Mental Health Attitudes, Support Preferences, and Prevalence of Self-Harm Among Young People

Keeva Tallon

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Supervisor: Dr. Lesley O’ Hara
Head of Department: Dr. Jonathan Murphy

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Department of Psychology
DBS
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ABSTRACT

Background: Mental health problems and self-harm are most prevalent during adolescence and emerging adulthood. There is a lack of research investigating young people’s reasons for engaging in self-harm and support preferences they would seek.

Objective: This study is intended to identify young people’s support preferences for mental health and self-harm, their willingness to seek help and the prevalence of self-harm

Method: This study was a cross sectional in between subject’s design. In the current study eighty-nine participants mainly between 15-25 years old completed online anonymous questionnaires on self-esteem, willingness to seek help inventory, and modified version of deliberate self-harm. Participants also viewed a vignette depicting a target with depression. A total of 10 adolescents took part from 2 schools in the research. Snowball sampling was used to recruit individuals over the age of 18 to 25 years.

Results: Majority of adolescents recognised the symptoms of depression from the vignette. 17% of respondents had engaged in self-harm. The most common reasons for self-harm were negative life events. Most common support preference was one to one therapy within mental health services. Low self-esteem predicted greater self-harm. High self-esteem predicted willingness to seek help. No gender differences on their willingness to seek support.

Conclusion: Self-harm is widespread but can be often a hidden phenomenon in youth. A vast number of young people delay in seeking any mental health and/or self-harm support and help.
1. INTRODUCTION

1.1 General Introduction

It can be said that the health and well-being of today’s youth have never been better. While this may be the case for the physical health of young people, the reality is that young people’s psychological and mental health has never been more damaging (Patel, Flisher, Hetrick, & McGorry, 2007). While the stigma of mental health has become less of a taboo to what it was years ago, individuals still feel reluctant and frightened to share their experiences with others. Mental Health is associated with the other dimensions of health and is defined as ‘a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community’ (World Health Organisation, 2005). Youth mental health refers to the mental and emotional well-being of young individual’s throughout the developmental phase of their journey into adulthood. This phase occurs approximately between the ages of 12 and 25 years.

1.2 Literature Review

Adolescence and young adulthood are crucial life stages for mental health; many difficulties emerge in early adolescence (Dooley, & Fitzgerald, 2012). The effect of mental health problems and disorders at this stage can be severe (Kosky, & Hardy, 1992). Social, emotional, and cognitive problems can be affected as a result and subsequently carried onto adulthood. For this reason, is it important to encourage young adolescences to seek help early. Youth mental health is a necessity for optimal psychological development, the development, and maintenance of positive social relationships, good physical health, the capability to care for oneself, efficient learning, and effective economic participation as
adults (Dooley & Fitzgeral, 2012). Almost 30% of third level college students meet the criteria for poor mental health (Said, Kypri, & Bowman, 2013). Common mental health issues among students are eating disorders, substance abuse, anxiety disorders, depression, and personality disorders (Blanco, Okuda, Wright, Hasin, Grant, Liu, & Olfson, 2008).

Self-harm is an act in which an individual deliberately initiates behaviour (such as self-cutting), or ingests a toxic substance, an illicit drug or none-ingestible substance of object, with the intention of causing harm to themselves with a non-fatal outcome (Madge, Hewitt, Hawton, Wilde, Corcoran, Fekete, & Ystgaard, 2008). This definition is the operational definition used throughout this research study. It is associated with varying levels of suicidal intent and a range of underlying causes for instance self-punishment, a cry for help, or loss of control (Griffin, Arensman, Corcoran, Wall, Williamson, & Perry, 2014). Deliberate self-harm is a major problem among Irish adolescents and majority don’t seek any help (Morey, Corcoran, Arensman, & Perry, 2008). Why individuals harm themselves and participate in self-harm behaviours is a complex human problem, with an exact purpose being difficult to distinguish. There is no ‘one size fits all’ to clarify why people engage in self-harm (Rowe, 2016).

Mental Health and Self-Harm in Ireland (Statistics and Previous Research)

Despite self-harm being a worldwide problem, there is an astonishing lack of research for the treatments of self-harm in children and adolescents. Ireland is the only country with a national registry of self-harm (Perry, Corcoran, Fitzgerald, Keeley, Reulbach, & Arensman, 2012). The Irish National Registry of Deliberate Self-Harm logged 42, 585 reports of Self-harm in Irish hospital emergency departments between 2003 and 2010 (Arensman, Larkin, Corcoran, Reulbach, & Perry, 2014). According to the Registry, which included all general
hospitals and paediatric hospital emergency departments in the Republic of Ireland, 8,708 individuals attended hospital in 2014 due to self-harm. Self-harm was found to be higher in young women aged 15-19 years old, in other words, one in every 147 girls. The peak rate for men aged was one in every 183 men between 20-24 years. In 2014, 66% of self-harm incidents involved medication overdoses. Drug overdose as a method of self-harm was more prevalent among women than men. The incidences occurred in 72% females and 58% males. Alcohol was implicated in 35% of the self-harm presentations. It was established that males (37%) self-harm cases involved alcohol more than female cases (33%). Another common method of self-harm was cutting, which included 26% of all episodes. Self-cutting was significantly more often involved in males than in females (28% and 24% respectively). 45% of presentations of self-cutting were most common among young boys under 15 years, girls under 15 years were 31%, while men under the age of 25 were 25%. Additionally, 7% of self-harm methods involved attempted hanging, 10% for males and 4% for females (Griffin et al, 2014). The majority of adolescents who self-harm do not attend the hospital for treatment (Madge et al, 2008) and therefore are never registered in the self-harm registry. A large-scale international comparative study of adolescent self-harm (CASE: Child and Adolescent Self-Harm in Europe) was conducted in Ireland, England, Netherlands, Belgium, Australia, and Hungary among 30,477 adolescents aged 14-17 years. The CASE study investigated the prevalence of deliberate self-harm acts and thoughts, reasons given, methods used, repetition, setting for the act, premeditation, hospitalisation, associations with alcohol and drugs, and whether other people were aware. Findings from the CASE study identified a lifetime prevalence rate of self-harm of 4.3% for males and 13.5% for females. The most common reasons for engaging in self-harm were ‘to get relief from a terrible state of mind’, ‘I wanted to punish myself’ and followed by ‘I wanted to die’ (Madge et al, 2008).
Suicide in Ireland among young people has created a sense of alarm and a great concern for the mental health and well-being of Irish young people. According to the National Office of Suicide Prevention Statistics (NOSP, 2010), the rate of suicide among young people in Ireland is the fourth highest in Europe. Self-harm is the major risk factor for suicide, yet as common self-harm is, it is a hidden phenomenon as the majority of self-harm occurrences does not come to the attention of health services (Hawton, Sanders, & O'Connor, 2012). While suicide is not the intention of self-harm, the association between suicide and self-harm is complicated for the reason that self-harming behaviour may be life-threatening. In addition, there is a greater risk of suicide among individuals who self-harm (Larkin, Di Blasi, & Arensman, 2014). At the same time, self-harm may be short-lived due to a response to a period of distress with no long-lasting implications (Moran, Coffey, Romaniuk, Olsson, Borschmann, Carlin, & Patton, 2012). It can also be a sign of the development of mental health problems, involving attempted and completed suicide, in later life (Hawton, Saunders, & O'Connor, 2012).

The ‘My World Survey’ the first national comprehensive study of youth mental health for those aged 12-25 years in Ireland found that youth mental health is increasing. (Dooley & Fitzgerald, 2012). The study found that two-thirds of young people reported talking to someone when they had problems. Males were unlikely to talk about their problems while females were more likely to. Over a fifth of young adults revealed that they had engaged in self-harm behaviours, and 7% attempted suicide. Young adults who did not seek help or discuss their problems with someone were found to have higher rates of self-harm, suicidal ideation, and suicide attempts. The survey found that the existence of one supportive adult present in a young person’s life is importance for their self-confidence, the ability to cope with their problems, sense of connectedness, and their well-being. More than 70% of young people disclosed that they receive support from an adult in their lives. The lifestyle and
Coping Survey was carried out on youth mental health in Ireland on 4,000 students (15-17 years) in the counties of Cork and Kerry. Young people were required to answer questions on the kinds of problems they may face and what helped them cope. 27% of adolescents surveyed were experiencing emotional, behavioural, personal, or mental health difficulties. No more than 18% of these young people sought professional help. Females compared to males showed more signs of depression (8% and 5% respectively) and had an emotional disorder (13% and 6% respectively). Females (14%) were also found to self-harm more than males (4%), Similar to McMahon and colleagues (2010) research which revealed self-harm to be more prevalent than males. The majority of adolescents stated their preference for seeking help if they were worried or upset was talking to friends. The next person they would likely to speak to was their mother, then siblings, and then to their father, while only a small number reported that they would talk to a healthcare professional or a teacher. Respondents were also asked for their thoughts on what could be done to improve things or young people. Young people’s recommendations included making young people aware of the help and treatment services that are available, give relevant information on mental health, educate young people, their family and friends on what to do, and to make it easy for young people to seek help in their schools and community.

Given the results of research conducted in Ireland, one in five young people is experiencing severe emotional distress, with only a small number in contact with any form of mental health services. The inconsistency between the comparatively high figures of Ireland’s youth with mental health problems and the low number of young people who seek help for their difficulties to a hidden population who are not seeking help (Dooley & Fitzgerald, 2012).

