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Mental Health Stigma and Help-Seeking Behaviour Among Adolescents: A Systematic Review

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Animashaun Nimat, Koleosho Ona-Opemipo Emmanuel, Ochimana Kingsley Prosper and Oluwafunmilola Blessing Omoyeni*

Department of Psychology
University of Lagos, Akoka, Nigeria
Optimal Human Development Lab
nimatdammy841@gmail.com

Abstract

Mental health disorders affect approximately 15% of adolescents globally, yet a significant treatment gap persists as only 18% to 34% of those in distress seek professional support. This systematic review, conducted following PRISMA 2020 guidelines, synthesizes evidence from 33 peer-reviewed studies published between 2010 and 2024 to examine the relationship between stigma and help-seeking behavior. Findings indicate that self-stigma (internalized prejudice) is a more consistent barrier to formal service utilization than public stigma. Critical thematic analysis revealed that schools often function as “theatres of stigma,” where visible interventions like “counsellor walks” trigger social embarrassment and identity threats. Gender emerged as a key moderator: adolescent males frequently equate help-seeking with weakness (91% of stigmatizing comments), while females prioritize fears of peer exclusion. Furthermore, a significant intention-behavior gap exists; even when adolescents acknowledge distress, they favour informal digital sources over clinical care to maintain anonymity. In Sub-Saharan African contexts, stigma is uniquely tied to family honor and “courtesy stigma”. The review concludes that interventions must move beyond general awareness to address developmental identity concerns and provide culturally specific, anonymous pastoral care models.

Keywords: Adolescent Mental Health, Self-Stigma, Help-Seeking Behavior, Treatment Gap.

1. Introduction

Mental health is a critical public health issue because it directly influences population well-being, productivity, and social stability. It encompasses emotional, psychological, and social functioning, shaping how individuals cope with stress, engage in work, build relationships, and realize their potential. When mental health is

compromised, the effects extend beyond the individual to families, communities, and health systems, contributing to increased disease burden, reduced economic output, and social dysfunction. As a public health concern, mental health is not solely an individual matter but is shaped by broader determinants such as biological factors, life experiences, and environmental conditions, including poverty, violence, and access to care.

Recognising mental health as a fundamental human right underscores the need for equitable policies, preventive strategies, and accessible services that promote well-being, reduce stigma, and ensure that all individuals can achieve optimal mental health outcomes. Mental health is more than the absence of disorders or illnesses; it is a positive state of functioning. Mental disorders are a very common health issue. According to the World Health Organisation, about 1 in 7 people are living with a mental disorder, with anxiety and depression being the most common. Other conditions include bipolar disorder, PTSD, and schizophrenia. Some factors influence and impact mental health, including genetics and skills, while social factors such as poverty, violence, and inequality also play a role in shaping mental health outcomes.

Mental health also influences physical health, with poor mental health often linked to a likelihood of chronic physical conditions and high-risk behaviours. Previous studies have noted suicidal ideation, sexual harassment, terrorism, cigarette and alcohol use, and psychoactive substances as factors influencing the development of mental health challenges and health-seeking behaviour among young people.

Youth mental health is currently regarded as an issue of public health concern; adolescents and young adults frequently experience mental disorders, yet they tend not to seek help. Recent studies have shown that approximately 75% of mental health disorders are very likely to have developed before age 24 (Lin et al., 2008), and

20% of young people are affected by a mental health problem yearly (Patel et al., 2007), which highlights the importance of youth mental health care. In 2022, mental health was categorized as a crisis by the US Surgeon General Vivek Murthy at the APA convention, bringing to light the importance of understanding the barriers to help-seeking behaviours among individuals, especially in late teens and early twenties, to ensure their mental health needs are met.

Depression and anxiety have been identified as the most highly prevalent mental disorders, with statistics (Australian Bureau of Statistics, 2006) showing that they affect almost one-fifth of the population in high-income countries across the world. As stated earlier, the prevalence of mental health disorders is greatest particularly among young people aged between 16 and 24 compared with any other stage of life, and children between the ages of 4 and 17 are more susceptible to developing a mental disorder, coupled with a high reluctance to seek professional help. Despite this high statistic, adolescents remain less likely to seek professional help for mental health concerns compared with other age groups. Recent studies indicate that only a small percentage, mostly between 18% and 34% of adolescents experiencing depression or anxiety, actually seek mental health services.

