Should I confide? ***Investigating Relationships between Self-esteem, Self-efficacy, General Mental Health and Help-seeking behaviours.***

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Abstract

The aim of the present study was to examine correlational relationships between self-esteem, self-efficacy, general mental health and help-seeking behaviours within an Irish context. Gender and age were also considered within the sample. The study was a quantitative correlational between subjects design using self-report measures to assess 91 participants (f = 53, m = 38, 18-40yrs = 58, 40yrs plus = 33). Multiple regression analysis showed a significant positive correlation between self-esteem and general mental health. An independent samples t-test found that participants of 40 years plus reported lower levels of self-esteem. The positive correlation found between self-esteem and general mental health did not support previous research but may be of interest for future research examining variables which affect general mental health within an Irish context. The difference in self-esteem levels may be an important finding in relation to investigating factors which affect self-esteem in older adulthood.

1. Introduction

1.1 Present study

In the modern world of today, it seems life for most people consists of higher standards than ever. The expectations for education, high flying career, having a family and monetary gains are inevitably creating a fast paced and stressful life. There appears to be an increasing materialistic mind set and competitiveness among various life domains.

In this regard individuals may feel it a struggle to progress in their lives and may constantly compare themselves to those around them who appear content. This can lead to psychological distress which can lead to deterioration in mental health if not addressed. Cromby, Harper and Reavey (2013, p. 9) describe this 'distress' relating to mental health as '*strong or overwhelming emotional states, of various kinds, that disrupt everyday life and prevent people from functioning'.*

If an individual cannot cope with the demands of life they may end up suffering psychologically. There are various ways to address this ranging from talking to a friend, partner, family, general practitioner, counsellor, therapist, helpline and many more. In recent years there have also been various mental health campaigns encouraging people open up about psychological issues. 'Mental health week' has been an incentive for the last few years to encourage people to openly speak about mental health. It ran from Sunday 5th October – Sunday 12th October in 2014 and devoted that week to free events such as book launches, information sessions and coffee mornings hosted by various organisations in the Irish mental health sector such as 'Grow'. All these events focused on the topic of mental health. This included 'world mental health day' on Friday 10th October in 2014 and free pins were given out to organisations to encourage the topic to be brought to the forefront (2014, Grow).

Help-seeking is a coping mechanism when people need help with the demands of their life (Chan, 2013, p. 572). However, not everyone will seek help. Appearances can be deceiving in regards to mental health. There are many people struggling to keep up with the demands of life who may find that a chat with someone close may help them move past issues. However, it is not always that simple. There are many people who would rather keep psychological distress a secret than confide unfortunately due to stigma related to mental health. How individuals cope with psychological stress may be also related to one's view of the self and external views within society, perceived societal reactions and perceived ability to cope with these.

Personal attributes and how these affect an individual and action taken based on beliefs is something which is very influential at a young age. The probability of mental ill health could be related to internal and external perceptions of the self and the perceived ability to cope and this may relate to how likely individuals are to seek help for mental health issues. The present study aims to investigate the personal attributes of self-esteem and self-efficacy as predictors of mental health and help-seeking behaviours. The research will also consider age and gender. The following literature focuses on the four main variables involved in the study, previous research findings in regard to these and the aims of the present study.

1.2 Findings regarding mental health and help-seeking

St Patrick's mental health services a leading mental health service in Ireland published results in 2013 from a survey they carried out which involved 500 members of the public nationwide. The results confirmed that stigma is still a significant factor in mental health and is largely due to lack of understanding of mental health problems. This lack of understanding is also preventing people from seeking help for problems. The findings from the survey included: 22% of people believe that those suffering from mental ill health are of

below average intelligence; 30% would avoid having someone with a mental health problem as a close friend; 60% would discriminate against hiring someone with a history of mental illness; 41% felt that undergoing treatment for a mental health problem is a sign of personal failure. The findings also included: 37% of people responded that a close family member has been treated, 52% revealed that close friends have been treated and 49% relayed that they know some work colleagues who have been treated for emotional or mental health problems.

Mr Paul Gilligan, CEO at St Patricks explains how we know that every family in Ireland is affected by mental illness so the above results are disturbing in this context (2014, St Patricks). An Irish survey published in 2007 which focussed on 'lifestyle, attitudes and nutrition in Ireland' reported that 52% of people agreed that if they were having mental health problems they would not want anyone knowing about it. The survey also reported that men and those of a higher status appeared more likely to agree with this statement as mental health may affect socio-economic status. The researchers suggested these attitudes may impact negatively on self-reported levels of mental health problems and help-seeking behaviours (Slan, 2007).

Vital signs Ireland (a report on the vitality of the nation) in 2013 claimed that mental health in Ireland appears to be 'hugely neglected'. The suicide rate in 2010 was above the European average of 10.2 coming in at 11.1. The suicide rate for men was 17.7 and for women 4.5, a marked gender difference. The most at risk of suicide are young men between 20 and 24 years. In 2010, 12% of Irish citizens sought professional help. The European average is 15% which shows that Irish citizens are apprehensive in seeking help for mental health (2014, Irelands Vital Signs). Mental health should be seen as a community issue which may stop people becoming marginalised for suffering mental ill health.

Mental health in Ireland appears to be a low priority for the Irish government, leading to slow development of services. In 2006 the government adopted 'a vision for change' (AVFC), a modern national policy framework, but they have been slow to implement this framework which should change the traditional medically led recovery models. This appears to be due to the challenges faced by those in power and the huge shift that must be made within services (Mental Health Reform, 2015).

1.3 Self Esteem

According to Baron, Branscombe and Byrne (2009, p.129), self-esteem is generally described as our overall or global attitude toward ourselves. This includes our positive and negative self-perceptions. It can be measured implicitly or explicitly but commonly is measured explicitly using the 10-item Rosenberg (1965) self-esteem scale.

Baron, et al., (2009, p.130) explain that '*self-esteem is responsive to life events'*. It can be elevated by positive feedback and can be temporarily reduced by negative feedback. In particular this can be related to the attainment or un-attainment of goals respectively. Individuals with low self-esteem may see a greater impact in the instance of negative feedback or what they see as their failure to succeed and their self-esteem may decline even further. Self-esteem may also be negatively affected by no feedback at all as feedback is extremely important in goal attainment. Feedback is held as highly important and even if self-esteem is stable to start with, too much negative feedback or no feedback at all could have a detrimental effect. This includes the standards an individual feels need to be met to be successful when compared with to others around them. If seeking help for mental health issues is seen as weak within a societal group this may impact on the individual if self-esteem is already low. It may cause avoidance of help-seeking and deterioration of mental health issues.

Kwan, Lu Lu and Hui (2009) carried out quantitative studies using self-report measurement tools to identify sources of self-esteem. Samples were acquired from American and Chinese universities. Through these studies they identified what they describe as three major sources of self-esteem: benevolence, merit and bias. Results showed that individuals may have high self-esteem due to: (a) they perceive themselves and others compassionately and positively (i.e. high benevolence), (b) they are accomplished and high in self-efficacy (i.e. high merit), (c) they hold an extremely positive view of the self (i.e. a self-positivity bias). The sample used in this study may not be fully representative of the population as the participants are all university students but the findings are still of interest and importance.

