

ORIGINAL ARTICLE

Cancer patient utilisation of psychological care in Germany: The role of attitudes towards seeking help

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Abstract

Objective: Even if significantly distressed, many patients with cancer do not seek psychological help. There is growing evidence that attitudes are central barriers for help-seeking, and instruments to assess cancer patients' attitudes towards help-seeking are urgently needed. This study aimed to evaluate the German *Attitudes towards Seeking Help after Cancer Scale* (ASHCa-G) and investigated the relationship between patients' attitudes and psychological care utilisation.

Methods: The ASHCa-G was presented to 270 patients with cancer (age 63.0 ± 12.7 years, 44.8% women). Item analyses, principal component analysis and associations with age, social support, help-seeking intention and psychological care utilisation were calculated. A hierarchical logistic regression was performed to ascertain the leading role of attitudes in explaining psychological care utilisation.

Results: Principal component analysis supported a two-component solution, which showed good internal consistency for the positive attitudes ($\alpha = 0.80$) and negative attitudes ($\alpha = 0.75$) subscales. The associations with age, distress and help-seeking intention confirmed the validity of the ASHCa-G. Positive attitudes explained most variance of cancer patients' current psychological care utilisation.

Conclusion: The ASHCa-G seems to be a reliable and valid questionnaire for assessing attitudes towards seeking psychological help among patients with cancer. Clinical practice might profit from identifying attitudinal barriers that hinder patients with cancer from seeking psychological help.

KEYWORDS

attitudes towards seeking help, cancer, oncology, psychological care utilisation, service use, validation

1 | BACKGROUND

During the diagnosis and treatment of cancer, approximately every second patient experiences clinically significant psychosocial

distress (Mehnert et al., 2018). Various psycho-oncologic treatments can reduce this distress with small-to-medium effects (Faller et al., 2013). Thanks to national guidelines and certification initiatives in the past years, distress screening and treatment

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offers are well implemented in standard care. Alarming, many patients with cancer who screen positive for distress still do not receive psychosocial care (Mitchell, 2013; Zeissig, Singer, Koch, Blettner, & Arndt, 2015).

This urgent phenomenon prompted several research groups to investigate factors that may contribute to the lack of admission of individuals with cancer to psychological care. On a socio-demographic level, there may be a tendency for lower age and being female (Ellis et al., 2009; Faller et al., 2017; McDowell, Occhipinti, Ferguson, & Chambers, 2011; Zeissig et al., 2015) to be related with higher psychological care utilisation, but the current evidence on this is equivocal (Clover, Mitchell, Britton, & Carter, 2015; Tondorf et al., 2018). From patient self-assessments, we know that low perceived social support (Ellis et al., 2009; Faller et al., 2017), high perceived need for help (Faller et al., 2017) and high distress (Clover, Kelly, Rogers, Britton, & Carter, 2013; Compen, Adang, Bisseling, van der Lee, & Speckens, 2018) are likely to be associated with higher care utilisation. When it comes to modifiable patient-related variables, emotionally distressed individuals most frequently name attitudinal barriers as the reasons for not seeking psychosocial help (Andrade et al., 2014; Sareen et al., 2007). Data from the European Study of Epidemiology of Mental Disorders revealed the significant role of beliefs about how effective, comfortable and socially accepted professional psychological help is (Have et al., 2010). These attitudes were still associated with mental healthcare use, even after controlling for previous use. Recent qualitative (Carolan, Smith, Davies, & Forbat, 2017; Lambert et al., 2014) and quantitative (Faller et al., 2017; Tondorf et al., 2018) studies confirm the role of attitudes as central barriers to help-seeking in the context of cancer. In a recent German multi-centre study on the correlates of cancer patients' reported utilisation of psychological care, attitudes accounted for the largest part of the explained variance (Faller et al., 2017). If we want to meet those needs, attitudes, being influential and modifiable factors, will have to be assessed and positive attitudes fostered as a matter of urgency.

To assess attitudes towards help-seeking in the context of cancer, Steginga et al. (2008) developed the Attitudes towards Seeking Help after Cancer Scale (ASHCa) grounded in the theory of planned behaviour (TPB). The TPB proposes influences (domains) that determine an individual's decision to follow a particular behaviour. The ASHCa scale was developed according to guidelines for TPB scale construction and then validated in a regional cancer treatment centre in Queensland, Australia, where it demonstrated good internal consistency. With regard to concurrent validity, the ASHCa positive attitudes subscale was associated with increased help-seeking intention and psychological care utilisation. The negative attitudes positively correlated with cancer-specific distress and age, but not with psychological care use (Stedinga et al., 2008).

