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"I Know I Need Help, but I Cannot Ask": Exploring Psychological and Social Barriers to Mental Health Help-Seeking Among Young Adults

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A B S T R A C T

Objective: This study aimed to explore the lived psychological and social barriers that prevent young adults in the United States from seeking mental health support despite recognizing that they need professional or interpersonal assistance.

Methods and Materials: This qualitative study employed a descriptive phenomenological orientation and included 26 young adults aged 18–29 years residing in the United States. Participants were recruited through purposive and maximum-variation sampling and were eligible if they had experienced psychological or emotional distress during the previous two years, recognized a need for support, and nevertheless delayed, avoided, or experienced substantial difficulty asking for help. Data were collected through individual semi-structured, in-depth interviews lasting approximately 45–75 minutes, supplemented by demographic information and interviewer field notes. Interviews explored perceived need, self-reliance, emotional disclosure, stigma, burden concerns, interpersonal experiences, and conditions facilitating help-seeking. Interviews were audio-recorded, transcribed verbatim, and analyzed using inductive reflexive thematic analysis. Coding, category development, constant comparison, negative-case examination, reflexive documentation, and iterative theme refinement were used to enhance analytical credibility and trustworthiness.

Findings: Analysis generated six overarching themes: pressure to manage distress independently, uncertainty about whether psychological problems were sufficiently serious to justify help, difficulty articulating internal experiences, fear that disclosure would negatively alter others' perceptions, reluctance to burden significant others, and conditional willingness to seek assistance when sufficient relational safety was present. These themes indicated that help-seeking was shaped by interacting psychological and social processes rather than isolated barriers. Participants commonly moved through a recursive pathway involving recognition of need, internal legitimacy assessment, communication readiness,

evaluation of anticipated social consequences, and a perceived balance between the benefits and costs of disclosure. When psychological and interpersonal costs remained high, help-seeking was delayed or avoided; when validation, trust, confidentiality, normalization, and explicit invitations to disclose reduced those costs, movement toward support became more likely.

Conclusion: Mental health help-seeking among young adults is best understood as a dynamic negotiation between recognized need and perceived psychological and social safety, suggesting that interventions should address not only mental health awareness but also self-reliance norms, legitimacy judgments, communication difficulties, stigma, burden concerns, and relational conditions that determine whether recognition of need is translated into action.

Keywords: *young adults; mental health; help-seeking; psychological barriers; social barriers; stigma; self-reliance; qualitative research; emotional disclosure; relational safety*

1. Introduction

Mental health difficulties among young adults constitute a major public health concern because this developmental period is characterized by substantial psychological, social, educational, occupational, and relational transitions. Emerging adulthood often involves leaving the family home, entering higher education or employment, developing intimate relationships, negotiating financial independence, and establishing a stable sense of identity. These transitions can increase vulnerability to anxiety, depression, loneliness, emotional exhaustion, self-harm, substance-related problems, and other forms of psychological distress. At the same time, young adults frequently occupy an ambiguous position between adolescence and established adulthood, in which they are expected to demonstrate independence while still developing the emotional, financial, and social resources necessary to manage complex life demands. Research on emerging adults has therefore increasingly emphasized not only the prevalence of psychological difficulties but also the gap between experiencing distress and obtaining appropriate support. This gap is particularly consequential because untreated or delayed treatment can allow symptoms to become more severe, chronic, and functionally impairing. Evidence suggests that health service non-use among adolescents and young adults cannot be explained solely by the absence of need; rather, psychological, demographic, social, and clinical factors interact to influence whether recognized distress is translated into service utilization (Reich et al., 2023). Similarly, prevention research has highlighted help-seeking intentions and actual help-seeking behavior as potentially modifiable targets for reducing anxiety and depression during emerging adulthood (Nauphal et al., 2023).

A central difficulty in understanding young adults' engagement with mental health care is that recognition of distress does not necessarily lead to disclosure or professional help-seeking. Individuals may understand that they are struggling, believe that support could be useful, and even intend to seek assistance, while nevertheless delaying or avoiding contact with professionals or trusted others. This apparent contradiction suggests that help-seeking should not be conceptualized as a simple function of symptom recognition. Instead, it represents a multistage decision-making process involving mental health literacy, perceived legitimacy of need, anticipated consequences of disclosure, confidence in available services, social norms, stigma, self-concept, and interpersonal trust. Studies examining mental health literacy among university students have demonstrated that knowledge about psychological problems and available counseling services is related to, but not synonymous with, willingness to obtain assistance (Younes et al., 2025). Research among Black male college students has similarly shown that mental health literacy and stigma are important components of help-seeking behavior, suggesting that knowledge and cultural meaning operate together when individuals evaluate whether professional support is acceptable (Gere & Salimi, 2025). Among university populations more broadly, self-stigma related to psychological help-seeking has also been linked to attitudes toward mental illness and levels of mental health literacy, underscoring the possibility that a person may understand mental health problems conceptually while still applying stigmatizing judgments to the self when considering care (Koutra et al., 2024).

Stigma remains one of the most frequently identified barriers to mental health help-seeking, but its operation is more complex than generalized fear of being associated with

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mental illness. Stigma can involve anticipated judgment by others, fear of negative labeling, concern about appearing weak or unstable, internalized beliefs about what needing psychological help signifies, and expectations that disclosure will damage valued social roles. Among nursing students, mental health stigma has been associated with attitudes toward seeking professional psychological help, demonstrating how professional identity and perceived expectations of competence may coexist with reluctance to access care (Abdelmonaem et al., 2024). Qualitative research with young people in different cultural settings similarly indicates that stigma is experienced through everyday social relationships and judgments rather than only through abstract beliefs about mental illness. Young Barbadians living with mental health conditions, for example, have described lived experiences in which stigma and help-seeking are closely intertwined (Gallimore et al., 2026). University students in the Western Balkans have also reported connections among mental health awareness, stigma, and attitudes toward obtaining support (Duraku et al., 2024). These findings support the view that young adults' help-seeking decisions are embedded in social environments in which disclosure can have perceived consequences for belonging, reputation, competence, and identity.

The expectation of self-reliance represents another important psychological barrier. Young adults may interpret emotional independence as a marker of maturity and may consequently regard the need for assistance as evidence that they have failed to cope adequately. This process is particularly visible in research involving boys and young men, for whom cultural expectations surrounding masculinity can intensify pressure to manage emotional difficulties privately. A systematic review examining adolescent boys and young men identified perceived barriers including masculine norms, stigma, difficulties recognizing or communicating emotions, and concerns about the consequences of help-seeking (Sheikh et al., 2024). Qualitative research with young men in the United Kingdom likewise demonstrated that informal help-seeking may be constrained by concerns about vulnerability, interpersonal risk, and how emotional disclosure is received within social networks (Burke et al., 2022). School-based research with older adolescent boys has further shown that engagement in mental health workshops depends on how interventions address theoretically informed barriers and facilitators related to participation, social acceptability, and communication (Lisk et al., 2023). Gender-related attitudes toward suicide prevention have also been observed in community-based programming, suggesting that willingness to acknowledge vulnerability and engage with prevention messages may vary according to socialized gender expectations (Honea et al., 2022). Together, this literature indicates that reluctance to ask for help may be linked not simply to lack of awareness but to the perceived incompatibility between help-seeking and valued identities such as strength, independence, competence, or emotional control.

A related barrier concerns whether individuals believe their distress is sufficiently serious or legitimate to justify assistance. Young adults may normalize persistent anxiety, exhaustion, low mood, academic pressure, relational difficulties, or self-critical thinking as ordinary consequences of contemporary life. This can produce a threshold problem in which help is viewed as appropriate only after symptoms become severe. Studies of university populations demonstrate that psychological distress can develop within highly demanding academic contexts, sometimes progressing to severe outcomes. Academic anxiety, for example, has been examined as a potential contributor to suicide planning and attempts among university students, illustrating the consequences of allowing substantial distress to remain unaddressed (Shah, 2025). Research on non-suicidal self-injury among college students similarly shows that pathways to obtaining help can be complicated even when behavior reflects significant psychological suffering (Emqi & Hartini, 2022). Among youth with eating disorders, help-seeking attitudes and behaviors are influenced by multiple barriers that can delay access to care despite potentially serious clinical consequences (Nicula et al., 2022). Such findings suggest that perceived severity is not necessarily aligned with objective clinical need and that young people may postpone seeking care while waiting for their circumstances to become unmistakably serious.

