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Title

"*I'm tired of being pulled from pillar to post":* A qualitative analysis of barriers to mental health care for trauma-exposed young people

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Abstract

Aim: Traumatic experiences in childhood are pervasive and associated with a range of deleterious mental health outcomes. Despite this, trauma-exposed young people often do not seek help from mental health services. While barriers to care for general mental health concerns are well established, less is known about those specifically facing young people who have experienced trauma. The present paper sought to examine the barriers in seeking mental health care faced by trauma-exposed young people through a qualitative analysis of online forums where individuals discuss and seek informal support for trauma.

Methods: This study used a qualitative, netnographic design, following the six-step LiLEDDa framework, developed for the analysis of online forums. Posts about trauma written in 2016 from five Internet forums targeting young people were included and analysed via thematic analysis.

Results: Barriers to mental health care for trauma-exposed young people were categorised into two interrelated themes: 1) structural and 2) relational barriers. Structural barriers related to practical challenges faced when accessing and engaging with mental health services. Relational barriers focused on interpersonal relationships with mental health service providers and how these influenced experiences of, and consequent engagement with, services.

Conclusions: Trauma-exposed young people appear to experience multiple barriers to mental health care, whereby interactions between structural and relational barriers determine ongoing engagement. Service-wide reform including trauma-informed mental health training

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for practitioners is urgently needed to improve access to care and engagement for this vulnerable group.

Keywords: barriers, help-seeking, trauma, abuse, young people, mental health services, internet forums

Introduction

Traumatic experiences in childhood, such as physical or sexual abuse and neglect, are common and associated with a range of negative health outcomes. In an American sample of 1,698 high-risk young people (aged 20-22), 82.5% reported one or more lifetime traumatic events and 59.9% reported four or more (Breslau, 2004). A meta-analysis of childhood sexual abuse estimates places global prevalence at 11.8%, with the highest rates found for girls in Australia and boys in Africa (Stoltenborgh, van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011). Trauma-exposed young people are more likely to develop posttraumatic stress disorder (PTSD), anxiety, depression and psychotic spectrum disorders, to self-harm or suicide, to have insecure relational attachments, and to engage in antisocial behavior and substance use (Cook et al., 2005; Gaweda et al., 2018; Gladstone et al., 2004; Layne et al., 2014; Varese et al., 2012).

Despite the prevalence of trauma in this population and its negative mental health impacts, young people have low rates of mental health service use. Findings from the 2011 Australian Census indicated that less than 10% of young people (aged 15-24) had used subsidised mental health-related services (Australian Bureau of Statistics, 2011). This is a major public health concern given that the highest burden of mental health disorders rests with young people, with almost one in four meeting criteria for a probable, serious mental

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illness (Gulliver, Griffiths, & Christensen, 2010; Mission Australia & Black Dog Institute, 2017).

An understanding of the factors that prevent young people from engaging with mental health services is paramount to increasing mental health service use and providing accessible, relevant and high quality services that respond to the needs of consumers. Previously reported barriers to care for young people with general mental health concerns include negative public attitudes about mental illness (i.e., stigma), issues with confidentiality and trust, concerns regarding the characteristics of the provider, lack of knowledge concerning mental health service availability, fear or stress about the source of help, lack of accessibility, (e.g., time, cost), discomfort speaking with a general practitioner, and negative past experiences (Gulliver et al., 2010; Martinez-Hernaez, DiGiacomo, Carceller-Maicas, Correa-Urquiza, & Martorell-Poveda, 2014; Rickwood, Deane, Wilson, & Ciarrochi, 2005). While the literature addressing barriers to care for young people with general mental health problems is extensive, less is known about the barriers specifically facing trauma-exposed young people.

To date, most research investigating barriers to mental health care at the service or provider level for trauma-exposed individuals has focused on adult populations, predominately war veterans. In a systematic review of 36 studies, barriers to care for war veterans and trauma-exposed adults from the general population included concerns regarding stigma, privacy and confidentiality, reactions and sensitivity of the provider, a sociocultural environment discouraging of disclosure, fear of the negative consequences of help-seeking, a lack of encouragement to seek help, and negative past experiences with services and

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accessibility issues such as time, distance and costs (Kantor, Knefel, & Lueger-Schuster, 2017).