The purpose of the present study was to investigate the role of specific attitudes towards help-seeking for German cancer patients' actual psychological care utilisation. Faller et al. (2017) have already shown the importance of the overall attitude for care utilisation, so our aim was to learn more about the specific beliefs

of patients. Therefore, we validated a German translation of the multi-item ASHCa in a sample of patients with cancer and investigated the role of these variables in predicting psychosocial care use. We hypothesised that psychometric properties and factor structure compare with the original scale. In order to investigate the validity of the German ASHCa, we assessed self-reported social support, distress levels and help-seeking intentions. We expected that higher scores on the positive attitudes subscale would be associated with increased help-seeking intentions and lower social support. For the negative attitudes subscale, we expected higher scores to correspond with higher age and distress levels. Concerning the role of attitudes for psychological care utilisation, we expected that especially positive attitudes would explain care utilisation, but not negative attitudes. If we are able to identify certain attitudes as relevant factors for the use of psychological care by German cancer patients, this may affirm the Australian suggestion to make attitudes potential targets for interventions on an individual and population level.

2 | METHODS

2.1 | Participants and procedure

Ethical approval was obtained from the local Medical Ethics Committee. A pilot version was first presented to an online sample of patients with cancer ($n = 42$) to explore acceptability of language and content. Subsequently, the final version of the German ASHCa scale was validated in a sample of patients receiving treatment at a Comprehensive Cancer Center (CCC). Patients were recruited from outpatient and inpatient oncology wards at the CCC from 5 September 2018 to 30 November 2018. Patients were eligible for study inclusion if they had a diagnosis of cancer (at any stage, different entities), were fluent in the German language and above the age of 18. Patients were approached by a Master's student and asked for voluntary participation. After providing informed consent, participants filled in the paper version of the questionnaire while waiting for medical treatment. In total, 294 patients provided informed consent, of which 274 returned their questionnaires to the study team (response rate 93.1%). After removing four incomplete cases (missing items on the ASHCa-G), the final sample for data analysis consisted of 270 patients with cancer.

2.2 | Measures

2.2.1 | Attitudes to seeking help after cancer

The English language original of the *Attitudes towards seeking help after cancer* scale was translated and back-translated (Appendix A) according to the recommendations of Beaton, Bombardier, Guillemin, and Ferraz (2000). The original ASHCa was developed based on the domains of the theory of planned behaviour (behavioural intention and control, subjective norms, salient beliefs, positive and negative attitudes). This resulted in a 20-item scale

asking respondents to rate their agreement with each item on a five-point scale from 1 (strongly disagree) to 5 (strongly agree). The items were separated into a three-item scale measuring behavioural intention and a 17-item scale measuring attitudes. In the original ASHCa, the 17 items were subjected to an exploratory factor analysis, which favoured a 2-factor solution after deleting two items. The first factor was interpreted as *Negative Attitudes to Help Seeking*, with 10 items addressing beliefs such as support being upsetting or making the person seem weak. The second factor, named *Positive Attitudes to Help Seeking*, included five items regarding positive expectations from patients and their doctor or family. The original two-factor solution (36% of variance) for the attitudinal items showed good internal consistency for the first factor *positive attitudes* ($\alpha = 0.75$) and the second factor *negative attitudes* ($\alpha = 0.81$).

2.2.2 | Help-seeking intention

We used our German translation of the previously mentioned three-item scale from Steginga et al. (2008) to measure behavioural intention for seeking psychological help. In this study, the internal consistency was $\alpha = 0.94$.

2.2.3 | Social support

Social support was measured using the German version of the ENRICH Social Support Instrument (ESSI-D; Kendel et al., 2011), consisting of five items assessing perceived emotional social support on a five-point scale from 1 (none of the time) to 5 (all of the time). In this study, internal consistency for the ESSI-D was $\alpha = 0.86$. The individual item ratings were totalled for further analysis, with higher scores indicating frequently perceived social support.

