The Effect of Jigsaw Intervention on Help-Seeking, Attitudes to Mental Health, and Social Distance.

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Abstract

As the focus on mental health in schools has increased so too has the number of agencies providing, services, talks and activities to support mental health promotion. While there is evidence to suggest that supporting community mental health through schools is beneficial there is little empirical evidence for many of the interventions on offer (Kelly, 2007). This study aims to examine the effect of Jigsaws school intervention on attitudes to mental health, help-seeking and social distance in a second level school in North Fingal. The research instrument was a self-administered questionnaire completed over three time points. This study found the intervention resulted in more positive attitudes to mental health and an increased awareness in sources of help. No effect was measured on barriers to help seeking. While mixed results were found in relation to social distance. Limitations of the current study and areas for research are discussed.
Introduction

There has been an increased focus on mental health internationally and domestically in recent years (WHO 2013, Education 2013). The number of voluntary and government supported initiatives currently working to support mental health awareness and outcomes for young people has also increased (Headstrong, Seechange.ie, Reachout. Belongto). Mental health is defined as a state of well-being in which an individual is able to cope with the normal daily stresses in life (World Health Organisation, 2005) and is considered the number one health issue for young people in Ireland (Headstrong, 2012).

The ‘My World’, National survey on mental health suggests that one in five young people experience some degree of emotional distress at any time (Headstrong, 2012, p.1). Both schools and communities have a role to play in supporting young people in difficulty. Recent guidelines for mental health promotion and suicide prevention in post-primary schools (Education 2013) advocate a whole school approach to mental health promotion in the context of the ‘continuum of support’ (NEPS, 2010a). However the relationship between young people and seeking help in school is complex. Sheffield, Fiorenza, & Sofronoff, (2004) found that young people were less willing to seek help from school counsellors than they were from friends and family; however the school counsellor was the most frequently used source of formal help. They also found that young people felt willing to seek help from teachers.

Guidelines on promoting health in schools (Education, 2013) encourages school to become ‘a health promoting school’ which plans and implements health related activities. As part of this process links between the schools and communities should be enhanced. However, Kelly (2007) points out that there is a lack of school based intervention studies.
Headstrong is the National Centre for Youth Mental Health in Ireland; a non-profit organisation, they work with communities and statutory services with the aim to empower young people in the area of mental health. Headstrong established Jigsaw in 2010. Jigsaw is a community based service which offers support to young people. Jigsaw works on a programme of service development, research and advocacy. There are currently ten Jigsaw sites nationally.

Jigsaw’s model is based on ecological systems theory by Bronfenbrenner (1979) and aims to bring together all the supports available to a young person thereby strengthening the community’s capacity to support the young person. One way in which this is achieved is through the provision of positive learning opportunities for young people and their community. The organisation works closely with a youth advisory panel in order to achieve this goal. They also provide clinical interventions for self-referred young people and work with their local community and schools promoting mental health awareness. In 2013 Headstrong launched Jigsaw North Fingal.

The rationale for Jigsaw is based on the findings that one in five young people are in a state of psychological distress at any one time and not receiving any intervention and while evidence based interventions do exist they are unfortunately not easily accessed by young people. It is also suggested that the current mental health system should not be expected to respond to the full range of problems experienced by young people and communities and that young people and their families should be involved in strategies and responses for responding to the need of their young people (Bates, Illback, Scanlan, & Carroll, 2009).

An important aspect of Jigsaw’s work is to encourage young people to talk to a person they trust if they have a problem. One of the tools used to achieve this goal is the ‘It’s Time to Start Talking’ presentation which is delivered to young people in secondary schools.
Jigsaw’s ‘It’s Time to Start Talking’ presentation is normally delivered by the Jigsaw clinical support worker. This person has a background in mental health intervention. The aim of the intervention is to introduce the idea of young people’s mental health as a continuum and to normalise messages around mental health as well as convey messages of hope. It is suggested that our mental health is similar to our physical health and can be poor or healthier at different times of our lives.

Secondly the intervention encourages young people to speak to an adult in their lives who they trust if they have a problem or are feeling down. This approach is supported by the findings of the one world survey (Headstrong, 2012) which identifies having ‘one good adult’ to talk to as a major protective factor for mental health problems in young people. This study will examine the effects of Jigsaw’s schools intervention on young people’s attitudes to mental health, and likelihood to seek help for their problems.

Adolescents

Young people are at particular risk of poor mental health given that adolescence is a time for biological and psychological change. The beginnings of mental health difficulties often occur in adolescence (Kessler et al 2007). Mental health problems in adolescence have been linked to the development of co morbid disorders and early onset of mental disorders correlate with greater severity and resistance to treatment (Chisholm, 2012). One in five young people with mental health problems do not receive the required treatment and therefore their issues remain unresolved and continue into adulthood (Pinto-foltz & Logsdon, 2009). Therefore adolescence is a key time for mental health education as positive attitude
towards mental health and help seeking are likely to result in better outcomes for young people who develop mental health conditions as well as young people who do not.

Adolescence is a particularly crucial period for development and teenagers who reported higher distress were also more likely to engage in risk behaviours such as drinking and drug taking (Headstrong, 2012). In addition Shefield, Fiorenza, & Sofronoff, (2004) report that rates of suicidal thoughts, self-harm and suicide attempts were found to be higher in those young people who did not seek help or talk about their problems.

As well as these challenges, the nature of adolescence has also changed. Young people are now experiencing the stresses of adolescence at a much younger age. At the same time they remain in education for longer, get married later and as a result delay fully entering the adult work.

Emotional distress begins in early adolescence and continues to increase throughout. This distress then peaks in the early twenties at which time young people show their highest levels of disengagement. Therefore educational strategies which aim to address and improve mental health in young people should be introduced to younger adolescents where possible. This may support the positive outlook on mental health and higher resilience reported by younger teenagers in the ‘My World’ survey (Headstrong, 2012).

*One Good Adult*

Literature suggests that having a key person to whom a young person can talk has a great influence on their psychological wellbeing. The presence of ‘One good Adult’ in the life of a young person is associated with a range of protective factors such as support from family, life satisfaction and self esteem (My World Survey, Headstrong, 2012 P. 94). Young
people who identified perceived low support from an adult in their life showed levels of depression and anxiety which were outside the normal range. As mentioned previously the Jigsaw intervention encourages young people to discuss their problems with an adult they trust before they become overwhelming. This study will examine the social support reported by the participants and changes in their awareness of such support as a result of the Jigsaw intervention.

