Trust over Self-Reliance and Stigma: Determinants of Adolescent Mental Health Help-Seeking

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ABSTRACT

Adolescent mental health is a critical global public health concern, with approximately one in seven individuals aged 10–19 years experiencing a mental disorder. In the Philippines, suicide ranks as the fourth leading cause of death among adolescents aged 15–19, yet utilization of professional mental health services remains low. This study examined perceived barriers and facilitators to mental health help-seeking among adolescents and explored differences according to age, sex, and religion. A descriptive–comparative design was employed among 263 adolescents aged 15–19 years from Laoag City and Batac City, Ilocos Norte. Proportional stratified random sampling by locality followed by simple random sampling was used. Data were collected using the Barriers to Access to Care Evaluation (BACE) and an adapted facilitators questionnaire. Both instruments underwent cultural adaptation and validation, including forward–backward translation into Iloko, expert content validation, and pilot testing. Acceptable internal consistency was demonstrated, with Cronbach's alpha coefficients of 0.88 for the BACE and 0.91 for the facilitators scale. Attitudinal barriers exerted the strongest influence on help-seeking, particularly self-reliance, which was moderately perceived as a barrier ($M = 1.84$, $SD = 0.99$). Trust emerged as the most influential facilitator, reinforced by family and peer support ($M = 1.94$, $SD = 1.03$). A significant sex-based difference was identified in stigma-related barriers ($p = .007$), with male adolescents reporting higher levels of internalized stigma. These findings underscore the need to address norms of self-reliance, reduce stigma—especially among males—and strengthen trust and mental health literacy through culturally and gender-responsive interventions to improve adolescent mental health service utilization.

Keywords*: Adolescent; Health Services Accessibility; Help-Seeking Behavior; Mental Health; Philippines; Social Stigma*

Introduction

Adolescence is a critical stage of human development marked by rapid physical, emotional, and psychological changes. During this period, individuals often face challenges related to identity formation, peer relationships, academic pressure, and social expectations, which can significantly affect their mental well-being. According to the World Health Organization (2021), one in seven adolescents aged 10 to 19 experiences a mental disorder, accounting for 13% of the

global burden of disease in this age group. Despite the growing recognition of adolescent mental health as a global concern, approximately 70% to 80% of adolescents do not seek professional help for mental health problems, and nearly 20% consider suicide as a result of these conditions (Agency for Healthcare Research and Quality, 2022).

In the Philippines, the situation reflects similar concerns. Suicide ranks as the fourth leading cause of death among adolescents aged 15–19, underscoring the urgent need for improved mental health support systems (Research Institute for Mindanao Culture & Burnet Institute, 2020). In the Ilocos Region, mental health-related deaths have been recorded despite a slight decrease in reported cases over recent years. Adolescents in this region remain a particularly vulnerable group, exhibiting low rates of help-seeking behavior despite increasing mental health challenges (Barrow & Thomas, 2022). Research indicates that adolescents' reluctance to seek mental health support stems from a combination of social, cultural, and structural barriers. These include stigma, economic constraints, limited awareness, and societal pressures to appear resilient (Radez et al.,2021; Martinez et al., 2020). In the Philippine context, mental illness is often perceived as a personal weakness, which fosters self-stigma and discourages open discussion about emotional struggles (Cummings, 2024). Although the enactment of Republic Act No. 11036, or the Philippine Mental Health Act, aims to promote mental health awareness and access to care, its implementation remains inconsistent, particularly in rural areas where access to services is limited (*RichestPH,* 2023). Efforts have been made to improve mental health literacy through school-based education programs and awareness campaigns. These initiatives, such as the integration of animated educational materials and classroom discussions, have shown potential in reducing stigma and encouraging help-seeking behavior (Ojio et al., 2024). Moreover, factors such as social support, trust in professionals, and positive attitudes toward mental health services have been identified as facilitators of help-seeking among adolescents (Radez et al., 2021; Mubeen et al., 2024).

However, significant gaps persist in understanding how these barriers and facilitators interact within the unique cultural and socio-religious context of Filipino adolescents. Despite existing studies, much of the current literature focuses predominantly on stigma while neglecting other influential factors such as family expectations, religious beliefs, and economic limitations (Soltani et al., 2024). Furthermore, differences between early and late adolescence, as well as gender-based variations in help-seeking behavior, remain underexplored (Pelch, 2018). Recognizing these gaps, there is a pressing need for localized research that examines both the barriers and facilitators influencing adolescents' decisions to seek mental health services in the Philippine setting. Hence, this study aims to determine the perceived barriers and facilitators in seeking mental health services among adolescents. Specifically, it seeks to identify the socio-demographic characteristics of the respondents and examine how these factors influence their help-seeking behavior. By exploring adolescents' perceptions, the study intends to provide insights that can inform culturally sensitive interventions and policies designed to enhance mental health literacy, accessibility, and service utilization among Filipino youth. Ultimately, the findings aim to contribute to

national and community efforts.

Methods

Research Design

This study employed a descriptive–comparative research design to examine perceived barriers and facilitators to mental health help-seeking among adolescents and to determine differences according to age, sex, and religion. The descriptive component focused on identifying levels of perceived barriers and facilitators, while the comparative component examined group differences without manipulation of variables.

