Help-seeking barriers for mental health issues in Irish adolescents

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Abstract

The barriers to help-seeking for mental health issues in adolescents were investigated in a sample of 125 secondary school students. The relationship between resistance to help-seeking and self-esteem was investigated. Differences in levels of resistance to help-seeking were looked at with regard to age group, gender, school demographic and whether participants knew someone with a mental illness. Data was collected using the Barriers to Adolescents Seeking Help scale (Kuhl et al., 1997), Rosenberg's (1965) Self-Esteem Scale, General Health Questionnaire (Short Format) (Goldberg, 1992) and two open-ended self-report questions. There were significant differences in levels of resistance to help-seeking reported for different age groups. A moderate negative relationship between self-esteem and resistance to help-seeking was also established. Finally, a strong negative correlation between self-esteem and general health was reported. Directions for future research would be to attain a larger sample and to explore the possibility of carrying out a longitudinal study.

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Introduction

Adolescent Mental Health

The World Health Organisation (WHO) defines adolescents as young people between the ages of 10 and 19 years (WHO, 2013). Mental health has been defined as a state of well-being in which the individual recognises their own abilities and is able to cope with normal daily stresses in life (WHO, 2005). According to the WHO's 2004 Global Burden of Disease study, mental health disorders account for nearly half (45%) of the disease burden in the world's adolescents and young adults (Gore et al., 2011).

Mental Health Ireland defines mental illness as *'the experiencing of severe and distressing psychological symptoms to the extent that normal functioning is seriously impaired'* (MHI, 2013). Mental health disorders were the most prevalent source of disability for young people aged 10-24 worldwide, accounting for 45% of total morbidity; these included major depression, substance abuse, schizophrenia and bipolar disorder. Common risk factors have been identified; particularly child maltreatment, inconsistent, cold and punitive parenting, parental mental illness and substance abuse, poverty, and dangerous environments (Smith & Carlson, 1997).

Research also recognizes that children can be affected in different ways by certain risks, depending on protective factors, including inherited traits and other biologically based characteristics, environmental opportunities, family support, and caring (Smokowski, 1998). The prevalence rate for mental and emotional disorders in children and adolescents has remained high over the past twenty five years. A typical school of one thousand students is expected to have 180–220 students with diagnosable psychiatric disorders, the most common being anxiety disorders, conduct disorder, and attention deficit disorder, with depression

more prevalent in secondary schools (Doll, 1996). According to Costello, Mustillo and Erkanli (2003) the prevalence of diagnosable psychiatric disorders among children and adolescents is estimated to be between 13% and 32%.

Adolescent depression is associated with numerous poor outcomes including significant decrements in school and work productivity and in educational achievement (Asarnow, Jaycox, & Duan, 2005). Additionally, depressive symptoms, externalizing behaviours, and stressful events are associated with an increased likelihood of attempting suicide among adolescents (Fordwood, Asarnow, Huizar, & Reise, 2007). Out of many mental health problems, adolescent depression remains arguably one of the most concerning. Lewinsohn, Rohde and Seeley (1998) estimated the disturbingly high figure that approximately 28% of adolescents will have experienced an episode of Major Depressive Disorder (MDD) by the age of 19 years.

One of the greatest concerns about adolescent depression is its link to suicide (Culp, Clyman, & Culp, 1995). Suicide is the most worrying aspect of mental health in adolescence; more young women than young men actually attempt suicide (about 1 in 100), but there are four times as many successful suicides in young men. Young people who self-harm describe that they do it to obtain relief from a 'terrible state of mind' (Samaritans, 2003). Overall, about 7% of adolescents report having suicidal ideas and more than one in four adolescents say that they feel depressed at least once a week. The main risk factor for suicide is mental illness. Suicide is frequently associated with substance misuse, low self-esteem and social isolation (Agerbo, Nordentoft, & Mortensen, 2002). Indeed, depression has been found to be the strongest single risk factor for attempted or completed suicides (Beautrais, Joyce, & Mulder, 1996). Moreover, there is evidence suggesting that there is a downward developmental trend in the age of onset of depression (Lewinsohn, Rohde, Seeley, & Fischer,

1993) and that contrary to what was previously thought, adolescent depression substantially elevates the risk of mental health difficulties in later adulthood (Harrington, 1992).

Suicidal behaviours have been shown to coincide with many psychological problems, including depressive episodes (Hollis, 1996), anxiety (D'Attilio & Campbell, 1990) and alcoholism (Buri, von Bonin, Strik & Moggi, 2009). There is also evidence that suicide behaviours are related to a range of perilous behaviours including risky sexual behaviour (Kim, Kim, Kawachi, & Cho, 2011), substance misuse (Zahran, Zack, Vernon, & Hertz, 2007) and delinquency (Bjorkenstam, Bjorkenstam, Vinnerljung, Hallqvist, & Ljung, 2011).

Among non-clinical adolescent populations, a negative correlation has been found between suicide ideation and help-seeking (Carlton & Deane, 2000) and perhaps more worryingly, referrals to hospitals in the United Kingdom for self-harm and suicide ideation (drug overdoses and self-injury) include approximately 19,000–25,000 young people per year (Hawton, Fagg, Simkin, Bale & Bond, 2000), indicating large numbers of young people in a seriously distressed state. Carlton and Deane (2000) and Deane, Wilson, and Ciarrochi (2001) also report that as suicidal ideation increases, willingness to seek help decreases, particularly help seeking from an appropriate source such as a mental health professional. Furthermore, adolescents with symptoms of mania are more likely to be sexually active, to have two or more partners in the past 90 days, and to test positive for a sexually transmitted infection (Brown, Hadley, & Stewart, 2010). For these reasons, early detection of mental health problems and treatment referral for adolescents is extremely important.

It seems that even those with severe problems may avoid seeking help or experience delayed referral. For example, some evidence suggests that many sufferers of anorexia nervosa do not seek help at all (Rastam, Gillberg, & Garton, 1989), and there appear to be significant, avoidable delays before help is obtained for early onset psychosis (Melle et al.,

2004). Effective treatments are available for many adolescent mental health disorders (Hodes, 2002) and early identification and intervention for these disorders results in better outcomes in response to less intensive interventions (Kramer & Garralda, 2000); it is just a matter of ensuring young people can access these treatments. According to Hoagwood, Jensen, Petti, and Burns (1996), research and treatment of child and adolescent mental and emotional disturbances have trailed behind those for adults and this is a continuing trend. Reliable and valid ways to measure what children find stressful, children's coping styles, and the contexts affecting disorders and treatments have been basically ignored (Hoagwood et al., 1996). However, Mowbray and Holter (2002) report that recent changes in the definitions and conceptualisations of childhood mental or emotional disorders have been positive and significant.

Why are adolescents so vulnerable?