Only a small amount of studies have investigated non-suicidal self-injury (NSSI) or deliberate self-harm of body tissue without conscious suicidal intent and the reason for this
engagement (Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007). Earlier research found that adolescence seems to be a period with an increased risk for non-suicidal self-injurious behaviours first arise during adolescence (Nock, 2010). According to Laye-Gindhu, and Schonert-Reichl (2005) the primary intention of adolescent self-harm is emotional regulation. A research study that was conducted found 28% of 424 adolescents indicated moderate/severe NSSI. These included biting, hitting, burning the skin, and cutting or carving. Adolescents reported the reason behind their self-harm is to 'stop bad feelings,' feeling ‘in control of situation’, and for a ‘reaction.' Studies conducted on the gender differences in NSSI in young people have varied, with several studies suggesting that girls engage in NSSI more than boys (Guerry & Prinstein, 2010) while in contrast to other studies revealing no gender differences for NSSI (Hilt, Nock, Lloyd-Richardson, Prinstein, 2008).

**Help-seeking – Barriers and Support Preferences**

Help-seeking behaviours are vital for mental health and well-being. Seeking help is fundamental if individuals are to contact appropriate mental health services. Help-seeking can be defined as actively seeking help from other people. Communication is used to obtain advice, information, and support on upsetting issues/problems (Rickwood, Deane, Wilson, & Ciarrochi, 2005). Two types of help seeking are formal (professionals; youth workers, counsellors) and informal help-seeking (social relationships; friends and family). Research has shown that adolescences tend not to seek help from professionals (Rickwood et al, 2005) as a first protocol they would ask for help from friends and family members. Past experience with help-seeking has shown to influence individual’s attitudes toward help-seeking for mental health. These could be from personal experiences (Rickwood et al, 2005), or knowing somebody who has previously availed of mental health services. College students have a
more positive attitude towards seeking help from mental health services if they knew someone who has sought help previously (Vogel, Wade, Wester, Larson, & Hackler, 2007). However, if these experiences were to be negative, it may have had the opposite effect.

There is limited research on barriers to seeking help for mental health issues in young individuals aged between 12-19 years old. The most cited reason for individual’s barrier to professional help-seeking is stigma (Corrigan, 2004; Vogel, Wade, & Ascheman, 2009). In a recent systematic review, it was established that over half of adolescents who self-harm do not seek help; however, if they do, they are expected to speak to friends and family, particularly if they are female (Rowe, French, Henderson, Ougrin, Slade, & Moran, 2014). Six of the nineteen studies explored barriers to seeking help. The two most important factors were; not knowing where to find help or what to expect from the support they might receive (Klineberg, Kelly, Stansfeld, & Bhui, 2013) and having difficulties with access to appropriate services, for example in rural areas (Fadum, Stanley, Rossow, Mork, Törmoen, & Mehlum, 2013). Intrapsychic issues were widespread, including worry that there would be a loss of confidentiality or of being stigmatised (Davies, 2008), apprehension that parents or professionals would be unable to help (Berger, Hasking, & Martin, 2013), with this accentuated by suicidal thoughts and behaviour or poor mental health (Watanabe, N., Nishida, Shimodera, Inoue, Oshima, Sasaki, & Okazaki, 2012). Additionally, young people tend to believe they could or should cope alone, and dismiss their self-injury as being less severe than it is (Fortune, Sinclair, & Hawton, 2008). Research has suggested that young self-injurers do not receive help and support from anyone (Ystgaard, Arensman, Hawton, Madge, Heeringen, Hewitt, & Fekete, 2009). The unwillingness seeking help with self-harm may be more prominent in younger age groups (Michelmore, & Hindley, 2012). Young people often depend on others to notice their problems and react appropriately, instead of seeking appropriate help and support (Leavey, Rothi, & Paul, 2011).
Yap, Reavley, and Jorm (2013) conducted telephone interviews with 3021 young people between 15 and 25 years with the aim of assessing stigmatising attitudes and help-seeking intentions and helplessness beliefs. Five stigma scales that were used included: personally held weak-not-sick and not dangerousness beliefs perceived in others, weak-not-sick and dangerous, and social distance. Findings from the study propose that young people are more likely to seek help from informal sources if they feel the problem to be less dangerous or unpredictable characterise it to personal weakness instead of an illness and possess less desire for social distance. Recent research conducted by Pumpa and Martin (2015) which is the first research study to explore young people’s attitudes towards seeking professional help, and autonomy, on help-seeking for self-injury. This study involved 220 university students and young adults. Findings suggested that positive attitudes to seeking help accompanied greater intentions of help-seeking, while greater perceived autonomy was linked with lower intentions of help-seeking. Current self-injurers reported significantly higher negative attitudes towards seeking help for mental health issues in contrast to previous individuals who self-harmed and those with having no history of self-injury.

Young people are somewhat dependent on adults to acquire appropriate help for them. However, in a lot of situations, parents lack the knowledge and skills to be of any help (Rothi & Leavey, 2006). In other circumstances, young people may be hesitant to seek help from their parents or family, especially when family members are perceived to be part of the problem. In such cases, young people become dependent on external resources, school-based support or the family doctor (Leavey Rothi, & Paul, 2011). In a UK study conducted in 2011, their results revealed seeking help from friends was their preference for anxiety (66%) and depression (68%). General Practitioner was considered to be an appropriate source of support by students for food problems (32%), hearing voices (30%), feeling suicidal (20%), depression (10%), or anxiety (9%). School-based support (school nurses, counsellors, and
pastoral) were considered to be helpful by students. These results illustrate a concern for the lack of trust placed in professionals as a support preference (Leavey, Rothi, Paul, 2011).

Watsford, Rickwood, and Vanags (2013) investigated the unwillingness of twenty young people aged between 12 and 24 years from a youth mental health service in Australia to seek professional help. The most dominant theme that became apparent was that young people were uncertain of what to expect if they attended a mental health service. The young individuals did not know what to expect from their role of a client and unsure of what the therapy would involve. Many people are unaware of what they can do for the prevention of mental ill health, and usually delay or avoid seeking treatment altogether and doubt recommended treatments (Jorm, 2012). Dooley and Fitzgerald (2012) found that nearly 10% of adolescents and 20% of young adults stated that even though they felt they should seek professional help they did not. These young people reported having low levels of personal well-being and high levels of distress.

1.3 Current Study

The purpose of this study is to identify young people’s willingness to seek appropriate mental health help and support and what support preferences they would use. The background for help-seeking among youth has significant implications for understanding their service engagement and outcomes. A secondary aim of his study will also explore the prevalence of Deliberate Self-Harm which lacks research. Another purpose of this current study is to explore whether self-esteem may be a potential barrier for young people to seeking help. Young people may be unwilling to ask for help due to having low self-esteem. A further aim of this study is to examine is there any predictor association between young people’s gender and their willingness to seek help. Another goal of the research was to gain an insight into
young people’s ability to recognise by reading a vignette the most commonly mental health
issue youth are faced with today.

According to the HSE (2013), there is a considerable amount of evidence to suggest
that mental health promotion programmes, when put into effect in schools, can generate long-
term benefits for young individuals involving emotional and social function and an increase
in their academic performance. Previous literature has shown a lack of research done on
mental health attitudes and barriers to help-seeking among adolescences, in particular among
the Irish population. Self-harm among young people is very common, and there is a gap in
research as to reasons why and what can be done to prevent it happening in the future. It is,
therefore, vital for such research on these issues to be carried out and to implement long-term
intervention programmes to promote mental health and well-being. Schools are in a unique
position to promote mental health and well-being as attending school is compulsory therefore
they spend a lot of their time there, and teachers are in the position to be able to identify
young people experiencing emotional distress. The results of the current study will expand on
previous youth mental health literature on a willingness to seek help, support preferences and
self-harm, findings will aid young people to build supportive relationships both within their
formal and informal support systems. It is important to determine interventions that can
encourage young people to view professional help-seeking as a useful life skill that can
enhance their well-being and to determine interventions to reduce individual issues that
influence deliberate self-harm and encourage alternative life skills for communication,
positive coping and social support.
1.4 Hypotheses

Three hypotheses have been adapted from the results of previous research and aim to investigate the following:

1. The first research hypothesis is that young people with low self-esteem will have higher rates of self-harm and will share a strong hypothesis. P < .05

2. The second hypothesis is to investigate whether higher scores on self-esteem will predict young people’s willingness to seek help. P < .05

3. The third hypothesis is to investigate help-seeking. It is hypothesised that females will have significantly higher levels of help-seeking behaviours. P < .05

4. After doing further reading into the area, a fourth hypothesis/null hypothesis was added; that there will be no significant relationship between gender, support preferences, self-esteem, willingness to seek help, and self-harm. P > .05
2. METHODOLOGY

2.1 Design

The present study utilised a cross-sectional, between subjects, quantitative survey design to explore adolescents and emerging adulthood attitudes towards mental health, their support preferences when seeking help, and the prevalence of self-harm. The predictor variables (PV) included gender, support preferences, and self-esteem. The criterion variables (CV) included mental health attitudes, willingness to seek help, and barriers to seeking help. Additionally, thematic analysis was used as a form of qualitative analysis to explore the views of mental health of the young people, their reasons for engaging in self-harm and what helped them to overcome/deal with the problem.

2.2 Vignette

A vignette (see Appendix 7) describing a fictional, gender-neutral young person named ‘Sam’ was included at the start of the survey to be read by the participants. Participants were asked to answer open-ended questions relating to the attitudes towards this fictional young person’s mental health. The vignette that was included depicted the most common mental health illness among adolescents; depression (Patton, Coffey, Romaniuk, Mackinnon, Carlin, Degenhardt & Moran, 2014). The vignette was in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM) IV. Participants were asked to specify whether ‘Sam’ was male or female to eliminate any gender bias. To assess whether the participant’s recognised that the person depicted in the vignette suffered from depression, an open-ended question included ‘what do you feel is wrong with Sam’ which was coded as a right or wrong diagnosis. Participants were asked also asked ‘imagine Sam was a friend of
yours. What would be useful in helping Sam?’ and ‘If you were in Sam’s position which support service would you use?’