Help Seeking

It is recognised that appropriate help seeking acts as a protective factor in developing mental illness in all age groups but especially in young people (Wilson, Deane, Marshall, Dalley 2008). However few programmes specifically focus on improving professional help seeking. As well as being associated with lower mental health distress, talking to others about problems is also associated with better adjustment in young people (Headstrong, 2012). There is also evidence that appropriately supported young people are more likely to recover from their difficulties and go on to develop coping strategies and can more effectively manage stress (Evens, 2005). Furthermore Prakashini and Hyland (2012) found that students who engaged with support services in Ireland, specifically the ISPCC, had higher levels of self-esteem and lower levels of stress. In this context it is essential that young people are encouraged to speak to others about their problems and distress.

While help seeking is recognised as a protective factor for mental health, levels of seeking social support are highest at age 12-13 and is at its lowest at 14—15 years (Headstrong, 2013). Girls are also reported to be more likely to seek help than boys (Rickwood, Deane, Wilson, & Ciarrochi, 2005). Therefore it is important for school based
programme to encourage help-seeking both formally and informally. As previously mentioned the Jigsaw presentation encourages young people discuss their problems with others and connect socially in order to maintain positive mental health. This study will examine the possible effects of the presentation on young people’s attitude towards seeking help.

Amato and Bradshaw (1985) argued that young people were influenced by a number of barriers to help seeking including a desire to maintain independence, anxiety around the consequences of such actions, denial of the problem and suitability of the help. Kuhl et al. (1997) suggested that young people do not seek professional help as they perceived family, friends and themselves as able to deal with the problems adequately. However intentions to seek help are a prerequisite for voluntary treatment (Junghee, Friesen, Walker, Colman & Donlan, 2012). High availability of a supportive adult in time of need was found to be a protective factor for mental health (Headstrong, 2013) however a small minority of young people access agencies.

Ross et al. (2012) demonstrated the success of a self-referral model for young people with mood and anxiety concerns. Help-seeking has also been found to be a protective factor in the prevention and treatment of mental health. In their 2008 study Wilson et al. found a negative correlation between suicide ideation and low help-seeking intentions.

Social Distance

Social distance is best understood as a proxy measure for eliciting discriminatory attitudes towards persons with mental illness (Marie & Miles, 2009, p. 1) and is related to social stigma. Social distance is higher when the condition is perceived to be severe and more
positive responses are generally recorded for conditions such as depression when compared
to Schizophrenia (Martin, Pescosolido, Olafsdottin, & McLeod, 2007). Stigma in relation to
mental illness can significantly impair quality of life across a range of areas (Maire & Miles,
2009). Given that adolescence is a time when individuals are tasked with developing a strong
sense of self and peer relationships it may be inferred that failure to successfully complete
this task could impact on an individual’s development, as well as the outcome for any mental
illness which may be present.

Therefore social distance in young people towards peers who present with mental
health difficulties may have an influence on the outcomes for those young people. Social
distance is measured on likely behaviour towards targets with mental illness for example in
Reavley & Jorm’s (2011) national survey of youth mental health in Australia, a vignette was
use to elicit responses form participants. This study found that young people reported patterns
of stigmatisation differed according to disorder, and mental illness was associated with
unpredictability. This study will look for changes in attitudes to social distance amongst those
who attend the ‘its time to talk’ presentation.

**Attitudes**

Stigma is a collection of negative attitudes beliefs, thoughts and behaviours that
influence the individual or the general public to fear, reject avoid, or discriminate against
those with mental health disorders (Pinto-Foltz & Logsdon 2009). Research suggests that
stigma in relation to mental health is high in Ireland with six out of ten adults reporting that
they would not want people to know if they were experiencing a mental health problem (HSE
2007). Stigma is both a barrier to help seeking and manifests itself through social interaction
in adolescents. As a major developmental task of adolescence is to develop a sense of self
through peer relationships, negative attitudes towards mental health is problematic for young
people. Reducing stigma and increasing positive attitude towards people with mental health can have a positive influence on behavioural problems, school achievement, school climate and reducing emotional and disciplinary problems (Chisholm, 2012). The growing pressure to take such issues in Irish schools is replicated in other countries; however, there is little agreement on what approach is best employed to effect change (Chisholm, 2012). Young people also report that they would like to receive more information on mental health.

As a result, intervention to reduce stigma should be universal and will help to reform culture leading to improvements in immediate and long-term mental health in adolescents (Pinto-Foltz & Logsdon, 2009). Stigma is under-studied in adolescents, and empirical studies of anti-stigma interventions are rare (Link, Yang, Phelan, & Collins, 2004). Therefore, interventions which do exist should be empirically studied and evaluated with the goal of replicating positive findings in other populations.

The aim of the current study

The aim of the current study is to investigate the effect of attending the Jigsaw North Fingal schools intervention ‘It’s Time to Start Talking’ on young people’s attitudes to mental health, help seeking, and social distance. A within-participants, quasi-experimental design will be utilised to attain results which will advance the understanding of the impact this intervention may be having on young people. The particular age group was chosen for this investigation as they are at a developmental stage where levels of distress are likely to be low but may increase with age until they reach their early twenties. Finally, the study will investigate the effect of group size on the impact of the intervention on attitudes to mental health, help seeking and social distance.
It is hoped that this study will help inform knowledge in the area of educational interventions for mental health in schools in Ireland. The number of services and strategies offered to schools by various agencies and interest in providing mental health education in schools is currently increasing. The current literature on the effectiveness of such interventions and talks is quite limited. However young people are more likely to seek help if they have some knowledge of the issues of mental health. The results of this study may provide valuable data which may further inform mental health awareness schemes and may suggest effective ways to further engage young people in learning about mental health.

**Hypothesis**

Hypothesis 1: Participants will show a more positive attitude towards people experiencing mental health difficulties after their participation in the ‘It’s Time to Start Talking’ address by Jigsaw North Fingal, with positive attitude maintained in the two week follow up condition.

Hypothesis 2: Participants will show a reduction in the barriers to help-seeking perceived by the young people after their participation in the ‘It’s Time to Start Talking’ address, with this reduction in perceived barriers maintained in the two week follow up condition.

Hypothesis 3: Participants will report a decrease in social distance of people who are experiencing mental health difficulties after their attendance at the ‘It’s Time to Start Talking’ address from Jigsaw North Fingal, with this decrease in social distance maintained in the two week follow up condition.
Hypothesis 4: There will be a statistically significant difference between the ‘small group talk’ condition and the ‘large group talk’ condition with regard to positive attitude to mental health.