The vulnerability of this age group is in part due to the wide range of developmental tasks typical of this stage of life, affecting multiple domains simultaneously (social, cognitive, physical, and emotional). This developmental stage is also challenged by the many psychological disturbances which occur during adolescence (Whitaker, Johnson, & Shaffer, 1990). Furthermore, young people are experiencing many of the personal and social pressures that adolescence brings at a much younger age and are taking longer to assume the responsibility of 'adulthood' (Arnett, 2004). They are entering marriage and parenthood later; education lasts longer and many young people in their late adolescence are exploring a variety of activities and experimenting with different careers in a way that was not possible for their parents (Bates, Illback, Scanlan & Carroll, 2009).

As such, adolescents represent a high risk group (Dubow, Lovko, & Kausch, 1990) in need of developmentally-appropriate psychological support. There is a strong relationship between poor mental health and many other health and development concerns for young people, including educational achievements, substance use and abuse, violence, and reproductive and sexual health. Behavioural and psychological problems were found to restrict children's capacities to perform normal activities (Bone and Meltzer, 1989). Such problems can increase the likelihood of academic underachievement, often leading to school exclusion (Barnes, 1998) and can negatively affect quality of life. The repercussions of this can have lasting effects into adulthood, both in terms of further psychological/mental health problems and in terms of social functioning in general. This can perpetuate a cycle of mental health problems from one generation to the next. Good mental health helps young people to reach developmental milestones that occur during adolescence (Kapphahn, Morreale, Rickert & Walker, 2006).

Mental Health and Irish Adolescents

There have been huge changes in Ireland's economy, socio-demography, culture, society and value systems in the last decade (Whelan & Layte, 2006). Changes such as a drop in standard of living can have significant consequences for young people, which can affect their mental health and well-being, this in turn, leads to some worrying trends. In Ireland, lifetime prevalence of deliberate self-harm in Irish adolescents aged 15-17 years is between 8% and 12%, while research has shown that it is three times more prevalent among females than males (McMahon, Reulbach, Corcoran, Keeley, Perry, & Arensman, 2010). The national Deliberate Self-Harm (DSH) registry in the Republic of Ireland reported that the highest rate

of hospital-treated DSH was for females aged 15-19, whereas the highest rate was in the 20-24 age groups for males (Perry, Corcoran, Fitzgerald, Keeley, Reulbach, & Arensman, 2012).

Scoliers et al. (2009) report that Irish young people are over-represented among those who die by suicide; the mortality rate from suicide in the 15-19 age groups in Ireland is the seventh highest in Europe (Eurostat, 2010). Once again it seems that young people are not seeking professional help for severe issues they are experiencing. In the 'My World Survey' report on Irish adolescents, Dooley and Fitzgerald (2012) found that three-quarters of their sample reported that they would be likely to use their friends as a source of support, followed by parents (69%), the internet (49%) and relatives (47%). In order to better meet the needs of this young population, it is important to identify factors that facilitate or impede young people's help-seeking behaviours, and to use this knowledge to improve the delivery of service information and the accessibility of child and adolescent mental health services.

Help-seeking behaviour

Despite the fact that mental and substance use disorders are major health problems during adolescence and young adulthood, the utilisation of mental health services is low for this age group. Only one-third of adolescents and young adults with mental health disorders use mental health services (Patel, Flisher, Hetrick, & McGorry, 2007). Variables that inhibit both the utilisation and success of counselling services are commonly described as "barriers" (Samargia, Saewyc, & Elliott, 2006). These are broadly categorized as "person-related" and "treatment related". Person related barriers are largely belief-based and include factors such as perceived need for autonomy and help-seeking fears. Treatment-related barriers are generally system issues that are often outside the individual's control (e.g., service imposed cost, therapist competency); however they also include beliefs about the benefits of prior help

(Saunders, Zygowicz, & D'Angelo, 2006). The need to identify and better understand the influence of belief-based barriers, which are prominent in the cognitive help-seeking process, is highlighted by quantitative and qualitative research (Wilson & Deane, 2001).

Several explanations have been offered for the low use of mental health services amongst young people; adolescents are generally physically healthy, they usually do not regularly consult a general practitioner (Patel et al, 2007). Another explanation is that young people may have a limited knowledge of the signs of mental health problems in themselves or others (Rickwood, Deane, Wilson, & Ciarrochi, 2005). For example, levels of correct recognition of depression and psychosis in case vignettes are lower in adolescents compared with adults (Wright et al., 2005). Thus, young people also may not recognize it when they personally are having serious mental health problems.

So it is evident that several significant psychological barriers to seeking help have been found among adolescents. Some researchers suggest that these include a perception of the problem as "too personal", a fear of lack of confidentiality, a conviction that the problem can be solved independently, a perception that no one can help solve the problem (Dubow et al., 1990) and suicidal ideation (Carlton & Deane, 2000; Wilson, Deane, & Cirarrochi, 2005). A further barrier concerns a lack of knowledge regarding existing help sources in the community (Dubow et al., 1990).

Some studies have found that the age of the individual affected the reasons for not seeking treatment. Young adolescents with mental health problems more often lacked the perception that they needed treatment (Kessler et al., 2001) and (Meltzer, Bebbington, Brugha, Farrell, Jenkins & Lewis, 2003) and more often thought that problems would get better by itself (Wells, Robins, Bushnell, Jarosz, Oakley-Browne, 1994) compared with older adolescents. However, other studies have reported conflicting patterns regarding the effect of

age on help-seeking behaviour. Schonert-Reichl and Muller (1996) reported that older adolescents tend to consult professional support sources more than younger adolescents who tend to consult their friends and mothers. However, Boldero and Fallon (1995) found that older adolescents tend to seek help from friends, whereas younger adolescents tended to seek help from family.

Seiffge-Krenke (1989) also investigated the relationship between distress and help seeking and found that increased distress caused withdrawal and a decrease in help seeking behaviour. She also identified several predictors of help seeking behaviour including low family conflict, the belief that treatment would be successful, previous experience with the mental health system and the presence of multiple school problems. Kellam, Branch, Brown, and Russell (1981) concluded that whether or not an adolescent seeks help is independent of age, socioeconomic status and level of distress and depended on the adolescent's perception of the person offering help.

Reluctance to seek help from formal medical or mental health sources provides a major obstacle for the prevention of suicide and self-harm (Kalafat, 1997). Several more studies have revealed multiple possible factors that may impact adolescent help seeking. These suggestions can be broadly categorized under five themes: (i) Problem definition and evaluation, (ii) Psychological correlates, (iii) Demographic factors, (iv) Factors related to social support and social networks and (v) Service-related factors (Kalafat, 1997).