To the best of our knowledge, there have only been two studies investigating barriers to mental health care for trauma-exposed young people. One of these surveyed professionals and the other was a case study of four Hispanic young people (Damian, Gallo, & Mendelson, 2018; Stewart, Orengo-Aguayo, Gilmore, & De Arellano, 2017). These studies found that barriers included distance to clinic, the caregiver's work schedule, confidentiality concerns, socioeconomic constraints, and a lack of cohesion among services. These studies are limited by their specific focus and emphasis on the perspectives of service providers and are therefore lacking the voices of service users. For these reasons, the barriers faced by young people who have experienced trauma remain largely unknown.

Given the negative impacts of trauma, its prevalence in young people and their tendency not to seek help for mental health issues, understanding barriers to care from the perspectives of trauma-exposed young people is vital to increasing mental health service use and reducing the negative outcomes associated with trauma. The present study examined barriers to mental health care for trauma-exposed young people through a qualitative analysis of Internet forum content where young people discussed their subjective experiences of trauma in an informal and anonymous context.

Method

Study Design

This study used a qualitative, netnographic design adapted from the LiLEDDa framework, developed for the analysis of Internet forums. Grounded in ethnography,

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netnographic research methods seek to understand social interaction in contemporary digital communities. The LiLEDDa framework is one such method that was developed in the context of nursing research, where online help-seeking and communication can mitigate power structures defining traditional health care systems (Salzmann-Erikson & Eriksson, 2012). LiLEDDa is an acronym designating the six steps involved in the framework, including: 1) review of existing literature and identification of research questions; 2) locating the field online; 3) making ethical considerations; 4) gathering the data; 5) data analysis and interpretation; 6) evaluating abstraction and the trustworthiness of findings.

Ethical Considerations

The current study was purely cross-sectional and observational, analysing data from a publically available source without any intervention or interaction with forum posters. The study was therefore not considered human subject research and consent was not required, a common perspective in Internet research scholarship (Bassett & O'riordan, 2002; Kozinets, 2010; Wilkinson & Thelwall, 2011). Nevertheless, a number of steps have been taken to protect poster anonymity and minimize data traceability given the sensitivity of the research topic (McDermott, Roen, & Piela, 2013). Poster nicknames and handles have been withheld along with specific forum names. Extended quotes have been paraphrased and potentially identifying information removed where doing so has not altered the original meaning of the text. This study was approved by the University of Melbourne Human Research Ethics Committee.

Identifying forums

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To identify forums, a Google search was conducted using terms related to trauma (trauma, posttraumatic stress, PTSD), young people (young people, adolescents, teens, youth) and Internet forums (forums, discussion, chat). The first 20 pages of Google results for each search were scanned. Forums were included if they specifically identified themselves as targeting young people, were publicly available without membership or password, and had at least 100 posts made on the forum within three months to confirm it was a living community (Salzmann-Erikson & Eriksson, 2012). For each combination of search terms, two authors (KT and JL) looked through each of the forums listed on the first 20 pages of the Google search results to check if they met the inclusion criteria. After working through all the search terms, five eligible online forums consistently came up in the search results. Two of these were based in Australia, two in the United States of America, one in the United Kingdom, and one was international. We determined that a point of saturation had been reached on account of no new eligible forums emerging in the results.

Threads within each forum were included for analysis if the lead post: was written in English; included the words ‘trauma’, ‘PTSD,’ or reference to an event considered within the literature to be traumatic; and the trauma discussed was experienced by the poster. In an attempt to capture a youth sample, any threads where the lead poster could clearly be identified as an individual over 25 years of age or below 13 years of age were excluded. Explicit demographic data, including precise geographical information, was unavailable as posters were anonymous.

Data Collection

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Data collection was conducted over a two-week period beginning November 25th 2016. Collection was restricted to posts published between January 1st and November 2nd 2016, and to the most recent 100 pages of posting due to the large quantity of available data and to standardise extraction across the forums. The final data set comprised 295 Microsoft Word document pages of forum posts, including 78 different threads written by a total of 176 unique posters.

