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Intentional Self-Injury as a Barrier to Help-Seeking in a College Population
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Chapter I

Review of the Literature

“For most of us, cutting or burning our own skin would be incredibly painful and almost impossible to carry out. For cutters, it is a strangely effective coping method for dealing with an inner pain so overwhelming it must be brought to the surface. /.../ Their action is a most graphic cry for help, in the words of one self-mutilator, ‘a bright red scream’.” (Strong, 1998, p.xvii)

It may be hard to understand and even scary to think about others hurting their bodies intentionally. The thought of the behavior is distressing in itself, but even more distressing are the recent study findings that more than 1 in 10 high school adolescents had intentionally self-injured at some point in their life. Intentional self-injury (ISI) is becoming an increasing problem among adolescents and college students (Ross & Heath, 2002). A study conducted at two northeastern Ivy-League universities in the United States found that 17% of students had engaged in ISI at some point in their life, and 71% of those had done so more than one time (Whitlock, Eckenrode, & Silverman, 2006).

In and of itself the above stated prevalence of ISI is alarming, but there are several additional reasons for concern for this particular population. Engaging in ISI is a self-destructive and potentially dangerous way to deal with emotional pain. Persons who engage in ISI behaviors are more likely to have: either considered or attempted suicide, engaged in eating disorder behaviors, been abused (Whitlock, Eckenrode & Silverman, 2006), been emotionally neglected (Gratz, 2003) and are more likely to have affective
and interpersonal problems (Laye-Gindhu, Schonert-Reichl, 2005). Intentionally injuring the self is effective in that it temporarily relieves distress, but it is also a self-damaging and maladaptive coping mechanism (Chapman, Gratz & Brown, 2005). The functions of ISI and ways in which ISI relieves distress will be discussed in more detail in later sections.

It is also concerning that recent studies have found that many of those persons who engage in ISI behaviors reported that they had not told anyone about their distress, let alone sought professional help for their problems (Evans, Hawton & Rodham, 2005; Whitlock, Eckenrode & Silverman, 2006). Intentional self-injury behaviors have the potential to become self-perpetuating behaviors (Favazza, 1989) and early intervention is important for several reasons. Early intervention allows the behaviors to stop before becoming chronic, to stop before becoming increasingly dangerous (Favazza) and helps the individual deal with his or her psychological distress as soon as it becomes distressing for them.

Several studies have researched barriers to professional help-seeking in a variety of populations, both clinical and non-clinical. There are many barriers to professional help-seeking for psychological distress, some barriers are external (Clarke, 2007), but the barriers that typically keep most individuals from seeking professional help are internal and have to do with the specific attitudes and inherent qualities, as well as the thoughts and feelings of the individual (Cachelin & Streigel-Moore, 2006; Clake, 2007; Homblow, Bushnell, Wells, Joyce, & Oakley-Browne, 1990).

The aim of this study is to examine why people who engage in ISI behaviors do not seek professional help equally often as other people in psychological distress. In general,
less than one-third of persons with mental disorders seek professional help (Andrews, Issakidis & Carter, 2001). Eisenberg, Golberstein and Gollust (2007) found that between 34-84% (depending on the disorder) of college students suffering from anxiety or depression did not receive help. Specifically related to engaging in intentional self-injury behaviors, Evans, Hawton and Rodham (2005) found that 53% of men and 42% of women who engaged in intentional self-injury who felt the need for help due to a serious personal, emotional, behavioral or mental health problem avoided seeking help, while only 33% of men and 29% of women who had not engaged in ISI behaviors avoided seeking help though they felt help was needed. The researchers also found that 27% of men and 30% of women who engaged in ISI did not feel the need to seek help.

Combining the numbers of persons who engage in ISI behaviors (whether feeling the need for help or not) results in a high number of persons who engage in ISI behaviors that are not seeking professional help, namely, 80% of men and 72% of women. Though this number is not necessarily higher than some persons in psychological distress, it is significantly higher than others.