Study Setting

The study was conducted in Ilocos Norte, Philippines, specifically in Laoag City and Batac City, two urbanized areas with relatively large adolescent populations and access to community-based health and educational institutions. Barangay San Lorenzo (Laoag City) and Barangay Baay (Batac City) were selected because they are densely populated urban barangays with mixed socioeconomic characteristics and accessible adolescent populations, allowing for efficient data collection and representation of urban youth contexts in the province.

Participants, Inclusion and Exclusion Criteria

The target population consisted of 770 adolescents aged 15–19 years residing in the selected barangays. Both in-school and out-of-school adolescents were included to capture a broader range of help-seeking experiences.

Inclusion criteria were: (a) age between 15–19 years, (b) residency in the selected barangay for at least six months, (c) ability to read and understand Filipino or English, and (d) provision of written parental consent and adolescent assent.

Exclusion criteria included adolescents with cognitive or developmental conditions that limited comprehension of the questionnaire, those who were acutely ill during data collection, and questionnaires with more than 20% missing responses.

Sampling Design and Sample Size

The minimum sample size of 263 respondents was determined using Slovin's formula at a 90% confidence level and a 5% margin of error. Proportional stratified random sampling was employed, with strata defined by city (Laoag City and Batac City) and school status (in-school and out-of-school adolescents). Sample allocation was proportional to the size of each stratum. Within each stratum, participants were selected using simple random sampling. Minor convenience elements were unavoidable due to participant availability and school schedules.

Research Instruments

Data were collected using a two-part self-administered questionnaire assessing barriers to and facilitators of mental health help-seeking. The first instrument was the Barriers to Access to Care Evaluation (BACE), originally developed by Clement et al. (2012), which has demonstrated robust psychometric properties. In its original validation, the treatment stigma subscale exhibited good internal consistency (Cronbach's $\alpha = 0.89$) and acceptable test–retest reliability (Lin's concordance coefficient, $\rho c = 0.816$). Construct and convergent validity were supported through significant correlations with established stigma measures, including the Stigma Scale for Receiving Psychological Help

(SSRPH; r = 0.30, p = 0.001) and the Internalised Stigma of Mental Illness Scale (ISMI; r = 0.40, p < 0.001). Content validity was established through a systematic literature review and expert consultation, and the scale demonstrated high acceptability and readability, with a median participant rating of 8 out of 10.

The second instrument was an adapted Facilitators of Mental Health Help-Seeking questionnaire, consisting of 18 items measuring three domains: mental health literacy (6 items), trust (6 items), and accessibility (6 items). This facilitator set was originally developed through an extensive review of the literature and community input to capture perceived enablers of accessing and utilizing mental health services. Responses were recorded on a four-point Likert scale ranging from 0 (not at all) to 3 (a lot), with higher scores indicating stronger perceived facilitation. Initial face validity was established through review by culturally informed individuals and pilot testing, which guided item refinement; however, formal psychometric indices were not reported in the original study.

For the present study, both instruments underwent cultural adaptation and validation. Forward–backward translation into the Iloko language was conducted by independent bilingual translators. Content validity was further established through expert review by a psychiatric nurse, a guidance counselor, and a public health researcher to ensure relevance, clarity, and cultural appropriateness. A pilot test involving 30 adolescents from a non-participating barangay was conducted to assess comprehensibility and reliability. Internal consistency reliability was found to be acceptable, with Cronbach's alpha coefficients of 0.88 for the BACE and 0.91 for the facilitators scale, supporting the suitability of both instruments for use in the main study.

Data Collection Procedure

After securing ethical approval, coordination was conducted with barangay officials and school administrators. Written parental consent and adolescent assent were obtained prior to participation. Questionnaires were administered in supervised settings to ensure comprehension and completeness.

Data Analysis

Data were anonymized and encoded prior to analysis. Descriptive statistics (frequencies, percentages, means, and standard deviations) summarized respondent characteristics and scale scores. Due to the ordinal nature and non-normal distribution of data, nonparametric tests were applied. The Mann–Whitney U test was used for two-group comparisons, while the Kruskal–Wallis H test examined differences across multiple groups. Dunn's post hoc test with Bonferroni correction was performed for significant results. Statistical significance was set at $p < .05$. Questionnaires with substantial missing data were excluded, while isolated missing responses were omitted from item-level analyses.

The interpretation of perceived barriers and facilitators was guided by predefined mean score ranges that reflected the degree of influence attributed by the participants. Mean scores ranging from 0.00 to 0.75 were interpreted as "not at all," indicating that the factor was not perceived as significant and was considered negligible or irrelevant. Scores between 0.76 and 1.50 were described as "a little," reflecting minimal perceived influence. Mean values from 1.51 to 2.25 were interpreted as "quite

a little," signifying that the factor was moderately impactful and considered reasonably important by participants. Finally, scores ranging from 2.26 to 3.00 were classified as "a lot," indicating that the factor was perceived as significant and strongly influential in shaping adolescents' help-seeking behavior.

Ethical Considerations

Ethical clearance was obtained from the University Research Ethics Review Board prior to data collection. Participation was voluntary, and confidentiality was ensured through anonymized questionnaires, secure data storage, and restricted access to data. Written parental consent and adolescent assent emphasized the right to withdraw at any time without penalty.

A distress management protocol was implemented to safeguard participants. Adolescents who exhibited emotional distress or disclosed suicidal thoughts were immediately referred to school guidance counselors or local health professionals, following established referral procedures and ethical guidelines.