Hypothesis 5: There will be a statistically significant difference between the ‘small group talk’ condition and the ‘large group talk’ condition with regard to perceived barriers to help seeking.

Hypothesis 6: There will be a statistically significant difference between the ‘small group talk’ condition and the ‘large group talk’ condition with regard to social distance.
Methods

Sample

Jigsaw North Fingal works with young people between the ages of 12 and 25. As part of this work they administer the ‘It’s Time to Start Talking’ to secondary schools in the local area. The sample for this project was originally second year students from two schools in the North Fingal area, however due to unforeseen circumstances one of the schools not able to participate in the study and no replacement school could be arranged. The sample was therefore made up of second year students from one school.

The school is a large co-education school. Second years were selected as they are at an age where they are likely to begin to struggle with issues around mental health but are unlikely to have previously received much information on this topic. The school places importance on pastoral care and students are encouraged to talk to year heads, teachers and counsellors within the school if they have problems. The school also employs one full time and two part time guidance counsellors as well as a full time chaplain to whom students may self-refer or be referred by a parent or teacher.

Three class groups of mixed ability were randomly selected from a total of seven class groups. This created an initial sample of 81. From this, two classes and half of one class were placed in group A and would receive the intervention in a large group and 13 students were placed in group B and would receive the intervention in a small group. The intervention (‘It’s Time to Start Talking’ presentation) was delivered by Jigsaw North Fingal’s Clinical Support worker.
All participants were informed of the nature of the study a number of weeks in advance of their participation. Students were provided with a written explanation of the study for their parents also received a text message from the schools’ communications system to inform them that the information and opt-out permission slip had been provided to the students (see appendix 1). Participants were also provided with a verbal explanation of the study from the researcher and an opportunity to ask questions. At each point of surveying participants were asked for their agreement to participate and reminded that they could opt out of the study at any time. One response was received from a parent who requested that their child did not participate. The surveys were administered by members of the teaching staff of the school. The staffs were provided with a clear explanation of the process and instructions as well as an opportunity to ask questions.

From the initial sample of 81 students 74 completed the survey before attending the intervention. Two participants were excluded on the bases of having the same identity code and gender, and one participant was excluded as they had not devised the code correctly. From the 4 participants remaining who did not complete the survey three did not complete as they were absent from school for a number of days and therefore were not available to complete the form whilst one student chose not to participate.

A total number of six participants were absent on the day of the intervention. Of this number five were excluded as their codes could not be tracked. One participant disenrolled from the school between the first survey and the intervention. This led to a total of 62 participants remaining in the study.

The third survey occurred two weeks post intervention. At this time 3 participants were excluded from the sample due to absence. This resulted in a final sample size of 59 participants. Of the final sample 26 males and 32 females were included. One participant did
not indicate their gender. Gender in group B included 5 males and 6 females. Group B was selected alphabetically from one class group.

Design

The study utilized a pre and post-test quasi-experimental design which sought quantitative data in the form of self-reported questionnaires. Independent variables include Jigsaw’s ‘It’s Time to Start Talking’, and size of group, while dependant variables included perceived barriers to help seeking, social distance, and attitudes to mental health. Two experimental groups were involved in the study; a large group control to which 65 participants were originally assigned and a ‘small group’ control to which 16 participants were originally assigned.

Materials

Participants were provided with a self-report questionnaire which contained a number of measures. Measures assessed participant’s attitudes towards peers with mental health issues, social distance, perceived barriers to help seeking, and perceived presence of ‘one good adult’ in the life of the participant. Participants were also asked to indicate their gender and whom they might approach for help if they had a problem. Participants were provided with 10 people who young people are likely to consult as well as an option to indicate others.

Measures

A vignette depicting a young person suffering from depression was used. This vignette was sourced from ‘National Survey of Mental Health Literacy and Stigma’ (Reavley
& Jorm, 2011). Participants were then asked a number of questions on their attitude to the person in the vignette. The measure contained seven items which required participants to indicate their attitude on a five point Likert scale. Higher score totals indicated more positive attitude towards the character. A Cronbach Alpha was performed on the attitudes section of the questionnaire. Where \( N=57 \) the Cronbach Alpha was .37.

The Vignette was also the bases for a measure of social distance. Questions asked participants to indicate their willingness to share social interactions with the character. This measure contained four items on a four point Likert scale, sourced from ‘National Survey of Mental Health Literacy and Stigma’ (Reavley & Jorm, 2011). Lower scores indicated more willingness to share social interactions with the character. A Cronbach’s Alpha was found to be .77 (\( N=56 \)).

The Barriers to Adolescent Seeking Help (BASH) scale (Kule et al., 1997) was used to rate young people’s opinions on help-seeking (see Appendix 3). This instrument consists of a 37 item scale. Responses are from 1-6 on Likert scale with higher total scores indicating more resistance to help seeking. All items but 7 were reverse coded with higher scores indicating higher external barriers. Kuhl et al. (1997) reported good reliability of this instrument; Split-half reliability was calculated to be 0.82 and Cronbach’s alpha was 0.91, while two week test retest was also reported to be 09.1. Cronbach’s alpha on this data set (\( N=50 \)) was reported to be .85.

Finally, social support in the lives of participants was measured. This could be related to whether or not they have the support of ‘One Good Adult.’ This measure contains 12 items on a 7 point Likert scale with higher scores indicating higher support. A Cronbach’s Alpha indicated score of .93 (\( N=57 \)).
Procedure

A pilot questionnaire was administered to 15 students from the same school that were in the year group below those participating in the study. These students were asked to mark on the page any item they did not understand or ask the researcher who explained the question. These students were able to devise the codes with no difficulty as well as complete the rest of the questionnaire. A small number of typographical errors were noted and corrected before data was collected.

Contact was first made with the participants approximately two week prior to the first data collection point as described above. At the time of data collection teachers were reminded that students may opt out of the study at any time and were asked to remind students of this. The questionnaire was accompanied by an explanation of the study. A separate information sheet, contain information and contact details for support were distributed to students (see appendix 2). Students completed the questionnaires during class time. Any student who normally has the support of a special needs assistant at that time, received reading support to complete the questionnaire. 16 students were assigned to a small group during this time. This was done by surname. The reason for this was explained to students.

Each participant was asked to place an identity code on their survey. This was made up of the first letter of their first name, the first three letters of the month they were born, and the date of their birthday e.g. TJuly13. Students received instructions on how to devise the
code from their teachers as well as a written explanation on the questionnaire. Student completed the questionnaires by ticking the boxes provided. The questionnaires were returned to the researcher by the teachers at the end of class.