Some studies have attempted to look at the barriers to professional help-seeking for individuals who intentionally injure themselves. However, to date, very few studies has attempted to research a specific theory of why individuals who engage in intentional self-injury seek less professional help than those who endorse psychological distress but do not engage in intentional self-injury. It is plausible that there are differences between those persons who engage in intentional self-injury and those who do not (but endorse psychological distress) that explain part of the reason why people who intentionally self-
injure seek less professional help. With more understanding professionals may be able to engage and help this population seek help in their suffering.

The following sections will define intentional self-injury as well as discuss various aspects of previous research pertaining to intentional self-injury, psychological distress, adolescents/college students, and barriers to professional help-seeking. Subsequently, this chapter will describe a theory of how it may be that persons who have engaged in ISI engage in less professional help-seeking than those who have not engaged in ISI but endorse psychological distress. This chapter will conclude with a description of an exploratory component of this study.

Definition of Intentional Self-Injury (ISI)

There is no commonly agreed on term for, or definition of, intentional self-injury (ISI). Some examples of terms used for engaging in ISI behaviors are self-harm, self-mutilation, self-wounding, parasuicide and deliberate self harm. Researchers vary in how they define ISI; some researchers limit the behaviors classified as ISI, whereas others include a wide range of behaviors.

Researchers do not always distinguish between the people who do or do not intend to commit suicide when engaging in ISI behaviors (Hawton & James, 2007; Linehan, 1993; Linehan, Comtois, Brown, Heard & Wagner, 2006; Skegg, 2005). Skegg included a broad definition of ISI where the self-harming behaviors do not have to lead to visible injuries; examples of such forms of ISI are intending to harm the self through starvation, exercise or medication negligence. It is uncommon that definitions of ISI include risk-taking behaviors such as dangerous driving, substance abuse and unsafe sex.
Several researchers have discussed the potential problems and benefits of varying definitions of ISI as well as using inconsistent terms to denote the behaviors. The varying definitions of ISI make studies both challenging to comprehend and hard to compare. Terms may be misleading, for instance, the term ‘parasuicide’ translated directly means ‘faulty-suicide’ but the original definition of parasuicide included any act that causes harm to the self, whether with intent to commit suicide or not (Linehan, Comtois, Brown, Heard & Wagner, 2006). As previously discussed, self-injury, self-mutilation, self-wounding and deliberate self-harm are not necessarily defined in the same way – each researcher decides how to operationalize the ISI construct in his or her study. Best (2006) stressed the importance of choosing the definition of ISI that best fits the purpose of a study as well as a definition that the researcher is able to measure. Depending on the purpose of the research, a comprehensive definition of ISI may or may not be the best choice.

For the purposes of this study intentional self-injury (ISI) is defined as any type of behavior that is self-inflicted with the intent to harm the self without intent to die (e.g. Andover, Pepper & Gibb, 2007; De Leo & Heller, 2004; Evans, Hawton & Rodham, 2005). The ISI behaviors do not have to result in scarring – but the ISI behaviors are a result of an individual’s desire to physically harm the self to relieve psychological distress (the connection between ISI and psychological distress is discussed in the following sections). This study incorporates behaviors such as, but not limited to: cutting, burning, carving, scratching, biting, rubbing sandpaper, glass or strong cleaning agents on skin, dripping acid onto skin, sticking sharp objects into skin (not including tattoos,
needles for drug use or body piercings), breaking bones, banging one’s head to the point of bruising, punching the self, or preventing wounds from healing (Gratz, 2001).

A limitation with this particular definition of ISI is that the definition may not take into account those individuals who engage in ISI during a state of dissociation (Briere & Gil, 1998) and therefore may, in fact, not feel that they are harming themselves on purpose. However, the role of dissociation in engaging in ISI behaviors is unclear (Armey & Crowther, 2008). However, and irregardless of intent to harm the self, the result of their actions during the dissociated state is self-injury (this limitation will later be a component of the discussion section).

ISI and Psychological Distress

Individuals who engage in ISI behaviors may suffer from any of a variety of psychological issues (e.g. Gratz, 2006; Laye-Gindhu & Schonert-Reichl, 2005; Ross & Heath, 2002).