Data Analysis

Data were analysed using thematic analysis (Braun & Clarke, 2006) and followed the LiLEDDa protocol (Salzmann-Erikson & Eriksson, 2012). Authors KT and JL, first read all data and independently conducted line-by-line coding of a subset of the data, giving full and equal attention to the semantic and conceptual content of the data. Initial codes of were discussed and a coding framework was agreed on. When inter-rater reliability reached 90%, the remaining dataset was coded independently by KT or JL. Once codes were determined, all were clustered into themes. For the purposes of this study, all codes organized under the theme “barriers to help-seeking” were examined and only codes at the service or provider level were included. The broadest possible definition of barriers to care was adopted when identifying the data subset, where any statement referring to the difficulties a young person faced when accessing or engaging with care were included. Codes were then critically analysed to identify themes at the latent level. Themes and sub-themes were discussed between co-authors until a consensus was reached.

Evaluation of Rigor

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Koch's (2006) hallmarks of qualitative rigor (credibility, transferability, and dependability) were employed to ensure the trustworthiness of results. Credibility was ensured by discussion of codes and themes within the research group to reach agreement. Transferability was addressed by including as much detail as possible (given ethical considerations and relative anonymity of forums) about the sample. Dependability was ensured by detailed reporting of how the data were collected, including decisions for inclusion and exclusion, and the process of coding, as well as reflection upon the author's own biases to allow for transparency.

Results

The barriers identified through the analysis of internet forum data were categorised into two interrelated themes: 1) structural and 2) relational barriers of mental health care. At the inception of this project, we set out to identify the structural barriers that prevented young people with trauma-exposure from accessing professional care. During the analysis, we discovered that young people encountered barriers to care for the effects of their trauma throughout their engagement with services and that structural barriers were intrinsically conntected with barriers that we have termed relational. It was impossible to disentangle the relational barriers from structural barriers within forum posts. Thus a decision was made to present these two themes together in the current article. Themes are presented in Table 1.

[Insert table 1 about here]

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Theme 1: Structural Barriers

Structural barriers were those related to practical and logistical challenges faced by trauma-exposed young people when accessing and engaging with mental health services. Although these barriers were structural at their core, young people often described relational elements within them that influenced their service experience. The following themes are arranged in order of the extent to which they were also interpreted relationally by the young people on the forums.

1a. The system is logistically complex

Young people described difficulties negotiating the administrative and logistical requirements of mental health services once they had initiated engagement, and their frustration about having to navigate a complex, fragmented and unaffordable system:

"I just keep hitting the wall. I am trying my hardest to get help and there is just no one here who seems to be able to offer any unless you're well off. I'm done with this system. I'm here in the waiting room as I write this... I really do not know anymore why I was put on this earth. I wish I never woke up from ICU [Intensive care unit] and I don't have the guts to end it myself today. I have been to [de-identified] trying to get a disability support plan, then to the district court to see victims support and now I am at the doctors".

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Posters frequently described effortful attempts to seek help, but voiced frustration and despair directed towards a complex and difficult system that did not provide appropriate care when it was needed. It wasn't that young people were unwilling to engage with services, but rather, that multiple negative experiences or unanswered calls for help eroded faith in professional services. A number of posters also commented on the disjointed nature of mental health care during their transition into adulthood, where services and professionals were no longer available to them once they turned 18. Many voiced concerns about having to move to a new service in this situation, an experience described as "scary" and "traumatic" in of itself. Indeed, consistency of care may be of particular importance for this group due to the relational attachment difficulties that are often experienced by young people with trauma exposure.

"After it happened I was seeing my counsellor at school 2-3 times a week for a couple of months. Since I have recently graduated I can't go to my counsellor anymore…I plan to try and find someone else…I'm just so terrified."

1b. Ineffective gateways for mental health

Posters described feeling as though the gateway services and mental health service staff did not have adequate training, were difficult to access or were ineffective at managing mental health issues. In many cases, posters specifically referred to general practitioner (GP) services or school counsellors as not having met their needs when they sought help. One poster explained:

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"I consider that the GPs I went to when I began to seriously suffer from stress let me down by not extrapolating from my reported symptoms to find others and to unearth the link between them and the underlying cause or anticipate worsening."