Miller and Moran (2012, p.16) discuss that according to William James, '*our self-esteem reflects the relationship between our successes and our aspirations'.* The difference between high and low self-esteem depends on how successful individuals are in achieving personal goals and aspirations. Self-esteem '*is influenced by beliefs about competence'.* In this case it may be seen as closely related to 'self-efficacy'. In fact, it has been questioned as to whether these variables are completely distinct from each other or not.

1.4 Self-efficacy

Henry Ford once said "*Whether you believe you can do something or you believe you cannot, you are probably right*" (Passer & Smith, 2008, p. 482). This quote is essentially what the term 'self-efficacy' is all about, belief in personal abilities. Self-efficacy for the individual is most famously described by Albert Bandura (1997) as '*their beliefs concerning their ability to perform the behaviours needed to achieve desired outcomes*' (Bandura, 1997: as cited in Passer & Smith, 2008, p. 480).

Bandura outlined four important factors within self-efficacy. He believed that past 'performance experiences' shape our beliefs about what can be achieved in the future; past

success predicts future success in the individual. 'Observational learning' is something Bandura also deemed important, observing someone else being successful may lead an individual to be more likely to believe that they too can be successful. Another factor he deemed as important is 'verbal persuasion'; if individual abilities are positively affirmed or disregarded by others this can affect efficacy beliefs. This is similar to feedback in regards to self-esteem. Lastly Bandura discussed that 'emotional arousal' can affect efficacy beliefs. High emotional arousal can be seen as anxiety and therefor can lower self-efficacy however if it can be controlled it can enhance self-efficacy (Passer & Smith, 2008).

Those who are high in self-efficacy may be more likely to stick to their goals and succeed through determination. If an individual is high in self-efficacy, they may be more likely to seek out help for a problem.

1.5 Self-esteem and self-efficacy as distinct variables

Previous studies have been carried out to investigate relationships between self-esteem and self-efficacy as distinct variables. These studies are of interest as self-esteem and self-efficacy appear to overlap in regards to individual personal self-beliefs. Lightsey, Burke, Ervin, Henderson and Yee (2006) carried out a study analysing data collected from two previous studies (N=160, N=75, undergraduate students) to investigate the relationship between self-esteem and generalised self-efficacy (GSE). They hypothesised that '*generalised self-efficacy predicts future self-esteem and that self-esteem predicts unique incremental variance in future negative effect*' (Lightsey et al., 2006, p. 72) and administered measures to participants twice over a 5-6 week period. The results contribute to evidence that GSE and self-esteem are distinct constructs. It was found that GSE may influence self-esteem as '*beliefs influence views and feelings about the self'* and '*self-related beliefs may shape self-esteem'* (Lightsey et al., 2006, p.73) but that even though related in this sense, they are

distinct as neither variable predicts the other. GSE relates to individual beliefs in ability to overcome obstacles in life whereas self-esteem relates to an individual perception of overall self-worth. The results also found that '*self-esteem may help shape negative affect*' (Lightsey et al., 2006, p.77).

Chien, Gully and Eden (2004) did a study '*to test whether general self-efficacy and self-esteem relate differently to motivational and affective constructs'* (Chien et al., 2004, p.375). They were looking to highlight and elaborate on a 'theoretical distinction' between generalised self-efficacy (GSE) and self-esteem. They collected survey data from two samples, students in an academic setting and employees in a work setting. The participants were administered generalised self-efficacy, self-esteem, motivational and affective measures (Chien et al., 2004, p. 380). The results showed that even though there was a strong correlation between GSE and self-esteem, there was also strong evidence of a theoretical distinction between them. GSE appeared to have a unique relationship with motivational variables and self-esteem with affective variables (with the exception of work self-esteem). Both variables '*relate similarly on task performance, but they do so through predictably distinct processes*' (Chien et al., 2004, pp.389 - 391). Chien et al., (2004, p. 391) explain that these variables should be used as distinct constructs in research for more valuable results. In regard to future studies investigating similarities and distinctions between these variables; it was discussed that a longitudinal study may show more valuable results. Also the majority of participants in the present study were women so a better mix of gender should be incorporated; however, the sample was still considered valuable as it looked at two different work settings with a mix of ages and backgrounds (Chien et al., 2004, p.391).

The above studies show ample evidence that even though self-esteem and self-efficacy are related and overlap, they are distinct constructs and that this distinction is

important to consider in research. Self-esteem appears to be directly related to affective states moreover whereas self-efficacy appears to relate more to motivational states.

1.6 Self-esteem, mental health and help seeking

Research investigating the relationship between self-esteem and mental health appears to largely focus on self-esteem and levels of depression in particular. Orth, Robins, Trzesniewski, Maes and Schmitt (2009) did a study to '*analyse reciprocal relations between self-esteem and depressive symptoms across the adult life span*' using data from two longitudinal studies (study 1, N=1,685; study 2, N= 2,479) (Orth et al., p. 472). In both studies; using the 10 item Rosenberg self-esteem scale and the 20-item Centre for Epidemiologic Studies Depression Scale, analysis indicated that '*low self-esteem predicted subsequent depressive symptoms, but depressive symptoms did not predict subsequent levels of self-esteem*' suggesting that low self-esteem could be a cause for depressive symptoms throughout the adult life span (Orth et al., 2009, p. 472).

Orth, Robins and Widaman (2012) also carried out some research in regard to the development of self-esteem across the lifespan. Their research was based on data from a longitudinal study across a 12 year period of a sample of 1,824 participants aged 16-97 years. The analysis indicated that self-esteem levels appear to increase between adolescence and middle adulthood, peaks at 50 years and then starts to decrease gradually in years reaching into old age. Orth, Maes and Schmitt (2015) using data from a German longitudinal study across a 4 year period of a sample of 2,509 participants aged 14-89 years found that self-esteem levels appear to increase through adolescence, young adulthood, middle adulthood and peak at 60 years and then decrease gradually into old age.

Moksnes and Espnes (2012) carried out a study using a cross sectional sample which included 1,209 adolescents age 13-18 years from public schools in Norway to investigate

gender and age differences on emotional states and self-esteem and to investigate the association between self-esteem and emotional states. The findings suggested that positive self-esteem is important for the emotional health and well-being of adolescents and that while girls reported the emotional states of depression and anxiety more commonly, boys were reported to be higher in self-esteem.

Sharma and Agarwala (2013) did a study examining the relationship among self-esteem, collective self-esteem and depression and the contribution of self-esteem and collective self-esteem in predicting depression. The study included 200 participants in Agra City, India aged 17-23 years. The results found a significant positive relationship between self-esteem and collective self-esteem; a significant negative relationship between self-esteem and depression but that self-esteem itself was not a predictor of depression. They found a high significant negative relationship between collective self-esteem and depression and found that collective self-esteem was a significant predictor of depression. The results infer that a good level of self-esteem and collective self-esteem can lead to a positive personality (a positive view of the self and the group) and this can enhance social support and possibly lead to a decrease in depression levels (Sharma & Agarwala, 2013).

Steiger, Allemand, Robins and Fend (2014) did a study hypothesising that level and change in self-esteem affect depression. Using data from a 23 year longitudinal study (N=1,527), they examined the prospective effects of global and domain specific self-esteem level and change on depressive symptoms two decades later. The analysis showed that both level and change in self-esteem served as predictors for adult depression. The results implied that the development of optimum levels of self-esteem in younger years is highly important for mental health in adulthood (Steiger et al., 2014).