The participants were asked to attend a talk from the clinical support worker at Jigsaw North Fingal. Participants were assigned to a large group and a small group by surname and class. The large group contained 65 participants and the small group contained 16. Participants listened attentively to the talk in the presence of a teacher as per Department of Education guidelines on outside speakers. Participants were encouraged to interact with the speaker by asking and answering questions, many of them chose to do this.

Participants were asked to complete the same questionnaire for the second time after the intervention had concluded. Once again any participant who normally receives the support of a special needs assistant at that time was supported with the reading of the questionnaire. The special needs assistant did not attend the presentation.

The final collection of data occurred under the same circumstances as the first. This occurred two weeks after the presentation.
Results

Preliminary Data Analysis

Exploration of data revealed that skewness and kurtosis for some measures were outside the normal range. There were also issues with significance and distribution in all measures. Given that no measure fully satisfied parametric assumptions, non-parametric tests were used throughout.

Analysis of attitudes to mental health

Question two of the self report questionnaire related to attitudes toward peers with mental health issues. Table 1 shows means and standard deviations for each question in this measure in the pre-intervention, intervention and post-intervention conditions.

Table 1

<table>
<thead>
<tr>
<th>Total attitudes to mental illness</th>
<th>Pre-Intervention</th>
<th>Intervention</th>
<th>Post-intervention</th>
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<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>John will snap out of his problem</td>
<td>3.28</td>
<td>1.18</td>
<td>3.60</td>
</tr>
</tbody>
</table>
A Friedman’s test was used to examine significant difference between the conditions in each item. All items were found to show significant difference, excluding item 4 ‘People with problems like John’s are dangerous’ which was found to approaching significance ($x^2(2)=5.688$, $p = 0.058$, 2-tailed). Item 1 ‘John could snap out of it’ showed a significant statistical difference between the conditions ($x^2(x)= 6.779$, $p =0.034$, 2-tailed). However a Wilcoxon test showed that while there was a statistically significant difference between the pre-intervention and the intervention ($Z=-2.265$, $p =0.024$, 2-tailed) there was no statistically significant difference between the intervention and the post-intervention for Item 1 ($Z=-1.244$, $p =0.214$, 2-tailed).

A Friedman’s test on Item 2, ‘John’s problem in a sign of personal weakness,’ showed a statistically significant difference ($x^2(x) = 18.584$, $p = 0.00$, 2-tailed). A Wilcoxon test found that there was a statistically significant difference between pre-intervention and intervention ($Z= -3.400$, $p =.001$, 2-tailed), however no significant difference was found between the Intervention and post intervention ($Z= -3.4$, $p = .762$, 2-tailed). Item 3 ‘John’s
problem is not a real medical illness’ showed significant difference overall ($\chi^2(2) = 7.416, p = 0.025, 2$-tailed). A Wilcoxon test found significance between the pre-intervention condition and the intervention condition, ($Z = -2.268, p = 0.023, 2$-tailed) however no significance was found between the intervention and the post-intervention conditions ($Z = -.404, p = .687, 2$-tailed).

As well as a Friedman’s test a Wilcoxon test was carried out on item 4 ‘People like John are dangerous.’ A change approaching significance was found between pre-intervention and intervention ($Z = -1.840, p = 0.06, 2$-tailed) as well as between intervention and post-intervention ($Z = -1.866, p = 0.062, 2$-tailed).

Item 5, ‘Avoid people with problems like John’s’ showed significant positive difference in attitudes towards the character over all in a Freidman’s test ($\chi^2(2) = 19.315, p = 0.00, 2$-tailed). A Wilcoxon test found significance between the pre-intervention condition and the intervention condition, ($Z = -3.024, p =.002, 2$-tailed) however no significance was found between the intervention and the post-intervention conditions ($Z = -1.279, p = .201, 2$-tailed).

Item 6 and 7, ‘People with problems like John’s are unpredictable’ and ‘If I had a problem like John’s I wouldn’t tell anyone’ both showed a significant positive increase in attitudes overall as a Friedman’s test indicated ($\chi^2(2) = 7.197, p =.027, 2$-tailed) and ($\chi^2(2) = 6.042, p =.049, 2$-tailed) respectively. A Wilcoxon test on item 6 showed a significant increase between the pre-intervention and intervention, ($Z =-2.182, p =.029, 2$-tailed) while no significance was found when a Wilcoxon test was run between the intervention and post-intervention ($Z = -.780, p =.435, 2$-tailed). A Wilcoxon test conducted for item 7 showed no significant difference was found between the interventions ($Z = -1.843, p = .65, 2$-tailed) ($Z = -.297, p = .767, 2$-tailed).
Analysis of sources of help

Participants were asked to identity adults to whom they would talk about their problems. Analysis showed that the mean amount of possible sources of help was 2.51 at pre-intervention, 3.29 at intervention, and 3.15 at post-intervention (N=59). Using the Greenhouse-Geisser correction, a repeat measures ANOVA found that there was a significant difference between the three conditions in terms of the number of sources from which the participants may seek help. \(F (2, 108) = 8.511, \ p = .001\). There was an overall effect size of 0.128, showing that 13% of the variation can be accounted for by the intervention.

Pairwise comparisons confirmed that that differences were significant in nature between the pre-intervention and the intervention (mean difference = .664, \(p = .006\), CI (95%) .150 – 1.138) however there was no significant difference between the intervention and post-intervention conditions (mean difference = -.136, \(p = 1.00\), CI (95%) -.571 – .300) as shown in Figure 1 Mean sources of help. It can be concluded that the ‘It’s Time to Start Talking’ intervention from Jigsaw resulted in a significant increase in the number of adults the participants could identify as possible sources of help. This increase was sustained at the post-intervention condition. 4 participants chose ‘I would not tell anyone if they had a problem’ at pre-intervention and intervention this represents 7% of the total sample and 3 participants selected this response at post-intervention. The breakdown of responses for sources of help are show in Figure 2-4
Mean sources of help measure

*Figure 1*

Sources of help, pre-intervention
Figure 2

Sources of help, intervention.

Figure 3

Sources of help, post-intervention
Analysis of Social distance

Question 4 measured participants’ responses to social interaction with a peer who presented with symptom of depression as described in a vignette. Using the Greenhouse-Geisser correction, a repeat measures ANOVA found that there was no significant difference between the three conditions in terms of social distance scores (N=56) and likelihood of social interaction with a peer displaying signs of depression were found to be ($F (2, 103) = .04, \ p = .947$). There was an overall effect size of 0.001, showing that 1% of the variation of scores could be accounted for by differing levels of likelyhood for social interaction.