Results and Discussion

Socio-demographic profile

Table 1 presents the sociodemographic data of the respondents as to their age, sex, and religion. The table displays both the frequency and the percentage for each profile variable to provide a more comprehensive presentation.

Table 1. Socio-demographic profile of the respondents

Age	f	%
15-17	162	61.6
18-19	101	38.4
	263	100
Sex		
Male	137	52.1
Female	126	47.9
	263	100
Religion		
Roman Catholic	140	53.23
Iglesia Filipina Independiente	57	21.67
Iglesia Ni Cristo	24	9.13
Born Again	24	9.13
Latter Day Saints	14	5.32
Baptist	2	0.76
Islam	1	0.38
Not Baptized	1	0.38
	263	100

As shown in Table 1, the majority of respondents (61.6%) are adolescents aged 15–17 years, while 38.4% are 18–19 years old. As for sex, the sample is relatively balanced, with 52.1% male and 47.9% female respondents. As for religion, most respondents identify as Roman Catholic (53.23%), while the smallest group consists of those who are not baptized (0.38%).

Perceived Barriers

This study identified the respondents' perceived barriers. The results are presented in Table 2a, Table 2b, and Table 2.

Table 2a. Perceived barriers to seeking mental health services among adolescents – Stigma-related

Barriers	Weighted Mean	Standard Deviation	Overall Interpretation
A. Stigma-Related			
Feeling embarrassed or ashamed	1.32	0.83	Perceived as having minimal influence
Being concerned that I might be seen as weak for having a mental health problem	1.14	0.98	Perceived as having minimal influence
Being concerned about what my family might think, say, do, or feel	1.54	1.00	Moderately perceived as impactful
Not wanting a mental health problem to be recorded on my medical records	1.13	1.00	Perceived as having minimal influence
Being concerned that I might be seen as "crazy"	1.14	1.01	Perceived as having minimal influence
Being concerned that people I know might find out	1.07	0.97	Perceived as having minimal influence
Being concerned that people might not take me seriously if they knew I was receiving professional care	1.08	1.01	Perceived as having minimal influence
Being concerned about what my friends might think, say, or do	1.12	1.04	Perceived as having minimal influence
Composite Mean	1.19	0.70	Perceived as having minimal influence

Table 2b. Perceived barriers to seeking mental health services among adolescents – Attitudinal

Barriers	Weighted Mean	Standard Deviation	Overall Interpretation
B. Attitudinal			
Disliking talking about my feelings, emotions, or thoughts	1.21	0.94	Perceived as having minimal influence
Being concerned about available treatments (e.g., medication side effects)	1.07	0.84	Perceived as having minimal influence
Wanting to solve the problem on my own	1.84	0.99	Moderately perceived as impactful
Thinking that professional care probably would not help	0.90	0.93	Perceived as having minimal influence
Fearing being put in the hospital against my will	1.14	1.07	Perceived as having minimal influence
Thinking the problem will get better by itself	1.36	1.00	Perceived as having minimal influence
Having had previous bad experiences with professional mental health care	0.72	0.91	Not perceived as significant
Thinking I do not have a problem	1.21	1.01	Perceived as having minimal influence
Preferring to get help from family and friends	1.38	1.00	Perceived as having minimal influence
Preferring alternative forms of care (e.g., traditional/religious healing or complementary therapies)	1.17	1.00	Perceived as having minimal influence
Composite Mean	1.20	0.54	Perceived as having minimal influence

Table 2c. Perceived barriers to seeking mental health services among adolescents – Instrumental

Barriers	Weighted Mean	Standard Deviation	Overall Interpretation
C. Instrumental			
Not being able to afford the financial costs involved	1.18	0.93	Perceived as having minimal influence
Being too unwell to ask for help	1.15	0.92	Perceived as having minimal influence
Having difficulty taking time off work	1.16	0.97	Perceived as having minimal influence
Being unsure where to get professional care	1.11	0.95	Perceived as having minimal influence
Having problems with transport or travelling to appointments	0.87	0.97	Perceived as having minimal influence
Not having professionals from my own ethnic or cultural group available	0.85	0.89	Perceived as having minimal influence
Having no one who could help me obtain professional care	1.04	0.97	Perceived as having minimal influence
Composite Mean	1.05	0.65	Perceived as having minimal influence

Perceived Facilitators

This study also determined the respondents' perceived facilitators. The findings are shown in Table 3a, Table 3b, and Table 3c.

Table 3a. Perceived facilitators to seeking mental health services among adolescents – Trust

Facilitators	Weighted Mean	Standard Deviation	Overall Interpretation
A. Trust			
Having positive past experiences	1.56	0.94	Moderately perceived as impactful
Having trust in the provider and their confidentiality processes	1.56	0.88	Moderately perceived as impactful
Having positive relationships with mental health professionals	1.43	0.98	Perceived as having minimal influence
Having social support or encouragement from family and friends	1.94	1.03	Moderately perceived as impactful
Having a community with positive attitudes toward seeking help	1.67	1.02	Moderately perceived as impactful
Having a compatriot (someone with lived experience of the mental illness)	1.67	1.02	Moderately perceived as impactful
Composite Mean	1.64	0.99	Moderately perceived as impactful

Table 3b. Perceived facilitators to seeking mental health services among adolescents – Mental Health Literacy