2.3 Participants
While many schools expressed an interest in the research, given the time constraints for completion of data, participation from the majority of secondary schools was hindered and suggested to be completed in the following term. Purposeful sampling of Transition Year cohort and 5th Year cohort was employed for the reason that state examinations are not required for these students. A total of 10 took part from 2 schools in the research. Both schools were mixed-gender. It was then considered also to include snowball sampling of individuals over the age of 18 to 25 years. The questionnaire was sent as a URL link to family, friends and student colleagues, who were requested to forward the link to their family and friends who met the age criteria. This type of sampling allowed for the greatest number of responses and ensured complete anonymity for the participants. Participation was voluntary with no monetary, or other rewards were offered.

2.4 Materials
The following instruments were compiled together onto an online survey tool using Google forms. Responses were made by ticking the box that applied to them. The materials utilized in the current study were self-report measures including Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965), Willingness to Seek Help Questionnaire (Mackenzie, Knox, Gekoski, & McCauley, 2004), Barriers to Adolescents seeking help (BASH) scale (Kuhl, Jarkon-Horlick, & Morrissey, 1997), and a Modified Version of Deliberate Self-Harm Inventory (DSHI; Lundh, Karim, & Quilisch, 2007). Other materials included in this study included the following; a letter of invitation (see Appendix 1) to the schools inviting them to
participate, short narrative of the research (see Appendix 2), parental and assent forms (see appendix 3 & 4), young person information sheet (see Appendix 5), and a list of local and national services (see Appendix 6).

**Rosenberg Self-Esteem Scale (RSES)**

Rosenberg’s Self-Esteem Scale was used to measure global feelings of self-acceptance and self-worth. The scale comprises of ten statements; five positively and five negatively phrased. The response format is structured as a four-point Likert scale (*strongly agree* to *strongly disagree*) (See Appendix 8). Examples of items include the following: ‘I feel that I’m a person of worth, at least on an equal plane with others.’ Items 1, 3, 4, 7 and 10 are scored strongly agree = 3, agree = 2, disagree = 1 and strongly disagree = 0, while items 2, 5, 6, 8 and 9 are reverse scored strongly agree = 0, agree = 1, disagree = 2 and strongly disagree =3. The items are then totalled (scores can range from 0-30). The total of the scores are added up for all ten items and the higher the score, suggests greater 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. Cronbach’s alpha was .892 which indicates a high level of internal consistency for this scale.

**Willingness to Seek Help Questionnaire**

This measure was chosen to investigate participant’s attitudes to seeking help for mental health. It consisted of twenty-four items and measures three concepts; psychological openness, help-seeking prosperity, and indifference to stigma (See Appendix 9). Participants were asked about their willingness to seek help for mental health problems, their views on seeking help for such problems and how open they would be to making themselves for such help. For these items, participants were asked to indicate on a 5 point Likert scale, ranging
from ‘strongly disagree’ to ‘strongly agree’ in the direction of positive attitudes towards help-seeking behaviour for mental illnesses. All the scores for each item are calculated to give an overall total, the higher the score, the higher the level of agreement with seeking help. Cronbach’s alpha reported to be .582.

**Modified version of Deliberate Self-Harm Inventory**

The original Deliberate Self-Harm Inventory (DSHI) is a self-report questionnaire that was constructed and validated by Gratz (2001). This survey consists of sixteen items that assess various aspects of deliberate self-harm (See Appendix 10). The modified version was chosen to explore the frequency of self-harming behaviour among young people. Responses were on a four-point Likert scale, ranging from ‘Never’ to ‘many times’, for example ‘Have you ever intentionally cut your wrist, arms, or other areas of your body?’. Cronbach’s alpha reported to be .872.

**Researcher-devised questionnaire**

The questionnaire devised by the researcher included demographic details such as gender, the level of education, whether they have been affected in the past or at present by a mental health issue and/or self-harm, and support services they would seek if they were affected by mental health. Support preferences were recorded by asking participants to tick all that apply to them (one to one therapy within schools, one to one therapy within mental health services, support groups, and online support). Self-harm was recorded if the participant answered in detail to the following question: ‘If you have engaged in deliberate self-harm, please tell us more about your details. How long before you told anyone?’ Participants were also asked to provide details on what helped them to overcome/deal with the problem and reasons for engaging in deliberate self-harm.
2.5 Procedures

A pilot study was administered to 8 college students before sending out the surveys to participants to calculate the time needed to complete the questionnaire, and to ensure that there were no problems with the procedure with the individualised links. Minor typographical errors were noted and corrected before data was collected.

Seventy-Six Irish second-level schools were randomly chosen from the education department website across Meath, Louth, and Dublin. The focus of these counties was chosen as mental health, and self-harm research was not conducted in these regions before. A letter of invitation and a narrative of the study were emailed to each of the schools and follow-up calls to participate in the research. Five youth clubs were also contacted. Two schools agreed to participate and recruit students to the study. Once permission was granted from the schools, they were sent via email the young person information sheet, parental consent form, student assent form, and a list of local and national services for the young person to contact in the event they felt vulnerable after completing the survey. The young person information sheet outlined that the purpose of conducting this research was to understand adolescences attitudes to mental health, prevalence of self-harm, preferences for support when seeking help, assurance of confidentiality and anonymity, and that the findings would contribute to determining interventions that can encourage adolescents to view help-seeking as a useful life skill that can enhance their well-being and to reduce individual issues that influences deliberate self-harm (DSH) and promote alternative life skills for communication, positive coping and social support.

The primary researcher visited each school on an agreed day with the school vice principals. The researcher verbally informed potential participants that the purpose of the study was to gather information on adolescent’s attitudes towards mental health, their support
preferences for seeking help and self-harm. It was requested that the participants would answer all items honestly. Student participants were given the opportunity to ask questions about the research and online survey. School principals distributed the young person information sheets, consent and assent forms, and a list of services. No monetary incentives were offered. Participants who returned both the consent and assent forms signed were returned to their school vice principals. A box was left in the school’s vice principals office for students to drop their signed forms into, this meant that students who wished to take part could anonymously leave their forms. Participants with both forms signed were included in the mailing list for the researcher, who then emailed the online questionnaires by individualised links, where participants simply clicked on the link and filled out the survey. The individualised links contained a unique study ID number (e.g. 159). If the researcher becomes concerned for the well-being of the respondent based on their responses to the questionnaire, the researcher may use the Study ID number to identify the respondent and take the necessary steps to report concerns to the school and parent/guardian. The first page of the online survey clarified the general purpose of the present research (see Appendix 11). Online questionnaires were used for this study as participants could think through their answer in a non-pressurised environment. Reminder emails were sent to students one week later to remind students to fill out the survey. The survey took approximately 15 minutes to complete. Participants recruited via snowball sampling were automatically directed to the survey via URL link.

2.6 Ethics

The current study was given approval by DBS School of Psychology Research Ethics Committee and the researcher adhered to all ethical principles in the code of professional ethics. Participants had the right to withdraw at any stage. The study was entirely voluntary,
and participants were not identifiable to protect the participants survey answers data was stored securely on a password protected laptop. As the research involved data collection with adolescents, informed parental/guardian consent and participant assent was necessary as well as permission from participating schools. Participants under eighteen years were verbally and in writing informed that confidentiality and anonymity cannot be guaranteed if information or an indication that a participant’s safety or well-being is being negatively affected. It was likely that participants might experience negative feelings associated with questions about distressing events. Potential participants were informed of this possible situation at the outset of the research. A list of local and national services was included at the end of the survey and distributed initially to the schools taking part if the questions answered in the survey should evoke any emotional discomfort, distress, memories and/or negative feelings. The researcher used a step-by-step procedure on how to manage any risk that may arise (See Appendix 12).
3. RESULTS

3.1 Overview

Data was analysed using SPSS (Statistical Package for Social Sciences) version 22 according to APA Publication Manual 6th edition (American Psychological Association, 2010). Data analyses included descriptive statistics (Mean, Standard Deviations, minimum and maximum), Chi-square, Linear Regression, and Spearman’s Rho correlation. Items from the Rosenberg’s self-esteem measure were reverse coded to that high scores indicated high individual self-esteem. Independent samples t-test was used to examine the difference between gender, self-esteem, and willingness to seek help. Spearman’s Rho correlation was used to check if high rates of self-harm were greater in individuals with low levels of self-esteem. Linear regression was used to test if individual’s high levels of self-esteem predicted young people’s willingness to seek help.

3.2 Descriptive statistics

Descriptive statistics were used to make comparisons of the data set. A report of the means ($M$), standard deviations ($SD$), minimum and maximum levels of the predictor and criterion variables are shown in Table 1 below. The self-esteem scale ranges from 0-30 with 30 indicating the highest score possible. Scores between 15 and 25 are within normal range and scores below 15 suggest low self-esteem.

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-esteem</td>
<td>17.43</td>
<td>5.46</td>
<td>7.0</td>
<td>30.0</td>
</tr>
<tr>
<td>Willingness to seek help</td>
<td>46.89</td>
<td>9.07</td>
<td>27.0</td>
<td>72.0</td>
</tr>
<tr>
<td>Self-harm</td>
<td>18.51</td>
<td>5.66</td>
<td>15.0</td>
<td>44.0</td>
</tr>
</tbody>
</table>

$N = 89$
The present study had a total of 89 participants \((N = 89)\) that completed the survey. No missing values were logged as the survey required participants to answer all questions before proceeding. 30.2\% of the respondents were male \((N = 27)\) the remaining 69.7\% of respondents were female \((N = 62)\), aged between 15 and 25 years. Participants were asked their level of education 2.2\% \((N = 2)\) of the participants were in transition year, 9\% \((N = 8)\) were in 5\textsuperscript{th} year, 50.6\% \((N = 45)\) were third level education, and 38.2\% \((N = 34)\) were other. 59.6\% \((N = 53)\) had been affected in the past by a mental health issue and/or self-harm, 32.6\% \((N = 29)\) were presently being affected by a mental health problem and/or self-harm.