A significant difference was shown between males and female on the social distance measure at pre-intervention. Males had a mean rank of 33.75 in the pre-intervention condition while females had a mean rank of 23.55 in pre-intervention with higher scores showing more resistance to social interaction. A Mann Whitney U revealed that males and females showed significant difference at the pre-intervention ($Z = -2.362 \ p = 0.018$, 2-tailed). However the
measure for social distance found that the difference between males and females was approaching significance at intervention ($Z = -1.732$, $p = .083$, 2-tailed) and showed no significant difference at post-intervention ($Z = -1.147$, $p = .251$). Mean rank scores for males were found to be 33.7 at intervention and 32.29 at post-intervention. Mean rank scores for females were found to be 26 at intervention and 27.23 at post-intervention.

A significant difference was show between the ‘small group’ condition and the ‘large group’ condition at pre-intervention and post-intervention. No significant difference was found between the ‘small group’ control and ‘large group’ control at the intervention. Mean rank for the ‘large group’ control was 26.06 at the pre-intervention, 29.36 at the intervention and 27.35 at post-intervention. Mean ranks for the ‘small group’ control 38.05 at the pre-intervention, 32.77 at the intervention and 41.55 at the post-intervention with higher scores showing less likelihood of social interaction. A Mann Whitney U showed significant difference between the ‘small group’ control and the ‘large group’ control at pre-intervention ($Z = -2.288$, $p = .022$, 2-tailed) and at the post-intervention ($Z = -2.503$, $p = 0.12$, 2 – tailed). A Mann Whitney U showed no significant difference at the intervention ($Z = -.601$, $p = .548$, 2-tailed).

While some change is social distance was shown this change was not significant. The difference in social interaction between genders reduced at intervention and this effect remained evident at post-intervention.

**Analysis of external Barriers to help seeking**

A Friedman’s test was conducted on the total score for the BASH measure and found no significant difference ($x^2(2) = 3.108$, $p = .211$) ($N=40$).
Table 2

Total External Barriers to Help Seeking (N=40)

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Pre-Intervention</th>
<th>Intervention</th>
<th>Post-intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Barriers</td>
<td>106.93</td>
<td>18.17</td>
<td>106.43</td>
</tr>
</tbody>
</table>

A repeated measures ANOVA, using the Greenhouse-Geisser correction, showed that there was no significant difference between the three time points, pre-intervention, intervention and post-intervention. \( F (2, 77) = 1.28, \ p = .285 \) with an effect size of 0.032. Therefore, it can be concluded that the Jigsaw intervention had no effect on altering perceived external barriers to help-seeking. However a Mann Whitney U showed significant difference between the ‘small group’ control and the ‘large group’ control. The ‘large group’ control has a mean rank of 27.6 at pre-intervention testing, 27.7 at intervention and 29.8 at post-intervention. The ‘small group’ control had a mean rank of 17.0 at pre-intervention, 15.2 at the intervention, and 15.7 at post-intervention. Significant difference was found across all three time points pre-intervention \( (Z = -2.050, \ P = .04, \ 2\text{-tailed}) \), intervention \( (Z = -2.337, \ p = .019, \ 2\text{-tailed}) \) and post-intervention \( (Z = -2.462, \ p = .014, \ 2\text{-tailed}) \).

It is possible to conclude that the ‘It’s Time to Start Talking’ intervention has no effect on perceived external barriers to help-seeking.

*Analysis of perceived support.*
The mean rank scores for support were shown to be 65.66 at pre-intervention, 68.6 at intervention, and 63.17 at post-intervention (53). A repeated measures ANOVA, using the Greenhouse-Geisser correction, showed that the reported level of support in the lives of the participants differed significantly between the three time points \(F(2, 100) = 5.614, p = .005\) with an effect size of 0.097. As a result, 10% of variation could be explained by the intervention. More specifically, pairwise comparisons highlighted that reported support increased at intervention (mean difference = -2.943, \(p = .312\), CI (95%) -7.345 – 1.458) However this decreased at post intervention (mean difference = 5.434 , \(p = .003\), CI (95%) -9.242 – -1.626). Therefore it can be argued that awareness of support peaked at the time of intervention and was maintained post-intervention.

**Discussion**

A considerable number of programmes are now available to school to assist them in meeting their responsibilities in supporting wellbeing in second level schools. However there is little empirical data on how this intervention assists students. This research project sought to examine the effect of the Jigsaw ‘its time to start talking’ intervention on attitudes of young people towards mental health to help seeking and social distance.

It was hypothesised that attending the intervention would have a significant impact on these variables and that the participants who attended the intervention in the small group control would show a greater change in attitudes than participants in the large group control.
Results presented above show strong support for the hypothesis that attending the ‘its Time to Start Talking’ presentation had a positive effect on participants attitudes towards mental health. Each question showed a change which could be considered significant or approaching significance between the pre-intervention measure and the intervention. While no significant difference was recorded between the intervention and post-intervention measures, suggesting that that the change in attitude was maintained for at least two weeks after the intervention.

Given the importance of peers in the life of young people it is of the upmost importance to the long and short term outcomes of young people with mental health issues that action is taken in school to reduce stigma and encourage positive attitudes towards mental health. The study suggests that the intervention was successful at significantly improving the attitudes of the participants towards mental health issue. Improving attitudes towards mental health in young people may have a secondary effect of improving attitudes to help seeking this can be a common barrier for both young people and adults (Pinto-Foltz & Logsdon, 2009). Improved attitudes among young people within a school and community may also result in improved academic outcomes and behaviour.

Pinto-Foltz and Logsdon (2009), called for evidence based intervention that address stigma in young people which is situated in the community. These findings suggest that the Jigsaw’s school intervention making head way in realising this. In addition changes to attitudes to mental health were maintained at the post-intervention time points, thus indicating that these changes may be somewhat permanent in nature. It would be beneficial to examine
this measure at six months or one year post intervention assess if attitudes remain improved. If there is a significant decrease in this measure at that stage it would suggest that the intervention is successful at increasing positive attitudes towards mental health and that adolescents may benefit from regular engagement with mental health promotion activities to ensure this change is maintained over the course of their development.

Hypothesis 2 – Barriers to help seeking

Results presented above indicate that there was no significant difference in scores on the Barrier to help-seeking scale (Kuhl et al., 1997) at any of the three time points. There was a significant difference in between the ‘small group’ control and ‘large group’ control at all three time points, however as this difference was present at the pre-intervention time it cannot be considered a consequence of the intervention.