Mental health help-seeking is also shaped by the individual's capacity to identify, organize, and communicate internal experience. A person may recognize that something is wrong while lacking language for describing what they are feeling or uncertainty regarding what type of support is appropriate. Mental health literacy is therefore not limited to recognizing diagnostic labels; it includes the ability to interpret distress, understand possible sources of assistance, and communicate needs effectively. A qualitative assessment of male college students demonstrated that mental health literacy and help-seeking behavior are

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interconnected and may be influenced by how students conceptualize mental health problems and available forms of support (DeBate et al., 2022). Studies among Asian American college students further indicate that service use reflects a complex interaction among cultural beliefs, perceived stigma, interpersonal factors, knowledge, and accessibility (Nguyen et al., 2023). A systematic review focusing on Asian American adolescents likewise identified multiple barriers to seeking mental health assistance, reinforcing the importance of understanding cultural and family contexts alongside individual psychological processes (Qi et al., 2025). Research informed by the Theory of Planned Behavior among Korean Americans additionally highlights the relevance of attitudes, social expectations, and perceived behavioral control in shaping help-seeking decisions (Ha et al., 2024). These perspectives suggest that knowing one needs help and being psychologically prepared to request it are distinct processes.

Family, peer, and cultural contexts can either facilitate or inhibit this transition from recognition to disclosure. Young adults frequently assess how significant others are likely to respond before asking for support. They may fear being dismissed, misunderstood, criticized, overprotected, or treated differently. Family expectations may also emphasize privacy, resilience, or the management of psychological difficulties within the family rather than through professional services. Qualitative research among young adults in Saudi Arabia has identified both barriers and facilitators related to stigma, social support, family beliefs, and service accessibility (Noorwali et al., 2022). Research among Pakistani adolescents similarly demonstrates that perceptions of mental health services are shaped by interpersonal and structural factors, including family and community influences (Nizam & Ali, 2021). A broader review of Indian research has likewise identified culturally embedded patterns influencing whether individuals seek help for mental health concerns (Sanghvi & Mehrotra, 2021). These studies indicate that help-seeking cannot be understood outside the relational systems in which young people live because decisions about disclosure may be influenced by perceived obligations to family, concerns about reputation, and culturally specific expectations regarding emotional expression.

The fear of burdening others represents a particularly important interpersonal mechanism. Young adults may conceal distress not because they do not trust friends or family, but because they believe disclosure will impose emotional responsibility on them. This concern can become especially pronounced when close others are already perceived as stressed, financially burdened, ill, or emotionally overwhelmed. In such circumstances, withholding distress may be interpreted by the individual as protective or considerate. Related processes have been observed in studies examining broader behavioral and mental health barriers in which individuals distinguish between barriers located within the self and those perceived in other people or the surrounding environment (Hallihan et al., 2025). Research involving first-year, first-generation college students and second-generation immigrant identities further illustrates how mental health challenges may emerge at the intersection of educational transitions, family expectations, and identity-related pressures (Horne & Chukwuere, 2025). These intersecting demands may intensify concerns about disappointing family members, appearing ungrateful for educational opportunities, or creating additional stress for people who have already invested heavily in the young adult's success.

Help-seeking barriers can become even more complex for young adults who occupy stigmatized or marginalized identities. LGBTQ+ youth, for example, may have to negotiate both mental health disclosure and identity disclosure, particularly when their social environments are perceived as unsafe. Research on coming out and self-disclosure among LGBTQ+ adolescents and youth demonstrates that disclosure itself is a psychologically consequential process shaped by anticipated acceptance, rejection, and social consequences (Sahoo et al., 2023). Among lesbian, gay, and bisexual college students, the concept of a "double closet" captures the intersection between concealed sexual identity and concealed mental health needs, suggesting that multiple forms of stigma may compound reluctance to seek care (Sánchez-Millán et al., 2025). Recent work evaluating strategies designed to increase mental health service utilization among young adult gender and sexual minorities further demonstrates the need for interventions that respond to population-specific barriers and facilitate trustworthy access to services (Rony et al., 2026). These findings highlight the importance of viewing help-seeking through an intersectional lens in which psychological vulnerability, identity management, stigma, and social safety are mutually influential.

Race and ethnicity can also shape trust, stigma, and perceptions of mental health care. Among African American young adults, psychoeducational interventions have been shown to influence willingness to seek help for depression, suggesting that culturally responsive information and

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normalization may alter help-seeking attitudes (Bamgbade et al., 2024). Research with Black male college students at historically Black universities further emphasizes the interaction between stigma, literacy, gender, and institutional context (Gere & Salimi, 2025). Although research addressing health promotion at Historically Black Colleges and Universities has often focused on health concerns beyond mental illness, intervention strategies in these settings provide broader evidence that culturally and institutionally tailored promotion can be important when addressing stigmatized health behaviors among young adults (Knight et al., 2025). More generally, systemic and cultural factors must be considered because mental health behavior is shaped not only by individual attitudes but also by whether services are perceived as relevant, accessible, respectful, and trustworthy.

Structural and institutional barriers further complicate psychological and social reluctance. Even when young adults overcome internal resistance, uncertainty about cost, confidentiality, waiting periods, eligibility, provider availability, or the process of entering care may discourage follow-through. Qualitative work with young adults in Australia has identified broader systemic health, educational, and social challenges that influence perceptions of mental health care (Cooper et al., 2025). Stakeholder research concerning mental health systems and services for emerging adults in Barbados likewise underscores the importance of service organization, accessibility, continuity, and responsiveness to the developmental needs of young adults (Kellman & Harewood, 2026). A qualitative evidence synthesis involving school-going adolescents in sub-Saharan Africa has similarly identified barriers and facilitators operating across personal, family, community, and service-system levels (Kakinda et al., 2026). Although these contexts differ from the United States, they collectively demonstrate that help-seeking behavior develops through interaction between personal readiness and the perceived responsiveness of available systems.

Technology and alternative modes of support may reduce some barriers while leaving others intact. Online counseling, digital resources, anonymous platforms, and telehealth can provide greater privacy and may be particularly appealing to individuals who fear face-to-face disclosure. Research among college students experiencing intimate partner violence suggests that openness to online counseling can vary according to individual and contextual characteristics, indicating that digital modalities may increase options for individuals reluctant to access traditional services (Nelson et al., 2022). However, accessibility alone does not necessarily eliminate shame, fear of judgment, or uncertainty about whether one's problems justify intervention. Similarly, activist and community contexts can influence how people understand psychological distress and available support, particularly when mental health experiences are connected with wider social pressures and collective stressors (Herbert et al., 2023). Accordingly, interventions that simply expand service availability may be insufficient unless they also address the psychological and relational processes that precede the decision to make contact.

The importance of relational safety is particularly evident in qualitative studies of populations facing elevated psychological risk. Research with Latina college students experiencing suicidal thoughts or behaviors has shown that help-seeking must be understood within family, cultural, institutional, and interpersonal contexts and that multiple perspectives are required to explain how young adults decide whether to disclose serious psychological distress (Bravo et al., 2026). Such findings suggest that young adults may be more likely to seek assistance when they expect validation, confidentiality, respect, and an absence of judgment. Conversely, previous invalidating experiences can become powerful deterrents because they provide a concrete basis for expecting future disclosure to be ineffective or harmful. Help-seeking may therefore depend on whether the person perceives a sufficiently safe recipient, whether that recipient actively communicates willingness to listen, and whether the individual believes that disclosure will produce support rather than social cost.

Despite substantial research on mental health stigma, literacy, service accessibility, cultural barriers, and demographic differences, an important conceptual gap remains. Much of the literature examines whether young people seek care, which factors statistically predict service use, or which barriers are endorsed after non-use. Less attention has been devoted to the subjective psychological interval between recognizing that help is needed and actually asking for it. This interval is critical because a young adult may possess adequate knowledge of mental health, have access to services, and acknowledge distress while still being unable to initiate disclosure. The central problem is therefore not simply "Why do young adults fail to seek help?" but "What happens psychologically and socially after a young adult realizes that help may be necessary?" Understanding this process requires close attention to self-reliance, legitimacy judgments, shame, emotional articulation, anticipated reactions, fear of burdening others, relational

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trust, previous disclosure experiences, and perceived safety. Existing findings across diverse populations strongly suggest that these factors interact rather than operate independently (Gallimore et al., 2026; Nguyen et al., 2023; Noorwali et al., 2022; Sheikh et al., 2024). A qualitative examination of these interactions can therefore clarify why awareness and intention sometimes fail to translate into action and can identify points at which supportive relationships, psychoeducation, institutional practices, and accessible services might interrupt cycles of avoidance.

Accordingly, the aim of the present study was to explore the lived psychological and social barriers that prevent young adults in the United States from seeking mental health support even when they recognize that they need help.