Table 2 (below) shows this demographic results and related data.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>27</td>
<td>30.3</td>
</tr>
<tr>
<td>Female</td>
<td>62</td>
<td>69.7</td>
</tr>
<tr>
<td>Level of education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TY</td>
<td>2</td>
<td>2.2</td>
</tr>
<tr>
<td>5\textsuperscript{th} year</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>3\textsuperscript{rd} level</td>
<td>45</td>
<td>50.6</td>
</tr>
<tr>
<td>Other</td>
<td>34</td>
<td>38.2</td>
</tr>
<tr>
<td>Mental health (present)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>29</td>
<td>32.6</td>
</tr>
<tr>
<td>No</td>
<td>60</td>
<td>67.4</td>
</tr>
<tr>
<td>Mental health (past)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>53</td>
<td>59.6</td>
</tr>
<tr>
<td>No</td>
<td>36</td>
<td>40.4</td>
</tr>
</tbody>
</table>

Visual determination of normality was conducted to carry out parametric or nonparametric tests. A histogram and scatterplot were used to analyse if a linear line of strength was shown. The data showed a bimodal distribution, requiring nonparametric tests.

### 3.3 Inferential statistics

To determine whether there was a difference present between male and female and their support preferences, a Chi-square test for independence was conducted (see Table 3). The
result indicated no significant association between gender and support preferences, $\chi^2 (3, n = 89) = 2.77, p = .43$

Table 3: Frequencies and Percentages of Gender and Support Preferences

<table>
<thead>
<tr>
<th>Support Preferences</th>
<th>Male n and % of total</th>
<th>Female n and &amp; of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>One to one therapy within schools</td>
<td>11.1% (n = 3)</td>
<td>11.3% (n = 7)</td>
</tr>
<tr>
<td>One to one therapy within mental health services</td>
<td>66.7% (n = 18)</td>
<td>66.1% (n = 41)</td>
</tr>
<tr>
<td>Support group</td>
<td>18.5% (n = 5)</td>
<td>9.7% (n = 6)</td>
</tr>
<tr>
<td>Online support</td>
<td>3.70% (n = 1)</td>
<td>12.9% (n = 8)</td>
</tr>
</tbody>
</table>

Hypothesis 1

The assumption that individuals with low levels of self-esteem would have higher levels of self-harm was calculated by a spearman’s Rho. A Spearman’s Rho correlation test found that there was a strong, positive monotonic correlation between self-esteem and self-harm ($r_s = - .31, n = 87, p < .001$). The lower the participant’s self-esteem was associated with higher rates of self-harm. Therefore, in this case, the researcher’s hypothesis was supported predicting a strong relationship between these two variables.

Hypothesis 2

A linear regression was conducted to determine if higher scores on self-esteem would predict young people’s willingness to seek help. Using simple linear regression, it was found that self-esteem significantly predicted willingness to ask for help $F (1, 87) = 6.68, P = 0.11$ (self-esteem, Beta = -.267) (see Table 4). High self-esteem in individuals were more likely to seek help. Therefore, the null hypothesis can be rejected.
Table 4: Model Summary

<table>
<thead>
<tr>
<th>Model</th>
<th>R Square</th>
<th>Adjusted R</th>
<th>Std. Error of the Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>.267*</td>
<td>.071</td>
<td>.061</td>
<td>8.80</td>
</tr>
</tbody>
</table>

a. Predictor value: Total self-esteem  
b. Dependent variable: IASHMS

Hypothesis 3

In relation to the third hypothesis of the research, it was expected that females would have a statistical difference between males, with females having a higher level of help-seeking behaviours. It was predicted that females would have a higher score in seeking help than males. Comparing males and females it was found that males had a mean rank of 43.67 compared to females who had a mean rank of 45.58. A Mann-Whitney revealed no significant difference in the willingness to seek help levels of males and females ($U = 801, z = -.32, p = .748$). Therefore, the null hypothesis is accepted.

Table 5: Mann-Whitney U displaying the differences in willingness to seek help between males and females

<table>
<thead>
<tr>
<th>Variable</th>
<th>Gender</th>
<th>Mean Rank</th>
<th>U</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>IASHMS</td>
<td>Males</td>
<td>43.67</td>
<td>801</td>
<td>.748</td>
</tr>
<tr>
<td></td>
<td>Females</td>
<td>45.58</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

P is significant at 0.05 significant values marked with *

A Mann-Whitney U test was also used to predict any significant differences that may exist between gender and their self-esteem. It was found that males had a mean rank of 49.19 compared to females which have a mean rank of 43.18. A Mann-Whitney revealed that males and females didn’t differ significantly ($U = 724, z = -1.01, p = .312$). In this case, the null hypothesis is accepted.
3.4 Vignette

1. Target Gender

After reading the vignette, participants were asked to indicate whether they thought ‘Sam,’ the character in the story was male or female. Interestingly, contrary to literature suggesting that depressive disorders in adolescence are more prevalent in girls than boys, 79% of respondents thought the target character to be male. Figure 1 displays the percentage of participants who anticipated Sam to be male or female.

*Figure 1: Target Gender of Sam*

![Figure 1: Target Gender of Sam]

2. Support Service Preferences

Participants were asked if they were in Sam’s position which support preference would they use. Figure 2 shows the percentage of support services considered by the respondents to be helpful for Sam. Participants were more liable to seek one to one therapy within a mental
health service. Those who correctly labelled Sam from the vignette as depressed were most likely to seek help from a mental health service.

Figure 2: Respondents Support Service Preferences

Support preferences

3.5 Thematic Analysis

A Microsoft program Nvivo 11 was used to analyse the data obtained from the open-ended questions. This program allowed the researcher to review the transcript and divide them into different themes. Transcripts were analysed using thematic analysis (TA). TA is a method used in qualitative analysis ‘for identifying, analysing, and reporting patterns (themes) within data’ (Braun & Clarke, 2006). TA was selected as the method of analysis mainly because of its accessibility and its flexibility for the researcher. An inductive approach to the data coding and analysis, ‘bottom up’ approach was preferred for this research. However, it is impossible to be entirely inductive, as the researcher will bring something to the data when it is being
analysed. Quotations from the open-ended questions are used throughout to ensure that the participants who took part have a voice in this research and to assist the reader’s understanding.

**Vignette - Recognition of Disorder**

Participants were asked to indicate what they believed to be Sam’s problem. For the correct diagnose for the vignette, forty-six participants correctly diagnosed Sam to be “suffering from depression” or to be exhibiting “common symptoms of depression”. Most of the other participants said that Sam being the age of sixteen was going through “hormonal changes” due to “puberty” and having a “hard time dealing with the physical and psychological changes in the late teen years.” Some respondents did not give a diagnosis but alternatively answered with general characterisations of Sam’s behavioural, social, or psychological issues. Many of the young respondents, may have been projecting personal experiences, identifying common life stressors that many adolescents experience. One respondent disclosed “I chose that same is a male due to the similarity in the issue that is affecting Sam to issues that have affected myself.” Additional a respondent, implied the spirit of existential ennui, proposing that “sometimes for all the things people do every day regularly they become exhausted with all these things. I think he is feeling bored”. Concerning an illustration of a young person experiencing depression, the respondents predicted Sam to be facing some typical adolescent problems including the pressure of school, experiencing family problems and bullying. The majority of Respondents showed to have a familiarity with depressive symptoms.
Vignette – Help and Support for Sam

TA analysis of the data generated themes relating to what would be useful in helping Sam. These themes included talking and listening, formal organisations, and activities.

1. Talking and listening

Participants commented that to help Sam; they would offer to talk and listen to him. This was found to be the most common theme that emerged. Examples of the participant’s responses were: “Offering a listening ear and a shoulder to cry on in a safe space”. “Talk to him…Externalise the problem”. “Call them, ask to meet up and talk.” “Talking to Sam about the problem, asking questions and letting Sam speak as opposed to just firing advice off the bat.” “Talk to him about it and let him know I’m always there for him.” “I would take the time out to talk to Sam.” “Listening to his problems.”

While the majority of respondents emphasised that both talking and listening would help Sam, one individual who choose male as Sam’s gender reflected the importance of gender differences in young people’s influences of help-seeking. It was suggested, “I’d open up to Sam about how it's ok to feel like he does. There is a lot of research on gender stereotype threat, but it rarely focuses on men. Men aren't allowed to be "weak." Sometimes it takes someone to show them it's ok”.

2. Formal organisations

Respondents mention that Sam should contact professionals, such as a general practitioner, therapist, mental health charities, counsellors, and a school teacher.

“Visit his GP.” “Seek medical advice.” “I’d send Sam to a good ACT therapist.” “I would suggest he talk to someone like Samaritans or SOSAD.” “See the school counsellor.” “Tell and adult or teacher or someone who knows Sam and that can help them.”
3. Activities

Some respondents suggested for Sam to engage in activities, for example, “try to encourage physical activity” and “I would go out of my way to involve Sam in activities with friends.”

**Deliberate Self-Harm**

Responses were analysed qualitatively using TA analysis. Themes identified through the researcher’s analysis were superficial cutting of the skin, developing an eating disorder, and potentially life-threatening overdoses. 19 out of the 89 participants (17%) answered this question in detail, revealing they had engaged in self-harm. The descriptions below demonstrate the type of self-harm behaviours utilised by young people which were not stated in the deliberate self-harm inventory questionnaire.