Another poster described feeling as though general practitioners were unable to provide adequate mental health support due to a lack of training:

"GP's and mental health are not a good combination. Don't get me wrong, doctors are very qualified people, but unless they have chosen to specialize in psychiatry (psychiatrists) they seem to know very little about mental health and psychiatric treatments."

Young people commented on the limitations of current mental health service pathways, generally describing them as ineffective routes to access appropriate care. Many posts highlighted ways in which these services may not be fulfilling their intended role as a mental health "home base" from which one can begin their recovery journey. Additionally, posters commented on the way the current system impacted the care they received. They described difficulties obtaining referrals, receiving conflicting information, treatment environments that did not provide a full account of their symptoms and being referred on due to staff not being trained to manage their needs. One poster explained:

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"I went to the doctor and have been diagnosed with anxiety. I also started to see a school counselor, only it didn't work out and she recommended I need a different type of therapy as I probably have PTSD due to a number of events that have happened to me and that all the anxious and depressed states I go into are a result of this."

1c. Lack of availability of professionals

Young people described feeling unsupported by the mental health system due to an insufficient supply of professional help; being placed on waiting lists; receiving delayed responses to help-seeking attempts; and the distance and unavailability of professionals. Young people appeared to interpret the unavailability of services and professionals as a reflection of the extent to which they were cared about and their lives valued. One poster described:

"Hospital doesn't care. They kicked me out and there's no beds anyway so there's no point going back there. It would be better for everyone if I just did what I am planning".

The posts from young people indicated that seeking professional help often came as a last resort when posters were not receiving this support from their community. When these calls for help went unanswered, posters described experiencing feelings of isolation and losing hope in their recovery:

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“I’ve been through the ringer with mental health services etc. I just want to know if anyone has experienced the same as me. I’d like to feel less alone”.

Despite service and professional availability being a structural, systemic issue, many young people described experiencing this on a personal level, where being denied access to care had a psychological impact on them. Forum posts from young people indicated a personification of the mental healthcare system, where posters believed access to be granted based on the extent to which the system “cared” about the help-seeking individual or perceived their needs as worthy of support.

“I am waiting to see my psychologist, but I won't see him until November and that is a really awfully long time for me. I am in more pain now then I have been in recent months. All this psychological burden I carry now is really hurting me so much and I don't know how much more I can take."

There was a sense of desperation in the posts from young people, where delays or a lack of response from services sometimes resulted in extremely negative consequences for the young person.

*"I want to do more than self-harm. I tried calling triage for the mental health team but they said it could take a while. I've been trying to follow my safety plan but I gave up and self-harmed. I can't f***ing do this anymore".*

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Other posters highlighted the extreme measures taken in efforts to access help:

"Do you think you keep overdosing in the hope that someone will finally notice and give you the help you need? I went through a stage where I felt like I had to do this because the mental health services weren't taking me seriously."

Forum posts indicated that when a young person was experiencing a crisis, unanswered calls for help often justified feelings of worthlessness. "The system" appeared to function as a representation of the overall value society placed on the young person as an individual. When access was denied, particularly in crisis, young people seemed to perceive this as indicative of the fact that they had been devalued or abandoned by society. These sentiments are perhaps unsurprising given that fear of abandonment is often characteristic of individuals who have experienced trauma.

1d. Insufficient treatment

Young people shared their distress over having to limit, delay, or cease treatment with a trusted organization due to resourcing issues and the difficulties negotiating support when subsidised care ran out.

"I had a therapist but the amount of sessions for the year has finished so until then that's all my supports at the moment. I hate that you only get a small number of sessions with a

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psychologist for free through mental health care plans; they need ways or options to get more especially for people who need it."

This rationing of services resulted in young people describing feeling as though the care they received was inadequate for them to effectively address their mental health needs and reach a stage at which they felt they could continue their recovery independently. For example, one young person on an Australian forum expressed concern when having to stop sessions for nine months until their annual sessions were renewed, due to the limited number of subsidised sessions available under Australian funding schemes:

“I told them straight up that I wasn't ready to leave and that if I didn't have any support I’m not sure what would have happened."