2. Methods and Materials

2.1. Study Design and Participants

This study employed a qualitative descriptive design with a phenomenological orientation to explore the psychological and social barriers that prevent young adults from seeking professional mental health support despite recognizing a personal need for such assistance. A qualitative approach was considered appropriate because the study focused on participants' subjective experiences, interpretations, emotions, interpersonal concerns, and perceptions of the social environment surrounding mental health help-seeking. Rather than attempting to quantify predetermined barriers, the study was designed to capture how young adults themselves understood the internal and external processes that influenced their decisions to disclose psychological distress, communicate a need for assistance, and approach professional mental health services. The phenomenological orientation further enabled an in-depth examination of the lived experience of recognizing psychological difficulties while simultaneously feeling unable, unwilling, or unprepared to request help. Particular attention was given to the meaning participants assigned to vulnerability, stigma, self-reliance, anticipated judgment, social expectations, previous experiences with disclosure, perceived burden on others, and uncertainty regarding the legitimacy or severity of their own psychological distress.

The study included 26 young adults residing in the United States. Participants were between 18 and 29 years of age and were recruited using purposive sampling supplemented by maximum-variation sampling to obtain diverse experiences with respect to gender, educational background, employment status, living arrangements, and previous exposure to mental health services. Eligibility criteria required participants to be between 18 and 29 years of age, currently reside in the United States, have experienced a period during the previous two years in which they believed they needed psychological or emotional support, and report that they had postponed, avoided, or experienced substantial difficulty asking for professional or interpersonal help for their mental health concerns. Participants were not required to have received a formal psychiatric diagnosis because the study was concerned with perceived need for psychological assistance rather than diagnostic status. Individuals who were unable to participate in an English-language interview or who were experiencing an acute psychological crisis requiring immediate clinical intervention at the time of recruitment were not enrolled in the interview component. Recruitment notices describing the general purpose of the research were distributed through university student networks, community organizations serving young adults, online community platforms, and social media channels accessible to individuals living in the United States. Interested individuals completed a brief eligibility screening, after which eligible participants received detailed information about the study and provided informed consent before participation.

Recruitment and interviewing continued until sufficient informational depth had been achieved and additional interviews no longer generated substantively new categories concerning the central phenomenon. Data saturation was considered in relation to both the repetition of major barriers and the adequacy of the data for explaining the psychological and social processes underlying delayed or avoided help-seeking. The final sample of 26 participants provided sufficient variation to examine both shared experiences and meaningful differences in the ways young adults interpreted mental health difficulties and decisions about seeking help. Participation was voluntary, and individuals were informed that they could decline to answer any question or discontinue participation at any point without providing a reason. Given the potentially sensitive nature of discussions concerning emotional distress, stigma, interpersonal relationships, and previous experiences of psychological difficulty, interviews were conducted with particular attention to privacy, participant comfort, and emotional safety. Personally identifying information was separated from interview records, pseudonyms or identification codes were assigned to transcripts, and all research materials were managed confidentially throughout the research process.

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2.2. *Measures*

Data were collected primarily through individual semi-structured, in-depth interviews, supported by a brief demographic and background information form. The semi-structured interview format was selected because it provided a consistent framework for addressing the principal research objectives while allowing participants sufficient freedom to describe experiences that were personally meaningful and that might not have been anticipated by the researchers. An interview guide was developed specifically for the study on the basis of the research aim and the conceptual distinction between psychological barriers originating primarily within the individual and social barriers emerging through interpersonal relationships, cultural expectations, and perceived social responses. Questions were deliberately phrased in an open-ended and nonjudgmental manner to encourage participants to describe their experiences in their own words rather than selecting from predetermined explanations. The interviews began with broad questions concerning experiences of psychological or emotional difficulty and gradually progressed toward more focused exploration of recognizing the need for support, considering whether to ask for help, deciding whom to approach, delaying or avoiding disclosure, and interpreting the possible consequences of seeking assistance.

The interview guide explored several interconnected areas. Participants were asked to describe situations in which they felt they needed psychological help but found it difficult to request it, how they recognized that their distress had become significant, and what thoughts and emotions emerged when they considered telling another person or contacting a mental health professional. Additional questions examined concerns about appearing weak, losing independence, being unable to explain emotions, being judged or misunderstood, having problems minimized, burdening family members or friends, damaging relationships, being labeled because of mental health difficulties, or experiencing negative consequences in educational, occupational, or social environments. Participants were also encouraged to discuss beliefs about self-reliance and personal responsibility, perceptions of whether their difficulties were sufficiently serious to justify professional assistance, comparisons between their own distress and the perceived problems of others, previous experiences of disclosure or treatment, family attitudes toward mental health, peer norms, cultural expectations, financial or practical concerns when these interacted with psychological or social barriers, and conditions that might make asking for help easier. Follow-up probes such as requests to elaborate on thoughts, emotions, interpersonal reactions, critical incidents, and decision-making processes were used to obtain richer descriptions and clarify the meanings participants attributed to their experiences.

The demographic and background form collected basic information relevant to contextualizing participants' accounts, including age, gender, educational status, employment status, living situation, and previous use of mental health services. These variables were not collected for statistical hypothesis testing but were used to assist interpretation of variation across participants' narratives. Interviews were conducted individually through secure videoconferencing or, when feasible and preferred by the participant, in a private face-to-face setting. Each interview lasted approximately 45 to 75 minutes. With participants' permission, interviews were digitally audio-recorded to permit accurate transcription. Recordings were transcribed verbatim, and transcripts were reviewed against the original recordings to identify transcription errors and preserve the intended meaning of participants' statements. Field notes were also recorded following each interview to document contextual observations, emerging analytical ideas, notable emotional or interpersonal features of the interview, and issues requiring further exploration in subsequent interviews. Data collection and preliminary analysis proceeded concurrently, allowing the interview process to become progressively more sensitive to emerging patterns without imposing predetermined categories on participants' accounts.

To enhance the credibility and appropriateness of the interview guide, questions were reviewed before formal data collection for clarity, sensitivity, neutrality, and consistency with the study objectives. Particular care was taken to avoid wording that assumed participants should have sought professional help or that framed reluctance to seek assistance as irrational or dysfunctional. Instead, the interview process treated help-seeking decisions as contextually situated responses that could reflect personal beliefs, emotional protection, interpersonal experiences, and perceived social risks. The interviewer adopted a reflective and non-directive stance and avoided evaluating participants' decisions or providing clinical interpretations during the interviews. When participants discussed emotionally difficult experiences, they were permitted to pause, redirect the conversation, or omit details they did not wish to disclose. This approach was intended to generate detailed and

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authentic accounts while minimizing pressure to disclose sensitive information beyond participants' preferred boundaries.

2.3. Data analysis

The interview data were analyzed using reflexive thematic analysis, with an inductive orientation that allowed patterns and themes to be developed primarily from participants' accounts rather than being organized according to a predetermined theoretical classification. Although the research questions distinguished broadly between psychological and social barriers, these categories were treated as sensitizing concepts rather than fixed analytical structures. This was important because many help-seeking barriers operated simultaneously at individual and interpersonal levels. For example, fear of judgment could be experienced as an internal anticipatory emotion while also being shaped by previous reactions from family members, peers, or broader cultural expectations. The analysis therefore focused on identifying recurrent meanings, experiences, and processes across the dataset while remaining attentive to contradictions, individual differences, and interactions among psychological, relational, and social influences.

Analysis began with intensive familiarization with the dataset. Each transcript was read several times while the researchers reviewed field notes and recorded preliminary observations concerning participants' experiences of distress recognition, concealment, disclosure, self-evaluation, anticipated social consequences, and decisions regarding professional support. Initial coding was conducted systematically across the complete dataset. Codes were assigned to meaningful segments of text that represented distinct experiences, perceptions, emotions, beliefs, interpersonal dynamics, or decision-making processes relevant to mental health help-seeking. Coding remained relatively close to participants' descriptions during the early stages of analysis and included both explicit statements and underlying meanings evident in the broader context of participants' narratives. Examples of the types of experiences considered during initial coding included minimizing one's own distress, uncertainty about deserving help, fear of being perceived as weak, difficulty translating emotions into words, concern about becoming a burden, expectation of invalidation, distrust arising from previous disclosures, pressure to manage problems independently, discomfort with professional vulnerability, anticipated stigma, and concerns about changes in how others might perceive or treat the individual after disclosure.

Following initial coding, conceptually related codes were compared and clustered into provisional categories. Constant comparison across participants was used to determine whether apparently similar experiences represented the same underlying process or reflected meaningfully different barriers. Relationships between categories were then examined to identify broader candidate themes capable of explaining recurring patterns in the data. Particular attention was given to the interaction between internal psychological processes and perceived social consequences. For instance, self-criticism was examined not only as an intrapersonal process but also in relation to social norms concerning independence, emotional control, competence, and expectations regarding how young adults should manage distress. Similarly, reluctance to disclose was analyzed in relation to both personal discomfort with vulnerability and participants' experiences or expectations of judgment, dismissal, misunderstanding, or altered relationships. Candidate themes were repeatedly reviewed against coded extracts and the complete transcripts to determine whether they demonstrated adequate internal coherence while remaining sufficiently distinct from one another.