1. Superficial cutting

   “Scarred stuff on my skin using an electronic shaker. Biting the buccal mucosa constantly to the point of it getting disfigured from the chronic biting.”

   “Dragged knuckles along walls hit ‘self’ with implements placed fingers in vices or pliers.”

2. Eating disorder

   “Refuse to eat and avoid food intentionally, ultimately developing an eating disorder and harming myself and my body.”

3. Overdose

   “Took an overdose.”

   “I once drank good night liquid.”
Precipitants of Deliberate Self-Harm

The question about the participant's involvement of deliberate self-harm attempted to answer and give an insight into young people’s self-injurious behaviours. Themes identified through TA analysis were superficial cutting, seeking help, and timeframe before seeking help. Examples of the young people’s descriptions of their acts of self-harm are provided below to illustrate the nature of the action.

1. Superficial cutting of the skin

“Have cut up my arms and legs and picked the scabs so it wouldn’t heal.”

“I had intentionally cut my palm.”

*I engaged in self-harm from an early age up until my early twenties, I primarily engaged in two forms, blunt for trauma in order to try focus my mind on a single point i.e. pain and provide some objective mark in the present moment...the second kind was cutting, this was usually in times when an episode was going beyond my control*

2. Seeking help

One of the participants who had self-harmed wanted others to see the self-harm; looking for a reaction, perhaps asking for help.

‘I remember when I was younger slightly trying to let people see it, on the Luas I’d push up my sleeves a little.’

3. Timeframe before seeking help

Participants who reported a history of self-harm were asked how long before they had the courage to ask for help or tell somebody.

“Was self-harming almost every day in several ways. I did this for a year before I sought help.”
“My form of self-harm lasted roughly a year… It was 1 year and 6 months before I told somebody about it.”

“It was over a year before I told my friend. My family members are still unaware I ever did it.”

“…I didn’t tell anyone until years later in therapy and again while getting the scars tattooed over.”

For other participants, access to help happened very quickly:

“Oh very soon it was a shock to myself that I did it and felt like I needed an answer.”

For some participants their first step in getting help for their self-harm was over a year before they sought help and confided in another person, revealing that it may have been difficult for individuals to tell someone. Help was sought from friends than a family member.

**Overcoming/dealing with Deliberate Self-Harm**

The following section includes a summary of the sources of support chosen by the young individuals based on their answers to the open-ended question on what helped them to deal with their self-injurious behaviour. Themes identified through the researcher’s TA analysis the main themes were mental health services, family/friends, school-based services, Other themes identified were identifying triggers, coping, self-acceptance, medication, exercise, time, and activities.

1. Mental health services

One of the main themes that helped the respondents from self-harming was access to formal sources of support, such as a “good counsellor”, “one to one psychotherapy”, “getting psychological help”. One of the participants attended a mental health service, after engaging
in self-harm progressed to suicidal ideation. “It ended up getting so bad that I attempted to take my life in other forms of self-harm, and I went to PietaHouse” (a free counselling service dealing specifically with suicidal ideation and self-harm). However, the same participant stated:

*I was young and didn’t want the help so I was stubborn and not open to being helped. I tried a little to engage and understand that what I was feeling was not okay for someone to feel, but I just didn’t click with the counsellor, and so I stopped going there. I soon went to another clinic and with general life progression and the help of seeking someone every week to vent out my mind, I slowly but surely stopped self-harming.*

While individuals may request professional help, it may be unsuccessful initially. Therapeutic relationship between the client and professional is essential for a successful long-term outcome.

*The ability to talk frankly with a therapist, the therapist himself was not exceptionally knowledgeable, and the effect I revived from therapy was somewhat of the old Dodo bird verdict, but nevertheless the ability to show completely how much distress I was in was a relief if nothing else. As up until that point I always felt that I had a constant internal battle within myself to control my mind, and if I let go for a second, I would completely lose control and most likely end up dead.*

2. Friends/family

Many respondents confided in family members and their inner circle of friends about their deliberate self-harm behaviour:

“Supportive and caring parents who helped me seek a good counsellor,”

“Talking with family and friends.”

“Telling a friend I was feeling depressed and suicidal.”

“My friends helped me; I would confide in them if I was upset they would cheer me up and be around me as much as they could so I wouldn’t be alone.”
3. School-based services

However, some respondents confided in other respected individuals such as a teacher who may find the situation less difficult to be objective. Concerning school-based services, it would appear that participants access help through a school counsellor “going for counselling to my psychology teacher”.

4. Identifying triggers

Participant’s responses also included identifying self-harm triggers. In particular, one respondent learned how to recognise their feelings that trigger their need to self-harm and by doing so developed healthier alternatives.

*My knowledge on the subject matter helps, I honestly do not know anyone who knows more about this subject than me...it is always a case of understanding that when I feel an episode emerging I take action and then simply wait for it to pass over...things that helped were engaging in projects which focused my mind, I completed a few degrees and in general directed the manic part of my mind towards healthy pursuits...certain forms of art and music really uplift me, Bach always picks me up and engaging in odd but pleasant rituals helps, i.e. playing Bac's air really loudly when no one is around while writing college assignments makes me feel inspired in somewhat of a transcendental way*

5. Coping and self-acceptance

“Learn how to cope with depression and anxiety.”

“Realisation that I have the option to change my view on things. That once you change your view on the situation, the situation itself will change.”

*Accepting the fact that, for lack of a better term, I am somewhat mad. Self-acceptance is important and understanding that I am what I am and that whilst it is different from the average and can be deeply distressing at times it can also be positive as I don’t think I would know nearly as much or understand nearly as much as I do if I had normal though patterns.*
Reasons for engaging in DSH

Self-harm is complex, having various aspects that pre-dispose, trigger, and maintain behaviour. Through TA analysis it appears from the open-ended question that triggers of self-harm among the young participants comprised of significant life events, trauma, distress, unhappiness and emotional pain. The central theme emerged was mental health issues, most commonly suffering from depression.

“High nervous tension and stress.”

“…due to abuse (e.g. neglect) in childhood.”

“Mam died.”

“It felt like a release and it made my low moods feel better…it was kind of the only thing I could control.”

“I was bullied a lot in school and out of school especially by boys so my self-esteem was very low.”

The quotes above are examples regarding the interpersonal traumas that trigger self-harming behaviour; the death of a significant other, being bullied and the internalisation (interpersonal) of those experiences, stress.
4. DISCUSSION

Dealing with mental health problems and self-harm is a hurdle many young people are confronted with in Ireland. This chapter illustrates the Irish-based research findings for youth mental health support preferences and self-harm. This study also investigated the willingness to seek help and support preferences young people would avail. This was achieved by using a quantitative cross-sectional in between subject’s design with qualitative elements including open-ended questions to gain a greater knowledge of young people’s deliberate self-harm. Findings are reported from a representative sample of 15-25 year olds. This age group was chosen due to the lack of Irish research on this cohort. Participants were not asked to include their nationality. However, this study was based in Ireland, and the researcher was aware that there were some different nationalities that participated in the study. More than half (60%) of young people indicated that they were affected by mental health issues in the past while 33% of the 89 participants were currently affected. In general, both males and females (67% and 66% respectively) indicated that they were more likely to seek help from mental health services if they were being affected by mental health.

4.1 Findings and Interpretation of Results

The results from this research presented interesting findings. The results suggest that individual’s self-esteem would contribute to higher self-harm. It was hypothesised that young people with low self-esteem would have higher rates of self-harm. A spearman’s Rho correlation was conducted to investigate if low self-esteem was correlated highly with self-harm. The lower participant’s self-esteem, the stronger the relationships between higher levels of self-harm. However, if self-esteem were found to be high, there would have been a negative correlation. Therefore, Key findings supported the original hypothesis predicting a
close relationship and the null hypothesis was rejected. This supports similar findings from Madge and colleagues (2011) that the increase in the severity of self-harm significantly was related to lower self-esteem.

The second hypothesis investigated whether higher scores on self-esteem would significantly predict young people’s willingness to seek help. Results from the linear regression indicated higher levels of self-esteem would contribute to young people to seeking help and support. Therefore, the null hypothesis was rejected. The third hypothesis investigated help-seeking behaviours, which females would have significantly higher levels than males. Although previous research has both supported and rejected this hypothesis, results from the Mann-Whitney represented no significant difference in scores between males and females. Therefore the null hypothesis was accepted. The findings from this study are parallel to Burns and Rapee (2006) results of research which established that there are no gender differences in help-seeking behaviours. A possibly reason for this study to find no statistical differences between males and females may be due to the study have a larger sample of females than males. A Mann-Whitney test was also conducted to find any differences between gender and their levels of self-esteem. Analysis revealed that there was no significant difference between these two groups.

If only a minority of those experiencing mental health difficulties and engaging in self-harm are willing to seek help, many young people are navigating the challenges of youth without any support from constructive services or help. There is numerous evidence from research that when appropriate support is provided to young people with mental health difficulties, many recover or at most acquire coping strategies to effectively manage the stresses in their lives (Evans, Hawton, & Rodham, 2005).
Young people’s depression literacy appeared to be quite accurate. Participants were able to correctly to identify depression and depressive symptoms from the vignette. This is not surprising from the recent rise in the level of awareness and attitudes to mental health from the HSE. Such campaigns should not limit to raising awareness about but to also encourage individuals who are being affected by mental health issues and/or self-harm to seek help.

When participants were asked to indicate what support preference they would seek help from if they were in the same position as the target character in the vignette, respondents were more likely to find support from one to one therapy within a mental health service (71%) and least likely to seek online support (23%).