Considering the above studies it appears that self-esteem levels may directly affect the probability of mental ill health later on in life and that self-esteem levels are something which should be considered important in regard to early development. Also the fact that some of these studies incorporate longitudinal methods, the findings can be deemed more robust. The majority of these studies focused on depressive symptoms, the present study will focus on the relationship between self-esteem and general mental health.

Chan (2013) published a paper providing "*an integrative review of the antecedents of interpersonal help seeking behaviour*" (p.571), looking at research from various fields of psychology and focusing on the cognitive aspects of help-seeking. It was discussed that some researchers believe that "*the potential cost of damaging their self-esteem often inhibits individuals from seeking help when they may need it*" (Chan, 2013, p.573). This is related to counselling psychology among many other fields of psychology. Self Esteem is our global attitude toward our selves (Baron, Branscombe & Byrne, 2009, p.129) and according to Chan (2013) can be influenced not only by personal beliefs but also by the beliefs of others. Chan (2013, p. 584) discusses that research has shown that '*self-stigma reduces individuals self-esteem and inhibits them from seeking help in mental health contexts'* (Corrigan, 2004; as cited in Chan, 2013). He also posits that it has been shown research that men are less likely to seek help than women (Nadler, 1991; as cited in Chan, 2013, p. 589).

Relevant research studies investigating the relationship between self-esteem and help-seeking as variables were sought out by the researcher, but to no avail. The present study in this case may shed some light on this apparent gap in the literature regarding these two variables. A study by Yeh (2002) involving 594 Taiwanese college students found that '*students with higher levels of collective self-esteem may be less inclined to seek professional psychological help*' (Yeh, 2002, p.26). 'Collective self-esteem' refers to the positivity of one's social identity. It values the group more than the individual (Yeh, 2002, p. 22). In this

case it may not be relevant to the present study as this is not the same as 'self-esteem' but considering the lack of relevant research on self-esteem and help-seeking it may be of slight significance.

1.7 Self-efficacy, mental health and help seeking

According to Bandura (1997: as cited in Passer & Smith, 2008, p.480) people who are high in self - efficacy have more confidence to persevere in the face of adversity and achieve more in life. This is commonly related to goal attainment and could also be related to seeking help for psychological problems.

A study by Judd, Jackson, Komiti, Murray, Fraser, Grieve, and Gomez, (2006) which aimed to '*examine the role of a number of attitudinal factors to help-seeking for mental health problems*' (Judd et al., 2006, p.770), conducted a cross-sectional community survey with a sample of 467 rural residents (58% = Female) in Australia. In the study, 27.6% (n = 129) of respondents had sought professional help for mental health problems and it was found that: more women than men reported help-seeking, perceived stigma did not influence lifetime help-seeking and those with lower levels of self-efficacy and stoicism appeared to be more likely to seek help. "*The findings of this study suggest that, general attitudinal factors are important determinants of help-seeking behaviour*". This study used a selected group (rural communities) and the mean age was 56 years so urban counter-parts and younger residents are not represented well. Also, current distress levels were focused on for life-time help-seeking and reports from respondents were retrospective (Judd et al., 2006, p.775).

Andersson, Moore, Hensing, Krantz and Staland-Nyman, (2014) did a study to investigate "*if general self-efficacy (GSE) is associated with self-reported mental illness and to examine if GSE is associated with help seeking behaviours and barriers to care*". They used a mailed questionnaire completed by 3,981 participants (19-64 years) who lived in

Western Sweden. It was found that 25% of man and 43% of women reported mental illness that may have needed treatment. Also in this sample 37% of men and 27% of women reported barriers to care. An association was found between GSE and self-reported mental illness. It was found that men and women with low levels of GSE were more likely to suffer from mental illness than those with high GSE and men were even more likely to suffer. Also, women with low GSE feel more ashamed when suffering from mental health problems. It was found that GSE did not affect people's choice to seek help if they felt they needed it. This study represented both urban and rural and urban areas of Sweden and a larger age range for a more representative sample of the population.

A study carried out by Garland (1994) on 198 school students between the ages of 10-19 years found that low self-efficacy was associated with negative help-seeking attitudes. '*Self-efficacy was the best independent predictor of help-seeking attitudes for the total sample*'. This suggests that it is vital that children learn how to ask for help as part of learning how to be independent and autonomous in all areas of life, supporting the theories of Nelson-LeGall (1980, 1981) (Garland, 1994, pp. 590-591).

These studies indicate mixed results in regard to whether self-efficacy has a significant relationship with help-seeking behaviours. The present study may shed more light on the relationship between these variables.

According to statistics, mental health is still hugely neglected in Ireland and there is still a stigma attached to seeking help for psychological issues. The issues surrounding mental health and seeking help are complex and different for every individual. However, through looking at research it appears that personal attributes such as self-esteem and self-efficacy may be predictors of mental health and help seeking behaviours. This may be seen through

high standards in society and self-perception as seen internally and externally which may reflect perceived capabilities.

1.8 Rationale, aims and hypothesis

The present study focuses on self-esteem and self-efficacy as possible underlying factors which may affect mental health and help-seeking behaviours. The researcher intends to focus on developing previous research in an Irish context. There appears to be a gap in previous research investigating self-esteem and help-seeking behaviours, also there appears to be mixed results in regard to the relationship between self-efficacy and help-seeking behaviours. The present study may help develop research in these particular areas. The aim of the study is to investigate whether self-esteem and self-efficacy are predicting factors for general mental health and also are they predicting factors for help-seeking behaviours. The research also examined gender and age within the sample in relation to these variables as comparative analysis. The research considered that older age groups (41yrs +) may have different outcomes in scores of main variables in comparison to younger age groups (18-40yrs) due to life experience, for example higher scores in self-esteem, self-efficacy and help-seeking behaviours and lower scores in general mental health issues.

These factors could help in our understanding of mental ill health and what influences help-seeking behaviours and in turn be a means for early intervention in mental ill health and encouraging positive help-seeking behaviours.

H1: It is hypothesised that there will be a statistically significant relationship between self-esteem and general mental health.

H2: It is hypothesised that there will be a statistically significant relationship between self-efficacy and general mental health.

H3: It is hypothesised that there will be a statistically significant relationship between self-esteem and help-seeking behaviours.

H4: It is hypothesised that there will be a statistically significant relationship between self-efficacy and help seeking behaviours.

2. Methodology

2.1 Participants

A non-probability convenience sample was drawn from the student population as well as a snowball sample from family, friends and work colleagues based on access to participants. The researcher sought verbal permission to enter a classroom setting for the student sample. Access was gained from all participants through informed consent initially. A total of 101 people participated but 2 of these were eliminated from the final sample due to incomplete measures and another 8 due to the presence of extreme outliers in data. The participants were not offered any incentives to participate, just invited of their own accord with informed consent. The final total sample consisted of 91 participants (n = 91), 58.2 % female (f = 53) and 41.76% male (m = 38). Within this sample, 63.74% (n = 58) were in the 18-40 years age range and 36.26% (n = 33) were in the 41 years and above range.

