The Influence of Childhood Therapy on Current Attitudes Towards Seeking

Mental Health Services.

Sophia Martin

16358986

National College of Ireland, School of Business, Dublin, Ireland.

July 2019

BA (Honours) Psychology

Submission of Thesis and Dissertation

National College of Ireland

Research Students Declaration Form

(Thesis/Author Declaration Form)

Name: Sophia Martin

Student Number: 16358986

Degree for which thesis is submitted: Bachelors of Arts (Honours) In Psychology, full-time.

Material submitted for award

(a) I declare that the work has been composed by myself.

(b) I declare that all verbatim extracts contained in the thesis have been distinguished by quotation marks and the sources of information specifically acknowledged.

(c) My thesis will be included in electronic format in the College Institutional Repository TRAP (thesis reports and projects)

(d) *Either* *I declare that no material contained in the thesis has been used in any other submission for an academic award.

Or *I declare that the following material contained in the thesis formed part of a submission for the award of

BA (Honours) in Psychology at National College of Ireland.

Signature of research student: _Sophia Martin_

Date: 31/07/2019

Submission of Thesis to Norma Smurfit Library, National College of Ireland

Student name: <u>Sophia Martin</u>   Student number: <u>16358986</u>

School: <u>National College of Ireland</u>   Course: <u>Bachelors of Arts (Honours) in Psychology, full-time</u>.
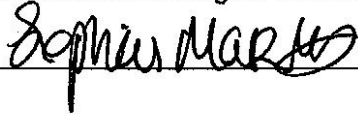
Degree to be awarded<u>: BA (Hons) in Psychology</u>

Title of Thesis: <u>The Influence of Childhood Therapy on Current Attitudes Towards Seeking Mental Health Services.</u>

One hard bound copy of your thesis will be lodged in the Norma Smurfit Library and will be available for consultation. The electronic copy will be accessible in TRAP (http://trap.ncirl.ie/), the National College of Ireland's Institutional Repository. In accordance with normal academic library practice all theses lodged in the National College of Ireland Institutional Repository (TRAP) are made available on open access.

I agree to a hard bound copy of my thesis being available for consultation in the library. I also agree to an electronic copy of my thesis being made publicly available on the National College of Ireland's Institutional Repository TRAP.

Signature of Candidate: _____

For completion by the School:
The aforementioned thesis was received by_____ Date:_____

This signed form must be appended to all hard bound and electronic copies of your thesis submitted to your school

Acknowledgements

I would like to thank my family for their unconditional love and support. Their faith in me never wavered, even when mine did. To my close friends who encouraged me throughout the past few months not to give up. I would like to thank everyone who has helped me in the past three years at National College of Ireland. Without them I would have never been able to get to where I am now. Thank you to all the friends I made at National College of Ireland, who never let me doubt myself during the past few months. The support from them made a world of difference. I would like to also thank everyone who shared my survey online and to all participants who took part, there would be no research without them. Finally, I would like to thank the staff at National College of Ireland who have who helped me for the duration of my thesis.

Abstract

Objective: This study aimed to investigate the relationship between childhood therapy and current attitudes towards seeking mental health services. Childhood therapy is defined in this study as any exposure to therapy or counselling under the age of 18. It also looked to find a link between child therapy and resilience later in adult life. Gender was investigated in relation to positive attitudes towards seeking mental health services. Attitudes and stigma are the main barriers that prevent people from seeking professional psychological care and mental health services. The Inventory of Attitudes Towards Seeking Mental Health Services was used to record the attitudes of 94 participants. The Resilience Appraisal scale was also used to measure the level of resilience a person had. There was no significant difference found for IASMHS scores for those who went to child therapy and those who did not. Resilience was also not significantly different between the two groups. This study was voluntary and those who engaged with this research may have already had positive attitudes toward seeking mental health services.

Table of Content

Chapter One. Introduction

Mental disorders can be defined as a disruption in cognitive functions that have a serious impact on the social, economic and emotional well being of an individual (Wong, Delmer & Kessler, 2002). They are a global concern with suicide as a leading cause of death in young adults across the world (Patton et al, 2009). Stigma surrounding mental health and mental disorders interferes and hinders with professional and adequate care for mental health. It can prevent individuals seeking help and lead their mental health to decline further, decreasing their chances of recovery (Clement et al, 2015). A significantly large volume of lifetime mental disorders begin from early childhood into adolescence (Tully, Hawes, Doyle, Sawyer & Dadds, 2019). The first onset of symptoms can start to develop under the age of 10 years old. Early intervention can help lessen the severity of the mental disorder later in life (Kessler et al, 2005). Research has shown that those who engage with mental health services respond well and receive treatment to help them recover. Despite evolution and progression of mental health services, there is a large number of individuals with mental health issues that do not seek help from mental health services (Kohn, Saxena, Levav & Saraceno, 2004).

1.1 Stigma and Attitudes Towards Seeking Mental Health Services.

Stigma is any negative social reaction to those who struggle with their mental health (Patten et al, 2016). Stigma has also historically caused issues with the development of mental health services and their quality (Sartorius, 1998). There is a large treatment gap for a vast amount of people who experience mental health difficulties. A response to this is to improve mental health services and progress in research worldwide (Eaton et al, 2011). With the rising

levels of those suffering from a mental disorder, there is a call for education on mental health worldwide. Mental health literacy is considered a tool to combat stigma and raise awareness (Patel, 2014). The words mental health and mental disorders carry a stigma that often leaves a heavy burden on those who suffer with their mental health.. It can be caused by multiple factors such as family, peers and past experience with mental health services. Stigma impedes individuals from engaging with mental health services as the fear of being discovered or discriminated against as a result of being associated with the taboo that follows mental health and mental disorders (Corrigan, 2004). Stigma adds to the burden of mental disorders that affect over 25% of the population, according to the World Trade Organisation (WTO, 2001). Health policy makers and professional health care providers have taken stigma into consideration when deciding on how to move forward with improving mental health services (Dalky, 2011).

