content/gnb/en/departments/health/Addiction/NewBrunswickAddictionCenters.html

Nova Scotia Provincial Mental Health and Addictions Crisis Line: 1-888-429-8167

Prince Edward Island Mental Health and Addictions Phone Line: 1-833-553-6983

Prince Edward Island - The Island Helpline: 1-800-218-2885 (toll-free)

Newfoundland & Labrador Provincial Mental Health Crisis Line: 1-888-737-4668 or (709) 737-4668

Newfoundland & Labrador Mental Health and Addictions Systems Navigator: 1-877-999-7589 or (709) 752-3916

Newfoundland & Labrador CHANNEL Peer Support Warm Line: 1-855-753-2560 or (709) 753-2560

If you have any questions, comments, or concerns, you are welcome to reach out to the Principal Investigator, Sarah Malashevsky at sarah.malashevsky@unb.ca, or her supervisor, Dr. Enrico DiTommaso at rico@unb.ca. If you have questions about the ethics of this study, you can contact Dr. Beth Keyes, Chair of the University of New Brunswick's Research Ethics Board, at REB@unbsj.ca; phone: 506-648-5994.

Thank you again for your contribution!

Appendix J

Debriefing Form for Social Media Participants

Thank you for taking part in this study!

We make sense of the world, our past, our present, and our hopes and dreams for the future through personal stories or narratives (Erikson, 1968). Narratives help people to connect with one another and with their own identities as they grow and change over time (McLean et al., 2010). The current study investigated sociocultural factors like previous experiences of mental health help-seeking, attachment to important others, and adverse childhood experiences. The data from this study will be used to learn more about how these sociocultural factors influence narrative development in emerging adults as well as future decisions about mental health help seeking. The information you have given us will be used to write a research paper about these topics. It is important to remember that your personal responses will remain confidential. Results from the information we collect will be shown together as a group; individual responses will not be shared or disclosed. Electronic data will be stored on a password protected USB stick in Dr. DiTommaso's office under his supervision. E-mail addresses collected for compensation purposes will be stored in a separate file on a separate USB stick and will not be connected in any way to the study data collected so responses remain anonymous. Only the primary investigator, her supervisor and others in his labs will see any of your responses.

If after completing the study you require mental health or substance use resources, please consult the resources below. **If you are in an emergency, call 911.**

Wellness Together Canada: https://wellnesstogether.ca/en-CA

If you are in distress, text WELLNESS to 741741

National Suicide Prevention Hotline: 1-800-273-8255

If you require referrals to services, dial 211.

Northwest Territories Helpline: 1-800-661-0844

Nunavut Kamatsiaqtut Help Line: 1-867-979-3333 or Toll-free at 1-800-265-3333 (24 hours).

Nunavut residents can also call the NWT Crisis/Helpline: 1-800-661-0844

Yukon Territorial Health Information Line: 8-1-1, or dial (604)-215-4700 if calling from a satellite phone.

Yukon Alcohol and Drug Services: 1-855-667-5777

British Columbia Crisis Intervention and Suicide Prevention Centre: Call 1-800-784-2433 (1-800-Suicide) or visit http://crisiscentre.bc.ca

British Columbia Mental Health and Substance Use Services: 310-6789 (310 Mental Health)

Alberta Mental Health Helpline: 1-877-303-2642

Alberta Addiction Services Helpline: 1-866-332-2322

Saskatchewan Mental Health & Addiction Services Directory (Select "Find Mental Health and Addictions Services in My Community"): https://www.saskatchewan.ca/residents/health/accessing-health-care-services/mental-health-and-addictions-support-services

Manitoba Suicide Prevention & Support Line: 1-877-435-7170 (1-877-HELP170)

Manitoba Addictions Helpline: 1-855-662-6605

Ontario Mental Health Helpline: 1-866-531-2600

Ontario Drug and Alcohol Helpline: 1-800-565-8603

Quebec Preventing Suicide: 1-866-277-3553

Quebec Health Resources: https://www.quebec.ca/en/health/health-issues/a-z/

Quebec Drugs Help and Referral: 1-800-265-2626

New Brunswick Suicide Prevention CHIMO Helpline: 1-800-667-5005

New Brunswick Regional Addiction Centers: https://www2.gnb.ca/content/gnb/en/departments/health/Addiction/NewBrunswickAddictionCenters.html

Nova Scotia Provincial Mental Health and Addictions Crisis Line: 1-888-429-8167

Prince Edward Island Mental Health and Addictions Phone Line: 1-833-553-6983

Prince Edward Island - The Island Helpline: 1-800-218-2885 (toll-free)

Newfoundland & Labrador Provincial Mental Health Crisis Line: 1-888-737-4668 or (709) 737-4668

Newfoundland & Labrador Mental Health and Addictions Systems Navigator: 1-877-999-7589 or (709) 752-3916

Newfoundland & Labrador CHANNEL Peer Support Warm Line: 1-855-753-2560 or (709) 753-2560

If you have any questions, comments, or concerns, you are welcome to reach out to the Principal Investigator, Sarah Malashevsky at sarah.malashevsky@unb.ca, or her supervisor, Dr. Enrico DiTommaso at rico@unb.ca. If you have questions about the ethics of this study, you can contact Dr. Beth Keyes, Chair of the University of New Brunswick's Research Ethics Board, at REB@unbsj.ca; phone: 506-648-5994.

Thank you again for your contribution!

Curriculum Vitae

Candidate’s Full Name: Sarah Malashevsky

Universities Attended (with dates and degrees obtained):

University of New Brunswick, Bachelor of Arts (Hons) Psychology, June 2021

Medicine Hat College, Social Work Diploma, June 2014

Publications:

Monette, C., Malashevsky, S., Law, D. (March 31, 2024). *Building Home Final Report*. Canada Mortgage and Housing Corporation Funders Report.

Conference Presentations:

Five-minute Honours Thesis presentation titled "Predicting Well-Being During the COVID-19 Pandemic", Atlantic Health Exploration and Discovery Collaborative Health Research Conference, Conference, 2021/8 - 2021/8

Undergraduate Thesis, “Pandemic Stress and Well-Being: The Mediating Role of Resilience,” Science Atlantic Conference, May 7, 2021