2.2 Design

The present study is a quantitative correlational between subjects survey design to measure relationships between self-esteem, self-efficacy, general mental health and help-seeking behaviours. Self-esteem and self-efficacy were predictor variables (PV) for both general mental health as a criterion (CV) and then help-seeking behaviours as a separate criterion (CV) in separate tests. Gender and age differences were also examined. In this case the gender was the independent variable (IV) and there were four dependant (DV) variables: self-esteem, self-efficacy, mental health and help-seeking behaviours and then separately age was the independent variable (IV) and there were four dependant variables (DV): self-esteem, self-efficacy, mental health and help-seeking behaviours.

2.3 Materials

The participants were given a questionnaire pack containing firstly an information sheet outlining the nature of the research and informed consent (see appendix 1), then a sheet asking for demographic variables (age and gender) and an informed consent indicator box to be ticked (see appendix 2). These were followed by 4 further questionnaires; all commonly used measurement tools, which will be described below. The researcher handed out the questionnaires with pens provided where needed and a folder for participants to put their completed questionnaires into.

Attitudes towards seeking professional help scale – short form (ATSPPH-SF)

The ATSPPH-SF scale was developed by Fisher & Farina (1995) to measure overall attitude towards seeking professional help (see appendix 3). There are 10 items which are all statements about attitudes towards seeking professional help including 'the idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts' and 'a person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help'. The respondent is asked to 'indicate your degree of agreement' using a likert scale ranging from 0 = disagree – 3 = agree. Items 2, 4, 8, 9 and 10 are reverse scored and then all scores are totalled and can range from 0-30. A higher score indicates a more positive the attitude toward, opening up about problems and seeking professional help. Fisher and Farina (1995) found internal consistency of 0.84 using cronbach's alpha which is considered very satisfactory. The present research found a score of .79 as well as all positive items which is satisfactory.

General self-efficacy scale (GSES)

The GSE scale was developed by Schwarzer & Jerusalem (1995) to assess an individual's sense of perceived self-efficacy (see appendix 4). The scale consists of 10 items, statements reflecting how people might cope with stressful and unexpected events and situations in their life. For example, 'I can always manage to solve difficult problems if I try hard enough' and 'I am confident that I could efficiently with unexpected events'. The respondent is asked to 'select an answer for each statement which indicates how much a statement applies to yourself' on a likert scale ranging from 1 = not at all true – 4 = exactly true. The scores from all 10 items are simply added together with scores ranging from 10-40. The higher the total the greater the person's generalized sense of self-efficacy. Schwarzer & Jerusalem (1995) found from various samples internal consistencies ranging between .76 - .90, using cronbach's alpha, most of which were in the high .80s which very satisfactory. The present research found a score of .81 as well as all positive items.

General health questionnaire (GHQ-12)

The GHQ-12 was developed by Goldberg (1992) as shortened version of his original GHQ-60 to detect non-psychotic psychiatric disorder and the degree of same disorder in the general population (see appendix 5). The scale consists of 12 items, all of which ask the respondent about possible symptoms or behaviours experienced lately, for example 'have you recently; lost much sleep over worry?' and 'have you recently; felt constantly under strain'. The respondent answers using a 4-point likert scale with answers similar to 'less than usual', 'no more than usual', rather more than usual' or 'much more than usual' depending on the nature of each question. There are two scoring systems for the GHQ-12. One is where responses are scored 0,0,1 &1 respectively (useful for detecting cases, with scores ranging from 0-12) and the other where responses are scored 0,1,2 & 3 respectively (likert scoring –

useful for looking at degree of disorder, with scores ranging from 0-36). All scores are then totalled in each case. The present research used the second likert scoring technique (0,1,2,3) to look at degree of a disorder. In this measurement the higher the score, the higher the likelihood of mental health issues. Internal consistencies for this measure using cronbach's alpha have been found to range between .82 and .90 which is highly satisfactory. The present research found a score of .88 and all positive items.

Rosenberg self-esteem scale (RSE)

The RSE scale was developed by Rosenberg (1965) to evaluate individual self-esteem by using statements that deal with general feelings about the self (positive and negative) (see appendix 6). The respondent is asked to respond to statements such as 'on a whole, I am satisfied with myself' and 'I certainly feel useless at times' by circling either SA (strongly agree), A(agree), D(disagree) or SD(strongly disagree). Items 1, 3, 4, 7 & 10 are scored SA=3, A=2, D=1 & SD=0, while items 2, 5, 6, 8 & 9 are reverse scored SA=0, A=1, D=2 & SD=3. The items are then totalled (scores can range from 0-30) and the higher the score, the higher the sense of individual self-esteem. The internal consistencies for the RSE scale have been found to range between .75 - .88 which is a very satisfactory level. The present research found a score of .88 and all positive items.

2.4 Procedure

Once the researcher received ethical approval from Dublin Business School Ethical Committee for Psychological research, the questionnaire pack was put together. In the classroom when drawing from the student population, the researcher started by way of introducing herself and then explaining that research was investigating relationships between self-esteem, self-efficacy and psychological adjustment and was being carried out in partial fulfilment of an Honours Degree in Psychology. The researcher explained about informed

consent (over 18 years), anonymity and the right to with draw any-time before the questionnaire was given to researcher for analysis. It was also explained that as the nature of the research was slightly sensitive, there was helplines at end of survey for confidential support (see appendix 7) and lastly that each questionnaire had instructions at the top to follow and the participants could take the first sheet with information about the research and researcher away with them. The researcher had a folder and as participants finished they were all taken and put in the same folder. The students were thanked at the end and told if they had any questions to contact the researcher. The same procedure was followed with snowball samples from friends, family and work colleagues in the locations of contact with participants as smaller separate groups.

2.5 Data analysis

The researcher checked the reliability of the measures using cronbach's alpha in SPSS. Then normality checks were carried out on the data which indicated the presence of outliers which were cut from the data. The researcher carried out descriptive statistics with relevant variables. The researcher carried out two multiple regressions to look for relationships between main variables (see design section) and independent t-tests were carried out to look for gender and age differences between main variables (see design section). The significance level was set at .05 for analysis using two-tailed tests.

3. Results

3.1 Descriptive statistics

Descriptive statistics were carried out to show the breakdown of gender and age in the sample. Females accounted for 58.24% of the sample and males 41.76% (see figure 1). In regards to age groups 63.74% of the sample were 18-40yrs and 36.26% were 41yrs and above (see figure 2).