Facilitators	Weighted Mean	Standard Deviation	Overall Interpretation
B. Mental Health Literacy			
Reading about the positive results of help-seeking.	1.62	1.03	Moderately perceived as impactful
Being provided with education about the available services.	1.60	0.95	Moderately perceived as impactful
Perceiving the mental health problems as serious.	1.74	0.98	Moderately perceived as impactful
Being provided with more mental health literacy.	1.42	1.00	Perceived as having minimal influence
Reducing stigma beliefs held within the community.	1.41	0.92	Perceived as having minimal influence
Composite Mean	1.56	0.98	Moderately perceived as impactful

Table 3c. Perceived facilitators to seeking mental health services among adolescents – Accessibility of Services

Facilitators	Weighted Mean	Standard Deviation	Overall Interpretation
C. Accessibility of Services			
Being provided with culturally appropriate mental health interventions that are sensitive to my culture.	1.23	0.97	Perceived as having minimal influence
Being provided with online adjuncts to traditional approaches.	1.30	0.97	Perceived as having minimal influence
Being provided with mental health information in English, Filipino, or Ilocano.	1.69	1.00	Moderately perceived as impactful
Including my family in the therapeutic process.	1. 30	1.03	Perceived as having minimal influence

Incorporating my religious beliefs into therapy.	1.24	1.00	Perceived as having minimal influence
Composite Mean	1.35	1.01	Perceived as having minimal influence

The findings highlight that, among stigma-related barriers, concern about family opinion (mean = 1.54) stands out as moderately impactful, whereas most other stigma items, including embarrassment or fear of being labeled, were perceived as minimally influential. This finding indicates that familial expectations continue to play a central role in shaping adolescents' willingness to seek professional mental health support, consistent with the Filipino cultural context where family influence is paramount. The overall composite mean for stigma-related barriers (1.19) suggests that societal judgment and fear of labeling are no longer dominant deterrents, potentially reflecting increased mental health awareness, school-based psychoeducation, and the growing normalization of mental health discussions among adolescents (Bhagavathi, 2022; Omondi, 2024).

Among attitudinal barriers, self-reliance emerged as the most notable obstacle, with "Wanting to solve the problem on my own" receiving the highest individual mean (1.84), interpreted as moderately impactful. This underscores the enduring influence of personal beliefs and internalized expectations of independence, which can discourage adolescents from seeking help even when services are available. Other attitudinal concerns, such as reluctance to disclose emotions or previous negative experiences, were perceived as minimal. These findings align with existing literature emphasizing the role of self-reliance and internal attitudes over structural barriers in determining help-seeking behaviors among adolescents (Litam & Chan, 2022; Rice et al., 2020).

Instrumental barriers, including financial and logistical concerns, were consistently rated as minimal, with the highest mean for affordability (1.18). This suggests that practical challenges, while present, are not the primary deterrent for the majority of respondents, likely due to increased access to affordable, school-based, and online mental health resources (Bhagavathi, 2022; Harvard Humanitarian Initiative, 2023). Similarly, perceived facilitators showed that trust, mental health literacy, and accessible information were moderately impactful, with family support (mean = 1.94) and recognition of problem severity (mean = 1.74) being particularly influential. These results underscore that adolescents are more likely to seek help when they perceive supportive social networks, culturally and linguistically appropriate services, and trustworthy professional relationships.

Overall, the data suggest a shift in adolescent help-seeking dynamics, where internal attitudes—especially self-reliance—and familial influence are more salient than stigma or logistical barriers. This emphasizes the need for interventions that actively engage families, promote developmentally and culturally tailored mental health literacy, and cultivate trusting

relationships between adolescents and professionals. For nurses and mental health practitioners, these findings highlight actionable strategies: normalize help-seeking as a strength, integrate families into psychoeducation, and provide accessible, confidential, and culturally responsive services. Ultimately, addressing the interplay of self-reliance and family expectations offers the greatest potential to enhance timely and effective adolescent engagement with mental health care.

Difference in perceived barriers in terms of age, sex, and religion

This study further examined the significant difference of perceived barriers in terms of age, sex, and religion, as presented in Table 4a, Table 4b, and Table 4c.

Table 4a. Difference of perceived barriers in terms of age

Variable	Age	
	U-value	*p-value*
Stigma-related Barriers	7815.5	0.542
Attitudinal Barriers	8611.5	0.472
Instrumental Barriers	8296.0	0.847

**. Significant at the 0.01 level (2-tailed); *. Significant at the 0.05 level (2-tailed)

As presented in Table 4a, for age, the results showed no significant differences in perceived stigma-related barriers (p = 0.541663), attitudinal barriers (p = 0.472048), and instrumental barriers (p = 0.847475) when adolescents were grouped by age. This finding indicates that adolescents aged 15–17 and 18–19 share similar views and experiences regarding the social stigma of mental illness, internal beliefs, and access-related challenges.

A systematic review identified stigma and negative perceptions toward mental health services as major deterrents for adolescents, regardless of their age (Aguirre Velasco et al., 2020). Adolescents commonly report stigma, embarrassment, low problem recognition, and a preference for self-reliance as key attitudinal barriers, with no significant variation observed between younger and older adolescents (Radez et al., 2021). These consistent patterns support the notion that perceived stigma and attitudes toward mental health care are not strongly influenced by age differences.

Instrumental barriers, such as high costs, limited-service availability, and long wait times, were identified as prominent concerns shared across all age brackets among adolescents (Mubeen et al., 2024). These findings align with the present study's outcome, which showed no significant age-related variation in access-related challenges.