Theme development involved an iterative process of combining, separating, refining, and renaming categories until the thematic structure represented both the breadth and depth of participants' accounts. Themes were not determined solely by the numerical frequency with which a topic appeared. Analytical importance was also evaluated according to the extent to which a pattern contributed to explaining why participants could recognize a need for psychological support while nevertheless remaining unable or reluctant to request assistance. Deviant and contrasting cases were actively examined to prevent the final interpretation from overstating uniformity within the sample. Participants who described relatively low concern regarding stigma but substantial difficulty with emotional articulation, for example, were considered alongside participants whose reluctance was strongly associated with family norms or anticipated judgment. This comparative approach supported a more nuanced account of help-seeking barriers and helped identify the different pathways through which similar behavioral outcomes, such as delayed disclosure or avoidance of professional services, could emerge.

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Several procedures were incorporated to strengthen the trustworthiness of the analysis. An audit trail was maintained throughout coding and theme development to document analytical decisions, revisions to the thematic structure, and the rationale for combining or distinguishing categories. Reflexive notes were used to identify assumptions that could influence interpretation, particularly assumptions regarding the presumed benefits of formal mental health treatment or the expectation that individuals who recognize psychological difficulties should necessarily disclose them immediately. The researchers repeatedly returned to the original transcripts during theme refinement to ensure that interpretations remained grounded in participants' accounts. Attention was also paid to negative cases and experiences that complicated dominant patterns. The final themes were defined in terms of their central organizing concepts and were supported by selected participant narratives capable of demonstrating both common patterns and variation within those patterns. Through this iterative analytical process, the study sought to develop a coherent and contextually sensitive explanation of the psychological and social mechanisms that make asking for mental health assistance difficult for young adults even when they recognize that support may be necessary.

3. Findings and Results

The final analytic sample consisted of 26 young adults from the United States, ranging in age from 18 to 29 years, with a mean age of 23.81 years (SD = 3.17). Fourteen participants (53.8%) identified as women, 10 (38.5%) identified as men, and two (7.7%) identified as nonbinary or gender-diverse. In terms of racial and ethnic background, 10 participants (38.5%) identified as non-Hispanic White, five (19.2%) as Black or African American, five (19.2%) as Hispanic or Latino, four (15.4%) as Asian American, and two (7.7%) as multiracial. Participants were geographically distributed across different regions of the United States, including eight participants (30.8%) from Southern states, seven (26.9%) from the Northeast, six (23.1%) from the Midwest, and five (19.2%) from Western states. Regarding educational attainment, eight participants (30.8%) had completed high school or some college education, three (11.5%) held an associate degree, 10 (38.5%) held a bachelor's degree, and five (19.2%) had completed or were currently completing postgraduate education. Nine participants (34.6%) were employed full time, seven (26.9%) were employed part time, six (23.1%) were full-time students who were not employed, and four (15.4%) were unemployed or between educational or occupational positions at the time of the interviews. Nine participants (34.6%) lived with parents or other family members, 10 (38.5%) lived with partners, roommates, or friends, and seven (26.9%) lived alone. Eleven participants (42.3%) had previously used at least one form of professional mental health service, whereas 15 (57.7%) had never received formal psychological or psychiatric care. Importantly, inclusion in the study required all participants to have experienced a period in which they personally recognized a need for psychological or emotional assistance while nevertheless delaying, avoiding, or experiencing marked difficulty requesting such assistance. Therefore, the findings describe barriers occurring after recognition of need rather than an absence of awareness that psychological support might be beneficial.

Qualitative analysis demonstrated that difficulty seeking help was rarely explained by a single isolated obstacle. Instead, participants described a layered process in which self-evaluative beliefs, emotional discomfort, anticipated interpersonal consequences, previous experiences of invalidation, and broader social expectations interacted with one another. Six overarching themes were developed from the data: pressure to manage distress independently, uncertainty about whether one's difficulties were legitimate enough to warrant help, difficulty translating internal distress into communicable language, fear of judgment and identity change, reluctance to burden or disrupt relationships, and conditional willingness to seek help when psychological and social safety were sufficiently established. These themes and their associated subthemes are summarized in Table 1.

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Table 1

Overarching Themes and Subthemes Representing Barriers to Mental Health Help-Seeking Among Young Adults

Overarching theme	Subthemes	Central meaning
"I should be able to handle this myself"	Self-reliance as maturity; independence as personal competence; reluctance to admit inability to cope	Asking for help was interpreted by many participants as evidence that they had failed to manage their own emotions or responsibilities.
"Maybe my problem is not serious enough"	Downward comparison; normalization of distress; waiting until symptoms become severe; uncertainty about deserving care	Participants frequently invalidated their own need for support because they believed other people were experiencing more serious difficulties.
"I do not know how to explain what is happening"	Difficulty identifying emotions; fear of becoming overwhelmed while talking; uncertainty about what to ask for; difficulty initiating disclosure	Recognition of distress did not necessarily translate into an ability to describe the problem or communicate a clear request for assistance.
"They may see me differently afterward"	Fear of judgment; stigma; loss of perceived competence; fear of being labeled; concern about academic or occupational reputation	Help-seeking was experienced as a potential threat to social identity and to the way participants believed others perceived them.
"I do not want to become someone else's problem"	Fear of burdening family or friends; protecting others from worry; fear of relational imbalance; concern about rejection or distancing	Participants frequently suppressed help-seeking in an attempt to protect important relationships or prevent others from feeling responsible for their distress.
"I can ask only when it feels safe enough"	Trust; explicit invitations to disclose; normalization of mental health care; confidentiality; validation; low-pressure access to professional care	Help-seeking became more possible when participants perceived that disclosure would be accepted, respected, and unlikely to produce negative interpersonal consequences.

As shown in Table 1, participants' accounts reflected a progression from internal self-regulation demands toward increasingly relational considerations. The first two themes were strongly associated with internal standards regarding independence and legitimacy. Participants commonly believed that adulthood required the capacity to manage emotional problems independently, and asking for help could therefore be interpreted as evidence of weakness, immaturity, loss of control, or personal inadequacy. This expectation was reinforced by the tendency to minimize distress. Many participants reported recognizing persistent anxiety, low mood, emotional exhaustion, loneliness, or difficulty functioning while simultaneously concluding that these problems were not sufficiently severe to justify professional attention. The third theme demonstrated an additional distinction between recognizing distress and being able to communicate it. Participants frequently understood that something was wrong but had difficulty naming emotions, organizing their experiences into an understandable narrative, or identifying what kind of help they were actually requesting. The fourth and fifth themes extended the barrier process into the social domain. Participants anticipated that disclosure might alter the way friends, relatives, colleagues, or professionals viewed them and were particularly concerned about being perceived as unstable, overly emotional, weak, incapable, or attention-seeking. At the same time, many attempted to protect others by withholding distress, particularly when family members or close friends were already perceived as experiencing their own difficulties. The final theme revealed that avoidance was not necessarily equivalent to rejection of mental health care. Rather, willingness to seek support was often conditional. Participants became more open to disclosure when they experienced trust, explicit permission to talk, validation, normalization of psychological care, and confidence that their information would remain private. Thus, the thematic structure indicated that help-seeking was not a binary decision but an ongoing negotiation between recognized need and perceived psychological and interpersonal risk.

Table 2

Psychological Barriers Identified Across Participant Interviews

Psychological barrier	Participants mentioning barrier, n	Percentage of sample
Pressure to manage problems independently	22	84.6%
Belief that distress was not severe enough to justify help	21	80.8%
Difficulty verbalizing emotions or explaining the problem	19	73.1%
Fear of emotional exposure or losing control during disclosure	17	65.4%
Uncertainty about what type of help was needed	15	57.7%
Shame or self-criticism related to needing help	14	53.8%
Doubt regarding whether professional support would be effective	11	42.3%

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Table 2 demonstrates that the most widespread psychological barrier was the expectation of self-reliance, which appeared in the interviews of 22 of the 26 participants (84.6%). Participants frequently described an internal rule that emotional difficulties should first be solved privately through distraction, self-discipline, exercise, work, studying, online information, journaling, or attempts to "wait it out." Help was commonly viewed as something that should be considered only after these self-management strategies had failed. Closely related to this pattern was the belief that one's distress had not yet reached a sufficiently serious threshold, reported by 21 participants (80.8%). Several participants described mentally comparing themselves with people who had experienced bereavement, severe trauma, psychiatric hospitalization, suicidal crises, or other highly visible forms of suffering and then concluding that their own anxiety, depressive symptoms, interpersonal difficulties, or emotional exhaustion did not justify professional attention. This comparison produced a paradoxical threshold for care: participants acknowledged that they were struggling but believed they needed to deteriorate further before asking for assistance would become legitimate. Difficulty verbalizing internal experiences was reported by 19 participants (73.1%), indicating that help-seeking involved not only deciding to disclose but also developing language through which distress could be communicated. Participants described knowing that they were "not okay" while being unable to explain why, identify a specific problem, or formulate a request beyond a general desire for relief. Seventeen participants (65.4%) were additionally concerned that beginning to speak might cause them to cry, lose emotional control, reveal more than intended, or become unable to stop discussing experiences they had previously contained. Uncertainty about the appropriate form of assistance was described by 15 participants (57.7%), particularly among individuals without previous experience of mental health services. They questioned whether they needed counseling, psychotherapy, psychiatric evaluation, peer support, or simply someone to listen. Shame and self-criticism were identified in 14 interviews (53.8%), often appearing as self-directed statements that needing assistance meant they were failing to cope with ordinary life. Finally, 11 participants (42.3%) expressed some degree of skepticism about whether professional support would be effective. Importantly, skepticism rarely appeared as an absolute rejection of therapy; instead, it interacted with other barriers by increasing the perceived cost of taking the interpersonal and emotional risk of asking for help when the benefit remained uncertain.