2.2.4 | Distress

We used the German version of the National Comprehensive Cancer Network Distress Thermometer to assess self-reported psychosocial distress (Mehnert, Müller, Lehmann, & Koch, 2006). This widely used instrument measures distress on an 11-point numerical scale from 0 (no distress) to 10 (extreme distress). A cut-off value of 5 or higher is recommended for identifying individuals with high psychosocial distress. The German Distress Thermometer has strong discriminatory power for screening highly distressed individuals; it correlates moderately with other common multi-item screening measures (e.g. HADS).

2.2.5 | Psychological care utilisation

To assess patient utilisation of psychological care, we asked participants 'Have you utilized psychological counseling/support in the past 6 months' and 'Have you utilized psychotherapy in the past 6 months'. Response options were 'yes' or 'no'. We chose the 6-month time

frame as it is a compromise between the varying time frames (3 to 12 months) in previous studies on care utilisation (Hamilton & Kroska, 2018). We followed the study of Faller et al. (2017) and combined both answers into one dichotomous yes/no variable.

2.2.6 | Demographic and medical information

Similar to the validation study of Steginga et al. (2008), we obtained information on the participants' sex, age, marital status, educational level and employment status. Medical characteristics like cancer type and site, age at diagnosis and treatment status were retrieved from the electronic health record.

2.3 | Statistical analysis

Sample size was determined by the recommendation of at least 200 participants needed for psychometric testing (Howard, 2015). Because there were only 4 cases with missing items, we made use of listwise deletion. Listwise deletion is considered a simplistic, yet effective method to resolve a missing data problem that involves only a small part of the sample (Schafer & Graham, 2002).

The psychometric properties of the final German ASHCa were first evaluated with standard item analyses (with mean item scores and standard deviations, item difficulties) and internal consistency (with corrected item-total correlations, Cronbach's alpha coefficient of the subscales and estimations of internal consistency when an item is deleted).

Second, the factor structure of ASHCa-G was examined by conducting a *principal component analysis* according to Steginga et al. (2008). The suitability of the data for factor analyses was evaluated with the Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy and Bartlett's test of sphericity. The number of components to be extracted was determined through a modified Horn's parallel analysis suggested by Glorfeld (2016), together with scree plot examination. This procedure reduced the tendency of alternative methodologies to extract too many factors. The extracted components were orthogonally rotated (varimax with Kaiser normalisation). Factor loadings > 0.30 were reported and interpreted.

In a third step, bivariate correlations (Pearson r) of the ASHCa-G subscales with age, social support, distress and help-seeking intention were calculated to interpret concurrent validity. A hierarchical logistic regression (method ENTER) with the criterion current psychological care utilisation was computed with the following predictor variables: (a) age and gender, (b) social support and distress, (c) positive attitudes to help-seeking and (d) negative attitudes to help-seeking. This corresponded to the approach of McDowell et al. (2011). The data analysis was carried out with SPSS version 25 (IBM Corp, 2017). We defined statistical significance as $p \leq .05$ on two-tailed analyses. The significance levels for the correlations were Bonferroni corrected to avoid type 1 error.

TABLE 1 Participant demographic and clinical characteristics

Socio-demographics		Medical characteristics		
Age (years)		Cancer site	<i>n</i>	(%)
<i>M(SD)</i>	63.0 (12.7)	Haematological	90	(34.9)
Range	20–86	Respiratory	67	(26.0)
Age at diagnosis (years)		Genitourinary	61	(23.6)
<i>M(SD)</i>	60.2(13.1)	Digestive/gastrointestinal	53	(20.5)
Range	19–86	Breast	20	(7.8)
Marital status (%)		Skin	15	(5.8)
Single	8.2	Mesothelial/soft tissue	13	(5.0)
Married	70.7	Head/neck	10	(3.9)
Widowed	8.2	Other	3	(1.2)
Divorced	6.8	Treatment status		
Educational level (%)		Curative	175	(67.8)
University degree	15.5	Palliative	83	(32.2)
University entrance	13.2	Cancer treatments received		
Intermediate school	22.8	Chemotherapy	163	(63.2)
Secondary school	46.5	Radiation	71	(27.5)
No formal schooling	2.0	Hormone/antibodies	36	(14.0)
Employment status (%)		Surgery	17	(6.6)
Currently working	15.6	None	32	(12.4)
Home duties	3.6	Other	10	(3.9)
Student	0.7			
Unemployed	0.4			
Retired	51.4			
Ill/disabled	27.1			
Other	1.1			

3 | RESULTS

3.1 | Sample

We obtained complete questionnaires from 270 of 294 patients. Their socio-demographic and medical characteristics are summarised in Table 1. Participating patients were mostly married and already retired, and 50% had received more than basic school education. Sexes were almost equally represented (45% female), and mean age was $M = 63.0$ ($SD = 12.7$). Except for the distribution of sexes (45% female vs. 59% female), the characteristics equalled the participant description of Steginga et al. (2008).