One study found that persons who engage in repeated intentional self-injury (ISI) “were significantly more likely to report a history of emotional, sexual and physical abuse” (Whitlock, Eckenrode & Silverman, 2006, p. 1943) and are more likely to have either “considered or attempted suicide, reported elevated levels of distress in the past 30 days, and/or had ≥ 1 characteristic of an eating disorder” (pp. 1943-1944). Laye-Gindhu and Schonert-Reichl (2005) reported that persons who engage in ISI behaviors exhibit more maladjustment in “emotional distress, antisocial behavior, anger control issues, anger discomfort, and negative self-esteem” (p.453) compared to those who do not engage in ISI behaviors; and that 83% of those persons who engaged in ISI behaviors reported suicidal ideation (in comparison to 29% of those who did not engage in ISI
behaviors). The researchers also found that significantly more persons who engaged in ISI behaviors (26%) had attempted suicide (compared to 6% of persons who had not engaged in ISI behaviors), and all of whom had attempted suicide multiple times. These results, along with discussion about the higher risk of suicide in Borderline Personality Disorder (BPD) patients who engage in ISI than BPD patients who do not engage in ISI in Linehan (1994), suggested that persons who engage in ISI behaviors are more likely than persons who do not engage in ISI behaviors to successfully commit suicide. Moreover, Laye-Gindhu and Schonert-Reichl discussed that there is most likely a higher risk for suicide in persons who engage in ISI behaviors repeatedly as they most likely feel that it is increasingly difficult to deal with the negative affect that brought on the behaviors in the first place.

Risk factors for engaging in ISI

There are risk-factors that may make a person more vulnerable to engage in ISI behaviors. Whitlock, Eckenrode and Silverman (2006) concluded that more than 50% of intentional self-injurers reported having been victims of abuse and that women are more likely than men to engage in ISI behaviors. Evans, Hawton and Rodham (2005) also found that women were more likely than men to have thoughts about and/or engaged in ISI behaviors. In a study by Ross and Heath (2002), 64% of the persons who engaged in ISI behaviors where girls. In her research Skegg (2005) compiled a list of risk factors that may make a person vulnerable to engaging in ISI behaviors. Some of these risk factors were: homosexual or bisexual sexual orientation, adverse childhood environment or experiences, interpersonal problems in adolescence, impulsivity and/or poor problem-solving skills. Hawton and James (2007) gathered information about ISI in young people
in the United Kingdom – they reported that some of the problems present in person’s who
self-injure before engaging in ISI may be relational problems with family, friend and
significant others, school or work issues, depression, bullying, low self-esteem, alcohol
and drug abuse, etc. A multitude of problems may stem from facing these types of
problems, engaging in ISI is one of them.

Ross and Heath (2002) discussed the possibility that persons who have engaged in
some type of ISI behavior are more likely to have mental health difficulties than persons
who have not engaged in ISI behaviors. ISI can be associated with a variety of clinical
disorders such as substance abuse disorders, eating disorders, posttraumatic stress
disorder, anxiety disorders, impulse-control disorders, dissociative disorders, mood
disorders, schizophrenia and borderline personality disorder (Suyemoto, 1998; Turner,
2002).

Self-injurious behaviors can also be present in persons who suffer from mental
retardation or autism. However, self-injurious behavior in these populations are more
likely stereotypical behaviors or behaviors to stimulate the self rather than an intentional
act to harm the self due to psychological distress (Suyemoto, 1998).

Functions of ISI

For the purposes of this study, engaging in ISI behaviors is best understood as a
coping strategy to reduce psychological distress.