Additionally, having to limit or cease treatment with a service prematurely appeared to have a psychological impact on young people, where having to prove the legitimacy and urgency of their struggles was experienced as distressing and hurtful:

"About a year ago I asked for more time and sessions. It took a long time to prove to his [counsellor] boss why I was asking for more time. After a long time and explaining why I would like more time and sessions they were granted to me, but it was a distressing time for me”.

Theme 2: Relational Barriers

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Relational barriers were those associated with the elements of the young person's relationship with mental health service providers and how these influenced their experience of, and engagement with, mental health services.

2a. Disruptions to the therapeutic relationship

Young people described their frustration with having to rebuild trusted relationships with professionals and cope with changes to therapy arrangements that were sometimes abrupt and unwanted. Posters described changes in therapists as a hindrance to their recovery, something that influenced the information they were willing to share about their experience, and a factor that reduced their motivation for ongoing engagement with formal services:

"I wondered if anyone knew of any services other than [mental health service] I could be referred to? I don't have anything against [mental health service] it's just that I'll be 18 soon and then I'll have to leave there too. I just feel like by the time they get my referral I'll get just a couple of sessions and then I'll have to find yet another counsellor. I'm tired of being pulled from pillar to post and not getting enough time to get well again".

Additionally, young people described experiencing feelings of abandonment, betrayal and rejection when therapy with a trusted professional came to an end:

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"I've been abandoned by a lot of people in my life and now I am being forced not to go to counselling and it seems I have no opinion on the matter, so my counsellor of 3 years is abandoning me".

Feelings of abandonment were described by young people even when the therapeutic relationship was longstanding and therapy ended gradually and in a planned way. Some posters described believing that their therapist would always be there as a support and did not foresee an end to the therapeutic relationship.

"It really hurt me when I heard this as so many people in my life have left and I even told my counsellor that I was convinced she would do the same to which she replied, 'no, I won't give up on you, far from it' but now all of that seems to have gone out the window."

2b. Invalidating responses from professionals

Young people described feeling blamed, dismissed, patronised, not listened to, and being met with insensitivity and a lack of empathy. One poster described feeling blamed when reporting an assault:

"One of my friends came forward to the school and told the office what happened, so I had to go in and talk to the counsellor. I stressed how desperately I didn't want to get my parents involved, but the counsellor said there were so many layers to my case…. By the 'many layers' she meant that because I had initiated everything up until it happened – I invited him

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to do stuff that day, he was in my car, I was the one driving, I basically put myself in that situation"

Although the context varied, a number of posters described feeling judged when providing an account of things that had happened to them, or symptoms they were having difficulty managing. There was a sense of disappointment and discouragement in the way posters articulated these experiences, and in many cases this appeared to set a precedent for the way young people engaged with services and professionals in the future. This precedent manifested as pessimism or ambivalence towards the role of mental health services. These sentiments often came after receiving conflicting information from multiple professionals or when young people felt their explanatory model was dismissed:

"I went back to the doctor and tried to explain only he completely dismissed what the counsellor, who I have been seeing every week for a year, had recommended. He said it is all just anxiety before I had even explained what has happened to me in the past four years, as I was struggling to bring it all up. I left feeling completely dismissed and not listened to and I have managed to cope on my own since then".

Young people described not feeling heard by professionals. Young people highlighted that professionals made quick judgements about their presenting issues and rushed to provide advice and solutions to issues before they had heard the full account of the young person's

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experience. Young people stressed wanting to feel listened to, empathised with, and believed, rather than be provided with answers and advice. One poster noted:

"I want to go back to the doctor to prevent it getting bad again only I'm scared they won't listen to me again. I've seen two different doctors at the surgery and both haven't helped or listened to me"

Posts from young people appeared to describe feeling stuck in an in-between space, where they were fearful or pessimistic about making further attempts to access professional care, but were equally struggling to manage distress independently.