Previous research has shown that stigma is the leading cause for individuals to avoid seeking professional care (Griffiths et al, 2006: Reavley & Jorm, 2011). In 2003 Corrigan, Thompson, Lambert, Sangster and Noel conducted a study to investigate the discrimination and stigma those who had serious mental disorder faced. They asked participants to self-report the stigma they faced for their mental disorder and to also describe discimination they face for other factors such as race, gender and religion. There were 1,824 participants in this study with 949 of them have reported experiencing more stigma in relation to their mental disorder than anything else. In Warsaw, Poland 442 people were recruited from various mental health services using convenience sampling to take part in a study by Switaj et al, 2012. All participants were over 18 years of age and were deemed fit to be in a stable condition by a professional. They were given the Consumer Experiences of Stigma Questionnaire (Wahl, 1999) to record the frequency and

type of stigma they faced. Stigma from co-workers was the most common reports with family a close second. Over half of participants also said they avoided mentioning their mental disorder in applying for jobs, school or housing to prevent stigma and facing backlash. The results showed high levels of stigma was experienced by those who attend mental health services and that they have had to actively hide the fact to avoid any social repercussion from friends and family. Another study carried out in 2010 by Have et al, found that previous use of mental health services were significantly associated with positive attitudes towards seeking mental health aid. The study looked to investigate the attitudes towards mental health help-seeking across Europe, focusing on countries such as Germany, Italy and Spain.

Gonzalez, Alegria, Prihoda, Copeland and Zeber, 2009, launched an investigation into the factors that influence attitudes towards seeking mental health services was carried out with 5,691 participants over the age of 18 years old. Participants were asked to report their age, gender, ethnical origin and education. They were also asked to include their marital status, income, insurance status, previous mental health treatments and their psychiatric needs. They used a cross-sectional nationwide probability sample survey that provided date prevalence from the DSM-IV. Their results showed that attitudes were majority positive while one third of the participants would feel slightly embarrassed or ashamed if their friends knew they were attending a mental health service. The main result was previous attendance to professional specialised care for psychological distress was positively associated with positive attitudes towards seeking mental health services and willingness to talk with a professional. Failure to engage with treatment for a mental disorder due to any reason can cause serious distress and negative effects on an individuals quality of life. A study carried out in America on the

prevalence of mental disorders found one in four children across the U.S. are in need of mental health services. This study highlights the need for improved children mental health service and focus on early intervention, treatment and prevention (Merikangas et al, 2010).

1.2 Child Therapy and Resilience.

Child therapy is lacking in research compared to adult therapy (Shirk & Karver, 2003). There is a growing interest in the area of child psychology as children themselves rely on adults, parents and professionals for their psychological care. It can be difficult for parents to distinguish if behaviours are due to common development or cause of concern. This can be especially difficult with young children (Tully, Hawes, Doyle, Sawyer & Dadds, 2019). Research has shown that if a parent has had previous experience with mental health services, depending on the efficiency and quality, it can impede their judgment of child mental health services (Nock, Phil, & Kazdin, 2001). Interventions include access to health care such as a general practitioner or a child mental health service (Bassilios et al, 2016). The number of children experiencing mental disorder is growing at an alarming rate and are expected to increase another 50% by 2020 compared to 2014 (McIntosh, Ty & Miller, 2014). One in five school students qualify for a mental disorder diagnosis but less than 20% of them receive treatment (Hoagwood & Johnson, 2003). The first point of contact with mental health services for the majority of children has been found to be education based. A longitudinal study of 3 years found 55% of participants first encounter with mental health care was through their school. The study concluded that although students were engaging in service at schools they were not followed up with child and adolescent mental health services (Farmer et al, 2003).

Resilience can be defined as the resistance to psychosocial risk experiences (Rutter,

1999). It also includes the ability to overcome emotional distress and adversity in an individual's environment. Resilience is also a skill that can be learned through cognitive behaviour therapy (CBT). Padesky and Mooney, 2012, created a four-step strengths-based CBT model to help build positive qualities. This model can be accessed at any age and can result in lifelong skills that are flexible to any situation. For children this resilience can play a key role in their developmental years and coping with any emotional distress later in life. Another model called FRIENDS created by Stallard et al, 2005, promoted emotional resilience was trialled with children aged 9-10 years old from six different schools. This CBT intervention aimed to test the efficiency of the programme. The results showed 197 children with significantly lower levels of anxiety and improved self esteem. In over half of the children identified to have severe emotional problems there were significant improvements. As well as being effective, the 190 children involved in this study reported it was fun and would recommend their it to friends. They also said they learned new skills and even helped another student with their skills. A 2006 study found long lasting effects of resilience based intervention for students post disaster in Israel. This study had parents teachers and children report symptoms on their post traumatic stress disorder (PTSD) symptoms shown by the child. Significant improvements were seen three months after the termination of the intervention. The results showed the importance of resilience in recovery and adjustment for children who have experienced traumatic events (Wolmer, Hamiel, Barchas, Slone, & Laor, 2011).

1.3 The current study

Based on previous studies it is evident that those who have engaged with a mental health

service before have reported a more positive attitude towards seeking mental health services. James and Buttle, 2008 found that those who had a history of engaging with mental health services scored higher on the Inventory of Attitudes Towards Seeking Mental Health Services (IASMHS: Mackenzie, Knox, Gekoski, & Macaulay, 2004). This scale measures if an individual has a positive or negative attitude towards seeking mental health services. They also discovered that young adults were more likely to have had contact with a mental health service than older adults. Resilience is often a key factor in therapy and can aid individuals in adapting to adverse and distressing events in their lives. Resilience and indifference to stigma have been associated, those who have engaged with therapy report lower levels of stigma and score high on resilience due to the skills they gained through therapy. In previous research being female has been a leading factor that influences the attitudes towards seeking mental health services.

1.3.1 Rationale. Previous experience with mental health services is the leading factor in influencing attitudes towards seeking mental health services. Children who engage with child therapy services often report lower levels of internalised stigma and improved self esteem. While there has been improvements in research surrounding the area of child therapy and its long term effects, the research neglects the stigma and lifelong impact it can have on attitudes. Majority of research conducted on child therapy is cross-sectional rather than longitudinal. This research is also cross sectional but aims to investigate the relationship of child therapy on current attitudes towards seeking mental health services. There are three hypotheses in this study, they are as follows:

Hypothesis 1: Adults who have attended child therapy under the age of 18 will score higher on the IASMHS than those who did not engage with child mental health services.

Research has shown that those who previously engaged with any type of mental health service report positive attitudes towards seeking mental health services and it is often a defining factor in their willingness to seek professional psychological care. This impacts their health as should they find themselves under emotional distress again they are more likely to reach out to mental health services and receive treatment.

Hypothesis 2: Individuals who have engaged in child therapy under the age of 18 will report higher levels of resilience on the Resilience Appraisal Scale.

Through different types of therapy, resilience skills and emotional coping have been key elements to treatment in children and adult therapy. Child therapy is often incorporated with CBT based interventions including resilience as research has shown that it plays a major role in recovery from a traumatic or emotionally distressing event. Resilience is also a useful life tool especially during the developmental years when children and adolescents alike need to adapt and adjust to major changes in their lives.