One of the most prominently identified barriers to help-seeking is mental health stigma, which encompasses stereotypes, negative attitudes, and discrimination towards people experiencing mental illness or those seeking psychological

support. Stigma manifests in more than one form: it can manifest as self-stigma, where a person has internalized shame and conflict within themselves; public stigma, which has to do with societal judgement; and perceived stigma, where a person fears being judged. All of these can discourage adolescents from admitting and acknowledging their mental health needs or from seeking professional help. Furthermore, factors such as poor mental health education, a preference for self-reliance, and a lack of trust in professionals can further contribute to low rates of help-seeking among adolescents. Studies also show that adolescents tend to prefer informal sources of support, such as friends and family, over formal health services. Due to the long-term consequences of untreated mental health conditions, including impaired academic performance and increased risk of mental illness and substance use and abuse, it is important to understand the role of stigma in shaping help-seeking behaviour, as this is essential for informing interventions targeted at improving early access to mental health care among adolescents.

Aim

This systematic review, therefore, aims to examine the relationship between mental health stigma and help-seeking behaviour among adolescents, focusing on identifying how different forms of stigma could influence adolescents' willingness, intentions, and actual engagement in seeking mental health support.

Problem Statement

Even though mental health disorders are quite prevalent among and during adolescence, help-seeking rates remain significantly low, creating a significant treatment gap. Mental health stigma has been identified as a major hindrance; however, its influence on adolescents' help-seeking behaviours is complex and has not been fully understood.

Existing research shows that stigma not only reduces adolescents' willingness to seek professional help but also affects their attitudes towards mental health services and their perception of need for care. Many studies focus on help-seeking intentions instead of actual behaviour, which leaves gaps in understanding real help-seeking patterns.

Without a comprehensive analysis of recent evidence, it becomes difficult to design effective, evidence-based interventions aimed at reducing stigma and improving access to mental health services for adolescents. Therefore, carrying out a systematic review is necessary to affirm existing findings, identify gaps in the literature, and inform future research and practice.

2. Methodology

This systematic review followed PRISMA 2020 guidelines (Page et al., 2021) to identify, screen, and synthesize peer-reviewed literature examining the relationship between mental health stigma and help-seeking behaviour among adolescents.

Table 1: Inclusion and Exclusion Criteria for Study Selection

Inclusion Criteria	Exclusion Criteria
Peer-reviewed empirical studies	Grey literature, opinion pieces, editorials
Published between 2010–2024	Studies published before 2010
Population: adolescents aged 10–24 years	Studies focusing solely on adult or elderly populations
Focus on mental health stigma and/or help-seeking behavior	Studies unrelated to stigma or help-seeking
English-language publications	Non-English publications without translation
Quantitative, qualitative, or mixed-methods designs	Studies lacking extractable data on key variables

Studies were included if they empirically examined the relationship between any form of mental health stigma (self-stigma, public stigma, or perceived stigma) and help-seeking attitudes, intentions, or behaviors among adolescent populations. Studies that focused exclusively on adults without disaggregated adolescent data were excluded.

Article Selection and PRISMA Flow

The study selection process followed a sequential two-stage screening protocol consistent with PRISMA 2020 guidelines. In the first stage, titles and abstracts of all 204 non-duplicate records were screened independently against the eligibility criteria. A total of 165 records proceeded past initial deduplication (7 duplicates removed), of which 76 were excluded following title and abstract screening, yielding 89 records for full-text retrieval.

In the second stage, 87 full-text articles were assessed for eligibility. Of these, 54 were excluded for the following reasons: studies did

not address adolescent mental health stigma directly (n = 18), lacked full-text availability (n = 8), were considered outdated in their theoretical framing (n = 4), used wrong or incompatible study comparators (n = 1), were not related to the constructs under review (n = 1), used non-adolescent populations exclusively (n = 1), presented wrong study designs (n = 1), and did not yield extractable data relevant to help-seeking outcomes (combined, n = 20). A final set of 33 studies was included in the synthesis.