2c. Lack of power over therapy process

Young people described feeling pressured by professionals to adopt particular perspectives, engage in therapies, and use strategies that were in conflict with their own explanatory models. Within the forum posts, there was an extended conversation between posters about their experiences of feeling pressured to engage in therapies they were not comfortable with:

"I did that 'hit the tree with a stick' therapy' - I hated it. The therapist was a twerp. Made me do it without my shirt on- I was still so paranoid and neurotic about my body, having been obese, that the whole process made everything worse I was too young and naive to say at the time, 'NO, I don't want to do that kinda THERAPY!' I was more stressed leaving that session than when I actually arrived"

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It was clear that posters experienced anger and resentment when feeling pressured in sessions, or when they were not engaged collaboratively in the direction of therapy. Responding to the previous post, another young person echoed strikingly similar sentiments:

"I refused, but he put the guilt on, and I felt pressured. Not good... It made me angrier. I just wanted to slam the therapist with the stick."

While the above quotes come from one forum interaction, the frustration and pressure experienced by posters, regardless of whether or not they were indeed pressured to comply with a therapist's demands, was something that was identified throughout all threads analysed. Posters described complying with a therapist's suggestions and demands even when this was in conflict with their own explanatory model or individual needs. This is something that warrants further investigation in vulnerable groups.

Importantly, despite young people having complied with the therapist's requests, it was unclear whether they had voiced their concerns to their therapist. It may be that the therapist remained unaware of the young person's feelings, and therefore the direction of therapy may have continued along a path that did not meet the young person's needs. The idea that posters didn't feel able or comfortable to voice their concerns about the direction of therapy to their therapist is of particular importance given the power-over dynamics that exist both in the therapist-client relationship and the power-over dynamics that are often associated with traumatic experiences.

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2d . Non-disclosure in the context of an ongoing therapeutic relationship

Young people described not having disclosed their trauma to professionals' despite being engaged with formal support services. This non-disclosure was present even for young people who had good relationships with their therapists or who had been engaged with them for some time. This resulted in young people describing feeling that their treatment was ineffective, possibly given that it did not address the core of their difficulties. In some cases, this led to young people disengaging from services. One poster explained:

"I was abused and haven't told my psychologist or psychiatrist. I don't know how to bring it up, because even though I have always had issues before all that happened, I feel like it is part of the problem why I am not making progress and can't change. In the very first consult, the psychiatrist flat out asked me and I said no".

Young people described feeling uncomfortable disclosing to therapists, even when they had disclosed to another therapist previously or undergone extensive trauma work:

"I still feel I have a lot more to process but I don't have a therapist I am comfortable doing it with".

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Another poster described how having to end therapy with a trusted professional prevented their disclosure. This poster was graduating from university, and therefore would no longer have access to the university counselling service and the therapist they were seeing:

"I have a good relationship with my counsellor and was seriously considering telling her about it or making a 'disclosure' as they call it, but before I did this I needed to know whether the support from my counsellor would be continued… sadly I've got four sessions left and my counsellor will have to stop seeing me".

Discussion

The aim of this paper was to identify structural barriers to professional services experienced by young people with trauma-exposure. Instead, investigation of Internet forum posts by young people revealed two interrelated themes: (1) Barriers related to the structural elements of a service; and (2) those related to the relational elements. Structural barriers appear to play an important role at the beginning, for example, current pathways to mental health services and the complexity and fragmentation of the mental health system made it particularly difficult for young people to access appropriate care and have their needs addressed. Structural barriers re-surfaced towards the end of service engagement, where insufficient sessions due to funding and resourcing limitations prevented young people from reaching a stage where they could continue their recovery independently. Importantly, forum posts suggested that the structural elements to services are often paired with relational, interpersonal elements and these remain central to the engagement of this vulnerable group.

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For example, how positively a young person is received by professionals within gateway services will have a huge impact on the decision of the young person to (or not to) persevere with engagement.

The structural barriers identified in this study have previously been reported in the industry, where the impact of funding limitations, a complex and fragmented system, the high cost of care and lengthy wait times limit service accessibility for young people (Bendall et al., 2018; Bush, 2018). These barriers have also been highlighted by mental health service providers, adult service-users in primary healthcare and young people for trauma-related issues (Chung et al., 2012; Damian et al., 2018; Stewart et al., 2017). These included a lack of coordination and integration among services, workforce shortages, socioeconomic constraints, and difficulties navigating the healthcare system.