A number of barriers inhibit the likelihood that young people will consult a General Practitioner (GP). Until recently, there has been little research that has either investigated youth perspectives about barriers to seeking help specifically from GPs or GPs' understanding of youth help seeking barriers, particularly for help with mental health problems. Seeking appropriate help when experiencing a range of psychological problems

can lead to a reduction in distress. Investigations suggest that seeking help for problems that are less distressing than suicidal ideation might have the dual effect of subsequently protecting against suicidal risk (Ciarrochi, 2003). Programs that facilitate appropriate help seeking by lowering barriers might bring troubled youths to treatment at more amenable stages of their problems (Kalafat, 1997).

Research on barriers to help-seeking behaviour has underlined the role of threat to self-esteem (Nadler, 1986) as a central factor affecting help-seeking behaviour. Seeking help is often perceived as indicative of personal weakness. As a result, an individual may refrain from seeking help in order to maintain positive self-esteem. Additional psychological barriers to seeking psychological help include treatment fearfulness (Kushner & Sher, 1991) and negative previous help-seeking experiences (Deane & Todd, 1996). Bolognini (1996) found that girls' self-esteem is more global and less differentiated by domain while boys separate the scholastic and behavioural part of their experience from the social. Global self-esteem has more influence on the level of depressive mood in girls than in boys.

The Present Study

Interest in help-seeking behaviour of both emotionally disturbed and non-disturbed adolescents has increased in recent years. It has been established that of an estimated 17 million adolescents, 20% show signs of emotional or behavioural disturbance (Whitaker et al., 1990). Of these, the majority do not receive help (Dubow et al., 1990) and those who do rarely receive help from mental health professionals (Seiffge-Krenke, 1989). Effective mental illness prevention programs are important for the safety of youths and adolescents. The research literature suggests that specific programs should exist to facilitate appropriate help seeking by lowering barriers to help seeking (Carlton & Deane, 2000). To date there is a

limited body of research addressing the issue of barriers to help seeking for mental health issues in young people aged 12-19. Furthermore, the majority of studies previously mentioned do not assess an Irish population. Australian researchers are the leaders in the area of adolescent mental health with a vast amount of studies carried out. This gap between Australian and Irish mental health research needs to be narrowed considerably.

A pilot study carried out by Kuhl, Jarkon-Horlick, and Morrissey (1997) aimed to develop an instrument to measure barriers to help seeking behaviour in adolescents. According to the authors the scale shows promise in helping to identify adolescents who might be opposed to therapeutic intervention, and could also help in understanding which barriers to help seeking are most significant. This study will aim to identify the most significant barriers to help seeking for mental health issues in Irish adolescents and it will also examine self-esteem as a potential barrier to help seeking. Studies of the relationship between self-esteem and mental health have been performed (Bolognini, Plancherel, Bettschart, & Halfon, 1996); however, there are limited studies that look at self-esteem as a barrier for adolescents seeking help for mental health issues. General health will also be looked at to investigate its relationship with self-esteem.

Hypotheses

Hypothesis 1:

The first research objective of this study is to investigate gender differences in help seeking behaviour. This study will look at levels of resistance to help seeking through the use of the Barriers to Adolescents Seeking Help Scale (Kuhl et al., 1997). It is hypothesised that males and females will have significantly different levels of resistance to help seeking.

Hypothesis 2:

The second research objective of this study is to look at significant differences in levels of resistance to help seeking between two different demographic schools. It is hypothesised that students from different demographic schools (urban and rural) will have significantly different levels of resistance to help seeking.

Hypothesis 3: The third research objective of the current study is to study the possibility of a significant relationship between self-esteem and resistance to help seeking. It is hypothesised that there will be a significant relationship between self-esteem and resistance to help seeking.

Hypothesis 4:

The fourth research objective of the present study is to investigate the presence of a significant relationship between self-esteem and general health. There will be a significant relationship between self-esteem and general health.

Hypothesis 5:

The fifth research objective is to examine whether knowing someone with a mental illness has an effect on levels of resistance to help seeking. It is hypothesised that there will be significant differences in levels of resistance to help seeking between students who know someone with a mental illness and those who do not.

Hypothesis 6: The sixth and final research objective of the current study is to investigate differences in levels of resistance to help seeking between different age groups of the sample. It is hypothesised that there will be significant differences in levels of resistance to help seeking between certain age groups.

Methodology

Participants

A sample population of 125 secondary school students were invited to participate in this study. All participants were obtained by means of convenience. The participants consisted of both male (n = 54) and female (n = 71) students from one urban school (n = 71) and one rural school (n = 54). The age group of study participants ranged from 13 to 18 years (see Table 1 below).

Table 1. *Demographic data of the participants*

Gender (%)	
Male	43.2%
Female	56.8%
Age (%)	
13	11.2%
14	18.4%
15	15.2%
16	30.4%
17	21.6%
18	3.2%
School (%)	
Urban	56.8%
Rural	43.2%

Design

The study utilised a mixed-methods design; quantitative data took the form of self-reported questionnaires and two optional open-ended questions constitute a qualitative element. Independent variables included age, gender, and school demographic, while dependent variables included self-esteem, general health and resistance to help seeking. For regression analyses, the criterion variable (CV) was specified as the barriers for adolescents seeking help and the predictor variables (PV) were gender, school demographic, self-esteem, general health and whether participants knew someone with a mental health illness.

Materials

The Barriers to Adolescents Seeking Help (BASH) scale (Kuhl et al., 1997) was used in this present study to investigate the help seeking behaviour of adolescents (see Appendix I for questionnaires). The instrument consists of a 37-item self-report questionnaire with responses being on a 1-6 Likert scale where higher total scores indicate more resistance to seeking help. The questionnaire yields a total score to indicate resistance to seeking help, as well as aiding identification of which factors in any particular group would most strongly act as a barrier to help-seeking behaviour. Kuhl et al. (1997) reported good reliability and validity for the BASH scale; split-half reliability was calculated to be 0.82 and Cronbach's alpha was 0.91, while a two week test-retest was also reported to be 0.91.

Rosenberg's (1965) self-esteem scale was used to measure self-esteem (see Appendix I for questionnaires). This is a ten question scale which assesses global self-esteem in child, adolescent and adult populations. The Rosenberg (1965) self-esteem scale correlates significantly with other self-esteem scales such as the Coopersmith Self-Esteem Inventory. Furthermore, it correlates in predicted directions with measures of depression, anxiety and

peer-group reputation (Rosenberg, 1965), thus demonstrating good construct validity. In terms of reliability, the Rosenberg (1965) self-esteem scale has a Guttman scale coefficient of reproducibility of 0.92 (Rosenberg, 1965), indicating excellent internal reliability (Corcoran, 2000). Moreover, Silbert and Tippett (1985) demonstrated that the scale has a two week test-retest reliability of 0.85, indicating excellent stability. Cronbach's alpha reliability measurement also demonstrates high reliability from 0.77 (Blascovich & Tomaka, 1993) to 0.88 (Rosenberg, 1986).