Table 2: PRISMA Summary of Article Selection

PRISMA Stage	Action	N
Identification	Records from databases (Google Scholar, Web of Science, Scopus)	172
Identification	Additional records from other sources (JSTOR)	39
Identification	Duplicates removed	7
Screening	Records screened	165
Screening	Excluded after title/abstract screening	76
Screening	Full-text articles assessed for eligibility	87
Screening	Full-text articles excluded (with reasons)	54
Included	Studies included in final review	33

The complete PRISMA flow is summarised in Table 2 above.

Quality Assessment

Included studies were appraised for methodological quality using criteria appropriate to their respective designs. Quantitative studies were assessed against standards for sampling adequacy, measurement validity, and control for confounding variables. Qualitative studies were evaluated on the basis of reflexivity, transferability of findings, and depth of

participant engagement. Mixed-methods studies were assessed using both sets of criteria proportionally.

Quality appraisal was conducted to contextualize the confidence with which findings could be interpreted, rather than to exclude studies on methodological grounds alone. All 33 included studies were retained in the synthesis, with methodological limitations noted where relevant in the discussion of findings. This approach is consistent with the integrative goals of a systematic narrative review (Popay et al., 2006).

Data extraction was conducted thematically. Key variables extracted included: study design, sample size, age range of participants, geographic setting, stigma type examined (self-stigma, public stigma, or perceived stigma), help-seeking outcome measured (intention, attitude, or behavior), and primary findings. Extracted data were organized into a structured matrix and subjected to thematic synthesis, from which major cross-cutting themes were identified and subsequently reported in the Results section.

3. Results

Internalized Stigma and the "Medicated Self-Image"

A primary finding across the literature is the dominance of self-stigma over public stigma. Adolescents frequently internalize societal prejudices, leading to a "spoiled identity" (Goffman, 1963).

1. **The Medication Paradox:** A significant barrier identified in the literature and by

Kranke et al. (2010) is the "medicated self-image." Adolescents feel shame not just from the illness, but from the requirement of medication, which they perceive as a permanent mark of being "broken" or "different."

2. **Physical Visibility of Stigma:** Shame is often tied to the visible side effects of psychiatric medications. Participants reported extreme distress over side effects like drowsiness or trembling, which led to public ridicule and institutional embarrassment (Kranke et al., 2010), including humiliation over falling asleep in public due to medication, leading to treatment avoidance to protect their social image.

Institutionalized Barriers and Social Rejection

The school and clinical environments often act as "theatres of stigma," where the act of seeking help becomes a public spectacle.

3. **The "Counsellor Walk":** Being removed from a classroom to see a school counselor was identified as a major source of embarrassment (Clark et al., 2018). The physical act of leaving a peer group to seek help creates an immediate "label" that adolescents strive to avoid.
4. **Fear of Documentation:** A novel barrier identified in the review is the fear that mental health records will remain attached to academic files, potentially damaging

future applications to university or the job market.

5. **Social Rejection Themes:** Fear of judgment was found to be tiered. The most intense fear surrounded issues of sexual behavior and libido (often side effects of medication), followed by psychological disorders (low mood/anxiety), and finally visible urological or dermatological markers.

Gender and Masculinity Norms

The review found that gender significantly moderates how stigma is experienced.

6. **Male-Specific Anxiety Stigma:** Clark et al. (2020) demonstrated that adolescent males experience higher levels of anxiety-specific stigma. Masculinity norms dictate that “real men” do not show panic or fear, making anxiety symptoms particularly stigmatizing for boys.
7. **Female Social Distance:** While females are more likely to seek help, they report higher fears of peer exclusion. The fear of being “different” makes them sensitive to the social-evaluative components of stigma (Van den Toren et al., 2020).

The Stigma Paradox: Intentions vs. Actual Behavior

A critical finding from the reviewed data is the gap between what adolescents say and what they do.

