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i. Title: Schizotypy and Help-Seeking for Anxiety

ii. Running Title: Schizotypy and Help-Seeking for Anxiety

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v. Abstract

Background: Delays in help-seeking for anxiety are common however, earlier interventions improve long-term outcomes. This holds importance for high schizotypes since anxiety relates to psychotic symptom development. The study investigated whether schizotypal traits and anxiety itself influence help-seeking behaviour.

Methods: A non-clinical student sample (N=800) completed the Schizotypal Personality Questionnaire, Depression, Anxiety, Stress Scale and General Help-Seeking Questionnaire, vignette version online.

Results: Recognising another's help need was associated with lower anxiety scores. A trend was observed between lower schizotypy scores and better recognition of self-need for help. Actual help-seekers (N=163) had significantly higher schizotypy and anxiety scores than non-help-seekers.

Conclusion: Schizotypal traits independently contribute to delays in help-seeking for anxiety. Approaching informal help sources whom also have anxiety symptoms can delay formal help-seeking, unless they have sought help themselves.

Key words: Schizotypy; anxiety; help-seeking; clinical staging models

vi. Main Text

Introduction

Anxiety has an average 12-month prevalence of 14.4% across different age groups in Australia, peaking at ages 35-44 years at 18% (Australian Bureau of Statistics, 2008). Anxiety is also an early risk indicator for developing psychotic disorders including schizophrenia (e.g. Bogren et al., 2010; Bratlien et al., 2015; Granö et al., 2014). Therefore, early identification of anxiety is important to stream those with emerging conditions into mental health services as well as a disorder in itself which requires intervention. Early intervention reduces lifetime medical care costs and improves long-term outcomes (Amminger et al., 2010; French, Shryane, Bentall, Lewis & Morrison, 2007; Hastrup et al., 2013; Osuch et al., 2015; Park, McCrone & Knapp, 2016). To increase uptake of early intervention, it is necessary to

1 promote early HS for anxiety. However, current understanding of early HS mechanisms is
2 poor.

3 One advantage of early intervention is that less invasive forms of treatment can be effective
4 when symptoms are less severe (Galletly et al., 2016). Clinical staging models (CSM) highlight
5 and promote early intervention (e.g. Addington et. al, 2019; McGorry & Nelson, 2016;
6 Passos, Jansen & Kapczinski, 2015); and, provide a structure for understanding symptoms on
7 a continuum, identifying appropriate treatment to the phase of illness presentation. CSM
8 outlines that anxiety could either be a clinical end point or the early phases of an emerging
9 mental health disorder (e.g. Galletly et al., 2016). To best utilise CSM for anxiety and
10 understand the factors which might predict progression, it is necessary to devolve the
11 mechanisms driving delays in HS for anxiety (Havinga et al., 2018; Wang et al. 2005).

12 HS is a journey beginning prior to an individual's awareness of being mentally unwell,
13 through to treatment completion and symptoms abating (Prochaska, DiClemente &
14 Norcross, 1992; Rickwood, Thomas & Bradford, 2012). Earlier HS will ensure that anxiety can
15 be alleviated, perhaps decreasing the likelihood of transition to a serious mental health
16 disorder. To date, research into early HS has mainly focused on suicidal ideation and
17 depression (e.g. Chang, 2014; Kenny, Dooley & Fitzgerald, 2016; Rudd & Joiner, 1995;
18 Wilson, Rickwood & Deane, 2007), emphasizing help source preferences rather than the HS
19 process. There is limited research highlighting the early processes of HS for higher-risk
20 individuals in the general population. Schizotypy can be used as an indicator of higher-risk in
21 the general population. Schizotypy is a personality trait associated with increased risk of
22 anxiety, depression and schizophrenia-spectrum disorders (Bolinsky et al., 2015;
23 Lewandowski et al., 2006; Rey, Jouvent & Dubal, 2009). This study aims to widen the HS
24 literature focus and determine whether schizotypy and anxiety symptoms impact
25 recognition of anxiety and the need for help for anxiety symptoms, informing development
26 of targeted intervention to increase uptake of early interventions more easily identified via
27 CSM.

28

29 **Methods**

30 **Participants**

31 First and second year undergraduate students attending an Australian university were
32 invited to participate in exchange for 0.5 course credit points. Data were collected from 835
33 students, 35 removed due to invalid responses. Complete data were collected from 800
34 students (76.8% female; mean age 20.96 years).

35 **Procedure**

36 Ethics approval was granted by the Human Research Ethics Committee at University of
37 Wollongong (application number 2019/392). Participants were recruited via an online
38 advertising board for student participant recruitment and all provided informed consent.
39 The survey was completed online through surveymonkey.com. Data were collected between

1 July 2014 and April 2016 as part of a larger study that also incorporated emotion regulation
2 and HS for other common mental health concerns.

3 **Measures**

4 HS for anxiety symptoms was assessed using the anxiety scenario from the General Help-
5 Seeking Questionnaire – Vignette Version (GHSQ-V; Wilson & Deane, 2012). Participants
6 read the following vignette:

7 *“Jane is 19 years old. In the last few weeks she has noticed that she has felt worried or scared*
8 *without any particular reason, and her hands have trembled a lot even though she doesn't*
9 *drink coffee or caffeine drinks. On a few occasions she has felt close to panic, and at the*
10 *same time became aware that her mouth has got really dry and that she has difficulty*
11 *breathing.”*

12 They are then asked to label what illness, if any, Jane or they may be experiencing and
13 whether help should be sought in either instance.