Hypothesis 3: Females will report more positive attitudes towards seeking mental health services than any other gender.

Females have reported higher levels of psychological openness and reduced stigma compared to other genders. This has been supported through various research. The suggested reason is that females face less stigma than other genders when it comes to their emotions. These stereotypes can damage perceptions of mental health services.

1.3.2 Aims. There are gaps in literature about early exposure to therapy and its effect on stigma in the population. This research aims to see if attending a child mental health service

under the age of 18 and gender impacts the attitude towards mental health service later in life. It also looks to investigate the relationship between child therapy and resilience. Improving the attitudes towards mental health services is theorised to deflate stigma and encourage mental health literacy among children and adults alike. Childhood therapy was defined in this research as any type of therapy, including counselling, talking therapy or cognitive behaviour therapy, received under the age of 18 years old.

Chapter 2. Methods

1.1 Participants

This study was conducted with 94 people. All participants stated that they were 18 years of age or older. There was 83 (88.3%) females, 9 (9.6%) males and 2 (2.1%) prefer not to say their gender. 50% (47 participants) declared they attended therapy under the age of 18 and 50% did not. Specific ages were not required. All 94 participants gave their consent to partake in this questionnaire. The only inclusion criteria for this study was the participant must be over the age of 18. The participants were recruited through social media (Facebook, Twitter and Instagram) between March 4th 2019 and April 12th 2019. This sample was gathered through convenience sampling. Snowball sampling was used as the survey was available for participants to share on their own social media. Participants took part in this study voluntarily.

1.2 Design

This research contains a between group design. It is a cross sectional and quantitative study. The study consisted of two scales. There were two dependent variables in this study. The first was current attitudes towards seeking mental health services. The second dependent variable is the level of resilience participants reported. The independent variable was attendance to childhood therapy under the age of 18.

1.3 Measurements

This study was conducted on Google Forms and all data was collected from the survey through this service. This gave all participants the ability to partake without revealing their

identities. No identifying information was required for this study. There were five parts to this study (1) information sheet, (2) demographics and consent, (3) The Inventory of Attitudes Towards Seeking Mental Health Services, (4) Resilience Appraisal Scale and (5) de-briefing sheet. Before the survey began, there was an information sheet detailing the nature of the study, what their answers will be used for and the participants rights to withdraw at any time without penalty. It also stated that all participants must be over 18 years old to complete the survey. See Appendix A for the information sheet. The next page recorded the demographics and consent of the participant. There were four questions on this page. Each was question was completed by clicking on the answer that suited the participant. There were three demographics recorded. These were that the participant was over 18 years old, their gender and if they attended had childhood therapy. The fourth question was a declaration of consent. If the participant wished to consent to the survey they must click yes to this question. See Appendix B for these demographic questions and consent.

The next part of the study was the Inventory of Attitudes Towards Seeking Mental Health Services (IASMHS: Mackenzie, Knox, Gekoski, & Macaulay, 2004). This contained a 24 item scale that the participants were asked to agree or disagree with. The statements were accompanied by a 5 point Likert scale. This is an adaption of the Attitudes Towards Seeking Professional Psychological Help Scale (ATSPPHS: Fisher & Turner, 1970). This consisted of 5 options for each statement as follows: 0(disagree), 1(somewhat disagree), 2(are undecided), 3(somewhat agree) and 4(agree). The IASMHS measures an individual's overall attitude towards seeking mental health services. There are three factors used to measure this. They are (a) psychological openness, (b) help-seeking propensity, and (c) indifference to stigma.

Psychological openness is measured from question 1 to 8. It is an individual's openness to acknowledge to an ongoing psychological problem and their ability to be open to seeking professional care. Help-seeking propensity is measured using questions 9 to 16. This is the willingness and ability of an individual to seek professional psychological help. The indifference to stigma scale contains questions 17 to 24. This factor measures the level of concern an individual would have about what other people would think if they sought out professional psychological care. See Appendix C for the IASMHS scale.

The next scale was the Resilience Appraisal Scale (Johnson, Gooding & Tarrier, 2008). This is a 12-item scale that also has three subscales. Emotional coping, social support and situation coping. Each is measured with four questions. Emotional coping scale is questions three, four, eight and twelve. Social support scale is questions one, two, six and ten. The third subscale situation coping is questions five, seven, nine and eleven. This scale has the same 5 point likert scale as IASMHS and is apart of the reason it was used in this study. As with the IASMHS the higher the score on the Resilience Appraisal Scale, the more resilient a person is. See Appendix D for this scale.

2.4 Procedure

2.4.1 Ethical Considerations. No significant ethical issues were predicted during this research as no vulnerable groups were used. All participants had to state they were over the age of 18 to take part in this study. Due to the nature of the two scales requiring thought and reflection, there may of been some discomfort for some participants. This could have caused psychological distress as some of the statements relate to struggling with mental health. To try to

prevent any difficulties arising for participants there were steps taken to ensure that any distress

caused did not outweigh the benefits of this current study. To prepare participants for the study

they were briefed prior to the survey. This was carried out by giving them information about the

nature of the study, what it included and what the results would be used for. They were given

information about the two scales and what they consist of. It was also stated that at any time

during the survey a participant wanted to withdraw they could do so without any penalty. They

were given instructions on how to withdraw if they so wished. They were informed that all they

had to do was close the browser they accessed the survey on. Participants were also informed

that there was no way for the student to know if they had withdrawn at any point. In the brief

there was a consent form, this highlighted that all participation in this survey is voluntary, that

there was no time limit on this survey and if they needed to take a break they could do so by

minimizing the browser. No identifying information was recorded or required in this study.

Contact information for the student and supervisor was given at the beginning if any participant

had questions surrounding the research. See Appendix A.

When the survey was completed there was a debriefing sheet. Participants were reminded

that they could still withdraw but that once they submitted their answer they could not change or

review their answers. Participants were thanked for their participation and reminded that this is

an undergraduate study. There were three contact information for Jigsaw, Pieta House and

Samaritans if any participants felt stressed or upset by the survey were urged to contact them.

See Appendix E for the debriefing information.

2.4.2 The Procedure Followed in the Present Day. A survey was made using the

programme Google Forms. This allows for the survey to be shared on social media and be

accessed by anyone with a link. The link was also made public so participants could share it to others. The social media used were Facebook, Instagram and Twitter. 50% of the participants had attended therapy under 18 years of age and 50% had not. The recruitment lasted over a month. The data obtained from the surveys was then put into IBM SPSS Statistics 25.0 in the form of a data sheet for statistical analysis of the results.

Chapter 3. Results

3.1 Descriptive Statistics

3.1.1 Frequencies. Table 1 below shows the frequency statistics for this study. All

categorical variables are in the current study are in the present data.