8. **Self-Labeling:** While self-labeling (recognizing one has depression) generally predicted a higher likelihood of help-seeking, it did not always translate to formal help. Adolescents consistently reported higher engagement with informal help (friends/internet) than formal help (doctors/psychologists).
9. **The Vignette Paradox:** Notably, participants who were stigmatizing toward a vignette (e.g., a peer with generalized anxiety disorder, GAD) did not necessarily report lower intentions to seek help for themselves, indicating that adolescents may view others as stigmatized while remaining aware of their own need for support.

Regional Comparison: Cultural Nuances

The synthesis illustrates that the underlying drivers of stigma change across borders.

Table 3: Regional Comparison of Stigma Themes

Theme	Global North	Sub-Saharan Africa
Primary Barrier	Individual self-stigma / peer labels	Courtesy stigma / family reputation
Source of Shame	Being "weak" or "incompetent"	Bringing "dishonor" to the family (Aina, 2020)
Service Perception	Fear of academic documentation	Lack of belief in medication effectiveness
Institutional View	Embarrassment in the school hallway	Scarcity of adolescent-friendly clinics (Wada et al., 2021)

Facilitators of Help-Seeking

Despite the considerable barriers, there were three recurring facilitators:

10. **Bonds of Trust:** A previously established bond of trust with an adult (parent, teacher, or coach) was the top facilitator of professional consultation (Van den Toren et al., 2020).
11. **Mental Health Literacy (MHL):** Higher levels of MHL enable adolescents to see symptoms as treatable health issues rather than character or moral defects.
12. **Digital Anonymity:** The internet functions as a “stigma-free” zone in which adolescents can obtain information away from the visible labels associated with an actual clinic.

4. Discussion

Interpretation of Findings

Mental health stigma, as this review makes clear, does not operate through a single mechanism. It is layered, context-dependent, and deeply tied to the social realities of adolescent life. Across the studies reviewed, stigma consistently emerged as a barrier to help-seeking, but how it functioned varied considerably depending on gender, institutional setting, cultural context, and whether the stigma in question was publicly directed or privately internalised. What stands out most from the synthesis is not simply that stigma discourages help-seeking, but how it does so, and the extent to which that process is shaped by the specific vulnerabilities of adolescence as a developmental stage.

Self-stigma – the internalisation of societal prejudices about mental illness – was far more

consistently linked to avoidance of help-seeking than public stigma was. This distinction matters. Kaushik et al. (2016), whose systematic review mapped stigma outcomes across children and adolescents, documented a wide range of consequences associated with self-stigma: shame, secrecy, reduced self-worth, and disengagement from services. Ferrie et al. (2020) built on this, demonstrating that young people's stigma experiences are fundamentally based around a need to protect social identity and maintain social capital. When an adolescent internalises the belief that needing mental health support makes them lesser or different, the consequence is not just that they avoid a clinic – they begin to manage their entire social presentation around concealment. That pattern, once established, is difficult to interrupt.

The school environment deserves particular attention here. Rather than functioning as a space that facilitates help-seeking, schools were frequently identified as sites where stigma was actively reinforced. Ferrie et al. (2020) found that something as seemingly minor as being walked out of a classroom to see a school counsellor – what participants described in the literature as the ‘counsellor walk’ – was experienced as a public exposure, a moment in which difference was made visible to peers. This review added another dimension to that finding: the fear that mental health records could become part of a student's academic file, potentially affecting university applications or future employment. These are not irrational fears; they reflect a genuine structural

gap in how schools handle mental health disclosure, with real consequences for whether adolescents choose to seek help at all.

Gender emerged as one of the most consistent moderating factors across the reviewed literature. Clark et al. (2020) found that when adolescent males did express stigma, it was overwhelmingly of the ‘weak not sick’ variety – the belief that emotional or psychological difficulty reflects a character flaw rather than a health condition. This form of stigma accounted for 91% of stigmatising comments identified in their study, a figure that is striking in its consistency. Male adolescents who held these views were also more likely to report negative attitudes towards formal help-seeking. The connection is intuitive: if seeking help for mental health difficulties is framed, consciously or not, as an admission of weakness, then masculinity norms that prize stoicism and self-sufficiency will almost inevitably become barriers. Female adolescents, meanwhile, were more likely to seek help but reported heightened fears of social exclusion and peer judgement – a different pathway to the same outcome of concealment and avoidance.