The General Health Questionnaire (short format) (GHQ-12) (Goldberg, 1992) was used to measure participants' general well-being at the time of study and consists of a 12-item self-report questionnaire with responses being given on a four-point scale. This scale is a shortened version of the well-validated 60-item General Health Questionnaire (Goldberg, 1978) which was designed to detect non-psychotic psychiatric disorder in people in community and medical settings. Goldberg and Williams (1988) have reported good reliability and validity. Good internal consistency was found with Cronbach's alpha values ranging from 0.82 to 0.90, while split-half reliability was 0.83 and test-retest reliability was 0.73.

Procedure

The principals in both schools were contacted via telephone and email. The study outline and aims and objectives were explained; both principals supported the research. The principals then invited participants to take part in the study through announcements made during classes. The principal of each school provided students with a parental consent form requesting participation in a study on mental health. The consent form provided a brief outline of the study. The form also contained the researcher's contact details should any

parent wish to obtain any more information about the study. Only participants who presented signed parental consent forms were permitted to take part in the study. Each participant was given an information sheet detailing the nature of the study, followed by a verbal explanation of the study. The participants then received a questionnaire which consisted of five sections and the researcher requested that they work individually. The questionnaire took an average of fifteen minutes to complete.

In the first section, students were asked to provide some information about their gender, age and whether they knew someone with a mental illness. They then completed Rosenberg's (1965) Self-Esteem Scale which they responded to with varying levels of agreement or disagreement. In the third section the students completed the BASH scale (Kuhl et al., 1997) by ticking a number on a 1-6 Likert scale (1 = Strongly Agree, 6 = Strongly Disagree). The fourth section participants answered a general health questionnaire (GHQ-12, Goldberg, 1992) by responding on a four point scale. The final fifth section participants had the option of answering two open-ended questions, "In your opinion, what do you think a mental illness is?" and "In your opinion, what causes a mental illness?"

Following this final stage, participants were debriefed (see Appendix II for debriefing protocol). The debriefing detailed the nature of the study and the participant's role in the study. It also gave the participants an opportunity to ask questions and gave them insight into the methods of psychological data collection. Debriefing also allowed the researcher to hear the views of the participants which could have an impact on data interpretation or may have implications for future research. Before participants left the classroom they were thanked for taking part in the study. The statistical package for Psychology, SPSS/PASW (v.18) software was used to analyse the data and test the null hypotheses.

Ethics

This study was examined by a college research ethics board before data collection began. Once the project was deemed ethical and viable, data collection commenced. Permission was granted to carry out research in both schools by the means of a signed written letter by each school principal. This study used secondary school students as participants. For ethical reasons these students were considered to be a vulnerable group and therefore parental consent was requested from each student. Only students with signed parental consent took part in the study. All participants were initially presented with an information sheet and the entire study was explained to them verbally by the researcher before they agreed to participate in the study.

A further ethical issue which needed highlighting was the extremely sensitive of topic of mental health which this present study addressed. In the event that a participant became distressed about the questionnaire and study content, they had the right to withdraw from the study at any stage before analysis of their data commenced. In addition, help-line numbers and useful websites such as The Samaritans, Aware, and Pieta House (permission was granted to recommend these services) were featured on the last page of the questionnaire which participants were able to take home with them. Furthermore, a full debriefing session was provided to all participants at the end of the testing.

It was explained to all participants that all information provided for the study will remain anonymous. No identifiable information appeared on any of the questionnaires and data sets were stored separately from informed consent documents.

Results

Data Management and Input

All questionnaires were screened for errors and blank answers. Some missing values were present which resulted in the data of some students being discarded from statistical analysis. Twelve participants did not complete the Rosenberg (1965) Self-esteem Scale, while nineteen participants did not complete the BASH scale. Reverse scoring was carried out where necessary, data was entered into SPSS and the appropriate statistical tests were run. The results of the descriptive statistics reported the mean score for Self-esteem (*n = 113)* was 18.96 (SD = 5.38), the mean score for the BASH scale (*n = 106)* was 115.41 (SD = 21.90) and the mean score for the general health questionnaire (*n = 125)* was 3.30 (SD = 3.11) (See Table 2).

Table 2. *Descriptive Statistics of Psychological Measures*

Variable	Mean	Standard Deviation
Self-esteem	18.96	5.38
Barriers Scale	115.41	21.90
General Health	3.30	3.11

The different categories of barriers were also investigated based on the thirteen categories set out by Kuhl et al. (1997) in original paper. Each question was designated to one particular category and the mean scores for each category was calculated to reveal the most and least significant barriers to adolescents seeking help for mental health issues (See Table 3).

Table 3. *Categories of Barriers to Help-Seeking in Order of Descending Means*

Category	Mean	Standard Deviation
Self-perception	4.50	0.93
Family as sufficient	4.22	1.53
Peers as sufficient	4.04	1.40
Alienation	3.42	1.16
Self-sufficiency	3.40	0.73
Time availability	3.31	1.54
Self-awareness	3.30	1.30
Confidentiality	3.14	1.33
Knowledge of resources	3.05	1.81
Locus of control	2.90	1.16
Affordability	2.82	1.52
Usefulness of therapy	2.81	0.64
Stigma	2.70	0.87
Perception of therapist	2.41	0.92

Testing for Normal Distribution

Analyses were conducted to assess whether BASH scores, self-esteem scores, and general health scores were normally distributed, as skewed distribution or kurtosis may warrant the use of non-parametric statistics. None of the constructs were severely skewed or peaked, thus indicating that the data sufficiently follow normal distributions to allow the use of parametric statistics, such as a *t*-test. For all tests of statistical significance, α was set at 0.05.

Testing for Reliability

The internal reliabilities of the BASH scale (Kuhl et al., 1997, Rosenberg 1965) Self-Esteem Scale and the GHQ-12 were assessed using Cronbach's alpha. This is a measure of scale reliability using the variance of respondents' scores on each item in relation to overall variance of the scale (Cortina, 1993). The test showed high levels of internal reliability for all three scales. The alpha coefficient for Rosenberg's Self-Esteem Scale was reported to be 0.87, which is generally considered to be high (Coolican, 2004). The alpha coefficients for the BASH scale and General Health questionnaire were reported to be 0.85 and 0.83 respectively, which again are considered to be high levels of internal reliability. On closer inspection of reliability results of the BASH scale it was observed that removal of statement 35, "I cannot imagine having a problem so serious that I would go for help", would result in higher internal reliability. However, inclusion of this statement still yields an overall high level of consistency.

Statistical Analyses

Using SPSS computer software package a number of statistical analyses were carried out on the data. These tests included independent *t*-tests to look at differences between variables, Pearson correlations to investigate relationships between variables, tests of regression to look at predictions, and one way analysis of variance to test for significant group differences. All tests were two-tailed.