Table 1.

Frequencies for thee sample of those who attended therapy under 18 years of age and those who

did not on categorical and demographic variables (N = 94).

Variable	Frequency	Valid Percentage(%)
Gender		
Female	83	88.3
Male	9	9.1
refer not to say	2	2.6
Have you Attended Therapy under 18?		
Yes	47	50
No	47	50
Please state that you are over 18 years old.		

Yes, I am over 18	94	100
No, I am not over 18	0	0

3.1.2 Descriptive Statistics. The mean score for the IASMHS overall was 43.17 (SD = 8.54; Median = 43; Cronbach's Alpha = 0.6). The scores were low as they ranged from 24-64 when there was a possible range of 0-96. The three subscale in the IASMHS received similar means overall with psychological openness had the highest mean score of 15.77 (SD = 4.05; Median 16), help seeking propensity had the lowest at 13.38 (SD = 3.72; Median = 13) and indifference to stigma had an average score of 14.13 (SD = 3.72; Median = 14).

For the Resilience Appraisal scale there was an overall mean score of 31.23 (SD = 9.22; Median = 32; Cronbach's Alpha = 0.8). The possible range for this scale is 0-60 while this research had a range of 5-48. Emotional coping received the lowest average score of 8.3 (SD = 3.94; Median = 8.5). Situation coping had a mean of 10.32 (SD = 3.44; Median = 10). Social support had the highest score within the subscales with an average of 13.62 (SD = 3.70; Median = 13.5).

Table 2

Descriptive statistics of IASMHS and Resilience Appraisal Scale.

	Mean (95% Confidence Intervals)	Std. Error Mean	Median	SD	Range

|					
IASMHS	43.17 (41.49-45)	.88	43	8.54	24-64
Psychological Openness	15.77 (14.90-16.48)	.42	16	4.05	5-28
Help Seeking Propensity	13.38 (12.63-14.16)	.38	13	3.72	6-22
Indifference to Stigma	14.13 (13.36-14.88)	.38	14	3.72	7-24
Resilience Appraisal Scale	31.23 (29.39-33.02)	.95	32	9.22	5-48
Emotional Coping	8.30 (7053-9.04)	.41	8.5	3.94	0-16
Situational Coping	10.32 (9.60-10.97)	.35	10	3.44	0-16
Social Support	12.62 (11.82-13.38)	.38	13.5	3.70	2-16

3.2 Inferential Statistics

3.2.1 Independent T-Test. Two independent t-tests were carried out to compare scores from the IASMHS and Resilience Appraisal Scale between those who attended therapy under 18 years old and those who did not. For the IASMHS there was no significant difference in scores ($t(92) = 1.33$, $p = .19$) with those who attended therapy under 18 years of age ($M = 44.34$, $SD = 7.83$) not scoring significantly higher than those who did not attend therapy under 18 years of age ($M = 42$, $SD = 9.14$). The difference in the means (mean difference $= 2.34$, 95% CI: 1.15 - 5.83) was small (Cohen's $d = .28$).

The second independent t-test was conducted with the Resilience Appraisal Scale results. There was also no significant differences in scores ($t(92) = 1.49$, $p = .41$) as those who attended therapy under 18 years of age ($M = 29.83$, $SD = 10.31$) did not score significantly more than those who did not go to therapy under 18 years old ($M = 32.64$, $SD = 7.86$).

3.2.2 One-way ANOVA testing variance of gender. A one-way between groups ANOVA was conducted to determine if there was a difference in gender and positive attitudes towards seeking mental health services [$F(2,91) = .88$, p=0.42]. This study gave three options for gender (female, male and prefer not to say). There was no statistically significant difference in scores from the IASMHS for three gender options. Post-hoc comparisons using the Tukey HSD test indicated that the mean score for males (M = 44.89, SD = 4.02) was not significantly higher (p = .46) than females (M = 43.16, SD = 0.90) or prefer not to say (M = 36, SD = 7). Below is Figure 1 displaying the means plot.

Figure 1 Means Plot
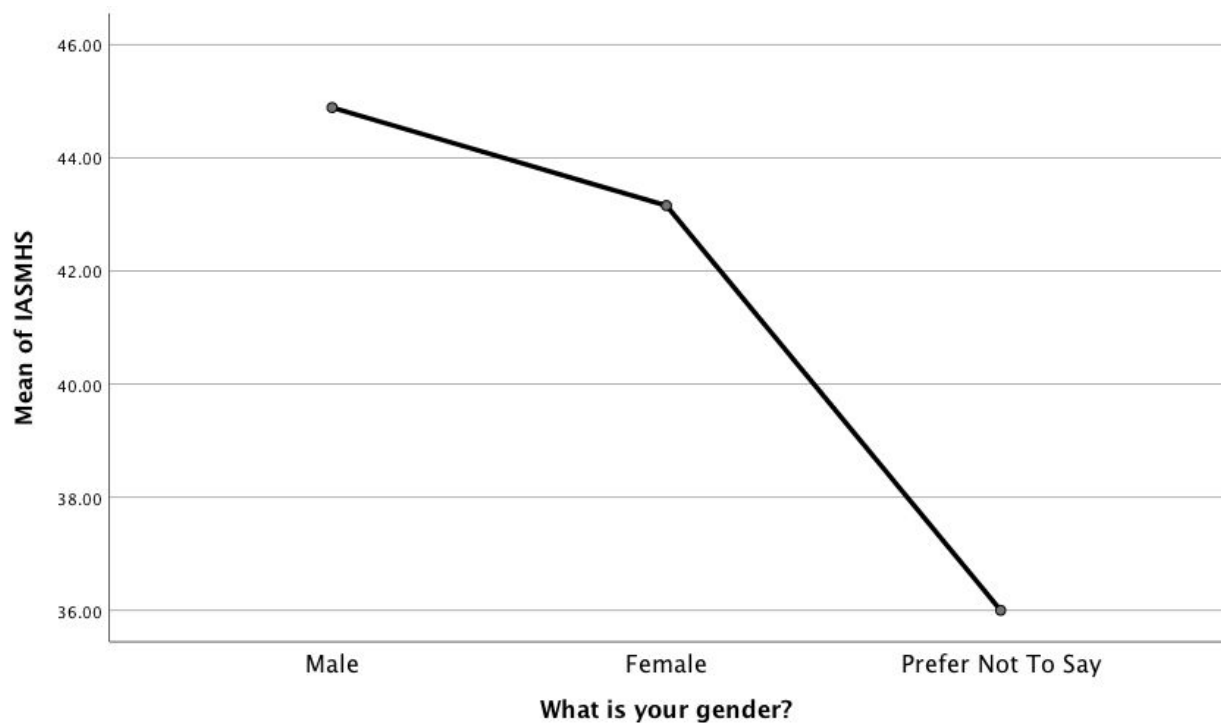
Chapter 4. Discussion

The objective of this research was to investigate the influence of childhood therapy on current attitudes towards seeking mental health services. There is a literature gap on the long term effect therapy under the age of 18 years old has on attitudes towards mental health services later in adult life. This study aimed to address this gap and support the hypothesis that those who engage with child therapy will score higher on the IASMHS and Resilience appraisal scale than those who did not attended therapy under the age of 18.