However appropriate help seeking is a protective factor in mental health across age groups and schools provide an excellent opportunity to reach large numbers of young people with health promoting messages (Wilson et al, 2008). Therefore while opportunities to discuss mental health with young people should target help-seeking intentions, Deane et al. (2005) found that intentions often have a low variance with actual help seeking behaviours. It is suggested that young people do not seek professional help as a result of anxiety around confidentiality and as they consider that family and friends are adequately equipped to deal with their problems (Amato & Bradshaw 1985). The ‘It’s Time to Start Talking’ presentation encourages the young person to speak to many members of their community if they have a problem. The instrument which was used in this study is a measure of external barriers to help-seeking. As this study found that the intervention had no effect on external barriers to
help seeking it is suggested that further research be considered on the effect of the intervention on internal barriers and attitudes to help seeking. This is especially relevant given the finding that the presentation significantly increased the number of possible sources from which help may be sought, which the participants reported. Additionally help seeking intentions are a strong protective factor in the mental health of young people as well as a complex issue therefore further explanation is highly recommended.

Hypothesis 3- Social distance

Results for social distance showed that there was no significant difference in likelihood of social interaction over the three time points therefore this hypothesis is rejected. However a significant difference was found in the scores of males versus females with male indicating less intention to socially interact with the young person in the vignette. On the other hand scores for females indicated they were much more open to social interaction with this young person. Over the course of the three time periods the scores for males and females became less polarised but did not equalise and females continued to show lower levels of social distance than males. The intervention seemed to show more influence on males than females. As interaction with peers can have a major influence on young people suffering with mental illness it is suggested that further research in this area may be helpful.

Hypothesis 4 – Small and large group controls attitudes

Also no significant difference was reported between the ‘small group’ control and ‘large group’ control. Both groups showed a significant improvement in positive attitudes towards mental health. Therefore findings suggest that the ‘Its Time to Start Talking’ intervention
could be successfully delivered to large numbers of students at any one time. This would imply that it is a convenient and cost effective intervention which can have a strong impact in a short amount of time. The ability to address large numbers of student at one time and maintain significant result will have great benefits for both time and resources of the Jigsaw North Fingal outreach workers. It is likely that this finding would be replicated in other Jigsaw cites nationally and further research in a variety of populations may be beneficial.

**Hypothesis 5 – Small and large group controls barriers to help seeking**

A significant difference was found between the ‘large group’ control and the ‘small group’ control across all time points on the BASH (Kuhl et al. 1997) barriers to help seeking measure. The ‘large group’ control showed significantly higher mean rank scores for each time point. Mean ranks scores for the small group decreased over the three time points a possible indicator that the intervention had some effect on the ‘small group’ control. However, given that the ‘small group’ condition had such a small number of participants it is suggested that further research in this area is necessary.

**Hypothesis 6 – small and large group controls social distance**

Results showed that there was a significant difference between the ‘small group’ condition and the ‘large group’ condition for social distance at the pre-intervention point. This difference was reduced at the intervention point but reappeared at the post-intervention testing point. Means rank scores indicate for the ‘large group’ condition remained somewhat stable over the three testing points indicating very little change in likelihood for social interaction as reported by the participants. However the mean rank scores of the ‘small group’ condition showed a large reduction in scores indicating greater likelihood of social
interaction at the intervention point. However mean ranks score for the ‘small group’ condition rose to a higher level than had been seen in the pre-intervention condition at post intervention. This indicated that if any change in social interaction was as a result of the intervention the intervention was more effective in the ‘small group’ control but the change was not maintained. This area would benefit from further research and examination.

Other findings

Wilson (et al 2008) found that young people prefer to speak to a friend or no one rather than an adult or health care professional if they are in psychological distress. Additionally they found that if a young person was to seek help from a professional they were most likely to speak to a GP. This study found a very different picture among the Irish population examined. More participants indicated that they would speak to a parent (45) than any other option across all time points. This was closely followed by a friend. Very few participants reported that they would not speak to anyone at all with only four participants choosing this option at any given time point.

Similarly responses indicating that participants would speak to a GP if they had a problem were low in this study and responses indicating this answer ranged between 7 at pre-intervention and post-intervention, and 9 responses at intervention. The number of participants who indicated they would speak to a counsellor if they had a problem rose considerably between the pre-intervention (9) and the intervention (18) and remained high at post-intervention (20), while the number of participants who indicated that they would speak to a guidance counsellor if they had a problem remained high across all time point (pre-intervention 17, intervention 17, post-intervention 19).
Interestingly the numbers of sources of help the participants identified as people they would be willing to talk to increased dramatically between pre-intervention and intervention. These results indicate that the ‘It’s Time to Start Talking’ intervention increases awareness and willingness of the young people who attending to speak to adults in their lives. This increase was evident both with both informal and formal sources of help. The increase was increase was still evident at the post- intervention testing point suggesting that this change is likely to be maintained. While there was no significant change between the intervention and post- intervention there was a slight drop. Therefore it is suggested that the same measure could be examined six months or one year post intervention to asses if this change is maintained. If there is a significant decrease in this measure at that stage it would suggest that while the intervention is successful at increasing awareness of informal and formal sources of help, adolescents may benefit from regular engagement with mental health promotion activities to ensure this change is maintained over the course of their development.

The final measure in the self-administered questionnaire was designed to indicate levels of social support in the participant’s lives. While mean rank scores were high, results showed a significant increase in score for this measure at the intervention time point when compared with the pre-intervention time point. This difference was also maintained at the post-intervention time point. While it is unlikely that the levels of support in the lives of the participants changed during the time of the study it is likely that by participating in the ‘It’s Time to Start Talking’ intervention the participants became more aware of the support in their live and therefore indicated higher levels of support at the later interventions. Help seeking behaviour of young people are fundamental to their mental health and wellbeing and young people may need encouragement to seek help from appropriate sources. In addition having a person in the life of a young person who they are willing to talk to and feel supported by is
likely to have a positive influence on their likelihood to engage in formal and informal help as well being a protective factor in mental health.

These results suggest that while the intervention did not have a direct effect on external barrier to help-seeking it did effect other aspects of help seeking is likely to have greatly influences the likelihood to seek help both of both a formal and informal nature. Further research in the areas outlined above are likely to prove beneficial in adding to understanding of the impact of the ‘It’s Time to Start Talking’ intervention on young people.

Limitations and further Research

While this study resulted in broad support for the hypothesis there are number of limitation which require further investigation. Firstly all participants in this study were form the same school population with similar socio economic backgrounds. Further research would be beneficial to establish if the result from this study are replicated in other populations and age groups.