3.2 | Standard item analysis

Item difficulties varied from $p_i = .17$ to $p_i = .64$, with a mean difficulty of $p_i = .39$ (Appendix B). The mean scores on the subscales were $M = 2.71$ ($SD = 0.81$) for positive and $M = 2.41$ ($SD = 0.64$) for negative attitudes. On a single-item level, patients agreed most with the fact that nobody would know their problems as much as they do ($M = 3.54$, $SD = 1.31$). Simultaneously, they agreed that searching for psychological help would be a positive experience ($M = 3.41$, $SD = 1.06$).

The mean corrected item-total correlation of the items with their subscales was $\bar{r}_{itc} = 0.47$, and the mean inter-item correlation was $\bar{r}_{iic} = 0.34$ (Table 2). The internal consistency of the subscales was $\alpha = 0.75$ for the negative attitudes subscale and $\alpha = 0.80$ for the positive attitudes subscale. The consistency could not be improved by removing any item.

3.3 | Principal component analysis

The KMO value of 0.78 exceeded the recommended value of 0.60 and Bartlett's test of sphericity reached statistical significance ($\chi^2 = 1,235.99$, $df = 136$, $p < .0001$). These statistics supported the appropriateness of dimensionality analyses with the existing correlation matrix. The modified Horn's parallel analysis indicated that two components should be extracted (random eigenvalues were only lower for the first two components), and also, the scree plot (Appendix C) allowed a two-component solution. The two components explained 47.21% of variance, and the loadings on the rotated components were clearly positive, with only few cross-loadings (Table 2). All items (except 3 and 7) could be definitely allocated to the same factor as in the original version. Items 3 and 7 showed higher loadings on the expected factor, so they were included into further analysis. Both items represent

TABLE 2 Psychometric properties of ASHCa-G

Item	Original subscale	NA	PA	r_{itc}	α if removed
14	NA	0.77		0.52	0.70
11	NA	0.76		0.44	0.72
10	NA	0.74		0.37	0.72
5	NA	0.70		0.49	0.71
8	NA	0.69		0.49	0.71
2	NA	0.67		0.49	0.70
12	NA	0.58		0.36	0.72
6	NA	0.57		0.36	0.72
16	NA	0.47		0.35	0.73
13	NA	0.41		0.22	0.74
17	NA	0.33		0.26	0.74
4	PA		0.87	0.71	0.71
3	PA	0.37	0.78	0.67	0.73
1	PA		0.75	0.63	0.73
7	PA	0.54	0.60	0.51	0.77
15	PA		0.58	0.40	0.79
9	PA		0.42	0.35	0.80
Eigenvalue	5.3	2.7	–	–	
Explained variance	31.5	15.7	–	–	
Internal consistency	0.74	0.79	–	–	
Mean inter-item correlation	0.26	0.44	–	–	

Factor loadings < .30 not shown, factor loadings > .30 bold.

Abbreviations: NA, negative attitudes, PA, positive attitudes, r_{itc} , corrected item-subscale correlations, α if removed, internal consistency of subscale when item is removed.

the perceived social norm or pressure from the doctor to seek for psychological support. This norm can not only be positively experienced, as doctors often put pressure on patients, when they see distress that patients cannot manage alone, but yet do not want help or think negative of it (Solano, Pirrotta, Ingravalle, & Fayella, 2009).

3.4 | Correlations with related measures and socio-demographics

Results showed positive correlations of positive attitudes to help-seeking with help-seeking intention, distress and actual psychological care utilisation (range: 0.36 to 0.80, see Table 3). Negative attitudes were slightly positively associated with distress ($r = 0.23$) and participant's age ($r = 0.21$), and negatively related to social support ($r = -0.19$). Positive and negative attitudes were also marginally correlated with each other ($r = 0.16$), but were no longer significant after Bonferroni correction.