"Much like a person may use alcohol or drugs, or indulge in other
self-destructive behaviors like anorexia or bulimia, one who self-
injures is trying to run away from or ‘turn off’ intolerable emotions
and/or memories. Or to gain some sense of control." (Turner, 2002, p.16)

For those individuals who engage in ISI due to psychological distress, the psychological distress can take many forms. Studies show there are many reasons why persons engage in ISI behaviors. For instance, ISI may be an outlet for feelings of self-hatred, sadness, anger, feeling the need to punish oneself as well as a way to release tension (Ross & Heath, 2002). Skegg (2005) reported that self-injury can be a distraction from painful feelings, a way to decrease dissociative symptoms, block upsetting memories and communicate stress to others. Engaging in ISI may stem from an inability to express emotions in adaptive ways (Gratz, 2006). Persons who engage in ISI behaviors are more likely to have problems regulating their emotions (Gratz) as well as use less effective coping strategies to deal with their problems (Andover, Pepper & Gibb, 2007). Persons who engage in ISI behaviors may be trying to escape from anguish or from a particular situation (Hawton & James, 2007). Laye-Gindhu and Schonert-Reichl (2005) discussed engaging in ISI behaviors as a way of communicating and externalizing pain.

In her article about risk factors and functions of ISI, Gratz (2003) listed a host of functions of engaging in ISI. Many of the functions of ISI are to relieve upsetting feelings such as anger, tension, guilt, loneliness and self-hatred, but ISI is also a way to provide a sense of control and safety, and to relieve cognitive distress. Gratz (2003) concluded that reasons for engaging in ISI are most likely many and that engaging in ISI may serve many functions simultaneously.

Engaging in ISI behaviors is a way to physiologically and psychologically reduce tension, and persons who engage in these behaviors may find that the behaviors become a
self-perpetuating cycle. As one woman explained (cited in Favazza, 1989) “the sight of my blood seems to release unbearable tension. At first a bruise or scratch was effective, but later it took more blood to ease the explosive tension.” (p.139). For this woman engaging in ISI behaviors became self-perpetuating, but more so, the ISI behaviors escalated over time.

Brain, Haines and Williams (1998) found that engaging in ISI reduced negative emotions when pain was self-inflicted and that a person may continue to engage in ISI behaviors because of the experience of tension reduction. Engaging in ISI behaviors becomes internally negatively reinforcing as the tension/distress that was previously felt is alleviated, the negative reinforcement may lead the person into a dangerous cycle of ISI. Brain, Haines and Williams (2002) reported that engaging in ISI behaviors is at first a frightening experience, but that the psychological response to engaging in ISI behaviors changes for those persons who engage in the behaviors repetitively. To study the phenomena of psychophysiological tension reduction, the researchers (1998) used personalized imagery scripts of four different types of events, an actual ISI incident, an accidental injury, an angry interaction and a low arousal neutral event. The scripts were read to persons who engaged in ISI behaviors, to persons who had engaged in ISI behaviors in the past as well as to persons who had not engaged in the behaviors. The researchers found that when persons who engaged in ISI behaviors were told their personalized ISI script they had a decrease in physiological tension as measured by breaths per minute, heart rate, finger pulse amplitude and skin conductance level during the part of the script where they were to imagine the ISI incident. These persons maintained the reduced physiological levels after the personalized story of the behaviors
was completed. The participants also reported their subjective response to the ISI imagery, where they reported that their negative feelings decreased during the ISI incident as well as after the incident was over. Those persons who had engaged in ISI prior to the experiment but were no longer engaging in the behaviors also showed reduction in physiological tension: however, there was a slight time lag before they reported that a decrease in subjective negative feelings took place. A 2002 study by Brain, Haines and Williams also examined the phenomena of psychophysiological tension reduction in response to ISI imagery and found that results supported previous research.

In conclusion, it is crucial to highlight that many researchers have found that engaging in ISI behaviors leads to a decrease in feelings of tension (Brain, Haines & Williams, 1998; Favazza, 1989; Gratz, 2003; Ross & Heath, 2002), that persons who engage in ISI behaviors have affective and coping skills problems (Andover, Pepper & Gibb, 2007; Gratz, 2006; Ross & Heath, 2002; Skegg, 2005), and that engaging in ISI behaviors to reduce psychological distress may become a self-perpetuating cycle (Brain et al.; Favazza).