Hypothesis 1: Significant differences between male and female scores on the BASH scale

A two-tailed Independent samples t-test was used to ascertain significant differences between male and female scores on the BASH scale. Females (M = 117.05, SD = 21.49) were found to score higher in the BASH scale than males (M = 113.26, SD = 22.44). The results of the *t*-test analysis found that male and female students did not differ significantly in their scores on the BASH scale (t (104) = -.882, $p > .05$, 2-tailed).

Hypothesis 2: Significant differences in BASH scores between two schools

A two-tailed Independent samples t-test was carried out to investigate whether differences in BASH scores existed between the urban and rural schools. Students in the urban school (M = 117.84, SD = 22.90) reported higher scores in the BASH scale that students in the rural school (M = 112.46, SD = 20.44). The results of the *t*-test showed that these differences were not significant (t (104) = 1.26, $p > .05$, 2-tailed).

Hypothesis 3: Significant relationship between self-esteem and BASH scores

A Pearson correlation was carried out to investigate if there was a significant relationship between self-esteem and BASH scores. The mean score for self-esteem was 18.96 (SD = 5.38) and the mean BASH score was 115.41 (SD = 21.89). A Pearson correlation found that there was a moderate negative significant relationship between self-esteem and BASH scores (r (96) = -.36, $p < .01$, 2-tailed).

Following this result a linear regression was used to determine whether self-esteem could predict help-seeking behaviour. From Table 4 it can be seen that self-esteem significantly predicted resistance to help-seeking (F, (1, 96) = 14.95, $p < .001$, $R^2 = .13$) (RSE, beta = -.367, $p < .001$).

Table 4. Regression analysis for Self-esteem and BASH scores

Criterion Variable	Model	Predictor Variable	B	Standard Error	β	Adj R^2	*F*	*df*	*p*
BASH Total	1	RSE Total	-1.483	.0383	-.367	.126	14.957**	1,96	.000

**$p < .01$ level

Hypothesis 4: Significant relationship between self-esteem and general health

A Pearson correlation was carried out to investigate if there was a significant relationship between self-esteem and general health. The mean score for self-esteem was 18.96 (SD = 5.38) and the mean score for general health was 3.3 (SD = 3.11). A Pearson correlation found that there was a strong negative significant relationship between self-esteem and general health (r (111) = -.627, $p < .01$, 2-tailed).

Hypothesis 5: Significant differences in BASH scores between participants who know someone with a mental illness and those who do not

A two-tailed Independent samples *t*-test was carried out to investigate whether differences in BASH scores existed between those who know someone with a mental illness and those who don't. Students who know someone with a mental illness (M = 118.29, SD = 22.69) revealed higher BASH scores than students who don't know someone with a mental illness (M = 113.04, SD = 20.27). The results of the *t*-test found that these differences were not significant (t (103) = 1.24, $p > .05$, 2-tailed).

Hypothesis 6: Significant differences in BASH scores between different age groups

A one-way non-repeated measures ANOVA was carried out to test for differences in BASH scores between the three age groups. From looking at Table 5 it can be seen that overall there was a significant effect of age group on BASH scores (F (2,103) = 3.38, $p < .05$). More specifically, Tukey HSD post hoc analyses highlighted that BASH scores of the youngest (13-14) group (M = 106.76, SD = 22.22) were significantly lower than the BASH scores of the oldest (17-18) group (M = 120.28, SD = 22.04, $p = .047$).

Table 5. *ANOVA table showing group differences in BASH scores*

Variables	Groups	Mean	SD	*F*	*df*	*p*
BASH Total	13-14	106.76	22.224	30.388*	2	.038
BASH Total	15-16	117.69	20.512	30.388*	2	.038
BASH Total	17-18	120.28	22.042	30.388*	2	.038

* p significant at .05 level.

Qualitative data

The qualitative section of the questionnaire consisted of two open ended questions: 'In your opinion what do you think a mental illness is?' and 'In your opinion what do you think causes a mental illness?' The students' responses were analysed by screening for a number of key based on the following definition of a mental illness: '*the experiencing of severe and distressing psychological symptoms to the extent that normal functioning is seriously impaired'* (MHI, 2013). The responses were interpreted by dividing them into three headings; 'Good Understanding'; 'Vague Understanding'; and 'Poor Understanding'. Upon analysis of the data, it was observed that 32% of the sample appeared to have a good understanding of what a mental illness is, 35% had a vague understanding, while 22% of the

sample had a poor understanding of what a mental illness is (11% did not answer). An example of an answer from a student who seemed to have a good understanding of what a mental illness is would be, “This is when your mind is badly affected by things that have happened to you or ‘cos of stress or other things. You can’t handle pressures and sometimes you feel alone ‘cos you can’t be with your friends and people think you’re weird but you’re not you’re just sad. Some people get bullied ‘cos they’re fat and then they get eating disorders or get depression and commit suicide.”

On examining the second question, there were significantly less answers for this; however, those students who did answer seemed to have a good understanding of the factors that may cause a mental illness. One obvious trend which was evident was the difference in standard of answers between the two schools and the percentage of students who had a good understanding of what a mental illness is. For the rural school, 55% of the students had a good understanding, whereas only 7% of the students from the urban school had a good understanding. A further observation made was the substantial amount of references made to bullying.

The qualitative section of this study provided very interesting findings which should be taken in to account when considering further research.

Discussion

Findings

The current study investigated adolescents' resistance to help seeking for mental health issues and aimed to identify the main factors that inhibit young people from seeking help. The study also looked at self-esteem as a potential barrier to help seeking. No significant differences between male and female levels of resistance to help seeking were found. Two further non-significant findings were reported; school demographic did not significantly affect resistance to help seeking; and whether participants knew someone with a mental illness or not did not appear to affect help seeking behaviour. However, significant results were reported for three further hypotheses. The first significant finding was that of the relationship between self-esteem and help seeking, the two variables were found to be moderately negatively correlated. Furthermore, self-esteem was found to be strongly negatively correlated with general health. Finally, the third significant finding involved significant differences in levels of resistance to help seeking between the three different age groups.

While investigating the individual barriers that are most significant for adolescents, it was found that the biggest barrier for adolescents seeking help for mental health issues was 'self-perception', which suggests that young people see themselves as not needing help from a professional. The second highest barrier was 'family as sufficient', followed by 'peers as sufficient'. This finding underlines the important influence that parents and other family members can have on a young person's life and suggest the importance of education for families on adolescent mental health problems and solutions. These results are also in keeping with findings demonstrating that friends represent a natural, important and

acceptable support source for adolescents (Boldero & Fallon, 1995 and Schonert-Reichl & Muller, 1996).