Low mental health literacy significantly affects adolescents' help-seeking behaviors and is widespread across both early and late adolescence (Renwick et al., 2022). These consistent findings suggest that despite age-based differences in developmental stage, adolescents face similar obstacles in accessing professional

mental health services

Table 4b. Difference in perceived barriers in terms of sex

Variable	Sex	
	U-value	*p-value*
Stigma-Related Barriers	6980.0*	0.007
Attitudinal Barriers	7695.0	0.128
Instrumental Barriers	8078.5	0.368

**. Significant at the 0.01 level (2-tailed); *. Significant at the 0.05 level (2-tailed)

As presented in Table 4b, for sex, the results revealed a significant difference in stigma-related barriers (p = 0.007276), indicating that male and female adolescents differ in their perceptions and experiences of mental health-related stigma. Specifically, male adolescents reported higher levels of internalized stigma, including feelings of embarrassment, fear of being judged, and reluctance to show vulnerability. This finding supports the notion that traditional masculine norms may inhibit emotional expression and increase the stigma perceived by male adolescents.

This result aligns with the findings that boys experience increased stigma as they age, with a heightened reluctance to seek help due to fear of judgment and social norms that discourage emotional disclosure (González-Sanguino et al., 2025). In contrast, female adolescents were found to be more open to discussing mental health issues and more likely to seek professional support, as they reported less concern about stigma and demonstrated more positive attitudes toward psychological services (Al-Krenawi et al., 2024).

Furthermore, male adolescents face unique barriers in help-seeking, particularly in the context of disorders such as eating disorders, where societal expectations surrounding masculinity discourage acknowledging psychological distress (Ganson et al., 2025). Similarly, male adolescents are more likely to view psychological treatment as a sign of weakness, a belief rooted in cultural and gender-based expectations that reinforce self-reliance and emotional suppression (Zhang et al., 2024).

Conversely, no statistically significant differences were found between males and females in attitudinal barriers (p = 0.127938) and instrumental barriers (p = 0.368301). This suggests that both sexes generally hold similar beliefs about self-reliance and face comparable practical challenges in accessing mental health services, including concerns about cost, availability of providers, and lack of awareness about where to seek help.

Attitudinal barriers refer to personal beliefs and dispositions that hinder individuals from seeking help. In a prospective cohort study conducted during the COVID-19 pandemic, researchers

observed that while young adult females reported significantly higher symptoms of depression and anxiety than males, there was no corresponding increase in their use of professional mental health services. Help-seeking behavior remained low across both sexes, with no statistically significant gender difference in changes over time. This suggests that attitudinal barriers to seeking mental health care may be similarly experienced by both males and females. The authors hypothesized that the persistence of self-reliance and stigma-related concerns likely contributed to help-avoidance in both groups, regardless of symptom severity (Upton et al., 2023). These findings align with the results of the present study and support the conclusion that sex does not significantly influence attitudinal barriers in mental health help-seeking among adolescents. Instrumental barriers, which include external factors such as cost, lack of available services, and insufficient information, were also experienced similarly by male and female adolescents in the study. Previous studies have shown that instrumental barriers such as cost, lack of available services, and insufficient information are commonly experienced by both male and female adolescents. One study reported that over one-third (36.6%) of participants cited financial burden as a barrier, and 33.2% did not know where to find professional mental health support (Islam et al., 2023). Another study found that 42.6% of participants were unsure of where to seek care, while 48.8% stated that they had no one to support them in accessing services (El-Azab et al., 2023). These shared instrumental challenges underscore the role of systemic and informational barriers over sex-based differences.

Table 4c. Difference of perceived barriers in terms of religion

Variable	Religion	
	H-value	*p-value*
Stigma-Related Barriers	1.745	0.883
Attitudinal Barriers	1.547	0.908
Instrumental Barriers	1.046	0.959

**. Significant at the 0.01 level (2-tailed); *. Significant at the 0.05 level (2-tailed)

As presented in Table 4c, for religion, the results revealed no significant differences in adolescents' perceived barriers to accessing mental health services when grouped according to religious affiliation. As shown in the table, the computed p-values were 0.883193 for stigma-related barriers, 0.907533 for attitudinal barriers, and 0.958766 for instrumental barriers. All of these values exceeded the 0.05 level of significance, indicating that religious affiliation did not meaningfully influence how adolescents perceive stigma, personal attitudes, or logistical obstacles related to mental health help-seeking.

The absence of a significant

difference suggests that religion, in this context, functions more as a shared cultural element than as a differentiating factor. Mental health stigma in the Philippines is strongly shaped by cultural and familial norms, cutting across regions and religious affiliations, and tends to outweigh the influence of individual religious identity on help-seeking behavior (Martinez et al., 2020b).

Religion alone does not strongly predict adolescents' willingness to seek mental health services. Rather, its impact depends heavily on the level of support, acceptance, and mental health literacy within faith communities. When religious leaders promote mental wellness and openly address mental illness without judgment, adolescents are more likely to seek help. Conversely, if mental health struggles are portrayed as spiritual weakness or sin, adolescents may internalize these views and avoid professional support. However, in many cases, the influence of religion is either neutral or inconsistent, which may explain the lack of significant difference found in this study (Ali & Eissa, 2022).