3.5 | Hierarchical logistic regression explaining current psychological care utilisation

In all, 16.8% of the 268 respondents had used at least one psycho-social service during the last 6 months. The model to explain this outcome was adopted from McDowell et al. (2011). Table 4 shows

that the model accounted for 18% of the variance, compared with 8.2% in the original study. In contrast to McDowell et al. (2011), gender was of no importance for current care utilisation. Only age could explain care utilisation ($OR = 0.98$, $p = .047$) before taking positive attitudes into account. Positive attitudes to help-seeking were the only significant individual variable in the complete model that explained current psychological care use. The odds ratio of $OR = 3.12$ equals an intermediate effect ($d = 0.63$), were McDowell et al. (2011) found an odds ratio of $OR = 1.69$ ($d = 0.29$).

4 | DISCUSSION AND CONCLUSIONS

The need for measures that address attitudes towards help-seeking has been highlighted as attitudes appear to be central barriers to psychological care utilisation in the context of cancer (Faller et al., 2017; Tondorf et al., 2018). To investigate the role of attitudes towards help-seeking of German cancer patients, we translated the ASHCa into German and tested its psychometric properties in a sample of patients with cancer. The ASHCa-G demonstrated good internal consistencies of the positive attitudes ($\alpha = 0.80$) and negative attitudes ($\alpha = 0.75$) subscales, which are similar to the English original (positive attitudes $\alpha = 0.75$ and negative attitudes

TABLE 3 Correlations of the ASHCa subscales with related measures and age

	M	SD	PA	INT	ESSI	DT	PCU	Age
Negative attitudes	2.42	0.63	0.16**	0.11	-0.19**	0.23**	-0.06	0.21**
Positive attitudes	2.71	0.81	-	0.80**	-0.03	0.43**	0.36**	-0.06
Intention	2.40	1.21	-	-	-0.07	0.41**	0.40**	-0.15*
Social support	4.50	0.69	-	-	-	-0.11	-0.01	-0.04
Distress	4.99	2.71	-	-	-	-	0.21**	0.10
Psychological care utilisation	-	-	-	-	-	-	-	0.12
Valid n	-	-	270	270	270	270	270	268

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

Abbreviations: PA, positive attitudes; INT, intention; ESSI, social support; DT, distress; PCU, psychological care utilisation.

TABLE 4 Hierarchical logistic regression explaining psychological care utilisation

Step	Variable	INT ESSI DT	OR (CI) Age
(1)	Age		0.98 (0.97–1.00)
	Sex		0.66 (0.30–1.02)
(2)	Social support		0.83 (0.56–1.09)
	Distress		0.95 (0.88–1.03)
(3)	Positive attitudes		3.12 (2.86–3.38)**
(4)	Negative attitudes		0.76 (0.47–1.05)
	Total model		$\chi^2 = 30.38$, $R^2 = 0.18$

** $p < .001$.

$\alpha = 0.81$). The stable internal consistency of the subscales supported the assumption that subscale scores can be meaningfully calculated. Also, principal component analysis reproduced the 2 factors of the ASHCa original explaining 47.21% of variance. Item difficulties were in the medium range with maximum discriminatory power for a further logistic regression explaining psychological care utilisation. Concerning the concurrent validity of the ASHCa-G, the proposed relations between attitudes and self-reported distress levels and social support were confirmed. All in all, the ASHCa-G with its separation of negative and positive attitudes can be seen as an appropriate measurement for behaviour-relevant attitudes.

With help of the ASHCa-G, we could gather more evidence on the association between positive attitudes and behavioural intention and psychological care utilisation. Positive attitudes towards psychological help-seeking showed a strong positive correlation with the intention to seek for psychological help. Also, the association with actual psychological care utilisation was moderate. The hierarchical logistic regression showed that only positive attitudes explained current psychological care use significantly. The complete model accounted for 18% of the variance with positive attitudes to help-seeking as single significant individual variable. These findings were in complete agreement with previous studies outside of Germany (McDowell et al., 2011; Steginga et al., 2008). The role of positive attitudes in explaining psychological

care utilisation can therefore be emphasised. In addition, it gave us more insight into the mechanisms behind the important findings of Faller et al. on the overall attitude of patients with cancer towards help-seeking.