Figure 1: *Breakdown of gender in sample*

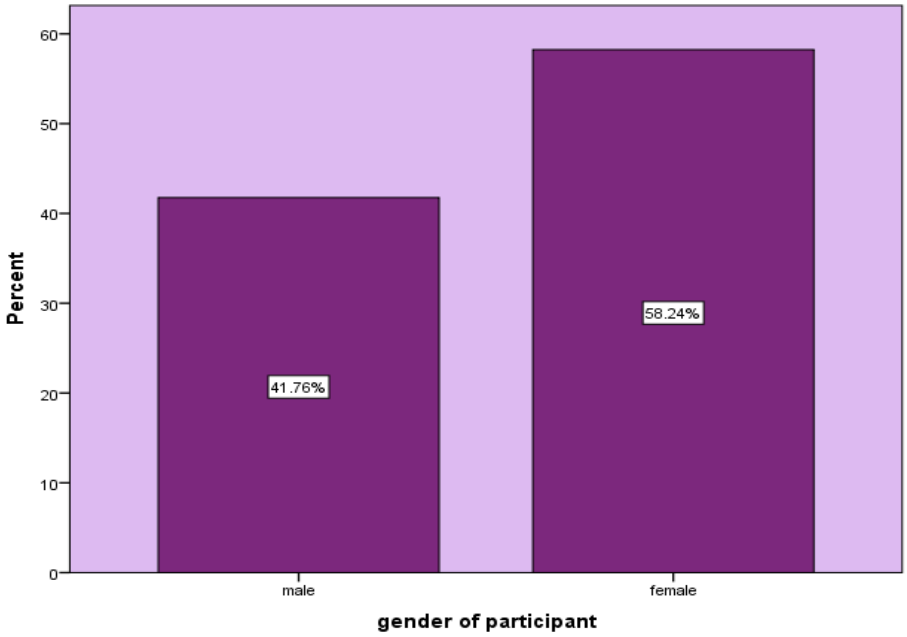
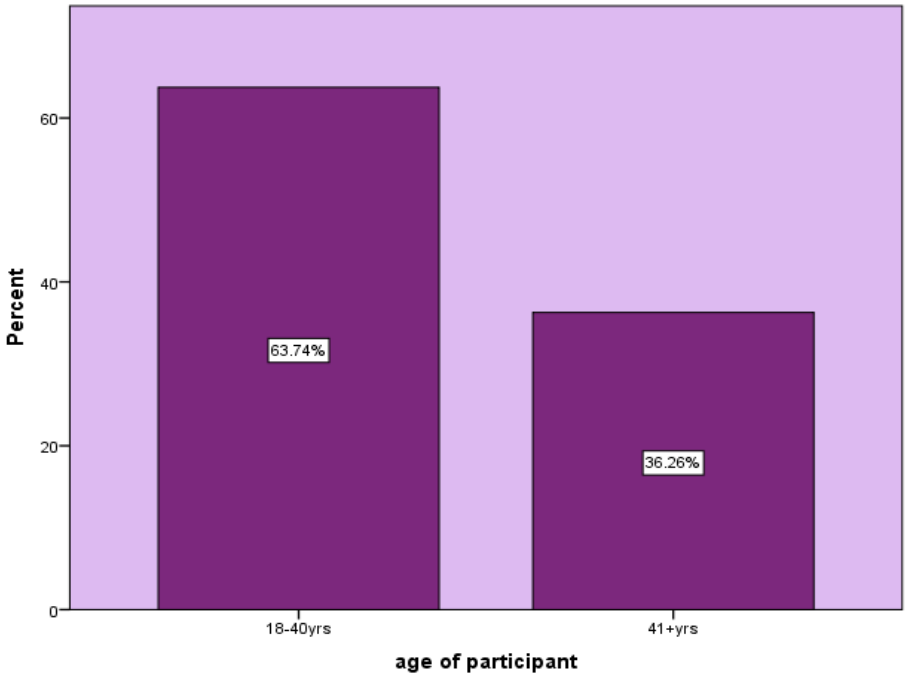


Figure 2: *Breakdown of age in sample*



Descriptive statistics were conducted to examine the psychological variables: help-seeking behaviour (HSS), general self-efficacy (GSE), general mental health (GHQ) and self-esteem (RSE).

Table 1: *Descriptive statistics for psychological variables*

Variable	HSS	GSE	GHQ	RSE
Mean	20.57	30.66	11.46	8.18
Median	21.00	30.00	11.00	8.00
Mode	19	29	11	10
SD	4.72	3.34	4.57	4.87
Variance	22.32	11.16	20.87	23.70

The scores for HSS scale range between 0-30. The mean for HSS was 20.57 (SD=4.72) (see table 1) which indicates a generally positive attitudes toward seeking psychological help within the sample.

The scores for the GSE scale range from 10-40. The mean for GSE was 30.66 (SD=3.34) (see table 1) which indicates an overall high sense of self-efficacy within the sample.

The scores for the GHQ scale range between 0-36. The mean for GHQ was 11.46 (SD=4.57) (see table 1) which indicates a low instance of mental health issues within the sample.

The scores for RSE range between 0-30. The mean for SE was 8.18 (SD=4.87) (see table 1) which indicates very low levels of self-esteem with the sample.

3.2 Inferential Statistics

A multiple regression was carried out to test self-esteem and self-efficacy as predictors of general mental health:

H1: It is hypothesised that there will be a statistically significant relationship between self-esteem (RSE) and general mental health (GHQ).

H2: It is hypothesised that there will be a statistically significant relationship between self-efficacy (GSE) and general mental health (GHQ).

Table 2: *Multiple regression statistics for self-esteem (RSE), self-efficacy (GSE) and general mental health (GHQ).*

Variable	Mean	SD	Beta	p value	Confidence Intervals lower	upper
GHQ	11.46	4.57				
RSE	8.18	4.87	.531	p<.001*	.318	.678
GSE	30.66	3.34	-.061	p=.528	-.346	.179

*significance level p<.05 adjusted R squared = .30

The results of the regression indicated that one predictor explained 30% of the variance (r squared = .30, f (2, 88) = 19.91, p<.001). It was found that self-esteem (RSE) significantly predicted general mental health (GHQ) (beta = .531, p<.001, 95% confidence intervals = .318 - .678) (see table 2). It also showed a positive correlation between self-esteem (RSE) and general mental health (GHQ) (see figure 3). The null hypothesis could be rejected for H1, but not for H2.

A multiple regression was also was also carried out to test self-esteem and self-efficacy as predictors of help-seeking behaviour:

H3: It is hypothesised that there will be a statistically significant relationship between self-esteem (RSE) and help-seeking behaviours (HSS).

H4: It is hypothesised that there will be a statistically significant relationship between self-efficacy (GSE) and help-seeking behaviours (HSS).

Table 3: *Multiple regression statistics for self-esteem (RSE), self-efficacy (GSE) and help-seeking behaviours (HSS).*

Variable	Mean	SD	Beta	p value	Confidence Intervals lower	upper
HSS	20.57	4.72				
RSE	8.19	4.90	.001	p= .996	-.221	.222
GSE	30.68	3.36	-.177	p=.129	-.572	.074

* significance level p<.05 adjusted R squared = .09

The results of the regression indicated that neither predictors explained the variance (r squared = .09, f(2, 87) = 1.45, p=.251) (see table 3). The null hypothesis could not be rejected for H3 or H4.

Independent samples t-tests were carried out to test differences between age and gender groups in relation to all four main variables. In the absence of directional hypothesis, two-tailed statistics were used.

An independent samples t-test was carried out to test age differences in self-esteem (RSE) scores.

Table 4: *Independent samples t-test statistics for age differences in self-esteem (RSE).*

Variable	Mean	SD	t	df	p value
RSE- 18-40yrs	8.93	4.96			
RSE- 41yrs +	6.85	4.48			
Equal variances assumed			1.994	89	p=.049*

* significance level p<.05 **confidence intervals (lower) .007 (upper) 4.158

Participants of 18-40yrs (mean = 8.93, SD = 4.96) were found to have higher levels of self-esteem (RSE) than participants of 41yrs + (mean = 6.85, SD = 4.48) The 95% confidence limits shows that the population mean difference of the variables lies somewhere between .007 and 4.158. An independent samples t-test found that there was a statistically significant difference between self-esteem levels of 18-40yr age group and 41yrs + age group (t(89) = 1.99, p=.049) (see table 4).