The study confirms that self-harm among young people is clearly a major problem, with 17% of young people in this study having engaged in self-harm. The majority of youth with deliberate self-harm indicated that triggers and reasons for their deliberate self-harm were serious emotional, personal, or mental health problems. Engaging in self-harm may set in motion for the risk of a suicidal act. Negative life events, including being bullied at school were associated with self-harm, which supports other studies findings that discovered that young people who experience negative life events are more inclined to self-harm (Hawton et al, 2012). Psychological characteristics and prevalence of self-harm, and concerning stressful life events and self-harm were also found in other countries (Madge et al, 2011).

The vast majority of young people had access to and commonly sought help from formal sources of support such as counselling and mental health services. Others with deliberate self-harm were likely to talk to their friends and family. These findings suggest that young people, parents and family members should be provided with education and advice on the best ways to help those with mental health and self-harm problems. Though this
is quite a lot of responsibility for adolescents and young adults. However, if they are one of the central sources of help for troubled youth, it is essential that they are provided with appropriate education in how to deal with their important role. Therefore, it is important for schools to increase mental health promotion and teaching in the context of programmes and workshops being implemented.

4.2 Strengths and Limitations of Research

This study hopes to fill the gap in youth mental health literature about self-esteem as a potential barrier to seeking help, support preferences young people would use, the prevalence of self-harm, and depression literacy. The open-ended question regarding support for overcoming deliberate self-harm provided the research with a better insight into the support young people found beneficial in overcoming their self-injurious behaviours and reasons for their self-harm. This provided the researcher with further information and gave a better understanding of the young people’s mental health and self-harm. The current research also offers a more of an understanding of support preference across typical mental health problems and support that helped to overcome and deal with deliberate self-harm. Furthermore, the survey results are underpinned by the data derived from the comments made by the young people themselves. The open-ended answers from the majority of the young people were brief with their responses. The information provided by these young people confirmed that self-harm is a worrying issue for young people, and their seeking of help and support was no less than a year and for some never sought help. This study highlighted a need for this to be investigated further.

The main findings are not likely to substantially have an impact by the limitations inherent in the collection of data from this study; however, they must be taken into consideration. In relation to the vignette, soccer was mentioned as the target characters’
hobby. This may have been suggestive to the respondents that ‘Sam’ was male. Another limitation to be considered is that the study represented results more from young adults than adolescents, with having a small school-based sample (TY = 2, 5th year = 8) and an unequal distribution of females and males that were included (F = 6, M = 27) could have influenced the results. The researcher would have preferred to have carried out this research study on a much larger school-based sample, however, due to time constraints of the dissertation having to be done in a short amount of time this was not feasible.

**4.3 Implications for Future Research**

Recommendations for future research for self-harm should ask participants their length of engagement and reasons for their hesitation in telling a supportive adult or attending a mental health service. An astonishing number of young people who self-harmed stated it was over a year before they sought any help. It would be helpful for future research to distinguish the reasons for this and implement strategies to help individuals ask for help for self-harm sooner before it leads to life-threatening results. Further research is needed to establish whether there is a lack of support or if young people would rather isolate themselves when experiencing mental health problems and self-harm. As mentioned before, there is a gap in self-harm research. Future research is needed to clarify why some young people may not seek help from professionals or talk with friends or family, having only a small number of individuals to talk to may be a risk factor for deliberate self-harm in young people. Longitudinal research would be suitable to shed light on young people’s views for not speaking out about their self-injurious behaviours.

While thematic analysis is an easy way of identifying and exploring themes that emerged from the respondent’s answers, it provided detailed accounts of young people’s reasons for engaging self-harm and what helped them to prevent from continuing. Possible
future research could include a qualitative approach of young people with mental health problems and deliberate self-harm and what support preferences that used and compared same. Finally, another recommendation to further this study is to include a qualitative approach incorporating interviews from principals and/or teachers about the school's mental health promotion and implementation of mental health programmes and thus comparing school’s attitudes towards young people’s mental health and well-being. Previous research findings on gender and stigma have been diverse. Future studies in the area should attempt to clarify the gender of the character being described in the vignettes, as the name of the individual in the current vignette was gender neutral. This will assist in surveying a gender-balanced sample.

4.4 Dissemination Plan

The purpose of the dissemination of the evidence-based findings of this research is to spread the information to an audience of mental health professionals, schools, health care settings, service organisations by attending conference presentations and workshops to improve services for young people. Beginning of dissemination will include publication in a peer-reviewed journal that regularly publishes mental health journals. However, publishing of this study, manual only strategy is not enough to create change among young people’s mental health and deliberate self-harm as key audiences such as programme implementers, mental health workers may be inclined to read the implementation research process. Press release and social media (e.g. Facebook/Twitter/LinkedIn SlideShare's/Google+) will also be considered as a disseminator for the research evidence. Information regarding the results from this should help to make a difference for young people experiencing mental health and self-harm and achieving positive outcomes.
Dissemination on-site and in-person visits to schools of programs that could be implemented. Efficient development of coping skills, especially problem-solving skills could be achieved through Cognitive Behavioural Therapy (CBT) in the hope of reducing adolescent self-harm, depressive symptoms, and enhancing emotional intelligence and strengths. A guide could be provided to teachers, students, family members on how to help someone with mental health problems and/or self-harm through a computer-based training program to reduce training costs. The lack of dissemination of evidence-based research for mental health problems in adolescents is poor, consequently resulting in barriers to offering effective and resourceful mental health care (Chambers, Wang, & Insel, 2010).

4.5 Conclusion

In conclusion, self-harm and mental health is a widespread problem. The present study found young people had no particular pattern of self-harm among young people, however, associations in the risks for engaging in self-harm, were both stressful life events and psychological characteristics. Results showed to have no gender difference in seeking help; higher self-esteem increased willingness to ask for help, and low self-esteem increased self-injurious behaviours. Self-harm is common among young people yet it is a hidden phenomenon and a vast amount delaying in seeking any support or help from friends, family, or professionals. It is vital that the global community thoughts are changed about young people and their mental health by ensuring that mental health services are developmentally and age appropriate in addition to young people having an active voice in determining what is best for them.
REFERENCES


Rowe, J. (2016). *What are “functional social supports” and how do they impact the desire to self-harm in individuals who have a history of intentional self-harm?* (Doctoral dissertation, University of Otago).


Dear Principal

Re: Permission to conduct research

Keeva Tallon is enrolled as a student in the Masters of Science in Applied Psychology at Dublin Business School. DBS psychology students are required to complete an independent research project as part of their Masters. Keeva wishes to conduct research within secondary schools using questionnaires to assess the prevalence of self-harm, attitudes to mental health and support preferences to help-seeking behaviour.

All research conducted by students is done for the purpose of meeting course requirements but for the purpose of this course there must be an applied aspect to the research i.e. it must aim to provide socially useful results/recommendations. Keeva is currently seeking formal ethical approval from DBS ethics committee for this research project idea and is requesting written permission, to collect research data from students across 8 schools.

Keeva (Email: keevatallon@hotmail.co.uk) has attached a study narrative with this letter and can provide further details about how she will conduct her research study if required.

Please feel free to also address any questions regarding this research to Dr. Jonathan Murphy, Programme Leader MSc in Applied Psychology, Department of Psychology, Dublin Business School.

Thank you for your time.

Yours Sincerely,

Dr Jonathan Murphy
Programme Leader MSc Applied Psychology

01-4178774
APPENDIX 2

Narrative of Study

According to the World Health Organisation (WHO), 1 in 5 adolescences is affected by a mental health problem. To date, there is very little research on Irish adolescences mental health attitudes and self-injurious behaviours. Results of this study will provide valuable data and expansion on previous adolescent mental health literature on attitudes and support preferences to help-seeking and deliberate self-harm (DSH).

The main aim of my study is to determine factors that inhibit help-seeking behaviours for adolescences mental health problems and to determine interventions that can alter adolescences cognitions and encourage to view professional help-seeking as a useful life skill that can enhance their well-being. In addition, identifying interventions that can reduce individual issues that influence-suicidal self-injury (NSSI) and deliberate self-harm (DSH) and encourage alternative life skills for communication, positive coping and social support. Also to help young students to build supportive relationships both within their formal and informal support systems.

Participation in this research study is voluntary. Students will be briefed on the study and consent forms will be provided to be brought home to get a parent and/or guardian to sign, assent form will also be given for the students. Students with no permission to take part in this research study will be excluded. Students who do take part will have the right to withdraw at any stage. All information provided will remain confidential and will only be reported as group data with no identifying information. All data will be kept in a secure location, and only those directly involved with the research will have access to them.

The research study will be conducted on transition year and 5th-year students in May 2016, as not to interfere with the junior and leaving certificate. Students will be required at home to fill out a 15-minute questionnaire or in school if you wish. Some of the questions included in the self-report questionnaires may provide some emotional discomfort. In the event that they feel vulnerable afterwards, each participant will be provided with a resource pack including contact information of local and national mental health services. In the event the researcher does become concerned for the welfare of any of the participants following their survey answers, you the school, parents and guardians of the participant will be notified. Appropriate support will be offered to the student and family.

A short Interview comprising of 4 questions with either a teacher or a school guidance counsellor will be conducted on what they feel are the primary mental health issues that are present in your school among the students.

If you any other further questions in relation to my study, please do not hesitate to contact me on 085-1490205 or keevatallon@hotmail.co.uk or my supervisor Dr. Lesley O’Hara at Lesley.ohara@ucd.ie
Mental Health Attitudes and Support Preferences towards Help-seeking and the Prevalence of Self-Harm Among Young People

**STUDY ID NUMBER:**
This will be provided by email with the survey. It is important that this ID number is included at the start of the survey.