Unique to the present study were the barriers concerning the relational elements of a service. Although there is a large body of research noting the importance that trauma-exposed individuals place on the therapeutic relationship, young people in this study appeared to perceive difficulties with the therapeutic relationship itself as a barrier that is deeply intertwined with known logistical barriers (Cohen, Mannarino, Kliethermes, & Murray, 2012; Wilson, Hutchinson, & Hurley, 2017). It is likely that present findings differ from previous research due to the method of data collection. Research in this area thus far has had a narrow scope and has mainly focused on the perspectives of providers (Chung et al., 2012; Damian et al., 2018; Paul, Gray, Elhai, Massad, & Stamm, 2006; Stewart et al., 2017).

The centrality of the therapeutic relationship

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A central finding in this study was the importance placed on the relational and interpersonal elements of mental health services, which often played a role from initial engagement with general practitioner services. Current gateways for mental health services appeared to be lacking the interpersonal qualities that seem vital for trauma-exposed young people. Time restrictions paired with the transactional style of contemporary healthcare structures may lead young people to interpret interactions with professionals as dismissive, insensitive and lacking in empathy. These same issues with the structure of mental health services also played a role toward the end of engagement, where young people experienced feelings of abandonment and betrayal in response to having to limit sessions or delay further treatment with a trusted organisation or therapist. This finding supports a large body of research recognizing the significance of the therapeutic relationship for people who have experienced trauma (Cohen et al., 2012; Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005; Wilson et al., 2017). These studies showed that relational collaborations, positive human connections, and an established positive and trusting relationship with the therapist were key factors to facilitate healing from trauma. Additionally, (Sweeney, Filson, Kennedy, Collinson, & Gillard, 2018) highlighted the importance of developing therapeutic relationships formed on transparency, authenticity and openness given that trauma-exposed individuals have often experienced betrayal, deception and power-over dynamics.

Power, Autonomy and Choice

Young people in the present study expressed their anger and frustration when feeling as though their personal experiences, knowledge and perspectives were not valued or acknowledged within the therapeutic environment. This resulted in young people describing

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feeling pressured to take on particular perspectives or to participate in therapeutic techniques that they were uncomfortable with or not agreeable to. The biomedical model largely adopted by health services positions trauma reactions as symptoms rather than adaptive coping responses to trauma (Elliott et al., 2005; Wilson et al., 2017). This can result in professionals unintentionally invalidating the resilience and perspectives of young people and the protective functions of symptoms and behaviors (Elliott et al., 2005; Wilson et al., 2017). These findings emphasise the importance of giving the trauma survivor a sense of autonomy, control and choice within treatment, allowing them to move away from the feelings of powerlessness and victimization that often occur as a result of trauma. The findings also highlight the unequal power dynamic that exists between the helper and helped in the therapeutic relationship, which may be exacerbated for trauma-exposed young people. Feeling pushed to participate when therapy takes a direction that a young person is not comfortable with may trigger the same feelings of powerlessness experienced during past traumas. Further, complying with the therapist's requests, even when they felt strongly against doing so may have been a protective mechanism developed by young people when they experienced past abuse by an authority figure (Elliott et al., 2005; Wilson et al., 2017).

Disclosure

An important finding in the present study was that some young people described not having disclosed their trauma despite being engaged with formal mental health services. In this respect, non-disclosure functioned as a barrier within care, resulting in the young person receiving treatment for more visible difficulties (e.g., depression). This may have accounted for why some young people found formal support services to be ineffective and subsequently

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disengaged. Another key finding was the way in which young people described disclosure, not as a discrete, single event, but rather, as an ongoing and deeply considered process to determine whether the environment and/or therapist was safe and appropriate for this. This is consistent with the findings of a qualitative literature review investigating disclosures of child sexual abuse, where, in the content of shame, self-blame and fear, disclosure was similarly viewed as an ongoing, iterative process facilitated within a relational context (Alaggia, Collin-Vezina, & Lateef, 2017). Young people have also described reluctance to approach trauma memories and difficulty acknowledging that trauma has occurred in trauma-informed psychotherapy (Tong, Simpson, Alvarez-Jimenez, & Bendall, 2018). Continuity of care appears critical for young people, as has been reported by adult survivors of child sexual abuse (Chouliara et al., 2011), where abrupt changes to therapists can lead to non-disclosure, particularly if relational elements of service engagement have been disjointed and unstable. This is reflected by a young person in the present study who decided against making a disclosure when they learned that care with their current therapist would be discontinued. Ongoing, consistent care from the same therapist where possible may promote a safe therapeutic environment facilitative of disclosures.