An independent samples t-test was carried out to test age differences in help-seeking behaviour (HSS) scores.

Table 5: *Independent samples t-test statistics for age differences in help-seeking behaviour (HSS).*

Variable	Mean	SD	t	df	p value
HSS- 18-40yrs	20.96	4.47			
HSS- 41yrs +	19.88	5.13			
Equal variances assumed			1.052	88	p=.296

* significance level p<.05 **confidence intervals (lower) -.966 (upper) 3.138

Participants of 18-40yrs (mean = 20.96, SD = 4.47) were found to have higher levels of help-seeking behaviours (HSS) than participants of 41yrs + (mean = 19.88, SD = 5.13) The 95% confidence limits shows that the population mean difference of the variables lies somewhere between -.966 and 3.138. An independent samples t-test found no significant difference between help-seeking behaviour (HSS) levels of 18-40yr age group and 41yrs + age group (t(88) = 1.05, p=.296) (see table 5).

An independent samples t-test was carried out to test age differences in self-efficacy (GSE) scores.

Table 6: *Independent samples t-test statistics for age differences in self-efficacy (GSE).*

Variable	Mean	SD	t	df	p value
GSE- 18-40yrs	30.40	3.30			
GSE- 41yrs +	31.12	3.42			
Equal variances assumed			-.995	89	p=.323

* significance level p<.05 **confidence intervals (lower) -2.172 (upper) .723

Participants of 41yrs + (mean = 31.12, SD = 3.42) were found to have higher levels of self-efficacy (GSE) than participants of 18-40yrs (mean = 30.40, SD = 3.30) The 95% confidence limits shows that the population mean difference of the variables lies somewhere between -2.172 and .723. An independent samples t-test found no significant difference between self-efficacy (GSE) levels of 18-40yr age group and 41yrs + age group (t(89) = -.995, p=.323) (see table 6).

An independent samples t-test was carried out to test age differences in general mental health (GHQ) scores.

Table 7: *Independent samples t-test statistics for age differences in general mental health (GHQ).*

Variable	Mean	SD	t	df	p value
GHQ- 18-40yrs	11.66	4.41			
GHQ- 41yrs +	11.12	4.90			
Equal variances assumed			.534	89	p=.595

* significance level p<.05 **confidence intervals (lower) -1.453 (upper) 2.521

Participants of 18-40yrs (mean = 11.66, SD = 4.41) were found to have higher levels of general mental health (GHQ) than participants of 41yrs + (mean = 11.12, SD = 4.90) The 95% confidence limits shows that the population mean difference of the variables lies somewhere between -1.453 and 2.521. An independent samples t-test found no significant difference between general mental health levels of 18-40yr age group and 41yrs + age group (t(89) = -.53, p=.595) (see table 7).

An independent samples t-test was carried out to test gender differences in help-seeking behaviour (HSS) scores.

Table 8: *Independent samples t-test statistics for gender differences in help-seeking behaviour (HSS).*

Variable	Mean	SD	t	df	p value
HSS – males	19.82	5.03			
HSS – females	21.12	4.45			
Equal variances assumed			-1.294	88	p=.199

* significance level p<.05 **confidence intervals (lower) -3.30 (upper) .696

Females (mean = 21.12, SD = 5.03) were found to have higher levels of help-seeking behaviours (HSS) than males (mean = 19.82, SD = 4.45) The 95% confidence limits shows that the population mean difference of the variables lies somewhere between -3.30 and .696. An independent samples t-test found no significant difference between help-seeking behaviour (HSS) levels of males and females (t(88) = 1.29, p=.199) (see table 8).

An independent samples t-test was carried out to test gender differences in self-efficacy (GSE) scores.

Table 9: *Independent samples t-test statistics for gender differences in self-efficacy (GSE).*

Variable	Mean	SD	t	df	p value
GSE – males	30.82	3.49			
GSE – females	30.55	3.26			
Equal variances assumed			.376	89	p=.707

* significance level p<.05 **confidence intervals (lower) -1.149 (upper) 1.686

Males (mean = 30.82, SD = 3.49) were found to have higher levels of self-efficacy (GSE) than females (mean = 30.55, SD = 3.26) The 95% confidence limits shows that the population mean difference of the variables lies somewhere between -1.149 and 1.686. An independent samples t-test found no significant difference between self-efficacy (GSE) levels of males and females (t(88) = 1.29, p=.199) (see table 9).

An independent samples t-test was carried out to test gender differences in general mental health (GHQ) scores.

Table 10: *Independent samples t-test statistics for gender differences in general mental health (GHQ).*

Variable	Mean	SD	t	df	p value
GHQ – males	10.82	3.80			
GHQ – females	11.92	5.03			
Equal variances assumed			-1.144	89	p=.256

* significance level p<.05 **confidence intervals (lower) -3.035 (upper) .818

Females (mean = 11.92, SD = 5.03) were found to have higher levels of general mental health than males (mean = 10.82, SD = 3.80) The 95% confidence limits shows that the population mean difference of the variables lies somewhere between -3.035 and .818. An independent samples t-test found no significant difference between general mental health (GHQ) levels of males and females (t(89) = -1.14, p=.256) (see table 10).

An independent samples t-test was carried out to test gender differences in self-esteem (RSE) scores.

Table 11: *Independent samples t-test statistics for gender differences in self-esteem (RSE).*

Variable	Mean	SD	t	df	p value
RSE – males	7.39	4.91			
RSE – females	8.74	4.80			
Equal variances assumed			-1.301	89	p=.197

* significance level p<.05 **confidence intervals (lower) -3.390 (upper) .707

Females (mean = 8.74, SD = 4.80) were found to have higher levels of self-esteem (RSE) than males (mean = 7.39, SD = 4.91) The 95% confidence limits shows that the population mean difference of the variables lies somewhere between -3.390 and .707. An independent samples t-test found no significant difference between self-esteem (RSE) levels of males and females (t(89) = -1.30, p=.197) (see table 11).

4. Discussion

4.1. Aims of present research

The aim of the present research project was to examine the personal attributes of self-esteem and self-efficacy as possible predictors of mental health and help-seeking behaviours. The research also considered age and gender within the sample as comparative analysis.

4.2. Self-esteem, self-efficacy and general mental health

It was hypothesised that there would be a statistically significant relationship between self-esteem (RSE) and general mental health (GHQ). It was also hypothesised that there would be a statistically significant relationship between self-efficacy (GSE) and general mental health (GHQ). A multiple regression was carried out to test both of these hypotheses. It was found that there was a significant relationship between self-esteem and general mental health (see table 2). Therefore, the null hypothesis could be rejected. However, these findings contradict past research. The mean scores for both variables were low (see table 1) which indicates low levels of self-esteem were related to a low instance of 'reported' mental health issues.