Since our findings emphasise the need to foster cancer patients' positive attitudes towards help-seeking, possible approaches need to be discussed. A recent meta-analysis looked at 23 studies that aimed to promote seeking professional help for mental health problems by changing attitudes towards help-seeking (Xu et al., 2018). The analysis yielded a small and statistically significant effect on attitudes towards formal help-seeking at post-intervention, which was stable until up to 5 months, but not longer. Successful interventions implemented videos or face-to-face interactions to share former patients' experiences with help-seeking to the study participants (Buckley & Malouff, 2005; Kosyluk et al., 2016). Another successful intervention to foster positive attitudes towards help-seeking was a professionally guided 3-month course (Hao & Liang, 2011). Participants were educated about the importance of professional help, the symptoms of distress, discussed stigma issues and myths about psychologists and practiced first contacts in role plays. Such courses could be offered on a population level as well as in a group with an increased risk of mental health problems (like cancer patients). As we also found that social norms influence positive attitudes, medical staff need to be trained in psychosocial competencies, as recently stressed (Senf, Fettel, Demmerle, & Maiwurm, 2019). In order to enhance positive attitudes effectively and permanently, it is therefore recommended to combine individual interventions for high-distressed patients (e.g. videos) and interventions on a population level (e.g. courses and medical training).

4.1 | Study limitations

The results of our study have to be interpreted within some limitations. First, all of our data were based on self-reports and were of a cross-sectional nature. Data stemmed from a local clinical sample like in the original validation study from Steginga et al. (2008), which in turn reduced external validity. Replications with patients in diverse care settings and in rural areas are therefore still required.

Second, we did not compare attitudes with other modifiable individual variables like anticipated stigma or mental health literacy. These variables were also recently considered to influence psychological care utilisation of patients with cancer (Cheung et al., 2016; Cohen et al., 2018; Rose et al., 2018). Third, we exclusively assessed patients' attitudes, although the attitudes of family members or primary caregivers probably influence help-seeking.

4.2 | Study strengths

The strength of our study is that it validated an instrument that assessed attitudes, which are highly relevant for cancer patients' psychological care. We were able to collect a diverse group of patients with cancer, that in its demographic and medical characteristics equalled the sample of Steginga et al. (2008). Specifically, the result of stable internal consistency suggested a broader use for international research and clinical practice. The ASHCa-G also paved the way to studying urgently needed individual and population-based interventions on promoting attitudes of patients with cancer in German-speaking countries. Focusing on attitudes, we followed recent WHO recommendations (Andrade et al., 2014) to consider them central keys to understanding and improving psychological care use. However, it must be kept in mind that attitudes are only one of the modifiable factors that determine seeking psychological help. Comparisons with other predictors like self-reported stigma and mental health literacy remain rare.

4.3 | Clinical implications

So far, it is safe to say that efforts should be made in clinical settings to foster cancer patients' positive attitudes to psychological help. All members of the professional care team (nurses, physicians, social workers and psychologists) could inform patients about the benefits of psychological support for coping with distress. Therefore, clinical practitioners should raise awareness of the benefits of psychological care in their healthcare teams. When speaking with distressed cancer patients directly, attitudes need to be assessed. In cases lacking positive attitudes, it might be helpful to explore specific experiences and information sources. Anecdotes or videos of previous patients sharing positive experiences have proved helpful for this purpose in clinical settings and online interventions.

In conclusion, we can state that the ASHCa-G is a reliable and valid instrument, which can be applied as a relevant outcome measure in future research with German-speaking cancer patients. The role of positive attitudes for help-seeking decisions of patients with cancer could be affirmed and hence demands to be borne in mind for future interventions. In clinical contexts, identifying specific attitudinal barriers with the ASHCa-G might help psycho-oncologists, for example with screening patients for help needs.

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CONFLICT OF INTEREST

The authors wish to disclose that they have no conflict of interest with respect to relationships that preclude the research, authorship and/or publication of this manuscript.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as in Germany, and sharing patient data is limited to the study purpose of patients' informed consent declaration. We are checking with the German provider of repositories for psychology PsychOpen which options for sharing clinical data still exist.