Further supporting this, religious coping styles, rather than religious affiliation per se, are more predictive of mental health outcomes. Adolescents who engage in positive religious coping, such as prayer, meditation, or support from faith mentors, may experience emotional relief. However, this does not necessarily translate to fewer systemic (instrumental) or psychological (attitudinal) barriers when accessing mental health services (Krause & Pargament, 2021).

In a cross-national analysis, the role of religion in adolescent mental health is often overshadowed by broader sociocultural factors, particularly in collectivist societies. These include persistent stigma, low mental health literacy, and lack of accessible services (Austin et al., 2024). This perspective is echoed by findings that, regardless of cultural or religious background, adolescents commonly identified stigma, self-reliance, and poor mental health awareness as key barriers that appeared consistent across various religious contexts (Radez et al., 2021).

Similarly, attitudinal barriers (e.g., the preference to handle problems alone) and structural barriers (e.g., long wait times, limited availability) were widely experienced across diverse populations of adolescents. There was no strong evidence that religious identity significantly alters the way adolescents perceive or respond to such barriers, which is consistent with the results of the present study (Aguirre Velasco et al., 2020).

Difference in perceived facilitators in terms of age, sex, and religion

This study further examined the significant difference of perceived facilitators in terms of age, sex, and religion, as presented in Table 5a, Table 5b, and Table 5c.

Table 5a. Difference of perceived facilitators in terms of age

Variable	Age	
	U-value	*p-value*
Trust	10456.5**	<0.001
Mental Health Literacy	10112.0**	0.001
Accessibility of Services	9850.0**	0.005

**. Significant at the 0.01 level (2-tailed); *. Significant at the 0.05 level (2-tailed)

As presented in Table 5a, for age, respondents aged 18–19 (late adolescents) had significantly higher perception of trust as a facilitator compared to those aged 15–17 (early adolescents) (U = 10,456.5, p < 0.001). While direct empirical comparisons between these age brackets remain limited, existing literature offers relevant developmental and social psychological perspectives. From a developmental perspective, cognitive maturation enhances older adolescents' ability to distinguish between generalized social trust and specific interpersonal trust. Flanagan and Stout (2010), as cited in Crocetti et al. (2021), explain that late adolescents become more discerning in judging when trust is warranted, likely contributing to higher trust scores. Similarly, Li and Fung (2012) emphasize that trust extends beyond the family as adolescents age, reflecting growing social autonomy and a greater willingness to trust mental health professionals—particularly important as trust involves confidence in confidentiality and provider relationships. From a social psychological perspective, Sweijen et al. (2023) show that adolescent trust varies by social closeness, with more trust placed in close ties and less in unfamiliar peers. Older adolescents' broader, more complex social networks offer more opportunities to develop stable, trusting relationships. In the mental health context, Hardin et al. (2020) argue that trust in providers is fostered through empathy, respect, and confidentiality—qualities older adolescents are better equipped to recognize due to emotional and cognitive growth. Jose et al. (2024) further demonstrate that Filipino adolescents' trust increases with positive verbal and nonverbal communication from providers, which late adolescents may interpret more effectively due to greater familiarity with social and health systems. However, as Mubeen et al. (2024) note, there is a lack of studies directly comparing trust development between early and late adolescence, underscoring the need for further targeted research.

The results further indicate that late adolescents (18–19 years) demonstrated significantly higher perception of mental health literacy compared to early adolescents (15–17 years) (U = 10,112.0, p = 0.001). While there is limited direct literature comparing the specific age brackets of 15–17 and 18–19, the available evidence consistently indicates that older adolescents possess greater mental health literacy. Studies suggest that younger adolescents in the Philippines, particularly those in middle school (typically aged 12–16), exhibit low to very low levels of health literacy. This has been attributed to a lack of engagement with health topics and a greater focus on non-health-related internet use (Javier, Tiongco, & Jabr, 2019). Although the age group 15–17 overlaps partially with

this range, this finding supports the notion that younger adolescents may face challenges in acquiring mental health knowledge. In contrast, older adolescents (16–19 years) have been found to exhibit higher levels of mental health literacy and resilience (Ramadhani et al., 2025). This developmental trend is reinforced by findings that older adolescents are more likely to gain mental health-related understanding through school-based programs and social media exposure (Singh et al., 2022). Letz (2021) further supports this, noting that older adolescents tend to have a better understanding of mental health and are more inclined to seek formal support. Age-related differences in literacy may also reflect educational progression. Senior high school students, typically aged 17–19, have been shown to possess a stronger likelihood of seeking professional help compared to junior high school students. This tendency is associated with their relatively higher levels of education and, by extension, improved mental health literacy (Zhao & Hu, 2022). Furthermore, Filipino senior high school students have been observed to hold more positive attitudes toward counseling, likely as a result of awareness campaigns and educational interventions (Sengco et al., 2024), which may indirectly reflect increased literacy.