Past research has indicated a significant negative correlation between two variables rather than a positive correlation. Orth, et al., (2009) used data from two longitudinal studies to examine the relationship between self-esteem and depressive symptoms across the life span. The found that low self-esteem levels predicted subsequent depressive symptoms suggesting that low self-esteem could be a cause for depression. Moksnes and Espnes (2012) carried out a study which suggested that positive self-esteem is important for the emotional health and well-being of adolescents. Sharma and Agarwala (2013) found a significant negative relationship between self-esteem and depression but that self-esteem itself was not a

significant indicator of depression. They found that collective self-esteem was found to be a much higher predictor of depression. However, the results still infer that an optimal level of self-esteem is still important in relation to depression levels. Steiger et al., (2014) carried out research using data from a 23 year long longitudinal study which implied that optimal levels of self-esteem in younger years is extremely important for mental health in later years. The present research found results which are in comparison with the above mentioned previous studies, which all infer that positive levels of self-esteem are highly important for mental health. The results of the present study are difficult to interpret. They are focussed on an Irish context (those living in Ireland), perhaps these results could be interpreted in relation to mental health stigma in Ireland to consider the data as somewhat useful in regards to important future research directions.

If these results are considered alongside previous findings in relation to mental health in Ireland, there could be an indication that people may be hesitant to report mental health problems. Even though self-report measures are anonymous, admitting mental health problems even to one's self may prove difficult as then it must be openly dealt with eventually. Initially this could lead to an even bigger decline in self-esteem which is why individuals may hesitate to admit to problems in the first place.

The 2013 survey carried out by St Patrick's mental health services involving the general Irish public somewhat disturbingly confirmed that stigma is still a significant factor in mental health and is largely due to lack of understanding of mental health problems. The survey indicated that as many as 22% of people believe that those suffering mental health are of below average intelligence and that 41% believe that undergoing treatment for a mental health problem is a sign of failure (2014, St Patricks). This lack of understanding is contributing to mental health stigma and potentially could cause under reporting of mental health problems. Considering the results of the present study and the findings of St Patrick's

survey, many people in Ireland may be suffering in silence due to lack of understanding and stigma. There may be individuals who have low self-esteem and linked mental health issues but either don't understand mental health or are too afraid to admit mental health problems.

The Irish survey 'Slan' published in 2007, reported that 52% of people would not want anyone knowing they had mental health problems. The researchers explained that this was linked with socio-economic status and may impact negatively on self-reported levels of mental health problems and help-seeking behaviours (Slan, 2007). Mental health in Ireland appears to be at the bottom of the government's priority list, year after year, due to 'challenges' implementing new national frameworks (Mental Health Reform, 2015). This needs to change. Future research into mental health stigma within an Irish context should be a priority relating to what the results of the present study could be indicating.

There was no significant relationship found between self-efficacy (GSE) and general mental health (GHQ). Therefore, the null hypothesis could not be rejected. Past research has indicated a relationship between self-efficacy and mental health. Andersson et al., (2014) carried out a self-report study on a large sample of 3,981 participants between 19-64 years and found that men and women with low levels of self-efficacy were more likely to suffer from mental illness. However, research concerning these two variables appeared limited.

4.3. Self-esteem, self-efficacy and help-seeking behaviour

It was hypothesised that there would be a statistically significant relationship between self-esteem (RSE) and help-seeking behaviours (HSS). It was also hypothesised that there would be a statistically significant relationship between self-efficacy (GSE) and help seeking behaviours (HSS). A multiple regression was carried out to test these hypotheses. The results of the regression indicated that neither, self-esteem (RSE) or self-efficacy (GSE) had a significant relationship with help-seeking behaviours (HSS). In relation to self-esteem (RSE)

and help-seeking behaviours (HSS), past research concerning a relationship between these two variables was sought out by the researcher but to no avail. It was hoped that the present research would fill this gap in the literature however, this was not the case. Previous research concerning the relationship between self-efficacy and help-seeking behaviours has indicted mixed results.

Judd et al., (2006) found that those with lower levels of self-efficacy appeared to be more likely to seek help, Andersson et al., (2014) found that self-efficacy did not affect people's choice to seek help if they felt they needed it and previously Garland (1994) found self-efficacy to be a predictor of help-seeking behaviours. If self-efficacy was low, people were less likely to seek help. These mixed results may indicate that the perception of self-efficacy varies among individuals. Individuals who are highly self-aware may perceive self-efficacy as a trait which if built upon through help-seeking will lead to future success. Therefore, whether low or high, self-efficacy can be utilised accordingly. However, self-efficacy could also be seen as a trait which is not malleable within an individual who is not so self-aware. As Henry Ford once quoted; "*Whether you believe you can do something or you believe you cannot, you are probably right*" (Passer & Smith, 2008, p. 482).

4.4. Age and gender comparisons

Independent samples t-tests were carried out to test differences between age and gender groups in relation to self-esteem (RSE), self-efficacy (GSE), general mental health (GHQ) and help-seeking behaviours (HSS). This analysis only revealed one significant result. An independent samples t-test found that there was a statistically significant difference between self-esteem levels of 18-40yr age group and 41yrs and above age group. Participants of 18-40yrs were found to have higher levels of self-esteem (RSE) than participants of 41yrs and over. These results support some previous research carried out to investigate the

development of self-esteem across the lifespan. Orth, Robins and Widaman (2012) carried out analysis on longitudinal data which indicated that self-esteem levels appear to increase between adolescence and middle adulthood, peaks at 50 years and then starts to decrease gradually in the years following and gradually decreases into old age. Orth et al., (2012, p.1283) investigated possible moderators of self-esteem across the lifespan and research indicated that educational attainment appeared to affect overall levels of self-esteem. Those who were more educated appeared to have more consistent higher levels of self-esteem across a certain period. Within this research, they also addressed whether self-esteem could be a cause or a consequence of life outcomes, testing self-esteem in relations to positive affect, negative effect and depression. They found that self-esteem affects life outcomes, but outcomes don't consequently affect self-esteem.

The present research considered that life experience may be a moderator of self-esteem however; present results appear to build upon previous research which could suggest that there is a higher importance placed upon younger age groups. Considering that approaching adulthood and young adulthood years are represented by personal and professional achievements and late adulthood and older adulthood represent winding down from these, it is not surprising that self-esteem starts to gradually decline after 50 years. Retirement and children growing up and moving on sometimes can be seen as a loss in these terms and people struggle to find a new meaning in this new phase of life.

4.5. Limitations of present research

The Present research study used two age groups within analysis, 18-40 years (emerging – young adulthood) and 41 years and above (middle – late adulthood). Perhaps breaking these groups down further may have led to more interesting findings and comparisons in regards to the main variables under investigation. It is also important to note

the limitations of self-report measures which were employed for the present study. Self-report measures may not be as reliable as an assessment or interview by an outside party who is non-biased. Past research also suggests that longitudinal studies of larger, further reaching sample sizes yield more robust and comparative findings in regard to the main variables examined.

4.6. Strengths and applications of present research and future directions

The present research found a significant relationship between self-esteem (RSE) and general mental health (GHQ). The results, although contradictory to previous research, led the researcher to an interesting finding regarding the data. It was found that while self-esteem scores were found to be low (indicating low levels of self-esteem), general mental health scores were also found to be low (indicating low instance of mental health). This led the researcher to consider earlier discussed findings in relation to mental health in Ireland (2014, St Patricks). Considering that these statistics indicated a huge instance of mental health stigma in Ireland and the present study found very low 'reported' instances of mental health problems (even in relation to low levels of self-esteem), this could be considered as idiosyncratic to Irish people. Future research could focus on an Irish context and consider shame and vulnerability as moderating factors in relation to mental health and mental health stigma as well as socio-economic status within society. This suggested research may help educate people and bring mental health to the forefront in Ireland. Therefore, facilitating successful treatment of mental health, and lessoning mental health stigma in Ireland.