Table 3

Social and Interpersonal Barriers to Mental Health Help-Seeking

Social or interpersonal barrier	Participants mentioning barrier, n	Percentage of sample
Anticipated judgment or negative evaluation	20	76.9%
Concern about burdening family members or friends	19	73.1%
Family or cultural expectations favoring emotional self-control	17	65.4%
Fear that relationships would change after disclosure	15	57.7%
Previous experiences of dismissal, minimization, or invalidation	13	50.0%
Privacy or confidentiality concerns	12	46.2%
Concern about academic or occupational reputation	10	38.5%
Absence of a person perceived as sufficiently trustworthy	9	34.6%

The social findings presented in Table 3 indicate that help-seeking decisions were strongly shaped by participants' expectations regarding how other people would interpret their distress. Anticipated judgment was identified in 20 interviews (76.9%), making it the most common social barrier. Participants did not necessarily report having been directly stigmatized; rather, many attempted to predict the consequences of disclosure before it occurred. They worried that family members, friends, romantic partners, supervisors, professors, or peers might regard them as emotionally unstable, overly sensitive, incapable, dramatic, or unreliable. Concern about burdening others was almost equally prominent, appearing in the accounts of 19 participants (73.1%). Participants frequently described monitoring the perceived emotional capacity of people around them and withholding their own difficulties when they believed others were already stressed, overworked, financially strained, physically ill, or coping with personal problems. In this sense, silence was sometimes understood by participants as an act of protection or consideration rather

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than simple avoidance. Family or culturally embedded expectations favoring emotional control and private coping appeared in 17 interviews (65.4%). Participants described family environments in which psychological difficulties were rarely discussed, emotional expression was discouraged, or seeking professional mental health care was interpreted as unnecessary unless a problem was extremely severe. Fifteen participants (57.7%) feared that disclosure could alter relational dynamics. They expressed concern that others might begin checking on them excessively, treating them as fragile, withdrawing from them, or redefining the relationship around their psychological difficulties. Previous experiences of invalidation were reported by 13 participants (50.0%) and appeared especially influential because they provided experiential evidence for future expectations of rejection. Some participants recalled previous attempts to disclose distress being met with advice to "get over it," comparisons with people who were perceived as having more serious problems, or responses that redirected attention away from their emotional needs. Twelve participants (46.2%) expressed concerns about privacy or confidentiality, including uncertainty regarding whether information shared with professionals, family members, or institutional personnel would remain private. Ten participants (38.5%) specifically feared consequences for academic or occupational identity, while nine (34.6%) reported that they could not identify a person who felt sufficiently safe or trustworthy to approach. Taken together, these findings demonstrate that the social environment was not simply a background context for help-seeking; it was actively incorporated into participants' internal decision-making through anticipated reactions, remembered experiences, and calculations about the possible relational costs of disclosure.

Table 4

Common Configurations of Interacting Psychological and Social Barriers

Barrier configuration	Core psychological process	Core social process	Typical help-seeking consequence	Participants displaying pattern, n
Self-reliance combined with minimization	"I should manage this myself" and "it is not serious enough"	Expectation that competent adults cope independently	Prolonged silent endurance and delayed professional contact	18
Emotional uncertainty combined with fear of judgment	Difficulty naming or explaining distress	Anticipation of misunderstanding or negative evaluation	Repeated intention to disclose followed by withdrawal	16
Shame combined with burden concerns	Self-criticism for needing support	Fear of creating emotional responsibility for others	Concealment from close relationships despite perceived need	14
Previous invalidation combined with distrust	Expectation that disclosure may not produce useful help	Memory of dismissal, minimization, or breaches of trust	Selective disclosure or avoidance of particular people and services	12
Worsening distress combined with perceived relational safety	Recognition that independent coping is no longer sufficient	Presence of a trusted, validating, or explicitly supportive person	Transition from avoidance toward disclosure or professional help-seeking	17

Table 4 illustrates that the most consequential barriers emerged through combinations of psychological and social processes rather than through independent factors. The most common configuration, evident in 18 participants, involved the interaction between self-reliance and minimization. Individuals in this pattern simultaneously believed that they should cope independently and that their difficulties had not yet become serious enough to justify assistance. These beliefs reinforced one another and created a prolonged period of silent endurance during which participants repeatedly postponed help-seeking while attempting additional self-management strategies. A second configuration, identified in 16 participants, combined difficulty articulating emotional experience with fear of being judged or misunderstood. These participants often approached the point of disclosure but withdrew because they anticipated that an incomplete, disorganized, or emotionally intense explanation would be interpreted negatively. Fourteen participants demonstrated a pattern in which shame about needing help was reinforced by concern about becoming a burden. In this configuration, participants often perceived themselves as responsible for protecting close others from their emotional difficulties, making disclosure feel simultaneously selfish and embarrassing. Twelve participants described a configuration in which previous invalidation contributed to generalized distrust.

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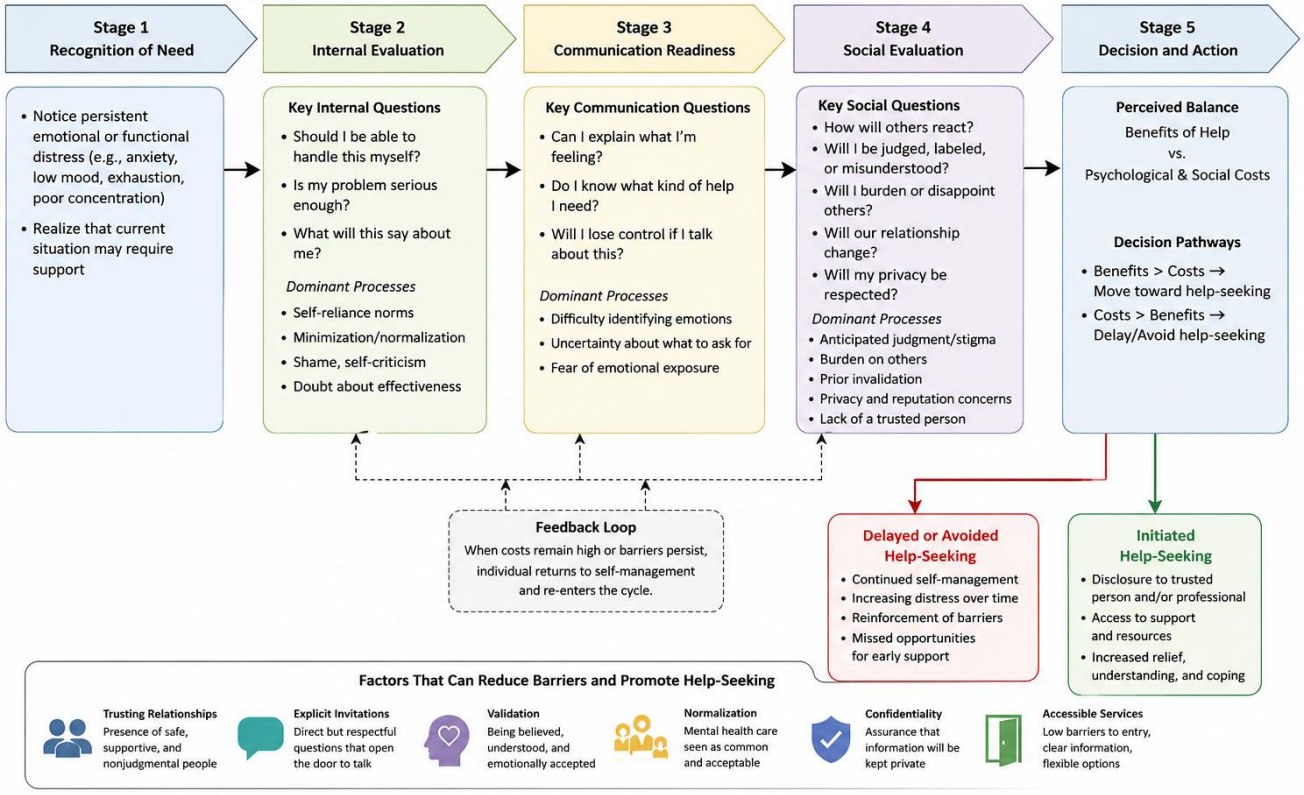
Rather than simply remembering a negative interaction, these participants incorporated earlier dismissal into future predictions, becoming more cautious about whom they approached and what they disclosed. The final configuration represents an important counter-process. Seventeen participants described situations in which worsening distress became sufficient to challenge self-reliance, but movement toward help-seeking generally occurred only when some form of relational safety was also present. This safety could involve a trusted friend asking directly about their wellbeing, a family member responding without judgment, a peer normalizing therapy, a professional explaining confidentiality, or a service that allowed relatively private and low-pressure initial contact. The findings therefore suggest that severity alone did not consistently produce help-seeking. Even when participants recognized that their condition had worsened, perceived interpersonal safety remained an important factor determining whether recognition would be translated into action.