4.1 Summary of the main results

The research question for this study was does attendance to therapy under the age of 18 years old influence current attitudes towards seeking mental health services? The aim was to highlight the relationship between child therapy, resilience, positive attitudes towards mental health service and the effect of gender. This study had three hypotheses that it aimed to show support for. The first hypothesis was that those who attended childhood therapy would have higher scores on the IASMHS than those who did not engage in child therapy. The results of the IASMHS for this research does not support this hypothesis. The findings show no significant difference in scores with those who did attend child therapy scoring an average of 44.13 out of 96 compared to those who didn't scoring a similar mean of 42. Both scores are very similar to the overall mean score of 43.17. These results support the findings of James and Buttle, 2008, who found no significant difference in IASMHS scores between young and older adults. The same consistent results of no significant difference in age were shown when young and older American-Korean adults were given the IASMHS to complete (Jang, Chiriboga & Okazaki,

2009). In contrast, Mackenzie, Gekkoski and Knox, 2006, found that older adults and females scored higher on the IASMHS then young adults. The results from the Resilience Appraisal Scale were not significantly different in regards to engagement with therapy under the age of 18 or those who had not experienced it. The hypothesis was rejected due to this. There is a large literature gap on resilience as a result of child therapy. This has been due to patients in child mental health services severing ties with services. Discontinued treatment often occurs in child mental health services (Burns et al, 2004).

A one way ANOVA was conducted to compare the means of female, male and prefer not to say scores on the IASMHS. The results showed no significant difference in mean scores. These results do not align with multiple previous research conducted on gender as a factor to influence attitudes towards seeking mental health services. Roskar et al, 2017 found females to have a higher reported level of positive attitudes towards seeking professional help during times of mental and emotional distress. This supports findings from Coppens et al, 2013 who found factors that influence negative attitudes towards seeking mental health services were male gender, older age and living alone. Research surrounding the different stigma genders face and how it impacts their willingness to attend mental health services have been well documented. A study carried out with the IASMHS found females held a more positive attitude then males. They also held significant difference scores for psychological openness (McClure, 2010).

4.2 Implications

This study's implications may not be reliable. According to the results it shows no significant difference in gender, attitude towards seeking mental health services and resilience

between those who have engaged with child therapy and those who have not. This is not supported by other studies nor does it represent the literature on this topic. The implications of these results in relation to the literature is to access a bigger sample size and to use a different recruitment process. Convenience sampling is simple for those conducting the study but can skew results as it may not reach the target population.

One implication of this literature is that the recent epidemic of raising awareness for mental health services has been successful. Public attitudes towards seeking mental health services and their levels of stigma may have been reduced. Health organisations globally have been focusing on increasing the utilization of mental health services (Mojtabai, Evans-Lacko, Schomerus, & Thornicroft, 2016). A study carried out to assess the effects of marketing interventions on stigma in England showed a 38-64% increase in knowledge, positive attitudes and intended behaviour. This campaign was aimed at reducing the stigma surrounding mental health through social contact (Evans-Lacko et al, 2013). Mental health literacy and rising levels in education could have affected the current study results. Access to the internet is also impacting mental health stigma. A study found that 55% of people are consulting the health information on the internet before contacting a health professional. These participants were more likely to contact a healthcare professional based on the information they received online. This impacts mental health as it increases the percentage of the public engaging with mental health services (Ybarra & Suman, 2006).

4.3 Strengths and Limitations

This study has many limitations. This current research does not explore the specifics of

the variables used. Gender in this study is not represented accurately as 88% (83 participants) of the sample were female. This hinders results as previous studies have shown that females are more likely to have help-seeking attitudes. The sample in this study is small with only 94 participants that does not represent the population. Due to how this research was advertised, those who hold negative attitudes towards mental health and mental health services may not of wanted to engage in the study. This would mean the results obtained are bias as those who were willinging to part take held reduced stigma views leading to a more positive result on the IASMHS. This study also does not specify the type of child therapy or the duration. The vague question of attendance could be misinterpreted and lead to inaccurate results. The lack of investigation into other contributing factors to attitudes towards seeking mental health services is a limitation. Other research carried out using the IASMHS have included age, gender, education, socioeconomic status and ethnicity to investigate positive and negative attitudes (Kessler, Agines, & Bowen, 2014).

A strength of this research is the Inventory of Attitudes Towards Seeking Mental Health Services. This 24-item scale has been evaluated and used in previous research providing accurate results. The three subscale measure help to measure different factors that influence how attitudes are made. The IASMHS has been tested for validity and reliability. Hyland et al, 2015 found that the scale held excellent internal reliability. The strongest predictor to actually engage with mental health services within the three subscales was the help-seeking propensity. The second scale used in this study is the Resilience Appraisal Scale only contained 12 items. The subscales were emotional coping, social support and situation coping. The scale has not been used frequently in previous research. It was chosen for this study as it was a 12 item scale that had

shown to give accurate results. The research it was used in had a large sample. A different scale with a more diverse measurement of resilience may have been more suitable in this experiment. The Connor-Davidson Resilience Scale (CD-RISC: Connor & Davidson, 2003) is a scale containing 25 items and is also a 5 point likert scale. It has been tested on the general public, clinical trials and has sound psychometric properties. The CD-RISC has been shown to have validity and is consistent with the results.