Adolescents aged 18–19 had significantly higher mean ranks compared to those aged 15–17 in terms of accessibility of services ($U = 9{,}850.0$, $p = 0.005$). Although there is limited literature directly comparing these age brackets in the Philippine context, relevant developmental and structural insights provide context. Older adolescents are generally more likely than younger ones to access professional help (Radez et al., 2020), a trend partially explained by increased autonomy and decision-making capacity in late adolescence (Pfeifer & Berkman, 2018). Compared to early adolescents, who often face legal barriers such as parental consent requirements for accessing mental healthcare in the Philippines (Juvenile Justice and Welfare Act of 2006; Mental Health Act of 2018), late adolescents aged 18–19 are legal adults and thus may access services more freely. Moreover, younger adolescents often experience privacy concerns and anticipate parental misunderstanding, which can hinder help-seeking even when services are available (Cavazos-Rehg et al., 2020). These constraints are less relevant to older adolescents, who may feel more comfortable independently engaging with health systems. From a service design standpoint, accessible youth-friendly healthcare is defined by ease of contact, professional diversity, and trust in providers (Ambresin et al., 2013; Goicolea et al., 2018). While service availability remains limited in the Philippines—especially for adolescents (Zurielle et al., 2021)—younger adolescents may face compounded challenges navigating these systems without adult assistance. Thus, the higher accessibility ratings among 18–19-year-olds may reflect both greater structural independence and fewer psychosocial and legal barriers.

Table 5b. Difference of perceived facilitators in terms of sex

Variable	Sex	
	U-value	*p-value*
Trust	7263.0*	0.026
Mental Health Literacy	6197.5**	<0.001
Accessibility of Services	7343.5.*	0.036

**. Significant at the 0.01 level (2-tailed); *. Significant at the 0.05 level (2-tailed)

As presented in Table 5b, for sex, female respondents had significantly higher perception of trust in mental health services than males (U = 7,263.0, p = 0.026). While some studies suggest that males may report higher general trust in doctors (Breslin et al., 2022; Derks, Lee & Krabbendam, 2014), these findings do not necessarily extend to mental health services specifically. Research focusing on help-seeking behaviors indicates that young males often hold negative expectations toward professionals and associate seeking help with weakness—attitudes that are less commonly reported among females (Radez et al., 2020). Females are also more likely to seek formal mental health support, a behavior associated with higher trust and lower barriers to help-seeking. These gender differences are frequently attributed to lower mental health literacy among males and social norms promoting hegemonic masculinity, which discourage vulnerability and professional reliance (Zhao & Hu, 2022; Clark et al., 2020). Given that trust in healthcare professionals is a key determinant of help-seeking (Souvatzi et al., 2024), it is plausible that these psychosocial and cultural factors contribute to the higher levels of trust observed among female respondents in this study.

The results further indicate that female respondents reported significantly higher perceived mental health literacy than males (U = 6,197.5, p < 0.001). This aligns with existing literature showing that females typically exhibit greater knowledge of mental health issues, are more adept at recognizing psychological disorders, and are less impacted by stigma related to emotional distress (Stunden et al., 2020; Krishna et al., 2024). Females' greater inclination to seek help is frequently attributed to both their higher mental health literacy and societal norms encouraging emotional expressiveness and help-seeking (Zhao & Hu, 2022; Clark et al., 2020). In contrast, males face more significant barriers, often shaped by hegemonic masculinity, poor recognition of symptoms, and limited awareness of available services (Sheikh et al., 2024). Furthermore, gender-based diagnostic inconsistencies suggest that traditional male depressive symptoms—such as aggression or substance abuse—may be underrecognized, contributing to underdiagnosis and delayed treatment in males (Shi et al., 2021). These patterns support the observed sex difference in perceived mental health literacy, underscoring the need for gender-sensitive interventions and educational strategies.

The results further indicate that female respondents reported significantly higher mean ranks than males for accessibility to mental health services (U = 7,343.5, p = 0.036). This result aligns with existing literature suggesting that

adolescent girls are generally more likely to seek help and perceive services as more accessible than boys (Bradford & Rickwood, 2014, as cited in Lui et al., 2024). Despite efforts to increase service accessibility for all adolescents, males—particularly adolescent boys—frequently disengage from health-care systems, citing barriers such as gender norms, stigma, and fears of exposure (Slotte et al., 2022). Males in general also tend to prefer online mental health support due to its perceived anonymity and privacy, yet their strong preference not to seek help at all reflects deeper accessibility issues linked to societal expectations and self-stigma (Lindborg et al., 2024). A possible factor for this is that male adolescents are more likely to cite perceived parental disapproval as a barrier to using mental health services — a factor that has been linked to their greater reluctance to access support, even when services are technically available (Chandra & Minkovitz, 2006, as cited in Radez et al., 2020). Moreover, a lack of mental health knowledge among parents and language barriers further restrict access, particularly when culturally tailored services are not available (Garney et al., 2024). These findings suggest that while structural accessibility may be improving, psychosocial and cultural barriers still disproportionately affect males' perceived and actual access to services.

Table 5c. Difference of perceived facilitators in terms of religion

Variable	Religion	
	H-value	*p-value*
Trust	2.230	0.816
Mental Health Literacy	2.586	0.763
Accessibility of Services	11.163*	0.048

**. Significant at the 0.01 level (2-tailed); *. Significant at the 0.05 level (2-tailed)

As presented in Table 5c, for religion, there is a significant difference only in accessibility of services (H = 11.163, p = 0.048), while the other two sub-variables trust (H = 2.230, p = 0.816) and mental health literacy (H = 2.586, p = 0.763) exceeds the 0.05 level of significance indicating that religion does not meaningfully influence their perception to trust and mental health literacy as facilitators to accessing mental health services. Initially, for accessibility of services, the difference was between Iglesia Filipina Independiente (IFI) and Iglesia Ni Cristo (INC), with IFI having the higher mean rank, which means that they have a higher perception of 'accessibility of services' as a facilitator compared to INC. However, to avoid a false positive result, Dunn's post hoc tests with Bonferroni correction were performed and indicated that none of the pairwise comparisons reached statistical significance. This suggests that while an overall difference among religious groups was detected, no group-to-group difference remained

statistically significant after adjusting for multiple comparisons.