Figure 1

Conceptual Pathway From Recognition of Mental Health Need to Delayed, Avoided, or Initiated Help-Seeking Among Young Adults



The conceptual pattern represented in Figure 1 captures the central process identified across the interviews. Participants generally began with recognition that their emotional state, functioning, relationships, motivation, anxiety, or mood had changed in a way that suggested a need for support. Recognition was followed by an internal evaluation in which participants asked, implicitly or explicitly, whether the problem was sufficiently serious, whether they should be able to solve it independently, and whether seeking assistance was consistent with their identity as competent and self-sufficient adults. When distress survived this internal screening, participants entered a second evaluative stage focused on communication: whether they could explain what they were experiencing, whether they knew what kind of support to request, and whether speaking openly would lead to loss of emotional control. A third stage involved anticipated social consequences. Participants considered who might be safe to approach, how that person might respond, whether they would become a burden, whether the relationship might change, whether information would remain private, and whether disclosure could threaten their social, academic, or occupational identity. When perceived psychological and social risks outweighed expected benefits, participants returned to self-

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management and concealment, creating a recursive cycle of delayed help-seeking. This cycle could continue even as distress worsened because worsening symptoms did not automatically eliminate beliefs about independence, shame, burden, or judgment. Conversely, movement toward help-seeking became more likely when one or more barriers were interrupted. An explicit invitation to talk could reduce uncertainty about initiating disclosure; validation could weaken beliefs that distress was illegitimate; normalization of therapy could reduce stigma; clear information about confidentiality could reduce perceived social risk; and the presence of a trusted person could make emotional exposure more tolerable. The model therefore reflects help-seeking as a dynamic negotiation between perceived need and perceived safety rather than a simple consequence of symptom severity.

Across the complete dataset, one of the clearest findings was the distinction between recognizing the need for help and granting oneself permission to ask for it. Participants rarely described complete unawareness of their emotional difficulties. Instead, many were capable of identifying that they were anxious, emotionally exhausted, persistently sad, unable to concentrate, socially withdrawn, overwhelmed, or no longer coping effectively. The difficulty emerged when this recognition had to be converted into an interpersonal action. Participants frequently applied a higher threshold to requesting help than to recognizing distress. They might privately acknowledge that they were struggling while simultaneously deciding that the situation was still manageable, temporary, insufficiently serious, or inappropriate to discuss. In several accounts, this threshold shifted repeatedly. Participants would decide that they should seek help during periods of acute distress but reverse the decision after temporarily feeling better, interpreting short-term improvement as evidence that assistance was no longer justified. This produced a cyclical pattern in which help-seeking intentions became strongest during periods of high distress but were often not acted upon before symptoms partially subsided.

A particularly important aspect of this process was the moral meaning attached to self-reliance. For many participants, managing distress alone was not merely a preferred coping strategy; it was associated with beliefs about maturity, competence, responsibility, and personal strength. Asking for help could therefore produce an identity conflict. Participants described wanting support while simultaneously wanting to remain the kind of person who did not "need" support. This conflict was especially visible among participants who were accustomed to being perceived by others as responsible, academically successful, emotionally stable, dependable, or supportive. For these individuals, disclosure threatened not only privacy but also an established interpersonal role. Some participants described being the person whom others normally approached for advice or emotional support and consequently found it difficult to reverse roles and become the recipient of care. The perceived contradiction between being dependable and needing help intensified reluctance to disclose distress.

The data also demonstrated that minimization was a central mechanism through which help-seeking was postponed. Participants often recognized genuine impairment but evaluated their experiences against an imagined hierarchy of suffering. If they could continue attending classes, going to work, communicating with friends, or completing basic responsibilities, they sometimes concluded that they were functioning "well enough" and therefore did not have a legitimate reason to seek professional support. This interpretation persisted even when maintaining daily functioning required substantial emotional effort. Others compared their experiences with individuals who had received formal diagnoses or experienced psychiatric emergencies and concluded that mental health services should be reserved for those with more severe conditions. Consequently, the absence of crisis became a justification for delay rather than an opportunity for early intervention.

Another recurrent finding concerned the problem of emotional translation. Participants often stated that their internal experiences felt complicated, vague, contradictory, or difficult to organize into language. This was particularly important for participants who had spent long periods concealing their distress. The longer experiences remained private, the more difficult some participants found it to identify a clear starting point for disclosure. They worried about being asked why they felt a certain way when they could not identify a single cause, or about being expected to provide a coherent explanation for distress that they themselves did not fully understand. This uncertainty sometimes created anticipatory embarrassment, because participants feared that an inability to explain their emotions would make their need for assistance appear less credible. For several participants, the phrase "I need help" itself felt too definitive because they were unsure what kind of help they needed, how much they wanted to disclose, or whether

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they were prepared to accept recommendations that might follow.

Fear of judgment emerged not simply as generalized concern about mental health stigma but as a more specific threat to identity and relationships. Participants anticipated different forms of judgment depending on the social context. Within families, they worried about disappointing parents, causing worry, or being told that their distress reflected a lack of resilience or gratitude. Within friendships, they feared becoming perceived as emotionally demanding or difficult to be around. In romantic relationships, some participants worried that disclosure might make a partner question the stability of the relationship or feel responsible for managing their emotional condition. In educational and occupational contexts, concerns centered more strongly on competence, reliability, professionalism, and privacy. These context-specific expectations indicate that mental health stigma operated through multiple social identities rather than as a single uniform belief.

The concern about burdening others was similarly complex. Participants did not merely fear rejection; many actively attempted to protect others from emotional strain. They evaluated whether family members or friends had enough emotional capacity to hear about their problems and often concluded that other people already had too many responsibilities. This led some participants to delay disclosure until they could identify a person who appeared emotionally available. Others attempted to reduce the perceived burden by sharing only partial information, presenting distress humorously, minimizing severity, or framing disclosure as a casual update rather than a request for support. These strategies allowed participants to test the interpersonal environment while retaining the possibility of withdrawing if the response felt uncomfortable.

Previous interpersonal experiences strongly shaped these calculations. Participants who had previously been dismissed, interrupted, lectured, compared with others, or told to be more positive were more likely to anticipate similar responses in future interactions. Even relatively subtle invalidation had enduring effects when it occurred during an earlier vulnerable disclosure. Some participants therefore described carefully selecting what to disclose to different people rather than simply deciding whether to disclose at all. A friend might be considered safe for discussing stress but not depressive symptoms; a family member might be trusted with practical problems but not emotional vulnerability; a professional might be considered confidential but emotionally unfamiliar. Help-seeking was consequently selective, layered, and dependent on perceived relational function.

At the same time, the findings showed that barriers were modifiable. Participants repeatedly described situations in which asking became easier because another person reduced the social and psychological work required to initiate disclosure. Direct but nonintrusive questions such as noticing that someone seemed different, expressing concern without pressure, or explicitly stating willingness to listen were described as particularly helpful. These interactions reduced the requirement for participants to create an opening independently. Normalization also appeared important. Participants who knew friends, relatives, colleagues, or public figures who had openly discussed therapy often described professional help as more acceptable and less identity-threatening. Similarly, clear explanations regarding confidentiality, what to expect from an initial appointment, and the fact that individuals did not need to arrive with a perfectly articulated problem reduced uncertainty about the professional help-seeking process.