Adolescence and young adulthood are the periods of life during which most mental disorders emerge. Impulse control disorders and phobias most commonly begin in the pre pubertal years, while other anxiety disorders, mood disorders, substance use disorders, and non-affective psychosis most commonly begin in adolescence or young adulthood (Kessler et al., 2007). Mental health and substance use disorders are the major health problems of young people, which account for most of their disability (Patel et al., 2007). According to Leaf et al. (1996), more than 70% of adolescents who suffer from mental problems do not receive care. Factors contributing to this unmet need among adolescents may include inaccessibility of mental health services, lack of problem recognition, and negative attitudes toward mental health services (Rickwood & Braithewaite, 1994).

One of the most consistent findings in the area of help seeking, including mental health, physical health, counselling, and academic work, is that females seek help to a greater degree than do males (Barnett et al., 1990). This is apparently true even when controlling for socioeconomic status (SES) and age (Barker & Adelman, 1994). Studies specific to adolescent help seeking have confirmed this trend (Garland & Zigler, 1994). In the present study, with regard to the first hypothesis, no significant differences were reported between male and female levels of resistance to help seeking. Females reported higher barriers to help seeking as indicated by the higher BASH scores, which is in contrast to results reported by Kuhl et al. (1997).

On investigating the second hypothesis of whether there were significant differences in BASH scores between the urban and rural schools, no differences were reported. However, one factor that needs to be taken into account while interpreting this result is the uneven

balance of participants from each school. Perhaps by increasing the number of schools in the sample and establishing equal numbers from each school, significant findings would result. Furthermore, originally one of the study's main aims was to investigate the differences in levels of resistance to help seeking between one school of low socioeconomic status and one school of high socioeconomic status. However, due to time constraints in the initial stages of the study, it was not possible to attain the necessary schools for this hypothesis. Further research carried out in Ireland in the area of help seeking would benefit from including the aspect of socioeconomic status considering literature exists that suggests help seeking varies directly with SES (Tijhius et al., 1990).

There is a wealth of research which looks at the relationship between self-esteem and mental health (Bolognini et al., 1996; Nadler, 1986); however, a limited amount of research investigating the relationship between self-esteem and help seeking behaviour exists. This study examined the relationship between self-esteem and adolescents' resistance to help-seeking; upon finding a significant correlation between the two variables, it was subsequently reported that self-esteem significantly predicts resistance to help seeking. This finding emphasises the fact that understanding the role of self-esteem plays a huge part in addressing adolescents help seeking behaviour. Moreover, self-esteem was also strongly correlated with general health, further strengthening the need for initiatives to address this issue.

Investigations carried out for the fifth hypothesis revealed that there was no significant differences in resistance to seeking help between students who know someone with a mental illness and those who don't. However, the findings from the final hypothesis revealed that there were significant differences in levels of resistance to help seeking between the three different age groups. It was reported that the younger age group (13-14) were least resistant to seeking help, while the older group were more resistant to help seeking which was indicated by the higher scores on the BASH scale. These findings however, are in contrast

with those recorded by Kuhl et al. (1997) who reported that BASH scores were not significantly affected by age.

Sources of support

With regard to the analysis of the categories of the BASH scale, some interesting findings emerged. The current study found that three biggest barriers to adolescents for seeking help were reported to be 'self-perception', 'family as sufficient to providing help', and 'peers as sufficient to providing help'. The least significant barriers were reported to be, 'usefulness of therapy', 'stigma', and 'perception of therapist'. These findings are somewhat supported by the original study carried out by Kuhl et al. (1997) which reported that the biggest barrier was family being sufficient to provide support, and peers as sufficient to provide support being the second biggest barrier. It appears that parents of adolescents play a major part in providing support for mental health issues, with adolescents viewing them as one of the major, if not the major sources of support. But when faced with the potential mental ill health of their child, some parents, for various reasons, do not act to help their child. Possible factors for this include poor parental understanding of mental health, services or sources help, parenting difficulties, parental ill health and low quality of life, inadequate help seeking strategies and in rare cases parental abuse or neglect (Kazdin & Wassell, 2000).

The findings of the current study are also in keeping with previous research which found that young people are more likely to seek help for themselves from people in their social networks, such as family or friends (Rickwood & Braithwaite, 1994), or from teachers (Boldero & Fallon, 1995). In the case of adolescents, up to 90% tell their peers of their distress rather than a professional (Kalafat & Elias, 1995). However, it is unclear how active adolescents are themselves in initiating help seeking beyond the peer group. In one study, less

than one third of adolescents sought help even though their problems included such serious difficulties as suicide ideation and depression (Dubow et al., 1990). In fact, some research has reported that when faced with an emotional problem, seeking help is adolescents' least preferred coping strategy (Copeland & Hess, 1995). It is known that peer groups become an increasingly influential source of support across adolescence (Coleman, 1980) and peer mentoring and "buddy systems" have been used successfully in several mental health programmes (Hektner, August & Realmuto, 2003). However, a more formal system of training adolescents to identify mental health problems among their peers and to facilitate pathways to care may be needed.

Little is known about how help-seeking beliefs develop or change through adolescence and into adulthood. According to Adams and Marshall (1996) young people become more autonomous and independent they seek to take increasing control of their lives. The current study has helped in establishing an understanding of potential factors affecting distressed adolescents' help seeking behaviour. In particular, the perception of one's ability to cope alone stands out as a particularly relevant aspect of self-esteem affecting attitudes toward seeking psychological help. On a practical level, this finding suggests that intervention initiatives are desperately needed. Specifically, interventions should focus on the ways in which certain attitudes and beliefs, particularly one's perceived ability to cope alone, may become an obstacle to seeking appropriate help. In addition, interventions need to increase adolescents' awareness of the benefits of psychological assistance as well as their knowledge of existing help services.

A study carried out by Juszczak, Melinkovich, and Kaplan (2003) supports the view that School Based Health Centres provide complementary services. The researchers argue that the school based health centres play a unique role in improving utilization of mental health services by hard-to-reach populations. According to Juszczak et al. (2003) the extent to which

community health centres and other health care providers, including managed care organizations, can build on the unique contributions of school based health centres can really influence access and quality of care for adolescents in the future. Where mental health services are available through the education sector, young people are far more likely to receive help through this route than any other. For example, Farmer, Estell, Leung, Trott, Bishop, and Cairns (2003) exploration of pathways into mental health services showed that around 60% of children initially received services through the education sector, while speciality services accounted for approximately 27%, general medicine 13%, child welfare 6.5% and juvenile justice 2.5%. In addition, it is also reported in this study that the majority of children with less severe problems were supported through school-based services and these children did not require services provided by other sectors. This may indicate that early intervention for children with milder problems should address psychological issues before they become potentially serious mental health problems.