4.4 Further Research

In context with the current limitations of this study, more in depth research is needed into the long term effects of childhood therapy on attitudes towards seeking mental health. Children's mental health services receive a unique stigma. Parents stigma and previous experience with mental health services can impact their child's attitudes towards seeking mental health services. Research found an association between parents negative experience with a mental health service influencing their decision to contact child mental health services. This is a major issue for children experiencing mental disorders as they rely on parents for their needs emotionally and health wise. Parents are the main instigators of children attending mental health services (Teagle, 2002). This comes from recognition of an emotional or behavioral issue occuring for their child. The literature gap currently is very large considering the leaps mental health has taken in the past 40 years. Having a positive attitude towards mental health services has been positively associated with lower levels of stigma. A very concerning meta-analysis of the current stigma held by the public shows it has only increased despite the effort to educate and reduce stigma (Mackenzie, Erickson, Deane & Wright, 2014). Directing research in the area of help-seeking behaviours

should be taken into consideration. Positive attitudes are the most consistent predictor of individuals seeking out mental health services (Vogel & Wester, 2003). The factors that influence stigma and how to reach those who experience self stigma needs to be investigated as there is a lack of research on how to access those individuals. Mental health literacy is seen as the key to reducing stigma. Engaging children with mental health education with an inclusive approach to reduce stigma have been proposed for 2020. Guidelines in the UK show teachers will receive mental health training in order to provide accurate and helpful information about mental disorder, mental health services and coping mechanisms to students (O'Reilly, Svirydzenka, Adams, & Dogra, 2018).

The future of mental health services for adults and children alike are expected to change drastically over the next decade. This cannot be achieved without diminishing the levels of stigma surrounding mental health services as a whole (Long, 2018) . This barrier prevents individuals from speaking to loved ones, engaging in mental health services and increases their risk of suicide.

4.5 Conclusion

This study does not support previous research conducted on attitudes towards seeking mental health services with regard to exposure to previous therapy. The results were not consistent with the literature on the subject. Suggestions for the reason behind this may be due to prior biases participants had. Those who engaged in this study may have already held positive attitudes towards mental health services regardless of their engagement with child therapy. They may have also experienced therapy over the age of 18 years old impacting their attitude.There

were three hypotheses in this study that were rejected. This study may encourage future research

to be more specific in their investigations into the factors influencing the current attitudes

towards seeking mental health services.

References

1.   Bassilios, B., Nicholas, A., Reifels, L., King, K., Spittal, M., Fletcher, J., & Pirkis, J.

(2016). Improving access to primary mental health care for Australian children. *Austrailian and New Zealand Journal of Psychiatry, 50*(11), 1074-1084.

2.   Burns, B., Phillips, S., Wagner, R., Barth, R., Kolko, D., Campell, Y., & Landsverk, J.

(2004). Mental Health Need and Access to Mental Health Services by Youths Involved With Child Welfare: A National Survey. *Child and Adolescent Psychiatry, 43*(8), 960-970.

3.   Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rusch, N., Brown, J., Thornicroft, G. (2015) What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine, 45*, 11-27.

4.   Connor, K., & Davidson, J. (2003). Development of a New Resilience Scale: The Connor-Davidson Resilience Scale (CD-RISC). *Depression and Anxiety, 18*, 76-82.

5.   Coppens, E., Van Audenhove, C., Scheerder, G., Arensman, E., Coffey, C., Koburger, N., Gottlebe, K., Gusmao, R., O'Connor, R., Postuvan, V., Sarchiapone, M., Sisask, M., Szekely, A., Vander Feltz-Cornelis, C., & Hegeri, U. (2013). Public attitudes toward depression and help-seeking in four European countries baseline survey prior to the OSPI-Europe intervention. *Journal of Affective Disorders, 150*(2), 320-9.

6.   Corrigan, P. (2004). How Stigma Interferes with Mental Health Care. *American Psychologist, 59*(7), 614-625.

7.   Corrigan, P., Thompson, V., Lambert, D., Sangster, Y., & Noel, J. (2003) Perceptions of Discrimination Among Persons With Serious Mental Illness, *Psychiatric Services, 54*(8), 1105-1110.

8.   Dalky, H. (2011). Mental Illness Stigma Reduction Interventions: Review of Intervention Trials. *Western Journal of Nursing Research, 34*(4), 520-547.

9.   Eaton, J., McCay, L., Semrau, M., Chatterjee, S., Baingana, F., Araya, R., Ntulo, C., Thornicroft, G., & Saxena, S. (2011). Scale up of services for mental health in low-income and middle-income countries. *Global Mental Health, 378*(9802), 1592-1603.

10.   Evans-Lacko, S., Malcom, E., West, K., Rose, D., London, J., Rusch, N., Little, K., Henderson, C., & Thornicroft, G. (2013). Influence of Time to Change's social marketing interventions on stigma in England 2009–2011. *The Brittish Journal of Psychiatry, 202*, 77-88.

11.   Farmer, E., Burns, B., Phillips, S., Angold, A., & Costello, J. (2003). Pathway Into and Through Mental Health Services for Children and Adolescents. *Psychiatric Services, 54*(1), 60-66.

12.   Fisher, E., & Turner, J. (1970). Orientations to seeking professional help: Development

and research utility of an attitude scale. *Journal of Consulting and Clinical Psychology, 35*,

79-90.

13.   Gonzalez, J., Alegria, M., Prihoda, T., Copeland, L., & Zeber, J. (2009). How the

relationship of attitudes toward mental health treatment and service use differs by age, gender,

ethnicity/race and education. *Social Psychiatry and Psychiatric Epidemiology, 46*(1), 45-57.

14.   Griffiths, K., Nakane, Y., Christensen, H., Yoshioka, K., Jorm, A., & Nakane, H. (2006).

Stigma in response to mental disorders: a comparison of Australia and Japan. *BMC Psychiatry,

6*(21), 1-12.

15.   Have, M., Graaf, R., Ormel, J., Vilagut, G., Kovees, V., & Alonso, J. (2010). Are

attitudes towards mental health help seeking associated with service use? Results from the

European Study of the Epidemiology of Mental Disorders. *Social Psychiatry and Psychiatric

Epidemiology, 45*(2), 153-163.

16.   Hoagwood, K., & Johnson, J. (2003). School psychology: A public health framework: I.

From evidence based practices to evidence based policies. *Journal of School Psychology, 41*,

3-12.

17.   Hyland, P., Boduszek, D., Dhingra, K., Shevlin, M., Maguire, R., & Morley, K. (2015). A Test of the Inventory of Attitudes Towards Seeking Mental Health Services. *Brittish Journal of Guidance and Counselling, 43*(3), 397-412.

18.   James, S., & Buttle, H. (2008) Attitudinal Differences towards Mental Health Services between Younger and Older New Zealand Adults. *New Zealand Journal of Psychiatry, 37*(3), 33-43.

19.   Jang, Y., Chiriboga, D., & Okazabi, S. (2009). Attitudes toward mental health services: Age-group differences in Korean American adults. *Aging Mental Health, 13*(1), 127-134.

20.   Johnson, J., Gooding, P., & Tarrier, N. (2008). Suicide risk in schizophrenia: explanatory models and clinical implications, the Schematic Appraisal Model of Suicide (SAMS). *Psychology and Psychotherapy: Theory, Research and Practice, 81*, 55–77.