4. Discussion

The present study explored the psychological and social barriers that prevented young adults in the United States from seeking mental health support despite recognizing that they needed assistance. The findings demonstrated that the gap between perceived need and actual help-seeking was not attributable to a single obstacle. Instead, participants described an interconnected process involving expectations of self-reliance, minimization of personal distress, difficulty articulating emotional experiences, fear of emotional exposure, anticipated judgment, concern about burdening others, previous experiences of invalidation, and uncertainty regarding the safety of disclosure. Six overarching themes captured this process: the belief that distress should be managed independently, uncertainty regarding whether problems were sufficiently serious to warrant help, difficulty explaining psychological experiences, fear that disclosure would change how others perceived the individual, concern about becoming a burden to significant others, and conditional willingness to seek support when the interpersonal environment felt sufficiently safe. Collectively, these findings indicate that recognizing a need for mental health support and granting oneself permission to seek that support are distinct psychological processes. The findings are broadly consistent with previous research showing that service non-use among adolescents and young

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adults remains influenced by psychological, sociodemographic, cultural, and clinical factors even when mental health difficulties are present (Reich et al., 2023), and they reinforce arguments that help-seeking intentions and behaviors should themselves be considered important targets within mental health prevention strategies for emerging adults (Nauphal et al., 2023).

One of the strongest findings concerned the expectation that young adults should be able to manage psychological difficulties independently. Most participants described self-reliance not simply as a coping preference but as an implicit standard of competence and adulthood. Asking for assistance could therefore threaten a valued identity as capable, independent, resilient, or emotionally controlled. This result is consistent with research on young men showing that self-reliance, restrictive emotional expression, and concerns about appearing weak can inhibit help-seeking for affective mental health problems (Sheikh et al., 2024). Qualitative evidence from young men has similarly demonstrated that informal help-seeking is shaped by vulnerability, anticipated interpersonal responses, and concerns surrounding emotional disclosure (Burke et al., 2022). Research involving older adolescent boys also suggests that engagement with mental health interventions depends partly on whether participation can be reconciled with prevailing beliefs about masculinity, social acceptance, and emotional communication (Lisk et al., 2023). Although the current study included participants of different genders, self-reliance emerged as a broader developmental expectation rather than a phenomenon restricted to men. This suggests that norms emphasizing independence may become particularly salient during emerging adulthood, when individuals are increasingly expected to manage educational, occupational, financial, and interpersonal responsibilities autonomously.

The prominence of self-reliance also helps explain why participants commonly postponed seeking professional support even when they recognized deterioration in their emotional functioning. Many described a sequence of attempting to solve problems privately, waiting for symptoms to improve, and viewing professional assistance as justified only after self-management had failed. This pattern supports previous evidence that mental health literacy alone does not guarantee service utilization. University students may possess awareness of mental health problems and counseling services while still reporting substantial barriers to seeking assistance (Younes et al., 2025). Similarly, work among Black male college students has highlighted the interaction among mental health literacy, stigma, and help-seeking behavior (Gere & Salimi, 2025). The present findings add to this literature by suggesting that knowledge of mental health services may be overridden by a personal rule that assistance should remain a last resort. From this perspective, interventions focused solely on increasing awareness may have limited effectiveness unless they also challenge the assumption that seeking help represents failure of independent coping.

A second major finding concerned participants' tendency to minimize or delegitimize their own distress. Many acknowledged persistent anxiety, low mood, exhaustion, impaired concentration, or difficulty functioning but concluded that their circumstances were not sufficiently severe to justify professional help. Participants frequently compared their experiences with more extreme forms of psychological suffering and interpreted the absence of crisis as evidence that they should continue coping alone. This finding aligns with research showing that help-seeking can remain delayed even among populations experiencing significant psychological or behavioral problems. Studies of youth with eating disorders have identified complex attitudinal and behavioral barriers that may postpone help-seeking despite potentially serious consequences (Nicula et al., 2022). Research concerning college students engaging in non-suicidal self-injury has likewise demonstrated that pathways to receiving help are not automatic even when psychological distress is behaviorally evident (Emqi & Hartini, 2022). The clinical importance of delayed recognition and intervention is further underscored by evidence connecting severe academic anxiety with suicide planning and attempts among university students (Shah, 2025). Together with the current findings, this literature suggests that young adults may apply excessively restrictive criteria to determining when professional support is legitimate, thereby allowing problems to intensify before assistance is sought.

The difficulty of translating psychological distress into language represented another important barrier. Participants frequently described knowing that something was wrong while being unable to name the experience, explain its causes, identify what type of assistance was required, or formulate an explicit request for help. This finding demonstrates that recognition of distress is not equivalent to communicative readiness. Mental health literacy therefore appears relevant not only in identifying disorders or knowing where services are located but also in providing individuals with a vocabulary through which internal experiences can be

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communicated. Previous qualitative research among male college students has emphasized connections between mental health literacy and help-seeking behaviors (DeBate et al., 2022), while studies among Asian American college students have identified interacting cultural, interpersonal, literacy-related, and service-level influences on mental health service use (Nguyen et al., 2023). Similar barriers have been identified among Asian American adolescents, for whom stigma, family context, cultural expectations, and perceptions of mental health services may collectively affect help-seeking (Qi et al., 2025). The present study extends these findings by showing that uncertainty can persist even when participants already recognize psychological need. Some individuals may know that support is necessary but remain unsure how to begin the conversation, what to say, or whether their inability to explain the problem will undermine the legitimacy of their request.

Fear of emotional exposure further intensified this communication barrier. Participants sometimes anticipated that speaking openly would cause them to cry, lose control, disclose more than intended, or become unable to manage emotions that had previously been contained. Thus, avoiding help could function as a form of short-term emotional regulation. Remaining silent reduced immediate vulnerability even when it prolonged distress. This interpretation is consistent with broader findings suggesting that help-seeking depends partly on perceived behavioral control and expectations regarding the consequences of disclosure. Research applying the Theory of Planned Behavior to Korean American help-seeking has highlighted the importance of attitudes, subjective norms, and perceived behavioral control in decisions about obtaining assistance (Ha et al., 2024). Similarly, international evidence indicates that the act of disclosure itself can carry psychological and interpersonal risks, particularly among young people navigating stigmatized identities (Sahoo et al., 2023). The current findings suggest that mental health interventions should distinguish between willingness to receive help and readiness to engage in the emotionally demanding act of asking for it.

Anticipated judgment was the most frequently reported social barrier and operated as a perceived threat to identity. Participants worried that disclosure could lead others to view them as weak, unstable, overly emotional, incapable, unreliable, or attention-seeking. This result strongly aligns with the extensive literature on mental health stigma and help-seeking. Among internship nursing students, mental health stigma has been associated with attitudes toward seeking professional psychological help (Abdelmonaem et al., 2024). Among university students, greater self-stigma surrounding psychological help-seeking has likewise been considered alongside mental health literacy and attitudes toward mental illness (Koutra et al., 2024). Qualitative work among Albanian university students has similarly identified stigma as an important component of attitudes toward seeking help (Duraku et al., 2024), while lived-experience research among young Barbadians has shown how stigma can become directly embedded within decisions about disclosure and mental health service use (Gallimore et al., 2026). The convergence of these findings across cultural contexts suggests that anticipated social judgment remains a significant mechanism through which mental health stigma translates into behavior.

The current findings further suggest that stigma is not experienced uniformly. Participants anticipated different consequences depending on whether disclosure occurred within family, friendship, romantic, educational, or occupational relationships. Among family members, concerns often involved disappointment, worry, or invalidation; among peers, participants feared being viewed as emotionally demanding; and within academic or occupational environments, concerns centered on competence, privacy, and reputation. This context-dependent nature of anticipated stigma is consistent with research showing that young people's help-seeking behaviors are embedded in culturally and relationally specific environments. Studies of young adults in Saudi Arabia have identified barriers and facilitators spanning personal, social, cultural, and service-related domains (Noorwali et al., 2022), while research among Pakistani adolescents has similarly emphasized the influence of family, community, and service factors (Nizam & Ali, 2021). A review of mental health help-seeking research in India also demonstrates the importance of culturally embedded beliefs and social relationships in shaping whether support is pursued (Sanghvi & Mehrotra, 2021). These similarities suggest that although the content of social expectations may differ across cultural contexts, the broader process of evaluating how disclosure might affect social relationships is highly relevant to help-seeking.

Concern about burdening others represented another particularly significant interpersonal barrier. Participants frequently withheld psychological difficulties because they believed that family members, friends, or partners were already experiencing sufficient stress and should not be given additional emotional responsibilities. This finding

complicates interpretations of non-disclosure as simply fear-based avoidance. In many accounts, silence was framed as protective, considerate, or relationally responsible. Participants were attempting to preserve important relationships and prevent their own distress from negatively affecting others. Research on barriers to behavior change has similarly distinguished between obstacles individuals attribute to themselves and those involving other people or social contexts (Hallihan et al., 2025). Moreover, young adults occupying complex family and educational roles may experience particularly strong expectations to remain competent and avoid creating additional strain. Research involving first-year, first-generation college students and second-generation immigrant identities illustrates how educational transitions, family expectations, and identity pressures can intersect with mental health challenges (Horne & Chukwuere, 2025). The present results indicate that messages encouraging young adults simply to "reach out" may overlook the relational calculations that precede disclosure. For someone who believes asking for help will harm another person, help-seeking must first become compatible with their understanding of relational responsibility.