Mental health literacy as a barrier to help seeking

From the qualitative component of this study it is evident that there is lack of knowledge regarding several aspects of mental health. For this section students were asked to respond to two questions; 'In your opinion what do you think is a mental illness is?' and 'In your opinion what do you think causes a mental illness?' In analysing the students' responses, a number of key words were screened for based on the following definition of a mental illness: '*the experiencing of severe and distressing psychological symptoms to the extent that normal functioning is seriously impaired'* (MHI, 2013). There were some worrying trends which appeared to show that the majority of the students did not seem to have a good understanding of what a mental illness is. This perhaps indicates the need for

more mental health awareness programmes to take place in secondary schools. However, it was found that over half of the sample showed a good understanding of the factors which may cause a mental illness.

One recent and significant development in the study of mental health that has the potential to help explain and more importantly, alleviate the difficulty of ensuring that people get the appropriate help when they need it has been the field of mental health literacy. The term was first used by Jorm, Korten, Jacomb, Christensen, Rodgers, and Pollitt (1997) to refer to "knowledge and beliefs about mental disorders which aid their recognition, management or prevention. Mental health literacy includes the ability to recognize specific disorders, knowing how to seek mental health information, knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking" (p. 182).

Studies to date suggest that the public does not possess a high level of mental health literacy. In their study on mental health literacy, Jorm et al. (1997) presented over 2,000 participants with two case vignettes—one of a person with depression, and one with schizophrenia. Only 39% could correctly identify depression, while only 27% of subjects could correctly label schizophrenia. Lauber, Nordt, Falcato and Rossler (2003) found a similar result for a depression vignette in a more recent study. The most important reason to raise adolescent mental health literacy is to increase the likelihood that young people can access the most appropriate help when needed. Mental health awareness programmes in schools have been shown to be effective in changing young people's opinions about mental health matters and help-seeking (Pinfold, Toulmin, Thornicroft, Huxley, Farmer, & Graham, 2003). Moreover, the ideas taught to children during mental health awareness programmes in schools have the potential to infiltrate the community more broadly (Rahman, Mubbashar, Gater & Goldberg, 1998).

Limitations

The present study has reported some significant finding on the topic of adolescent mental health and help seeking. However, there are some limitations of the study which need to be taken into account. The Barriers to Adolescents Seeking Help Scale is a relatively new scale, therefore its reliability and validity may be questioned. Despite the authors reporting good levels, they have suggested that further research be carried out to establish the reliability and validity of the instrument in more diverse populations. Furthermore, in the current study, the use of the GHQ-12 questionnaire did not seem appropriate for the sample as some of the wording had to be changed to make it more user-friendly and despite these changes, it still lead to some misunderstanding of the language/phrases used. With regard to the open ended questions, perhaps a more stringent method of analysis of the qualitative data is required followed by some statistical analysis. Another suggestion for further research using this method would be to investigate mental health knowledge of students from different socioeconomic backgrounds and analyse the responses for statistical significance. One final limitation of the study would be that of the sample size. Due to some students not answering some questions, a lot of missing data was recorded which caused the amount of valid data for analysis to diminish. Therefore, it would be encouraged to attain a larger sample size. However, even though the sample size was reduced, there were still significant results reported which suggests the study addressed a very important issue. A final suggestion would be to attempt a longitudinal study looking at the variables in this study; this would no doubt lead to more conclusive findings.

Conclusion

Across the life span, young people represent the age group with the highest prevalence of mental health problems and disorders and they are also a group that is more likely to present symptoms related to psychological or behavioural disorders (e.g., suicide, depression, alcohol and drug dependence) rather than symptoms related to solely physical illness (Scanlon, 2002). Studies on help seeking among adolescents demonstrate the under-use of formal and professional sources of support (Kuhl et al., 1997). This has worrying implications for both immediate and long term development.

The current study explored adolescents' resistance to help sources in order to further our understanding of the factors that affect adolescent help-seeking behaviour. This study has highlighted the impact of the type of help sources on adolescent help seeking behaviour. In general, teenagers prefer receiving help from informal sources such as parents and friends rather than from formal sources such as teachers, doctors, school counsellors, and psychologists (Schonert-Reichl & Muller, 1996). Several reasons may underlie this preference. First, seeking help from informal sources carries with it a lower psychological cost and is likely perceived as less threatening to the self. Second, seeking help from friends and family is likely perceived as a normative act whereas turning toward formal help sources, particularly to psychologists, may be perceived as stigmatic (Wills, 1992). It is also likely that adolescents perceive close others as better able to understand their difficulties and that they will continue to value them despite the exposure of their weakness (Wills, 1992). The preference of friends over other sources of help is in keeping with the growing prominence of the peer group during adolescence in general (Raviv et al., 2000). Furthermore, informal sources of help are more accessible and less expensive than formal ones.

It is increasingly recognized that seeking help for personal problems proceeds through stages and often starts by accessing informal sources of help before formal treatment seeking. This process can be quite complex and lead to considerable delays from the start of the cognitive help seeking process to when treatment services are obtained (Wills & Gibbons, 2009). Longitudinal research is needed to track this process as well as following the relationship between help seeking beliefs, intentions and help seeking behaviour from early adolescence to adulthood. In the meantime, adolescents' intentions to seek professional mental health care might be improved by prevention and early intervention initiatives. Initiatives might include helping adolescents' recognize that part of being more independent in their journey into adulthood, is being aware of when they are not able to manage their mental health problems on their own and knowing when and how to seek the support of others. Indeed adolescent intervention programs (Kalafat & Elias, 1994) have demonstrated their ability to increase adolescents' awareness of emotional distress among their peers and encourage a more positive attitude toward seeking help. Such interventions have the potential to help adolescents play an important role in narrowing the service gap and thereby increase the number of distressed peers receiving appropriate professional help. In the area of research, more emphasis needs to be placed on developing well designed research involving controls, and on improving reliability and validity of diagnostic classifications and measurement of symptoms.

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Appendices

APPENDIX I: Study Questionnaire

Dear Student:

My name is Simon and I am a postgraduate student in Psychology at Dublin Business School. As part of my research project, I am looking at the behaviours of young people in relation to them seeking help for personal and emotional (i.e. mental health) issues.

The questionnaire will take 15-20 minutes to answer. There are no right or wrong answers and your answers will be kept completely anonymous. Please DO NOT put your name on the questionnaire.
You do not have to answer any of the questions you do not want to. You have the right to withdraw at any time before handing up the questionnaire; however it is important to understand that by completing and submitting the questionnaire, you are giving your consent to participate in the study. Once it has been handed up it is not possible to withdraw your questionnaire, but answers cannot be traced back to any individual.

Your help with this research is strictly voluntary.
If you are in agreement to fill out the questionnaire, please answer the questions below as accurately and honestly as possible by ticking the box beside the answer that best represents your opinion. Should you require any further information about the research, please contact me on [redacted].

Thank you very much for your time.

SECTION 1:

1. Gender: Male ☐ Female ☐
2. Age ☐
3. Do you know anyone with a mental illness? Yes ☐ No ☐

SECTION 2:

Below is a list of statements dealing with your general feelings about yourself.