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APPENDIX A

Item	Original Item	German Translation
1	Most people who are important to me think I should contact a health professional for emotional/psychological support	Die meisten Menschen, die mir wichtig sind, denken, ich sollte psychologische Unterstützung aufsuchen
2	It would be difficult for me to contact a health professional for emotional/psychological support	Es wäre schwierig für mich, psychologische Unterstützung aufzusuchen
3	My doctor thinks I should contact a health professional for emotional/psychological support	Mein Arzt denkt, ich sollte psychologische Unterstützung aufsuchen
4	It would be beneficial for me to contact a health professional for emotional/psychological support	Es wäre für mich von Vorteil psychologische Unterstützung aufzusuchen
5	I am too tired and unwell to contact a health professional for emotional/psychological support	Ich bin zu müde und krank, um psychologische Unterstützung aufzusuchen
6	There is not much advice around how to contact a health professional for emotional/psychological support	Es gibt wenig Informationen darüber, wie man psychologische Unterstützung bekommen kann
7	My doctor expects of me to contact a health professional for emotional/psychological support	Mein Arzt erwartet von mir, dass ich psychologische Unterstützung aufsuche
8	Contacting a health professional for emotional/psychological support would be a painful experience	Psychologische Unterstützung aufzusuchen wäre eine schmerzhaft Erfahrung
9	Most people who are important to me would contact a health professional for emotional/psychological support	Die meisten Menschen, die mir wichtig sind, würden psychologische Unterstützung aufsuchen, wenn sie Bedarf dafür hätten
10	It would seem weak to ask for support	Es wäre ein Zeichen von Schwäche, um Unterstützung zu bitten
11	I do not have the time to contact a health professional for emotional/psychological support	Ich habe keine Zeit, psychologische Unterstützung aufzusuchen
12	It would be upsetting for me to contact a health professional for emotional/psychological support	Es wäre aufwühlend, psychologische Unterstützung aufzusuchen
13	I do not like other people telling me what to do	Ich mag es nicht, dass andere Leute mir sagen, was ich tun soll
14	I would think less of myself for needing support	Ich würde schlechter von mir denken, wenn ich Unterstützung brauche
15	Contact a health professional for emotional/psychological support would be a positive experience	Psychologische Unterstützung aufzusuchen, wäre eine positive Erfahrung
16	I would feel better about myself knowing I didn't need support from others	Ich würde mich besser fühlen, wenn ich wüsste, dass ich keine Unterstützung von anderen brauche
17	Nobody knows more about my problems than I do	Niemand weiß mehr über meine Probleme als ich selbst

APPENDIX B

Item means and standard deviations, item difficulties

Item		<i>M</i>	<i>SD</i>	<i>p_i</i>
1	Most people who are important to me think I should contact a health professional for emotional/psychological support	2.48	1.25	.37
2	It would be difficult for me to contact a health professional for emotional/psychological support.	2.34	1.25	.33
3	My doctor thinks I should contact a health professional for emotional/psychological support	2.40	1.16	.35
4	It would be beneficial for me to contact a health professional for emotional/psychological support	2.70	1.31	.42
5	I am too tired and unwell to contact a health professional for emotional/psychological support	1.95	1.15	.24
6	There is not much advice around how to contact a health professional for emotional/psychological support	2.83	1.38	.46
7	My doctor expects of me to contact a health professional for emotional/psychological support	2.01	0.97	.25
8	Contacting a health professional for emotional/psychological support would be a painful experience	2.11	1.07	.28

(Continues)

APPENDIX B (Continued)

Item		<i>M</i>	<i>SD</i>	<i>p_i</i>
9	Most people who are important to me would contact a health professional for emotional/psychological support	3.24	1.20	.56
10	It would seem weak to ask for support	1.72	0.98	.18
11	I do not have the time to contact a health professional for emotional/psychological support	1.70	0.91	.17
12	It would be upsetting for me to contact a health professional for emotional/psychological support	2.83	1.32	.46
13	I do not like other people telling me what to do	3.32	1.33	.58
14	I would think less of myself for needing support	1.81	1.03	.20
15	Contact a health professional for emotional/psychological support would be a positive experience	3.41	1.06	.60
16	I would feel better about myself knowing I didn't need support from others	3.23	1.34	.56
17	Nobody knows more about my problems than I do	3.54	1.31	.64

p_i = item difficulty

APPENDIX C

Parallel analysis for factor extraction