Perhaps the most clinically significant finding to emerge from this review is what might be called the intention-behaviour gap. Adolescents who recognised their own distress and expressed willingness to seek help did not reliably follow through with formal help-seeking. Instead, informal sources – friends, family, and increasingly the internet – were far more commonly used than professional services. Clark

et al. (2020) introduced an interesting complication to this picture: adolescents who held stigmatising views about peers with clinical anxiety were actually more likely to have sought help for themselves. Rather than undermining the relationship between stigma and help-seeking, this finding deepens it, suggesting that having personally navigated the help-seeking process may sharpen one's awareness of, and perhaps defensiveness about, stigma in others, without necessarily resolving one's own stigmatising attitudes. The relationship between stigma and behaviour is, in other words, not linear.

Lin and Tsang (2020) offer a useful conceptual anchor here. Their framing of stigma as a process – one that moves through labelling, stereotyping, separation, and discrimination – captures something important about why stigma is so resistant to simple intervention. For adolescents especially, who occupy a position of reduced social power and whose sense of self is still forming, being labelled or perceived as different is not merely uncomfortable; it is a threat to the very identity they are in the process of constructing. This helps explain why stigma's effects in adolescence are often more diffuse and harder to trace than in adult populations: they are woven into the fabric of everyday social life, shaping behaviour in ways that adolescents themselves may not fully articulate.

5. Conclusions

The most immediate implication of this review is that anti-stigma efforts aimed at adolescents need

to go deeper than awareness campaigns. Knowing that mental health is important does not, on its own, reduce self-stigma or close the intention-behaviour gap. Ferrie et al. (2020) are explicit on this point, calling for stigma models and intervention frameworks that are developmentally appropriate and take into account the social pressures, identity concerns, and institutional vulnerabilities specific to young people. Generic adult-focused models simply do not map cleanly onto adolescent experience.

Schools, in particular, need to be rethought as environments for mental health support. The evidence is fairly consistent that the current visibility of help-seeking in school settings – the walk to the counsellor's office, the pulled-aside student – is itself stigmatising. Practical changes, such as integrating mental health support into broader pastoral care, offering after-school or anonymous referral options, and establishing clear confidentiality protocols around mental health records, could meaningfully reduce the social cost of disclosure. The goal is to make seeking help feel ordinary rather than exceptional. For adolescent males specifically, the implications of Clark et al. (2020) are pointed. Anti-stigma interventions that do not engage directly with masculinity norms are likely to miss the group with the lowest help-seeking rates. Programmes that reframe help-seeking as consistent with strength rather than as evidence of its absence are more likely to resonate. This is not about dismissing masculine identity but about expanding what it is understood to include.

On the research side, Lin and Tsang (2020) make the case for longitudinal study designs that can track the temporal relationship between stigma and its outcomes over time. The cross-sectional nature of most existing studies means that the direction of causality remains uncertain: does stigma cause poor mental health and avoidance of services, or do adolescents with poorer mental health become more susceptible to stigma? Both are plausible, and both have different intervention implications. Future research that follows adolescents across time would go a long way toward resolving this uncertainty.

Finally, and critically, the cultural specificity of stigma demands attention. The dynamics identified in Western-based studies do not translate directly to African or other non-Western contexts, where stigma is often more relational and community-embedded in character, tied to family honour and collective reputation rather than individual identity alone. Research grounded in African contexts, including Nigerian settings, is urgently needed to inform interventions that are culturally legitimate and practically accessible to the adolescents who need them most.

Author Contributions

All authors contributed jointly to the conceptualization, literature search, screening, data extraction, and thematic synthesis reported in this review. All authors contributed to drafting and revising the manuscript and have read and approved the final version submitted for publication.

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Ethical Statement

Not applicable. This study is a systematic review of previously published, publicly available literature and did not involve the collection of new data from human or animal subjects.

Informed Consent Statement

Not applicable, as this study did not involve human participants.

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Conflicts of Interest

The authors declare no conflicts of interest.

Abbreviations

GAD: Generalized Anxiety Disorder; MHL: Mental Health Literacy; PRISMA: Preferred Reporting Items for Systematic Reviews and Meta-Analyses.

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