21.   Kessler, E., Agines, S., & Bowen, C. (2014). Attitudes towards seeking mental health services among older adults: Personal and contextual correlates. *Aging and Mental Health, 5*(2), 1-10.

22.   Kessler, R., Berglund, P., Demler, O., Jin, R., Merikangas, K., & Walters, E. (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 63*, 593-602.

23.   Kohn, R., Saxena, S., Levav, I., & Saraceno, B. (2004). The treatment gap in mental

health care. *Bulletin of the World Health Organisation, 82*(11), 858-866.

24.   Long, N. (2018). Looking into the future: The potential impact of emerging trends on

child and family mental health services. *Clinical Child Psychology, 23*(1), 3-8.

25.   Mackenzie, C., Erickson, J., Deane, F., & Wright, M. (2014). Changes in attitudes toward

seeking mental health services: A 40 year cross temporal meta-analysis. *Clinical Psychology*

Review, 34, 99-106.

26.   Mackenzie, C., Gekoski, W., & Knox, V. (2006). Age, gender, and the underutilization of

mental health services: The influence of help-seeking attitudes. *Aging & Mental Health, 10*(6),

574-582.

27.   Mackenzie, C., Knox, V., Gekoski, W., & Macaulay, H. (2004). An adaptation and

extension of the attitudes toward seeking professional psychological help scale. *Journal of*

Applied Social Psychology, 34, 2410-2435.

28.   McClure, A. (2010). Willingness of Individuals to Seek Mental Health Treatment: The

Impact of Gender and Parent Therapy Experience. *Masters Theses & Specialised Projects,* Paper

187.

29.   McIntosh, K., Ty, S., & Miller, L. (2014). Effects of School-Wide Positive Behavioural

Interventions and Supports on Internalizing Problems: Current Evidence and Future Directions.

Journal of Positive Behaviour Interventions, 16(4), 209-218.

30.   Merikangas, K., He, J., Burstein, M., Swanson, S., Avenevoli, S., Cui, L., Benjet, C.,

Georgiades, K., & Swendsen, J. (2010). Lifetime Prevalence of Mental Disorders in US

Adolescents: Results from the National Comorbidity Study-Adolescent Supplement(NCS-A).

Journal of the American Academy of Child & Adolescent Psychiatry, 49(10), 980-989.

31.   Mojatabi, R., Evans-Lacko, S., Schomerus, G., & Thornicroft, G. (2016). Attitudes

Toward Mental Health Help Seeking as Predictors of Future Help-Seeking Behavior and Use of

Mental Health Treatments. *Psychiatric Services, 67*(6), 650-657.

32.   Nock, M., Phil, M., & Kazdin, A. (2001) Parent Expectancies for Child Therapy:

Assessment and Relation to Participation in Treatment. *Journal of Child and Family Studies,

10*(2), 155-180.

33.   O'Reilly, M., Svirydzenka, N., Adams, S., & Dogra, N. (2018). Review of mental health

promotion interventions in schools. *Social Psychiatry and Psychiatric Epidemiology, 53*(7),

647-662.

34.   Padesky, C., & Mooney, K. (2012). Strenghts-Based Cognitive-Behavioural Therapy: A Four Step Model to Build Resilience. *Clinical Psychology & Psychotherapy, 19*(4), 283-290.

35.   Patel, V. (2014). Why mental health matters to global health. *Transcultural Psychiatry, 51*(6), 777-789.

36.   Patton, G., Coffey, C., Sawyer, S., Viner, R., Haller, D., Bose, K., & Mathers, C. (2009). Global patterns of mortality in young people: A systematic analysis of population health data. *The Lancet, 374*(9758), 881-892.

37.   Patten, S., Williams, J., Lavorato, D., Bulloch, A., Charbonneua, M., Gautam, M., Moss, P., Abbey, S., & Stuart, H. (2016). Perceived Stigma among Recipients of Mental Health Care in the General Canadian Population. *The Canadian Journal of Psychiatry, 61*(8), 480-488.

38.   Reavley, N., & Jorm, A. (2011). Stigmatising attitudes towards people with mental disorders: findings from an Australian National Survey of Mental Health Literacy and Stigma. *Australian and New Zealand Journal of Psychiatry, 45*, 1086-1093.

39.   Roskar, S., Bracic, M., Kolar, U., Lekic, K., Juricic, N., Grum, A., Dobnik, B., Postuvan, V., & Vatovec, M. (2017). Attitudes within the general population towards seeking professional help in cases of mental distress. *International Journal of Social Psychiatry, 63*(7), 614-621.

40.   Rutter, M. (1999). Resilience concepts and findings: implications for family therapy. *Journal of Family Therapy, 21*, 119-144.

41.   Sartorius, N. (1998). Stigma: What can psychiatrists do about it? *Lancet, 352*, 1058-1059.

42.   Shirk, S., & Karver, M. (2003). Prediction of Treatment Outcome From Relationship Variables in Child and Adolescent Therapy: A Meta-Analysis Review, *Journal of Counselling and Clinical Psychology, 71*(3), 452-464.

43.   Stallard, P., Simpson, N., Anderson, S., Carter, T., Osborn, C., & Bush, S. (2005). An evaluation of the FRIENDS programme: a cognitive behaviour therapy intervention to promote emotional resilience. *Archives of Disease in Childhood, 90*, 1016-1019.

44.   Switaj, P., Wciorka, J., Grygiel, P., Anczewska, M., Schaeffer, E., Tyczynski, K., & Wisniewski, A. (2012). Experiences of stigma and discrimination among users of mental health services in Poland. *Transcultural Psychiatry, 49*(1), 51-68.

45.   Tully, L., Hawes, D., Doyle, F., Sawyer, M., & Dadds, M. (2019). A national child mental health literacy initiative is needed to reduce childhood mental health disorders. *Australian and New Zealand Journal of Psychiatry, 53*(4), 286-290.

46.   Vogel, D., & Wester, R. (2003). To seek help or not to seek help: The risks of

self-disclosure. *Journal of Counselling Psychology, 50*, 351–361.

47.   Wahl, O. (1999). Mental health consumers experience of stigma, *Schizophrenia Bulletin, 25*, 467-478.

48.   Wolmer, L., Hamiel, D., Barchas, J., Slone, M., & Laor, N. (2011). Teacher-Delivered Resilience-Focused Intervention in Schools With Traumatized Children Following the Second Lebanon War. *Journal of Traumatic Stress, 24*(3), 306-316.