ISI and the College Population

This research will study ISI behavior in the college population for several reasons. First and foremost, rates of college students who engage in ISI behaviors are alarmingly high. For example, in a study by Whitlock, Eckenrode and Silverman (2006), 17% of college students had engaged in ISI behaviors at some point in their life while Gratz (2001) reported that 33% of her undergraduate sample had. However, there is no reliable estimate of the number of college students who engage in ISI (Whitlock, Eckenrode &
Silverman, 2006). Studies have found variable percentages of the number of young adults who have engaged in ISI behaviors. In the United Kingdom, Young, van Beinum, Sweeting and West (2007) found that approximately 6% of young men and 8% of young women had engaged in ISI behaviors at some point in their life. Ogle and Clements (2008) found that approximately 9% of college women met criteria for engaging in ISI behaviors; in other studies, between 12-17% of adolescents have engaged in ISI behaviors at some point (Briere & Gil, 1998; De Leo & Heller, 2004; Laye-Gindhu & Schonert-Reichl, 2005; Whitlock, Eckenrode & Silverman, 2006). It is difficult to know how accurate these percentages are because the behavior is a secretive behavior and therefore is most likely underreported (Briere & Gil). Also, studies may operate on different definitions of ISI which, in turn, may impact the percentage of persons engaging in the behavior and make the percentages difficult to interpret, rely on or compare.

Secondly, ISI behaviors have been linked with another problem behavior common on college campuses, namely eating disorders. Mintz and Betz (1988) studied the prevalence of eating disordered behaviors among undergraduate women; they found that, although only approximately 4-5% of women met diagnostic criteria for an eating disorder, 61% of women had some form of eating behavior problem. In a study of undergraduate women taking the Eating Disorder Examination Questionnaire, it was found that approximately 17% of the women engaged in subjective binge episodes, 8% engaged in dietary restraint, 6% engaged in objective binge episodes, 6% engaged in excessive exercise and 4% engaged in diuretic misuse on a regular basis (Luce, Crowther & Pole, 2008). Levitt, Sansone and Cohn (2004) reported that 25% of outpatient bulimics and 22% of outpatient anorexics engaged in ISI behaviors. In an inpatient sample of
women suffering from eating disorders, 44% reported having engaged in at least one ISI behavior (Claes, Vandereycken & Vertommen, 2001); 35% of another sample of inpatient women suffering from eating disorders reported engaging in ISI behaviors at some point in their life (Paul, Schroeter, Dahme & Nutzinger, 2002).

Third, ISI has also been linked with substance abuse behaviors (e.g. alcohol consumption, drug use), which are also common on college campuses. Slutsker (2005) studied alcohol use disorders among college students and non-college-attending young adults – she found that approximately 18% of college students and 15% of non-college-attending young adults had significant alcohol-related problems. Wechsler, Lee, Kuo, Seibring, Nelson and Lee (2002) surveyed students at 119 undergraduate colleges and found that approximately 44% of college students reported engaging in binge drinking. Favazza and Conterio (1989) found that 28% of the persons who engaged in ISI were “concerned about their drinking, 18% considered themselves alcoholics; 30% have used street drugs (mainly marijuana, “speed,” cocaine and “downers”).” (p. 287). Ogle and Clements (2008) studied ISI and alcohol involvement in college women and found that women who engaged in ISI behaviors did not use alcohol more often or in larger amounts than other college women. However, the researchers found that participants who engaged in ISI behaviors engaged in more risky behaviors when intoxicated, reported more negative consequences of drinking and experienced more impairment when drinking.

Fourth, college students are an accessible population to study in the large numbers needed for this study. College students are readily available, reliable participants as well as capable of reading, understanding and answering questionnaires. Further, this study will focus on intrinsic barriers to treatment, rather than external barriers (e.g., cannot
afford treatment, not knowing where to turn for help). College students often (and will in this case) have free treatment available to them, as well as knowledge of on-campus mental health resources, thus removing some of the main extrinsic barriers.