Previous experiences of invalidation also shaped participants' subsequent willingness to seek assistance. Individuals who had previously been dismissed, minimized, criticized, compared unfavorably with others, or given unwanted advice often generalized these experiences to future situations. Such experiences appeared to transform anticipated stigma from a hypothetical concern into an expectation grounded in prior interpersonal evidence. This may help explain why trust emerged as an essential condition for help-seeking. Similar patterns appear in qualitative studies emphasizing the importance of relational context in understanding mental health disclosure and service utilization. Research involving Latina college students experiencing suicidal thoughts or behaviors has demonstrated that help-seeking must be interpreted within family, cultural, interpersonal, and institutional contexts rather than as an isolated individual decision (Bravo et al., 2026). Research among LGBTQ+ populations similarly illustrates how expectations of acceptance or rejection can influence disclosure decisions (Sahoo et al., 2023), while work on LGB college students has highlighted the compounded psychological burden created when mental health needs and stigmatized identity concerns must both be concealed (Sánchez-Millán et al., 2025). These studies support the present finding that psychological safety is often constructed through prior relational experiences.

The results nevertheless demonstrated that help-seeking barriers were not fixed. Participants became more willing to disclose when another person actively created a sense of interpersonal safety by asking directly about their wellbeing, listening without judgment, validating their distress, normalizing mental health care, or respecting confidentiality. This is an important finding because it shifts attention from asking only why young adults do not seek help toward identifying social conditions that make help-seeking possible. Psychoeducational interventions among African American young adults have demonstrated the potential to improve willingness to seek help for depression (Bamgbade et al., 2024), suggesting that stigma reduction and culturally responsive education may alter perceived acceptability of support. Likewise, research examining strategies to increase mental health service utilization among young adult gender and sexual minorities emphasizes the importance of targeted approaches responsive to population-specific barriers (Rony et al., 2026). Evidence from youth mental health programming also suggests that attitudes toward prevention and engagement may be influenced by the way interventions are framed and delivered (Honea et al., 2022). Together, these findings suggest that help-seeking can be facilitated when environments reduce the psychological work required of the distressed individual.

Structural accessibility also interacted with psychological readiness. Participants indicated that confidentiality, clarity about what would happen during an initial appointment, and low-pressure access could make seeking help more manageable. This finding aligns with research showing that systemic, educational, and social challenges influence young adults' perceptions of mental health care (Cooper et al., 2025). Stakeholder perspectives on emerging-adult mental health services similarly emphasize the role of service organization and responsiveness (Kellman & Harewood, 2026), while qualitative synthesis evidence from adolescents indicates that help-seeking barriers and facilitators occur across individual, family, community, and health-service levels (Kakinda et al., 2026). Alternative modalities may also reduce some practical and interpersonal barriers. Openness to online counseling among college students suggests that digital options may be meaningful when privacy, convenience, or discomfort with face-to-face disclosure affect service preferences (Nelson et al., 2022). The present study nevertheless indicates that accessibility should not be equated with psychological approachability. A

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service can be available while still feeling inaccessible if the young adult anticipates judgment, cannot explain the problem, or remains uncertain whether their distress warrants care.

The findings also have implications for understanding help-seeking among young adults whose mental health experiences intersect with broader social identities and collective pressures. Research on activist mental health has illustrated that psychological experiences can be shaped by social conditions and collective stressors (Herbert et al., 2023). Similarly, culturally responsive health-promotion strategies implemented within institutions such as Historically Black Colleges and Universities demonstrate the broader value of tailoring sensitive health communication to specific populations and social contexts (Knight et al., 2025). These perspectives reinforce the conclusion that mental health help-seeking should not be conceptualized solely as an individual health behavior. Rather, it is socially situated, identity-sensitive, and responsive to whether available communities and institutions communicate that psychological vulnerability can be disclosed without loss of dignity, belonging, or competence.

5. Conclusion

Taken together, the findings support a dynamic conceptualization of mental health help-seeking. Recognition of need initiated rather than completed the decision-making process. Participants subsequently evaluated whether they should manage the problem alone, whether their distress was legitimate, whether they could communicate it effectively, how others might respond, and whether disclosure would create psychological or relational costs. When anticipated costs outweighed perceived benefits, participants returned to self-management and concealment, producing a recursive cycle in which help-seeking could be repeatedly delayed. When relational safety, validation, normalization, confidentiality, and accessible pathways reduced these costs, movement toward disclosure became more likely. This process helps explain why increased symptom severity alone may not reliably produce service use. Young adults may become increasingly aware that they need assistance while remaining unable to cross the interpersonal threshold required to request it. The findings therefore reinforce the importance of viewing the intention-behavior gap in help-seeking as a psychologically and socially meaningful phenomenon rather than as simple resistance to care.

6. Limitations & Suggestions

Several limitations should be considered when interpreting the findings. First, the study involved a relatively small purposively selected sample of 26 young adults and was designed to provide depth of understanding rather than statistical representativeness; consequently, the prevalence of specific themes cannot be generalized to all young adults in the United States. Second, participation required willingness to discuss mental health and help-seeking experiences, which may have resulted in self-selection of individuals who were more reflective about psychological difficulties or more comfortable discussing them than young adults who consistently avoid disclosure. Third, participants retrospectively described periods in which they recognized a need for assistance but did not seek help, creating the possibility of recall bias and reconstruction of earlier motivations through their current perspectives. Fourth, the sample included considerable demographic variation, but its size did not permit comprehensive examination of differences associated with gender, race and ethnicity, socioeconomic status, sexual orientation, immigration background, rural or urban residence, or previous mental health service use. Fifth, although the study distinguished psychological and social barriers analytically, these processes were highly interdependent, and assigning particular experiences to one category necessarily simplified some of their complexity. Finally, interviews captured participants' subjective perceptions of anticipated judgment, burden, confidentiality, and relational consequences; these expectations may not always correspond to how other people or professionals would actually respond.

Future research should examine the proposed pathway from recognition of psychological need to actual help-seeking in larger and more diverse samples and determine whether the identified stages can be replicated across different groups of young adults. Longitudinal studies would be particularly valuable for following individuals from the initial recognition of distress through decisions to disclose, delay, or obtain professional support, thereby reducing reliance on retrospective accounts and clarifying how barriers change over time. Mixed-method research could develop quantitative measures of perceived legitimacy of need, self-reliance, communication readiness, burden concerns, anticipated identity change, and relational safety

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and test their relative contributions to help-seeking intentions and behavior. Future studies should also examine how these processes vary by gender, race and ethnicity, socioeconomic resources, sexual and gender identity, cultural background, family structure, educational status, and prior treatment experiences. Comparative research involving college students, employed young adults, unemployed young adults, and individuals not engaged in higher education would help determine how institutional context affects help-seeking. Additional research should investigate critical transition points at which intentions are abandoned or transformed into action, including the influence of direct invitations to disclose, peer modeling, previous positive or negative help-seeking experiences, digital mental health options, and first-contact experiences with services. Intervention studies could subsequently test whether reducing the perceived psychological and social costs of asking for help produces greater service uptake than approaches based primarily on increasing mental health knowledge.

Mental health promotion for young adults should move beyond messages that simply encourage individuals to "ask for help" and instead address the specific psychological and social processes that make asking difficult. Psychoeducation should explicitly challenge the belief that professional assistance is appropriate only during severe crises and frame early help-seeking as compatible with independence, competence, and responsible self-management. Schools, universities, workplaces, community organizations, and healthcare services should provide clear information about what happens during an initial mental health contact, what kinds of concerns are appropriate to discuss, and how confidentiality is protected. Professionals should recognize that individuals may arrive without a clear explanation of their distress and should normalize uncertainty rather than expecting clients to present a well-organized account of their problems. Training for peers, educators, supervisors, and family members should emphasize nonjudgmental listening, validation, direct but respectful invitations to talk, and avoidance of minimizing or immediately attempting to solve another person's distress. Services should provide low-threshold entry points, including brief consultations, confidential digital contact, flexible scheduling, and opportunities to seek information before committing to treatment. Particular attention should be given to young adults who are accustomed to occupying competent or caregiving roles because they may experience receiving support as especially identity-threatening. Finally, interventions should communicate that disclosing distress does not make an individual a burden and that supportive relationships can accommodate reciprocity, thereby reducing one of the most persistent interpersonal barriers identified in the present study.

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Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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All authors equally contributed in this article.

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In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

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