49.   Wong, P., Delmer, O. & Kessler, R. (2002). Adequacy of Treatment for Serious Mental Illness in the United States: Research and Practise. *American Journal of American Public Health, 92*(1), 92-98.

50.   Ybarra, M., & Suman, M. (2006). Help seeking behavior and the Internet: A national survey. *International Journal of Medical Informatics, 75*, 29-41.

Appendices

Appendix A

The Information Sheet.

The Influence of Childhood Therapy on Current Attitudes Towards Seeking Mental Health Services.

Information about the study.

This study is being carried out by a student from National College of Ireland (NCI). It is a final year project in their undergraduate. The results collected from this survey will only be used in their project. It will be stored securely. It will only be viewed by the student, their supervisor and the examinations board of NCI.

The Nature of the Study.

This study is looking at the effect of childhood therapy on attitudes towards seeking mental health services. This study investigating the relationship between attitudes towards mental health services and having experienced childhood therapy.

Consent

Your participation is voluntary. You do not have to complete this survey. You can withdraw at any time and will not be penalized. To withdraw, you need to close the browser the survey is open on. The student will not be informed that you did not complete the study or that you

withdrew. There is no time limit on this survey. You may complete it at your own pace. To take a break, you must leave the browser tab open. You can minimize it and return to it when you are ready. Your answers will still be there.

Requirements

You must be over 18 years old to participate in this study. You do not have had to attend childhood therapy to take part in this study. You will be only asked your age and gender. There is no identifying information asked. You will not be asked to give your name or email address. This survey should take 15 minutes to complete. You will be asked to rate each statement from 0-4 on how much you agree or disagree. This will be the scale on both surveys.

0- completely disagree

1- somewhat disagree

2- neutral

3- somewhat agree

4- completely agree

There are two parts to this survey, the first is the Inventory of Attitudes Towards Seeking Mental Health Services. This scale will measure your attitude towards seeking mental health service and is made of three sub scales (help seeking propensity, indifference to stigma and psychological openness). The second section is Resilience Appraisal Scale which will measure your resilience which is broken into three sub scales (emotional coping, situation coping and social support).

Contact Information

If you have any questions or concerns about this survey, please email

x16358986@student.ncirl.ie and your answers will be answered as soon as possible. The

supervisor for this study is Dr Conor Nolan. You can contact him at conor.nolan@ncirl.ie

By clicking you consent, you are saying you have read all of the above information and

voluntary consent to taking part in this survey.

Appendix B

Demographic Questions and Consent

Q1: Please state that you are over 18 years of age.

- Yes I am over 18 years of age.

- No, I am not over 18 years of age.

Q2: What is your gender?

- Female.

- Male.

- Prefer not to say.

Q3: Have you attended therapy/counselling under the age of 18?

- Yes.

- No.

Q4: Do you give your consent to take part in this survey?

- Yes, I give my consent.

- No, I do not.

Appendix C

The Inventory of Attitudes Towards Seeking Mental Health Services

Inventory of Attitudes toward Seeking Mental Health Services (IASMHS)

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 refers 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 disagree (0), somewhat disagree (l), are undecided (2), somewhat agree (3), or agree (4):

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

Disagree 0 1 2 3 4 Agree

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.

Disagree 0 1 2 3 4 Agree

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

Disagree 0 1 2 3 4 Agree

4. Keeping one's mind on a job is a good solution for avoiding personal worries and

concerns.

Disagree 0 1 2 3 4 Agree

5. If good friends asked my advice about a psychological problem, I might

recommend that they see a professional.

Disagree 0 1 2 3 4 Agree

6. Having been mentally ill carries with it a burden of shame.

Disagree 0 1 2 3 4 Agree

7. It is probably best not to know everything about oneself.

Disagree 0 1 2 3 4 Agree

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.

Disagree 0 1 2 3 4 Agree

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

Disagree 0 1 2 3 4 Agree

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

psychological problems.

Disagree 0 1 2 3 4 Agree

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

Disagree 0 1 2 3 4 Agree

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

of time.

Disagree 0 1 2 3 4 Agree

16. I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out about it.

Disagree 0 1 2 3 4 Agree

17. Having been diagnosed with a mental disorder is a bolt on a person's life.

Disagree 0 1 2 3 4 Agree

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.

Disagree 0 1 2 3 4 Agree

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

Disagree 0 1 2 3 4 Agree

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

Disagree 0 1 2 3 4 Agree

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

Disagree 0 1 2 3 4 Agree

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

Disagree 0 1 2 3 4 Agree

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

Disagree 0 1 2 3 4 Agree

24. I would be embarrassed if my neighbor saw me going into the office of a

professional who deals with psychological problems.

Disagree 0 1 2 3 4 Agree

Appendix D

Resilience Appraisal Scale

1. If I were to have problems, I have people I could turn to.

    Disagree 0 1 2 3 4 Agree

2. My family or friends are very supportive of me.

    Disagree 0 1 2 3 4 Agree

3. In difficult situations, I can manage my emotions.

    Disagree 0 1 2 3 4 Agree

4. I can put up with my negative emotions.

    Disagree 0 1 2 3 4 Agree

5. When faced with a problem I can usually find a solution.

    Disagree 0 1 2 3 4 Agree

6. If I were in trouble, I know of others who would be able to help me.

    Disagree 0 1 2 3 4 Agree

7. I can generally solve problems that occur.

    Disagree 0 1 2 3 4 Agree

8. I can control my emotions.

    Disagree 0 1 2 3 4 Agree

9. I can usually find a way of overcoming problems.

    Disagree 0 1 2 3 4 Agree

10. I could find family of friends who listen to me if I needed them to.

    Disagree 0 1 2 3 4 Agree

11. If faced with a set-back, I could probably find a way round the problem.

    Disagree 0 1 2 3 4 Agree

12. I can handle my emotions.

    Disagree 0 1 2 3 4 Agree

Appendix E

Debriefing Sheet.

By clicking submit, you are consenting to take part in this study. If you no longer wish to take part, just close the browser window and your answers will not be saved or sent to the researcher.

Thank you for participating in my final year project. I am investigating the relationship between childhood therapy and attitudes towards seeking mental health services. I am also investigating the link between childhood therapy and resilience later in life.

I am a final year psychology student in National College of Ireland. If you have any queries about this study please do not hesitate to contact me at x16358986@student.ncirl.ie or supervisor Dr Conor Nolan at conor.nolan@ncirl.ie

If you feel distressed or upset by this survey, there is a list of services and contacts to get in touch with.

Pieta House: 1800 247 247 or info@pietahouse.ie

Samaritans: 116 123 or jo@samaritans.ie

Jigsaw:+353 1 472 7010 or info@jigsaw.ie