Finally, college students are at risk for developing ISI behaviors as a coping mechanism for dealing with the educational and social stressors present at college. It is a commonly known fact that college is a stressful time for individuals, and starting college is a big adjustment for most. College may be the first time an adolescent is away from home; college is a time for developing a sense of independence, making new social connections as well as keeping up with challenging coursework. In some individuals ISI behaviors may continue from high school, people who engage in ISI typically have their first episode in adolescence and the majority of individuals continue ISI behaviors for several years (Favazza, 1989; Turner, 2002; Whitlock, Eckenrode & Silverman, 2006).

Barriers to Professional Help-Seeking

There are many barriers to treatment that are overarching and apply to all individuals who contemplate seeking treatment. Clarke (2007) reviewed literature on barriers to help-seeking for mental health issues, and described the barriers in terms of different models for how people use health services, as well as discussing intrinsic (internal) and extrinsic (external) barriers.

Intrinsic barriers are a person’s inherent tendencies and/or fears about seeking professional help, most of which are attitudinal in nature. For instance, some of the intrinsic barriers discussed by Clarke (2007) are that people have a tendency to procrastinate, they have a tendency to misinterpret and/or minimize their symptoms, they may fear embarrassment if they present for help and find that nothing is wrong, and they
may be reluctant to change their lifestyle. Other intrinsic barriers are being embarrassed about one’s problems, having fear of what others will think about them and/or their problems, being reluctant to answer personal questions (Clarke; Hornblow, Bushnell, Wells, Joyce, & Oakley-Browne, 1990), and having a fear of stigma or feel shame about seeking help (Clarke). Hornblow et al. found that it was common for people to think their problem was something they should be able to handle themselves, that the problem would get better by itself or that they did not think that anyone could help.

Several studies have researched specific intrinsic or attitudinal barriers to professional help-seeking in terms of the risks and benefits associated with professional help-seeking. Vogel and Wester (2003) found that those individuals who were less able to see the benefits of self-disclosure and who felt less likely and less comfortable self-disclosing personal/emotional information were less likely to have positive attitudes about treatment. Vogel et al. (2007) found that those persons who had more positive attitudes and intentions about help-seeking were more likely to either know someone who had been in treatment or had themselves been encouraged by someone else to seek help.

Extrinsic barriers are barriers that do not have to do with the specific attitude or internal tendencies/fears inherent to the person. Clarke (2007) discussed external barriers as those barriers that are related to how available, how affordable and how accessible they are. Hornblow, Bushnell, Wells, Joyce, and Oakley-Browne (1990) found that some people did not know where to go for services, that they were worried they would not be able to afford the bill, did not know how to get there or that the hours of service did not fit their schedule. According to Clarke, extrinsic barriers are influenced by gender, age, ethnicity, socioeconomic status as well as the type of problem, severity and comorbidity.
For the purposes of this study, intrinsic barriers are the main focus. Intrinsic barriers have been shown to be the most common barriers for persons who do not seek professional help (Cachelin & Streigel-Moore, 2006; Clake, 2007; Hornblow, Bushnell, Wells, Joyce, & Oakley-Browne, 1990). However, because the exploratory part of this study looks more broadly at barriers to professional help-seeking, extrinsic barriers are taken into consideration during that part of the study.

In the following sections specific research on intrinsic barriers for the adolescent and young adult population as well as specific barriers for those who engage in ISI behaviors will be explored. The reasons why intrinsic barriers are the specific focus for this study will also be addressed.

*Specific Barriers for Adolescents/Young Adults*

There have been several studies that have looked at help-seeking (both formal and informal) and barriers to help-seeking specifically in adolescents and young adults (e.g. Moskos, Olson, Halbern & Gray, 2007; Nada-Raja, Morrison & Skegg, 2003; Wisdom, Clarke & Green, 2006). Intrinsic barriers seem to be the most common barriers for those adolescents/young adults who do not seek professional help.