14 Anxiety was measured using the Depression Anxiety Stress Scale-21 (DASS-21; Lovibond &
15 Lovibond, 1995). The Schizotypal Personality Questionnaire (SPQ; Raine, 1991) was used to
16 assess schizotypy.

17 **Statistical Analyses**

18 Data were analysed using *t*-tests to determine any significant differences in anxiety or
19 schizotypy scores between participants who did and did not recognise anxiety and need for
20 help in themselves or Jane. Means and standard deviations are outlined in Figure 1
21 (schizotypy) and Figure 2 (anxiety). The association between actual HS and recognition of
22 need for help was calculated using chi square.

23 **Results**

24 ***Recognising anxiety/need for help in Jane***

25 Anxiety and schizotypy scores did not differ between those who successfully recognised
26 Jane’s symptoms and those who did not. Schizotypy scores also did not differ between those
27 who recognised Jane’s need for help and those who did not.

28 However, participants who failed to recognise Jane’s need for help did have higher anxiety
29 scores when compared to those who did ($t(798)=-2.594, p=.012$).

30 ***Recognising anxiety/need for help in self***

31 No significant differences in anxiety scores or schizotypy scores were found between those
32 who did and did not identify the symptoms in the vignette as anxiety. Similarly, no significant
33 differences were found in anxiety scores between those who did and did not identify self-
34 need for help. However, there was a trend for those who recognised that they would need
35 help for anxiety to have lower schizotypy scores ($t(798)=-1.926, p=.055$).

36 ***Actual HS***

1 Participants were asked if they had sought help for similar problems in the last 8 weeks.
2 Actual help-seekers (n=163) had significantly higher anxiety, $t(216.230)=-10.019$, $p<.001$, and
3 schizotypy scores, $t(798)=-7.736$, $p<.001$, than non-help-seekers (for mean scores see Figure
4 3).

5 No significant association was found between actual HS and recognising Jane's need for
6 help. However there was a significant association between actual HS and recognition of a
7 hypothetical self-need for help, $\chi^2(1) = 16.818$, $p<.001$. Based on odds-ratio calculation, the
8 odds of recognising a hypothetical self-need for help were 2.92 times higher if actual HS for
9 anxiety symptoms had taken place in the eight weeks prior to participation.

10

11 Discussion

12 To maximise the usefulness of CSM, stage one for anxiety, delays in HS for anxiety need to
13 be reduced (Havinga et al., 2018; Wang et al. 2005). However, to date the mechanisms
14 driving HS delays are poorly understood. This study aimed to investigate whether self-
15 reported schizotypy and anxiety influenced a hypothetical HS process. Our study found that
16 participants who failed to recognise Jane's need for help reported significantly higher
17 anxiety than those who did recognise her help need. However, when comparing the same
18 responses between actual and non-help-seekers, no significant association was found,
19 despite the former reporting significantly higher anxiety scores. These findings suggest that
20 approaching a highly anxious confidante for assistance with one's own anxiety may
21 contribute to delays in HS from professional help sources, unless the confidante has
22 previously sought help themselves. Simply put, who we choose to confide in can influence
23 our HS journey.

24 Given the frequency with which social networks are used for initial HS, promoting help-
25 seekers' discussion of anxiety and HS experiences with family and peers may help early
26 recognition of anxiety symptoms and need for help (Kenny, Dooley & Fitzgerald, 2016;
27 Wilson & Deane, 2010). This could be achieved through advertising campaigns. Mental
28 health clinicians could also have effective discussion regarding initial HS barriers and if/how
29 clients could use their experience to help friends and family.

30 Further research is needed to investigate how schizotypy influences the interpretation of
31 anxiety symptoms and HS needs. Lower schizotypy scores were observed in those who
32 recognised a hypothetical self-need for help compared to those who did not; further
33 research is needed to consider how schizotypy might impair emotional intelligence (Aguirre,
34 Sergi & Levy, 2008; Albacete, et al., 2016). However, actual help-seekers reported higher
35 schizotypy scores than non-help-seekers. Potentially, schizotypy might interfere with
36 recognition of symptoms in others but not self. Alternatively, symptoms may need to reach a
37 higher threshold before high schizotypes consider intervention necessary.

38 Recognition of anxiety and need for help are early steps in HS, these do not occur soon
39 enough for many who experience anxiety. This is problematic for the successful
40 implementation of CSM. The current study suggests that help seeking by anxious individuals

1 could delay formal HS. Given the prevalence of anxiety, this may be a common occurrence,
2 particularly young adults (Australian Bureau of Statistics, 2008; Kenny, Dooley & Fitzgerald,
3 2016; Wilson & Deane, 2010). Further, this study suggests that schizotypal traits may
4 contribute independently to delays in HS. Routine assessment for anxiety by healthcare
5 gatekeepers, such as General Practitioners utilising the StepCare service, can assist with
6 identification of anxiety symptoms and circumvent some of these HS obstacles (Black Dog
7 Institute, 2020). CSM would then be helpful in streamlining and clarifying the subsequent
8 treatment process and supporting a more preventative approach.

9

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15

Data Availability Statement

16 The data that support the findings of this study are available from the corresponding author
17 upon reasonable request.

18

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