**Introduction**
Your child is being asked to be involved in a study researching mental health attitudes and support preferences when seeking appropriate support and prevalence of self-harm among Irish adolescents. S/he was selected as a possible participant because your child is in the age range (15-18 years) that is of interest to the study. You are asked that you read this form and ask any questions that you may have before allowing your child to participate in this study. This study will contribute to the researcher’s completion of her master’s thesis.

**Purpose of Study**
The purpose of the study is to determine interventions that can encourage adolescents to view help-seeking as a useful life skill that can enhance their well-being and to reduce individual issues that influence deliberate self-harm (DSH) and promote alternative life skills for communication, positive coping and social support. Ultimately, this research may be published. This study will be conducted in the Month of May.

**Description of the Study Procedures**
Should you decide to allow your child to participate in this research study, you will be asked to sign this consent form once all your questions have been answered to your satisfaction. This study consists of a survey that will be administered to individual participants at home via email or in class. Your child will be asked to provide answers to a series of questions related to their attitudes to mental health, support preferences they would seek if needed and various aspects of self-harm. Participation in this study will require 15 minutes of your child’s time.

**Risks/Discomforts of Being in this Study**

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Some questions may cause some emotional discomfort. In the event your child experiences any negative feelings and feels vulnerable after the research, a list of local and national services will be provided for your child to contact. If the researcher does become concerned for the welfare of your child following their survey answers confidentiality and anonymity will have to be broken. You and the school with be notified and appropriate support will be offered.

**Benefits of Being in the Study**

It is not guaranteed that your child will personally experience benefits from participating in this study. Others may benefit in the future from the information we find in this study.

**Payments**

You/your child will receive no payment/reimbursement.

**Anonymity**

This study is anonymous. The records of this study will be kept strictly confidential. Research records will be maintained in a secure location, and all electronic information will be coded and secured using a password protected file. It will not be possible to identify your child in any information that is published.

**Confidentiality**

All information that is collected about your child during the course of the research will be kept strictly confidential. The only exception to this would be if a significant risk to your child is identified by the researcher, in which case this information will be passed on to the school principal, and you the parent/guardian.

The results of this research will be presented at Dublin Business School and Psychological Society of Ireland. Your child will be identified in the research records by a code number. Your child is not asked for his/her name. The researcher retains the right to use and publish non-identifiable data. When the results of this research are published or discussed in conferences, no information will be included that would reveal your child’s identity. All data will be stored in a secure location accessible only to the researcher. Upon completion of the study, all information that matches up individual respondents with their answers will be destroyed.

**Right to Refuse or Withdraw**

The decision to participate in this study is entirely up to you and your child. Your child may refuse to take part in the study at any time. Your child has the right not to answer any single question, as well as to withdraw entirely from the survey at any point during the process without any negative consequences.

**Right to Ask Questions**

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact, Keeva at 1656232@mydbs.ie or Dr. Lesley O’Hara at Lesley.ohara@ucd.ie. If you
like, a copy of the final aggregate results of this study will be sent to you. If you have any other concerns about your rights as a research participant that has not been answered by the researcher, you may contact Dr. Jonathan Murphy, Programme Leader MSc in Applied Psychology, Department of Psychology, Dublin Business School.

Consent
Your signature below indicates that you have decided to allow your child participate as a research subject for this study and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep, along with any other printed materials deemed necessary by the study researcher. Please return this piece of paper to the school principal.

☐ I have read and understood the information provided about this research project
☐ I have had an opportunity to ask questions and to have them answered.
☐ I understand that I may withdraw my child/children or any information that we have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
☐ I give consent for my child/children to participate in this research.

I wish to receive a copy of the report from the research (please tick one): Yes ☐ No ☐

Name of Child (printed): ____________________________

Parent/Guardian Name: ____________________________

Parent/Guardian
Signature: ____________________________ Date: ________

Email Address: ____________________________

Name of school: ____________________________

Researchers Signature: ____________________________ Date: ________
APPENDIX 4

Mental Health Attitudes and Support Preferences towards Help-seeking and the Prevalence of Self-Harm Among Young People

**STUDY ID NUMBER:**
This will be given to you by email with the survey. Please keep a record of this and include your study ID number at the start of the survey.

To be completed by individuals under the age of 18. This must be accompanied and returned to the school with a parental consent form.

A research study is being carried out to understand adolescences attitudes to mental health and preferences when seeking appropriate support and self-harm. Mental health is all about looking after your head. At times life can be tough, and we all go through ups and downs in our health, relationships, work or school. Good mental health involves having the skills and support networks to deal with life’s challenges. A *mental health problem* can occur when an individual’s thoughts and/or feelings are troubling them, affecting their day to day activities and/or relationships.

A research study is a way to learn more about people. If you decide that you want to be part of this study, you will be required to fill out a survey at home taking approximately 15 minutes. Questions will include a short story of a young person and questions on how to solve the problem. You will also be asked a series of questions about self-esteem, attitudes to help-seeking and self-harm.

Participation is completely voluntary and you do not have to take part. You also have the right to withdraw from the study even if you have started the survey. Participating in this survey is completely confidential and anonymous. Questionnaires used are anonymous therefore you will not be asked for your name, and you are only identifiable to me by your study ID number. No identifiable information will appear on any of the questionnaires.
Once data has been collected after you have completed the survey, you cannot withdraw. Results from the survey will be kept on a password protected computer. It is not known if you will directly be helped by being in this study.

If you experience some emotional discomfort, emotional memories, or negative feelings about some of the questions asked, please contact one of the lists of services that are provided. If the researcher becomes concerned for your welfare confidentiality and anonymity cannot be guaranteed and may have to be broken. If information has been disclosed or an indication that your safety or well-being is being negatively affected your school and parent/guardian will be notified, and you and your family will receive appropriate support.

When this research is finished, a report will be written up about what was learned. This report will not include your name or that you were in the study.

If you have any further questions or concerns don’t hesitate to contact me at 1656232@mydbs.ie

If you decide to be part of this study, please sign your name below and return it to your principal with your parental consent form. Thanks

☐ I have read and understood what this research is about and my involvement.

☐ I understand that while the information is being collected, I can stop being part of this study whenever I want and that it is perfectly ok for me to do this.

☐ If I stop being part of the survey, I understand that all information will be destroyed.

☐ I would like to participate in this research.

Participants name: ________________________________________________

Participants Signature: ___________________________________________ Date: ______________________
APPENDIX 5

Young Person Information Sheet

**Title of the study:** Mental Health Attitudes and Support Preferences Towards Help-seeking and the Prevalence of Self-Harm Among Young People

**Introduction**
I would like to invite you to take part in this research project conducted by a researcher from Dublin Business School. The study is being carried out to understand adolescents attitudes to mental health and reasons to why some adolescents do not seek help and reasons for self-harm. Please take the time to read this information sheet as it will tell you what the study is about, why it’s being conducted and your involvement of taking part.

**What is the purpose of the study?**
This research study is focused on determining interventions that can encourage adolescents to view help-seeking as a useful life skill that can enhance their well-being and to reduce individual issues that influences deliberate self-harm (DSH) and promote alternative life skills for communication, positive coping and social support.

**Why have I been asked?**
To date, there is very little research on Irish adolescences mental health attitudes and self-injurious behaviours.

**Do I have to take part?**
No. The decision to participate in this study is entirely up to you. You can stop your involvement in this study at any time.

**What if I change my mind during the study?**
At any stage you feel that you want to stop taking part in this research, you are free to stop and take no further part. There are no negative consequences for changing your mind about being in the study and you do not have to explain why. Any research data collected before your withdrawal will not be used.

**Who else is taking part in this study?**
Young people aged 15-18 from your school and other secondary schools from Louth, Meath, and Dublin. Only transition and 5th year students will be asked to participate as not to interfere with the junior and leaving certificate.
What will I have to do?
You will be asked to complete a series of online questionnaires. There will be questions regarding attitudes to mental health, Support preferences you would prefer, and self-harm. It will take approximately 15 minutes to complete the set of questionnaires. You can complete these questionnaires by yourself at home using a computer.

What are the possible benefits of taking part?
It is not guaranteed that you will personally experience direct benefits from participating in this study. However, others may benefit in the future from the information that is found in this study.

Will my taking part in this study be kept confidential?
Yes. Ethical procedures and legal practice will be followed, and all information about you will be handled in confidence. All information that is collected about you during the research will be kept strictly confidential. The only exception to this will be if the researcher becomes concerned for your welfare or if your well-being is being negatively affected. In this event, the researcher may need to pass information to your school, and parent/guardian. All data records related to your participation in this research study will be stored in a secure location accessible only to the researcher. The information you provide will not be identifiable to you and instead a code number will be used so that you will not be recognised. It is important to include your study ID number that will be contained in the email sent to you with your survey.

What will happen to the results of this research study?
It is intended that results from this research will be published and that individual participants will be not be identified in any report/publication.

Who has reviewed this study?
The research has been reviewed and approved by the DBS School of Psychology Research Ethics Committee and the researcher adhered to all ethical principles in the code of professional ethics.

What if I have more questions or do not understand something?
If you do not understand any aspect of the research, please contact either of the researchers and discuss any questions that you might have. It is important that you feel completely at ease during the research.