Clinical implications

The current gateways to mental health care for trauma-exposed youth are not adequate to ensure appropriate triage and referral. This is often via general practitioners, who in current service models do not have time to appropriately engage and assess trauma-exposed young people. This may in turn result in ill-fitting referrals that do not address the core issues the

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young person is dealing with, significantly delay the young person's recovery, or result in them disengaging due to inappropriate care.

Further mental health training is required for all mental health practitioners, including general practitioners, in trauma-informed care (Bendall et al., 2018). This should include training in the relational needs of trauma survivors to create an environment more facilitative of disclosures of trauma. Alaggia et al. (2017) found that positive disclosure experiences were those that involved feeling safe, believed, listened to and not feeling judged by the person disclosed to. Further, there was evidence that the creation of safe spaces and environments where information and education are provided about traumas such as sexual abuse could promote open dialog and facilitate disclosure for young people with trauma-exposure. Even without disclosure, health professionals should be aware that any young person may have experienced trauma and should treat all help-seeking young people accordingly. Mental health professionals should strive to include young people in therapeutic decisions, make it clear that the young person's perspective is valued and that they have choices about the direction of treatment, providing them with a sense of autonomy and partnership.

Finally, this study provides further evidence that the limited number of sessions and resources currently accessible under Australian funding schemes are inadequate for the needs of trauma-exposed young people (Bendall et al., 2018). Our findings show strikingly how young people, particularly in regard to disruptions to a trusted therapeutic relationship, perceive this lack of resources in a relational way.

Limitations

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The present study has a number of limitations. First, we were unable to ascertain sample demographics due to our method of data collection. The lack of information regarding the exact geographic location of forum posters is a notable limitation given the importance that rural and urban distinctions might have for access to care. While a number of efforts were made to ensure posters were young people that had experienced trauma, the anonymous nature of Internet forum posting prohibited access to this information. However, this methodology simultaneously enabled the unique perspectives of trauma-exposed young people to be captured in an organic online environment. The ability to capture the freely expressed views of those who may not be engaged with formal support services, which may be due to prior negative experiences, the absence of government subsidised treatment, or general discomfort seeking formal support, is not possible with traditional methods of data collection, and is thus a notable study strength. Second, it is important to acknowledge the possible influence of researcher bias during analysis. The first author is a white, middle class Australian female with undergraduate education in psychology, five years' experience working in youth mental health research and a keen interest in trauma, which likely influenced her interpretation of the results. Additionally, the two authors who coded the original dataset are also white, middle class, Australian females with post-graduate education in psychology. A number of measures were employed to maximize the rigor of the analysis during coding and interpretation, which included independent double coding, ongoing reflection, and a collaborative consensus driven approach with the wider research team (Koch, 2006).

Future directions and concluding remarks

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Given the long-lasting, negative impacts of trauma, investigating ways to ensure that services are safe places for trauma-exposed young people is vital to reducing the burden of mental-ill health and the suffering of trauma related difficulties. The themes identified within this study indicate that the current structure of mental health services lack the interpersonal qualities that appear to be vital for trauma-exposed young people to remain engaged and establish the safe and stable environment that is necessary for recovery. Urgent implementation of trauma-informed care training for gateway practitioners is needed. Given this is one of the few studies to capture service experiences of trauma-exposed young people, further research is needed. Evaluation of the experience of care of young people after implementation of trauma-informed care in youth mental health services is of high priority.

Conflict of Interest Statement

None

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Table 1

Themes and Sub-Themes Related to Barriers to Mental Health Care for Trauma-exposed Young People

Theme	Sub-theme
1. Structural Barriers	1a. The system is logistically complex
	1b. Ineffective gateways for mental health
	1c. Lack of availability of professionals
	1d. Insufficient treatment
2. Relational Barriers	2a. Disruptions to the therapeutic relationship
	2b. Invalidating responses from professionals
	2c. Lack of power over therapy process
	2d. Non-disclosure in the context of an ongoing therapeutic relationship

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