As a result of the small sample size, particularly in the ‘small group’ control it would be beneficial to conduct research with larger sample size and more than one ‘small group’ control. This is especially important in context of the time and resource pressure which would inevitably be a feature of small group deliver. It would also be beneficial to conduct a one year follow up measure on all measures in which the hypothesis was accepted to ensure that such impacts were relatively permanent change.

Application
Given the change in attitudes to mental health and help-seeking found to be as a result of the Jigsaw intervention it as well as the theoretical support for community based projects such as Jigsaw it is likely that all communities would benefit from such services being introduced in their areas. Furthermore the study shows that there are many benefits for students who attend the ‘It’s Time to Start Talking’ presentation and therefore school should feel confident including such a presentation in any mental health promotions activities they are engaging in.

Findings suggest that this talk can be delivered in large groups with little effect on outcomes. This could mean that the Jigsaw outreach workers can reach more students with their resources. However, further research in this area would be prudent given the small sample size in the ‘small group’ control.

Conclusion

There is currently a focus on mental health in young people and the need for young people to be supported and educated by both their school and communities. Given the challenges that this present it is important that time, funding and resources are directed towards educational activities which are supported by empirical evidence that the intervention creates a positive change in the way young people think about mental health. The results of this study strongly suggest that Jigsaw’s ‘It’s Time to Talk’ presentation for schools not only impact positively on the young people’s attitudes to mental, and help-seeking, but that this positive impact is sustained. Therefore it is important that Jigsaw continues to provide this service for schools and are supported in doing so. Schools may also feel confident this presentation can create
positive and lasting change in students when choosing to include it in their mental health programme.
Reference


Headstrong (The National Centre for Youth Mental Health) &UCD school of Psychology Dublin (2012), My World National study of Youth Mental Health in Ireland. Dublin

Headstrong (The National Centre for Youth Mental Health) The Evidence Base for: School-based Mental Health Intervention.


Appendix 1.

Study of attitudes towards mental health in young people

INFORMATION SHEET FOR PARENTS

Research Topic: Attitudes of young people towards mental health and help seeking.

Researcher: Aoife Walsh student researcher
Dr John Hyland Supervisor,

Background and Purpose: In my research I am interested in finding out about young people’s attitudes towards mental health and help-seeking. As part of this study students will be asked about their opinions on mental health and if they would seek help if they were experiencing personal problems or upset. This will be done by questionnaire. Students will then attend a talk from Jigsaw North Fingal encouraging students to speak to someone if they are experiencing problems. Students will then complete the questionnaire for the second time. I am doing this research as part of my studies at DBS, and I am working with Dr John Hyland, whose contact details are included above.

What happens if my child takes part? I will be visiting your child’s school during class time, at a time arranged with the principal. I will ask all participating children in the class to fill in a questionnaire. It is a standard questionnaire designed for young people. If you decide your child will not take part your child will be present in the classroom but will not fill in the questionnaire. They will be asked to read quietly while the others take part.

If you do not wish for your child to participate in the study but would like them to attend the talk from headstrong this can be facilitated.

What will happen to the results of the study? The study’s results will be published in academic journals and presented at academic conferences. However at no point will any children be identifiable.

How will my child’s information be protected? The children’s answers will remain confidential. When doing questionnaires each child will be given an ID. This will be used for any information relating to the study. The information which links names and numbers will be stored separately in a
secure location in DBS until the research is completed. Once the study has been completed your child’s name will be removed and all the data will be destroyed after 10 years.

**Voluntary Participation:** It is up to you and your child to decide whether your child is going to take part or not. Participation is completely voluntary. Your child is free to withdraw at any time. I will remind the children of this when I meet them.

**Important: The consent form!** There is a consent form attached to this information sheet. If you do not wish for your child to participate please return the signed opt out form to Sr Ger Mullen, Portmarnock Community school.

**Further Information:** This research is being conducted to assist researchers with finding out about how young people feel about mental health whether they are likely to seek help for their problems and we very much hope that you will agree to let your child take part in the research. If you require any assistance or have any questions about the research study, please feel free to contact me. The research will be conducted throughout the month of January.

**PARENT’S Opt out CONSENT FORM**

Attitudes of young people towards mental health and help seeking.

**Researcher:** Aoife Walsh, Student researcher,

John Hyland, Supervisor,

I do not agree to my son/daughter ____________________ class________ taking part in this research.

Thank you.

Parents Name: _______________________________________________________________
Appendix 2.

Information sheet for students

We are currently doing some research to try and find out about how young people feel about mental health, their problems and looking for help. We would greatly appreciate it if you would answer some questions about this.

The questionnaire will take you about 10mins to complete. There are no right or wrong answers and we would like to know about your opinion. If you are not sure of an answer mark the one which you think best describes you and move on.

The questionnaires are anonymous and no one will know what you wrote.

You do not have to take part if you do not want to. If you do not want to take part simply don’t fill out the rest of the pages.

We hope you do participate and would like to thank you for your help.
List of Contacts

If you ever want to talk to someone the following are some people who will listen

- Your school guidance counsellor
- You school chaplain
- Childline
  1800 66 66 66
- Jigsaw North Fingal
  01) 960 3020
- Aware (Depression )
  1890 303 302
- Body wise  (eating disorders)
  1890 200 444
- Belong2 (Gay, Lesbian, Bisexual and Transgender support)
  01) 8721055
Appendix 3.

Questionnaire

The first letter of your first name (T is your name is Tom) □

The first three Letters of the month you were born (Jul if you were born in July) □ □ □

The date of you birthday (Eg 13 if you were born on the 13th of July) □

Q1 Male □      Female □

Please read the short story below and answer the following questions. There are no right or wrong answers.

John is a 15 year old who has been feeling unusually sad and miserable for the last few weeks. He is tired all the time and has trouble sleeping at night. John has lost his appetite and has lost weight. He can’t keep his mind on his studies and his marks have dropped. He puts off making any decisions and even day to day tasks seem too much for him. His parents and friends are very concerned about him.

Q2 To what extent do you agree with the following statements?