This result reinforces the notion that accessibility-related facilitators—such as

culturally appropriate services, language-inclusive materials (e.g., in Ilocano, Filipino, or English), service proximity, affordability, and the inclusion of family or religious values—are perceived similarly across religious affiliations. Regardless of whether the respondents identified as Roman Catholic, Iglesia ni Cristo, Born Again Christian, or others, these elements appear to be equally valued and viewed as necessary for effective mental health access. Supporting this, adolescents prioritize discretion, familiarity, and convenience when accessing services, characteristics that transcend religious identity (Slotte et al., 2022). Munira et al. (2023) also noted that in Southeast Asian contexts, inclusive and easily accessible services, often supported by family and school-based systems, are critical facilitators of help-seeking regardless of individual religious affiliation. Additionally, Ilocano adolescents share several cultural and psychosocial characteristics that likely explain the uniform perception of accessibility. Ilocano youth are often described as family-centered, respectful of authority figures, and community-oriented—traits that contribute to a collective value system rather than one heavily segmented by religious differences (Pascua, 2022). In conclusion, while cultural and religious factors can shape impressions of how reachable mental health care is through community support, there is no dominant inter-religious contrast – consistent with the finding that aggregate group differences disappear in pairwise comparisons.

Similarly, trust in mental health professionals appears consistent across religious groups in the Philippines. Trust in clinicians tends to be high and broadly similar across faith traditions. Surveys of religious communities consistently find that most believers - whether Catholic, Protestant, or otherwise - are open to professional treatment when it is endorsed by their community (American Psychiatric Association, 2024). The strong Christian influence in Filipino culture, particularly Catholicism, emphasizes compassion and support, which can foster trust in mental health services (Del Castillo et al., 2023). Moreover, the integration of religious practices, such as prayer, into mental health interventions has been found to enhance the therapeutic alliance between clients and professionals, further reinforcing trust across different religious affiliations (Del Castillo et al., 2023). These data imply that trust in therapists is driven more by perceptions of provider competence and reducing stigma than by doctrinal differences. Because professional standards and confidentiality are viewed similarly by practitioners of all faiths, community surveys observe no significant divergence – i.e., Catholics, Protestants, etc., all report largely equivalent confidence in mental health specialists as a resource.

Similarly, perceptions of the value of mental health literacy do not vary significantly by religion. In practice, congregants across faiths tend to acknowledge the same basic knowledge – for example, attributing common conditions to biological or situational causes – and agree that understanding mental illness is important for help-seeking (The Catholic University of America, 2022). Additionally, studies suggest that mental health literacy (MHL) levels among Filipinos are generally consistent across different religious affiliations. A study on Filipino college students found average Mental Health Literacy (MHL) scores, with differences more attributable to factors like the type of educational institution rather than religious background (Argao et al., 2021). Moreover, culturally adapted mental health literacy

programs, such as 'Tara, Usap Tayo!', have been effective in improving MHL among Filipino migrant workers, indicating that tailored interventions can enhance understanding regardless of religious affiliation (Martinez et al., 2022). These findings highlight that mental health literacy, as a facilitator to accessing services, is perceived similarly across different religious groups in the Philippines.

Conclusion

This study provides empirical evidence on the perceived barriers and facilitators influencing mental health help-seeking among adolescents in Ilocos Norte, Philippines, highlighting the complex interplay of individual, social, and contextual factors. The findings demonstrate that attitudinal barriers—particularly self-reliance—remain the most salient impediment to professional help-seeking, while stigma-related and instrumental barriers exert comparatively minimal influence. These results suggest a shift from overt societal stigma toward more internalized beliefs that discourage adolescents from seeking formal mental health care.

Trust emerged as the most influential facilitator of help-seeking, reinforced by family support, positive interpersonal relationships, and confidence in mental health professionals. Mental health literacy and access to linguistically appropriate information further supported adolescents' willingness to seek care, underscoring the importance of education and clear communication in mental health service utilization. Differences in perceptions by age and sex indicate that late adolescents and female adolescents generally report higher levels of trust, literacy, and perceived accessibility, whereas male adolescents continue to experience greater stigma-related barriers. Religious affiliation, however, showed limited influence on most barriers and facilitators, suggesting that broader sociocultural norms and family dynamics play a more decisive role than doctrinal differences.

From a clinical and public health perspective, these findings emphasize the need for culturally sensitive, gender-responsive, and developmentally appropriate mental health interventions. Programs aimed at adolescents should explicitly address norms of excessive self-reliance, normalize help-seeking as a sign of strength, and actively involve families as supportive partners in care. School- and community-based initiatives that strengthen trust in providers, enhance mental health literacy, and ensure accessible, youth-friendly services may be particularly effective in improving service uptake.

Despite its contributions, this study has limitations, including its cross-sectional design and reliance on self-reported measures, which limit causal inference and may be subject to response bias. The localized setting may also affect generalizability to other regions. Future research should employ longitudinal and mixed-methods designs to explore how barriers and facilitators evolve and to capture deeper contextual insights. Nonetheless, the present findings offer valuable guidance for nurses, mental health practitioners, educators, and policymakers seeking to improve adolescent mental health service access and utilization in the Philippine context and similar settings.

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