This study also uncovered a difference in levels of self-esteem in relation to age groups. It was found that those aged between 18-40 years had higher levels of self-esteem than those of 40 years and above. These results supported previous research findings that self-esteem gradually climbs from emerging adulthood to middle adulthood, peaks at 50

years then gradually declines. It is important note that self-esteem may be of utmost importance after 50 years coming up to retirement. Individuals may feel self-conscious adjusting to a new way of life and struggle to find meaning after letting go of a lifetime career and watching their children grow up and leave home. Future research looking in depth, into factors which effect self-esteem after 50 years, for example, retirement could be of importance, particularly in relation to mental health in later years.

Further research should also be considered to examine the relationship between self-esteem (RSE) and help-seeking behaviours (HSS) as interestingly the researcher could not find available research and found no significant results in the present study to fill the apparent gap in the research. Also the relationship between self-efficacy and help-seeking behaviours deserves further research as the present study did not find significant results and previous result has shown mixed results.

The present study found a significant relationship between self-esteem (RSE) and help-seeking behaviours (HSS). A positive correlation was found which is contradictory of previous research emphasising a negative correlation. However these findings were considered interesting in relation to the reporting of mental health issues within an Irish context. The researcher considered post hoc that factors such as shame and vulnerability in relation to mental health should be considered in future research. These factors could affect reporting of mental health issues and mental health stigma in Ireland. In addition the study found that levels of self-esteem were higher in participants between 18-40 years than in participants 40 years and older. These results support previous research in the area and it should be considered that a focus of self-esteem in older adulthood could be detrimental to how people adjust to new life phases such as retirement.

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Appendix 1

My Name is Emily Ashe and as partial fulfilment of my Honours Degree in Psychology I am undertaking a research project which investigates the relationships between self-esteem, self-efficacy and psychological adjustment.

I would like to invite you to participate in this research. To take part you must be over the age of 18 years of age. There are 4 questionnaires attached, each with instructions to be followed at the top. If you do decide to take part please follow the instructions carefully and answer all questions. The survey should only take about 5 minutes to complete. You are not obliged to take part in this study but if you do take part you can withdraw at any time before you hand over your completed questionnaire. Due to the sensitive nature of the study I have also included confidential helplines at the end should you feel you need support afterward.

The completed questionnaires are anonymous and will in no way be identifiable. All questionnaires and data pulled from them will be held safely in a locked cabinet and password protected laptop. The information will be dealt with confidentially by the researcher and can only be accessed by the researcher and project supervisor Dr Patricia Orr (xxxxxx@dbs.ie).

I would like to take this opportunity to thank you for taking part in this research. If you have any questions about the research, please do not hesitate to contact me by email. You may take this sheet away with you if you like.

Emily Ashe

Appendix 2

I confirm that I am over 18 years of age (please tick box to confirm)					
Gender (please tick appropriate box)				Male	Female
Age (please tick appropriate box)	18-25yrs	26-40yrs	41-55yrs	56-70yrs	Other age

Appendix 3

Please read the sentences below and select an answer for each statement which indicates how much the statement applies to you.

0 = Disagree 1 = Partly disagree 2 = Partly agree 3 = Agree

1	If I believed I was having a mental breakdown, my first inclination would be to get Professional attention.	
2	The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.	
3	If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.	
4	There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.	
5	I would want to get psychological help if I were worried or upset for a long period of time.	
6	I might want to have psychological counselling in the future.	
7	A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.	
8	Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.	
9	A person should work out his or her own problems; getting psychological counselling would be a last resort.	
10	Personal and emotional troubles, like many things, tend to work out by themselves.	

Appendix 4

Please read the sentences below and select an answer for each statement which indicates how much the statement applies to you.

1 = **Not at all true** 2 = **Hardly true** 3 = **Moderately true** 4 = **Exactly true**

1	I can always manage to solve difficult problems if I try hard enough.	
2	If someone opposes me, I can find the means and ways to get what I want.	
3	It is easy for me to stick to my aims and accomplish my goals.	
4	I am confident that I could deal efficiently with unexpected events.	
5	Thanks to my resourcefulness, I know how to handle unforeseen situations.	
6	I can solve most problems if I invest the necessary effort.	
7	I can remain calm when facing difficulties because I can rely on my coping abilities.	
8	When I am confronted with a problem, I can usually find several solutions.	
9	If I am in trouble, I can usually think of a solution.	
10	I can usually handle whatever comes my way.	

Appendix 5

Please answer ALL the questions simply by circling the answer which you think most nearly applies to you.

Have you recently:

1.	Been able to concentrate on whatever you are doing?	**Better than usual**	**Same as usual**	**Less than usual**	**Much less than usual**
2.	Lost much sleep over worry?	**Not at all**	**No more than usual**	**Rather *more* than usual**	**Much more than usual**
3.	Felt that you are playing a useful part in things?	**More so than usual**	**Same as usual**	**Less useful than usual**	**Much less useful**
4.	Felt capable of making decisions about things?	**More so than usual**	**Same as usual**	**Less so than usual**	**Much less capable**
5.	Felt constantly under strain?	**Not at all**	**No more than usual**	**Rather more than usual**	**Much more than usual**
6.	Felt you couldn't overcome difficulties?	**Not at all**	**No more than usual**	**Rather more than usual**	**Much more than usual**
7.	Been able to enjoy your normal day-to-day activities?	**More so than usual**	**Same as usual**	**Less so than usual**	**Much less than usual**
8.	Been able to face up to your problems?	**More so than usual**	**Same as usual**	**Less able than usual**	**Much less able than usual**
9.	Been feeling unhappy and depressed?	**Not at all**	**No more than usual**	**Rather more than usual**	**Much more than usual**
10.	Been losing confidence in yourself?	**Not at all**	**No more than usual**	**Rather more than usual**	**Much more than usual**
11.	Been thinking of yourself as a worthless person?	**Not at all**	**No more than usual**	**Rather more than usual**	**Much more than usual**
12.	Been feeling reasonably happy, all things considered?	**More so than usual**	**About same as usual**	**Less so than usual**	**Much less than usual**

Appendix 6

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.	On the whole, I am satisfied with myself.	**SA**	**A**	**D**	**SD**
2.	At times, 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 certainly feel useless at times.	**SA**	**A**	**D**	**SD**
7.	I feel that I'm a person of worth, at least on an equal plane with others.	**SA**	**A**	**D**	**SD**
8.	I wish I could have more respect for myself.	**SA**	**A**	**D**	**SD**
9.	All in all, I am inclined to feel that I am a failure.	**SA**	**A**	**D**	**SD**
10.	I take a positive attitude toward myself.	**SA**	**A**	**D**	**SD**

Appendix 7

I would like to thank you again for taking part in this research; your participation is greatly appreciated. If you feel you need any confidential support after taking part please see confidential helplines below.

Samaritans Ireland: free call **(01) 116 123** (open 24 hours a day)

http://ie.reachout.com/getting-help/online-and-telephone-help/samaritans-ireland/

The Aware Support Line: **1890 303 302** Available Monday – Sunday, 10am to 10pm (local rates apply).

http://www.aware.ie/help/support/support-line-information/#cost