If you ***strongly agree*** with the statement circle **SA**.
If you ***agree*** with the statement circle **A**.
If you ***disagree*** with the statement circle **D**.
If you ***strongly disagree*** with the statement circle **SD**.

1.	Overall, I am satisfied with myself.	**SA**	**A**	**D**	**SD**
2.	Sometimes I think I am no good at all.	**SA**	**A**	**D**	**SD**
3.	I feel that I have a number of good qualities.	**SA**	**A**	**D**	**SD**
4.	I am able to do things as well as most other people.	**SA**	**A**	**D**	**SD**
5.	I feel I do not have much to be proud of.	**SA**	**A**	**D**	**SD**
6.	I feel useless at times.	**SA**	**A**	**D**	**SD**
7.	I feel that I'm a person of worth, at least equal with other people.	**SA**	**A**	**D**	**SD**
8.	I wish I could have more respect for myself.	**SA**	**A**	**D**	**SD**
9.	Overall, I am inclined to feel that I am a failure.	**SA**	**A**	**D**	**SD**
10.	I have a positive attitude toward myself.	**SA**	**A**	**D**	**SD**

SECTION 3:

Below is a list of questions dealing with feelings on how you might get help for personal/emotional problems and who you might get help from. Please tick the box underneath the answer that best represents your opinion.

	Strongly Agree = 1	Agree =2	Sort of Agree =3	Sort of Disagree =4	Disagree =5	Strongly Disagree =6
1. My friends would think I was crazy if I saw a counsellor.						
2. If I had a problem, my friends could help me more than a counsellor.						
3. If I had a problem I would solve it by myself.						
4. If I had a problem, my family would help me more than a counsellor.						
5. Even if I wanted to, I wouldn't have time to see a counsellor.						
6. If I had a problem and told a therapist, he would not keep it secret.						
7. People who see counsellors are crazy.						

8. If I saw a counsellor my family would think I was weak.						
9. The idea of going to a counsellor is pretty scary to me.						
10. A counsellor might make me do or say something that I don't want to.						

	Strongly Agree = 1	Agree =2	Sort of Agree =3	Sort of Disagree =4	Disagree =5	Strongly Disagree =6
11. I think counselling can be bad.						
12. I think that counsellors really want to help people.						
13. Going to a counsellor means you don't have the strength to handle the problem yourself.						
14. From what I know, most people get help from getting counselling.						
15. My parents have said they really don't believe in counselling.						
16. I would never want my friends to know that I was seeing a counsellor.						
17. I'd never want my family to know I was seeing a counsellor.						
18. Adults really can't understand the problems that kids have.						
19. Counsellors are more helpful to						

adults than to teenagers.						
20. I know where I could find a counsellor if I needed one.						
21. Counselling can often help teenagers with problems.						
22. Counsellors really can't understand teenager's problems today.						
	Strongly Agree =1	**Agree =2**	**Sort of Agree =3**	**Sort of Disagree =4**	**Disagree =5**	**Strongly Disagree =6**
23. Even if I had a problem, I'd be too embarrassed to talk to a counsellor about it.						
24. If I went to a counsellor it would make me feel like I was crazy.						
25. If I ever talked to a counsellor about personal things, I'm sure my family would hear about it.						
26. I could not afford to see a counsellor even if I wanted to.						
27. If I ever went to a counsellor, my						

parents would be pretty upset.						
28. If I had a problem, my parents would think that speaking to a counsellor was a good idea.						
29. No matter what I do it will not change the problems I have.						
30. My problems will go away by themselves.						
31. I know people who have been helped by getting counselling.						

	Strongly Agree =1	Agree =2	Sort of Agree =3	Sort of Disagree =4	Disagree =5	Strongly Disagree =6
32. I have had problems in the past which really upset me.						
33. If I went to see a counsellor, I might find out I was crazy.						
34. My family thinks that anyone who goes to a counsellor is crazy.						
35. I cannot imagine having a problem so serious that I would go for help.						
36. I think I should work out my own problems.						
37. People don't need counsellors to help them with their problems.						

SECTION 4:

This section is about how your general health has been in the last while. Please answer the questions by underlining or ticking the answer that best represents your personal feelings to the question.

1.Have you recently been able to concentrate on whatever You are doing?	**No not at all**	**The same as normal**	**A bit more than normal**	**A lot more than normal**
2. Have you recently lost much sleep over worry?	**No not at all**	**The same as normal**	**A bit more than normal**	**A lot more than normal**
3. Have you recently felt that you are playing a useful part in things?	No not at all	The same as normal	A bit more than normal	A lot more than normal
4.Have you recently felt capable of making decisions about things?	No not at all	The same as usual	A bit more than normal	A lot more than normal
5.Have you recently felt constantly under strain?	No not at all	The same as normal	A bit more than normal	A lot more than normal
6.Have you recently felt you couldn't overcome your difficulties?	No not at all	The same as normal	A bit more than normal	A lot more than normal

7.Have you recently been able to enjoy your normal day-to-day activities?	No not at all	The same as normal	A bit more than normal	A lot more than normal
8.Have you recently been able to face up to your problems?	No not at all	No more than normal	A bit more than normal	A lot more than normal
9.Have you recently been feeling unhappy and depressed?	No not at all	The same as normal	A bit more than normal	A lot more than normal
10. Have you recently been losing confidence in yourself?	No not at all	The same as normal	A bit more than normal	A lot more than normal
11.Have you recently been thinking of yourself as a worthless person?	No not at all	The same as normal	A bit more than normal	A lot more than normal
12.Have you recently been feeling reasonably happy, all things considered?	No not at all	The same as normal	A bit more than normal	A lot more than normal

SECTION 5:

1. In your opinion what is a mental illness?

2. In your opinion what causes a mental illness?

THANK YOU!

Thank you very much for taking the time to complete this survey.

If any of the statements have upset you and you would like to talk to someone about it, here are some contact details of people and organisations that might be able to help:

- **Childline – 1800 66 66 66 or TextTAlk on 50101** www.childline.ie

- **Aware -1890 303 302** www.aware.ie

- **Samaritans - 1850 60 90 90** www.samaritans.org

- **Pieta House -01- 6010000** www.pieta.ie

- **You should also contact your school counsellor or chaplain if you feel you need to talk to someone.**

APPENDIX II: Debriefing Protocol

DEBRIEFING PROTOCOL

When all data were collected, a debriefing session using the following protocol was carried out with all participants.

- Participants were informed of the exact nature of the study, i.e. the research questions and aims of the study.

- Participants were told about their role in the study.

- Participants were allowed to ask any questions they had regarding the research process, data analysis, previous findings and the implications of the results.

- Participants were once again informed that the data would remain completely anonymous.

- Participants were made aware of the various relevant contact details and websites of relevant organisations should the study have caused them any distress.

- Participants were thanked for their contribution to the study.