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree or disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>John could snap out of the problem.</td>
<td></td>
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<tr>
<td>John’s problem is a sign of personal weakness.</td>
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<tr>
<td>John’s problem is not a real medical illness.</td>
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<tr>
<td>People with problems like John’s are dangerous.</td>
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<tr>
<td>Avoid people with problems like John’s problem.</td>
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<tr>
<td>People with problems like John’s are unpredictable.</td>
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<tr>
<td>If I had this problem I wouldn’t tell anyone.</td>
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</tbody>
</table>
Q3. If I had a similar problem to John’s I would be most likely to seek help from:

(please tick the box, you may select more than one if you wish to)

A parent  A relative  A Friend  A Counsellor
A GP/Doctor  A telephone helpline  A Psychologist  Guidance Counsellor
Teacher  I wouldn’t look for help
Other

Q4. To what extent would you be willing to:

(tick the box that best represents you opinion)

<table>
<thead>
<tr>
<th>Activity</th>
<th>1. Definitely willing to</th>
<th>2. Probably willing to</th>
<th>3. Probably unwilling to</th>
<th>4. Definitely unwilling to</th>
</tr>
</thead>
<tbody>
<tr>
<td>To work on a school project with a person like John.</td>
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<tr>
<td>Go out with a person like John.</td>
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<tr>
<td>To invite John around to your house.</td>
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<tr>
<td>To develop a close friendship with John.</td>
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</table>
**Q5.** Below is a list of statements about how you might get help for personal/emotional problems, and who might you get help from. Please indicate how much you agree or disagree with each statement by ticking the box which best describes your opinion:

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Sort of Agree</th>
<th>Sort of Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My friends would think I was crazy if a saw a counsellor.</td>
<td></td>
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<tr>
<td>2. If I had a problem, my friends could help me more than a counsellor.</td>
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<td>3. If I had a problem I would solve it myself.</td>
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<td>4. If I had a problem, my family would help me more than a counsellor.</td>
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<td>5. Even if I wanted to, I wouldn’t have time to see a counsellor.</td>
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<td>6. If I had a problem and told a counsellor, they would not keep it secret.</td>
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<td>7. People who see counsellors are crazy.</td>
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<td>8. If I saw a counsellor my family would think I was weak.</td>
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<td>9. The idea of going to a counsellor is pretty scary.</td>
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<tr>
<td></td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Sort of Agree</td>
<td>Sort of Disagree</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
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<tr>
<td>10.</td>
<td>A counsellor might make me do or say something that I don’t want to.</td>
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<td>11.</td>
<td>I think counselling can be bad.</td>
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<td>12.</td>
<td>I think that counsellors want to help people.</td>
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<tr>
<td>13.</td>
<td>Going to a counsellor means you don’t have the strength to handle the problem yourself.</td>
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<tr>
<td>14.</td>
<td>From what I know most people get help from getting counselling.</td>
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<td>15.</td>
<td>My parents have said they really don’t believe in counselling.</td>
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<td>16.</td>
<td>I would never want my friends to know I was seeing a counsellor.</td>
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<tr>
<td>17.</td>
<td>I’d never want my family to know I was seeing a counsellor.</td>
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<td>18.</td>
<td>Adults really can’t understand the problems that kids have.</td>
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<tr>
<td>19.</td>
<td>Counsellors are more helpful to adults than to teenagers.</td>
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</tr>
<tr>
<td></td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Sort of Agree</td>
<td>Sort of Disagree</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
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<tr>
<td>20.</td>
<td>I know where I can find a counsellor if I need one.</td>
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<tr>
<td>21.</td>
<td>Counselling can often help teenagers with problems.</td>
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<tr>
<td>22.</td>
<td>Counsellor really can’t understand teenager’s problems today.</td>
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<tr>
<td>23.</td>
<td>Even if I had a problem, I’d be too embarrassed to talk to a counsellor.</td>
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<td>24.</td>
<td>If I went to a counsellor it would make me feel like I was crazy.</td>
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<tr>
<td>25.</td>
<td>If I ever talked to a counsellor about personal things, I’m sure my family would hear about it.</td>
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<tr>
<td>26.</td>
<td>I could not afford to see a counsellor even if I wanted to.</td>
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<td>27.</td>
<td>If I ever went to a counsellor my parents would be pretty upset.</td>
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<td>28.</td>
<td>If I had a problem, my parents would think that speaking to a counsellor was a good idea.</td>
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<td></td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Sort of Agree</td>
<td>Sort of Disagree</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
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<td>29. No matter what I do it will not change the problems I have.</td>
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<td>30. My problems will go away by themselves.</td>
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<td>31. I know people who have been helped by getting counselling.</td>
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<td>32. I have problems in the past that have really upset me.</td>
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<tr>
<td>33. If I went to see a counsellor I might find out I was crazy.</td>
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<td>34. My family thinks that anyone who goes to see a counsellor is crazy.</td>
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<td>35. I cannot imagine having a problem so serious that I would go for help.</td>
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<td>36. I think I should work out my own problems.</td>
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<td>37. People don’t need counsellors to help them with their problems.</td>
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</tbody>
</table>
The following are some statements people have made about the types of support they have in their lives. For each statement please indicate whether you Very strongly disagree, strongly disagree, disagree, are not sure, agree, strongly agree or very strongly agree by circling the response that best describes your feeling.

<table>
<thead>
<tr>
<th></th>
<th>Very strongly disagree</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Not sure</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Very strongly disagree</th>
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</thead>
<tbody>
<tr>
<td>Q1. There is a special person who is around when I need them.</td>
<td>1 2 3 4 5 6 7</td>
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<td>Q2. There is a special person with whom I can share my joys and sorrows.</td>
<td>1 2 3 4 5 6 7</td>
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<td>Q3. My family really tries to help me.</td>
<td>1 2 3 4 5 6 7</td>
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<tr>
<td>Q4. I get the emotional help and support I need from my family</td>
<td>1 2 3 4 5 6 7</td>
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<tr>
<td>Q5. I have a special person who is a real source of comfort to me.</td>
<td>1 2 3 4 5 6 7</td>
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<tr>
<td>Q6. My friends really try and help me.</td>
<td>1 2 3 4 5 6 7</td>
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<td>Q7. I can count on my friends when things go wrong.</td>
<td>1 2 3 4 5 6 7</td>
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<td>Q8. I can talk about my problems with my family.</td>
<td>1 2 3 4 5 6 7</td>
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<tr>
<td>Q9. I have friends with whom I can share joys and sorrows.</td>
<td>1 2 3 4 5 6 7</td>
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<tr>
<td>Q10. There is a special person in my life who cares about my feelings.</td>
<td>1 2 3 4 5 6 7</td>
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<td>Q11. My family is willing to help me make decisions.</td>
<td>1 2 3 4 5 6 7</td>
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<tr>
<td>Q12. I can talk about my problems with my friends.</td>
<td>1 2 3 4 5 6 7</td>
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