Further information and contact details
If you have any further questions or concerns about this study don’t hesitate to contact Keeva by email on 1656232@mydbs.ie

Thank you for taking the time to read this information sheet!
APPENDIX 6

List of Local and National Services

If you feel anyway vulnerable, please contact at least of the following services

- **SOSAD Ireland**: a registered charity whose mission is to help anyone affected by suicide through awareness campaigns, suicide prevention, suicide intervention and suicide postvention. SOSAD also deals with mental health issues. SOSAD is available **24 hours a day, 7 days a week** for anybody who is in crisis.
  All SOSAD numbers are 24 hour emergency lines.
  Web: [www.sosadireland.ie](http://www.sosadireland.ie) or [info@sosadireland.ie](mailto:info@sosadireland.ie)
  - SOSAD Drogheda: Phone: 041 9848754  Mobile: 086 669 8735
  - SOSAD Navan: Phone: 046 9031855  Mobile: 083 371 2622
  - SOSAD Dundalk: Phone: 042 9327311  Mobile: 083 424 1882

- **AWARE**: AWARE provides support and information to individuals and families affected by depression.
  - Helpline: 1890 303 302
  - Phone: 086 162 948
  - Online support: [wecanhelp@aware.ie](mailto:wecanhelp@aware.ie)
  - Email: [info@aware.ie](mailto:info@aware.ie)
  - Web: [www.aware.ie](http://www.aware.ie)

- **Jigsaw Meath**: Jigsaw aims to ensure that young people have a voice in their own mental health and wellbeing concerns and that the community is supported in finding innovative ways to provide solutions.
  - 26 Brews Hill, Navan, Co. Meath
  - Phone: 046 906 7246
  - Email: [meath@jigsaw.ie](mailto:meath@jigsaw.ie)

- **HSE information Helpline**: The ‘HSE info line’ aims to provide the public with any access to information on over 100 health and social service topics.
  - 8am to 8pm Monday-Sunday with a 24hr Answer Machine Service
  - Phone: 1850 24 1850
  - Email: [info@hse.ie](mailto:info@hse.ie)

- **Support Helplines**:
  - ChildLine: [www.childline.ie](http://www.childline.ie)  (Live chat)  Phone: 1800 66 6666
  - Samaritan’s: Free call: 116 123
  - Teenline: If you are feeling lonely, isolated, down, vulnerable, depressed or suicidal: 1800 83 3634
  - HeadsUP: List of support services for youth, free text HeadsUP to, 50424

- **Support Websites**:
  - [www.spunout.ie](http://www.spunout.ie): Youth-led national charity to empower young people to create personal & social change
  - [www.reachout.com](http://www.reachout.com): Provides information on stress, anxiety, bullying, suicide, depression, bipolar, and other issues that can affect your mental health and well-being
  - [www.yourmentalhealth.ie](http://www.yourmentalhealth.ie)
INTRODUCTION:

1. Please read the following case about Sam.
2. Answer the questions about your personal opinion.

CASE 1:

Sam is 16 years old. For the past few weeks, Sam is feeling unusually sad, and miserable and has found it difficult to concentrate in school. Sam has always done well in school but recently this has changed. Generally, Sam is sociable and attends Soccer every week, but recently has stopped attending weekly practices and has decided not to take part in the Soccer tournament. Even though Sam is tired all the time, Sam has trouble sleeping nearly every night. Sam doesn’t feel like eating and has lost some weight. Sam does not recall anything, in particular, has happened over the past few weeks, and Sam does not understand what is going on or why. Sam has become noticeably withdrawn from friends and family in the past several weeks.

1. Is Sam male or female?
2. What do you feel is wrong with Sam?
3. Imagine Sam was a friend of yours. What would be useful in helping Sam?
4. If you were in Sam’s position which support service would you use?
   a. One to one therapy within schools
   b. One to one therapy with mental health services
   c. Support group
   d. Online support
APPENDIX 8

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**.

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>SA</th>
<th>A</th>
<th>D</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>On the whole, I am satisfied with myself.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>At times, I think I am no good at all.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>I feel that I have a number of good qualities.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>I am able to do things as well as most other people.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>I feel I do not have much to be proud of.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>I certainly feel useless at times.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>I feel that I’m a person of worth, at least on an equal plane with others.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>I wish I could have more respect for myself.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>All in all, I am inclined to feel that I am a failure.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>I take a positive attitude toward myself.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 9
Inventory of Attitudes Toward Seeking Mental Health Services

The term professional refers to individuals who have been trained to deal with mental health problems (e.g., psychologists, psychiatrists, social workers, and family physicians). The term psychological problems refer to reasons one might visit a professional. Similar terms include mental health concerns, emotional problems, mental troubles, and personal difficulties.

For each item, indicate whether you strongly disagree (0) partially disagree (1) neither agree or disagree (2) Partially agree (3) strongly agree (4)

1. There are certain problems which should not be discussed outside of one's immediate family. .............. 0 1 2 3 4

2. I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems. ......................... 0 1 2 3 4

3. I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems. ......................... 0 1 2 3 4

4. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns. .............. 0 1 2 3 4

5. If good friends asked my advice about a psychological problem, I might recommend that they see a professional. ......................... 0 1 2 3 4

6. Having been mentally ill carries with it a burden of Shame. ......................... 0 1 2 3 4

7. It is probably best not to know everything about
8. If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy.

9. People should work out their own problems; getting professional help should be a last resort.

10. If I were to experience psychological problems, I could get professional help if I wanted to.

11. Important people in my life would think less of me if they were to find out that I was experiencing psychological problems.

12. Psychological problems, like many things, tend to work out by themselves.

13. It would be relatively easy for me to find the time to see a professional for psychological problems.

14. There are experiences in my life I would not discuss with anyone.

15. I would want to get professional help if I were worried or upset for a long period of time.

16. I would be uncomfortable seeking professional help for psychological problems because people in me
17. Having been diagnosed with a mental disorder is a blot on a person's life. 

18. There is something admirable in the attitude of people who are willing to cope with their conflicts and fears without resorting to professional help.

19. If I believed I were having a mental breakdown, my first inclination would be to get professional attention.

20. I would feel uneasy going to a professional because of what some people would think.

21. People with strong characters can get over psychological problems by themselves and would have little need for professional help.

22. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.

23. Had I received treatment for psychological problems, I would not feel that it ought to be "covered up."

24. I would be embarrassed if my neighbour saw me going into the office of a professional who deals with psychological problems.
APPENDIX 10

This questionnaire asks about a number of different things that people sometimes do to hurt themselves. Please be sure to read each question carefully and respond honestly. Often, people who do these kinds of things to themselves keep it a secret, for a variety of reasons. However, honest responses to these questions will provide us with greater understanding and knowledge about these behaviours and the best way to help people. Please answer yes to a question only if you did the behaviour intentionally, or on purpose, to hurt yourself. Do not respond yes if you did something accidentally (e.g., you tripped and banged your head on accident). Also, please be assured that your responses are completely confidential. Please tick the box for each answer.

For each item, indicate whether you (1) never (2) once (3) more than once (4) many times

1. Have you ever intentionally cut your wrist, arms, or other areas of your body?

   1  2  3  4

2. Have you ever intentionally burned yourself with a cigarette, lighter or a match?

   1  2  3  4

3. Have you ever intentionally carved words, pictures, designs or other marks into your skin?

   1  2  3  4

4. Have you ever intentionally severely scratched yourself, to the extent that scarring or bleeding occurred?

   1  2  3  4

5. Have you ever intentionally bit yourself, to the extent that you broke the skin?

   1  2  3  4

6. Have you ever intentionally rubbed sandpaper on your body?

   1  2  3  4

7. Have you ever intentionally dripped acid onto your skin?

   1  2  3  4

8. Have you ever intentionally used bleach, comet, or oven cleaner to scrub your skin?

   1  2  3  4
9. Have you ever intentionally stuck sharp objects such as needles, pins, staples, etc. into your skin? (not including tattoos, ear piercing, needles used for drug use, or body piercing)

1 2 3 4

10. Have you ever intentionally rubbed glass into your skin?

1 2 3 4

11. Have you ever intentionally broken your own bones?

1 2 3 4

12. Have you ever intentionally banged your head against something, to the extent that you caused a bruise to appear?

1 2 3 4

13. Have you ever intentionally punched yourself, to the extent that you caused a bruise to appear?

1 2 3 4

14. Have you ever intentionally prevented wounds from healing?

1 2 3 4

15. Have you ever done anything else to hurt yourself that was not asked about in this questionnaire? If yes, what did you do to hurt yourself? ________________________________

1 2 3 4

16. Have you ever intentionally hurt yourself in any of the above-mentioned ways so that it led to hospitalization or injury severe enough to require medical treatment?

1 2 3 4
APPENDIX 11

Mental Health Attitudes, Support Preferences, and Prevalence of Self-Harm Among Adolescences and Emerging Adulthood

My name is Keeva, and I am a master’s student in Dublin Business School carrying out research on attitudes towards mental health issues, support preferences when seeking appropriate support and prevalence of deliberate self-harm (DSH) among Irish adolescences and emerging adulthood (15-25 yrs.).

The survey begins with some demographic questions and is followed by a short vignette (story) of a young person facing some problems. It is followed by questions on how to solve the problem. You will then be asked to complete a series of questions about self-esteem, attitudes toward seeking help, and self-harm. It will approximately take 15 minutes to complete.

Participation is entirely voluntary, and you do not have to participate. You also have the right to refuse to answer any questions and to withdraw from the study at any time. Participating in this survey is completely confidential and anonymous.

However, for those under the age of 18 (with a study ID number), if I become concerned about your welfare confidentiality and anonymity cannot be guaranteed and may have to be broken. If information has been disclosed or an indication that your safety or well-being is being negatively affected your school and parent/guardian will be notified, and you and your family will receive appropriate support.

* Required
I understand and agree to participate in this research study *

- [ ] Yes
- [ ] No
APPENDIX 12

RISK MANAGEMENT PLAN

If a student is seen at risk, a statement of intent to break confidentiality must be made by the researcher before assessment to inform them of the course of action that needs to be taken should the student disclose any information that would put themselves at risk.

Ensure you have obtained details of student’s school and study ID number

The risk is defined as suicide intent, serious deliberate self-harm, serious harm.