Nada-Raja, Morrison and Skegg (2003) found that attitudinal factors toward help-seeking were the biggest barriers in help-seeking (e.g. thinking one should be strong enough to handle ones problems, thinking the problem would solve itself, being too embarrassed to tell someone, etc.). Other barriers found were fear of stigma factors (e.g. being afraid of what others may think, objections from family members, afraid of being hospitalized, etc.) as well as practical factors (e.g. unable to pay for services, lack of time, unable to get health services, etc.). Moskos, Olson, Halbern and Gray (2007) found that
in adolescents/young adults who had completed suicide, the barriers to professional help-seeking (as reported by parents in interviews about their child) where mostly attitudinal – i.e. not wanting to admit to a problem, believing nothing could help, feeling embarrassed about the problem, regarding help-seeking as a weakness or failure, etc. In general, researchers have found that adolescents and adults face similar difficulties and barriers for seeking professional help.

However, adolescents face several barriers that adults may not. Adolescents may fear that their parent(s) or guardian(s) will find out about their problems. Some general barriers faced by adolescents when contemplating treatment are: wanting to feel normal, connected, and autonomous (Wisdom, Clarke & Green, 2006). In their study Wisdom et al. found that adolescents want to feel normal; they do not want to feel weak or be judged as being “weird”. The adolescents were afraid of not feeling connected to the professional, and they were also afraid of losing their autonomy. The adolescents in the study reported “wanting the involvement and guidance of parents and providers, but the freedom and autonomy to make decisions on their own” (p.141). Though adolescents and adults face mostly the same barriers to professional help-seeking, adolescents have some additional concerns regarding seeking professional help.

Specific Barriers for Those Engaging in ISI Behaviors

The purpose of this study is to research the barriers to professional help-seeking among college students who engage in ISI behaviors. Few studies have looked at the professional help-seeking behaviors of those persons who engage in ISI behaviors. However, despite the little research available, it has been established that persons who engage in ISI behaviors present less for professional help than do those persons who are
in psychological distress but do not engage in ISI behaviors (e.g. Evans, Hawton & Rodham, 2005).

Evans, Hawton and Rodham (2005) found that persons who engage in ISI behaviors seek professional help less often than those who endorse feeling psychological distress and do not engage in ISI behaviors. Of the adolescents who engaged in ISI behaviors 20% reported that no one knew of the behaviors. Whitlock, Eckenrode and Silverman (2006) found that 40% of persons who had engaged in ISI behaviors had not sought professional help, 36% of persons who had engaged in ISI behaviors had never told anyone of their problems. Nada-Raja, Morrison and Skegg (2003) found that 54% of a group of persons having engaged in ISI behaviors had not sought help (professional help or other help).

Although the studies mentioned above have several key differences (for instance, Evans, Hawton and Rodham (2005) studied high school students engaging in ISI behaviors in the past year; Nada-Raja, Morrison and Skegg (2003) studied 26-year-olds who had engaged in ISI in the past year; and Whitlock, Eckenrode and Silverman (2006) studied college students who had engaged in ISI at some point in their life), all three studies found that a significant amount of persons who engage in ISI behaviors do not seek professional help. This finding is distressing, and the follow-up question becomes why? Why do persons who engage in ISI behaviors seek help less often than those who do not engage in ISI behaviors?

Nada-Raja, Morrison and Skegg (2003) reported that 83% of their sample of young adults who had engaged in ISI behaviors but had not sought professional help did not believe they needed to seek help; 39% did not seek help due to attitude related barriers;
approximately 11% due to practical barriers; and approximately 7% due to fear of stigma.
Favazza (1989) also briefly mentioned the possibility of fear of stigma hindering
someone who engages in ISI behaviors to be honest about their problems. Best (2006)
may agree that there is some legitimacy to why persons who engage in ISI behaviors may
be afraid of coming forward with their problems; he writes that people who are not
knowledgeable about ISI behaviors may react to those who engage in the behaviors with
panic, shock, disgust, etc.

Researchers have found that those adolescents who had engaged in ISI behaviors
talked less about their problems with others than did adolescents who did not engage in
ISI behaviors (Evans, Hawton and Rodham, 2005). The adolescents who deliberately
self-harmed were more likely to isolate themselves from others when they were upset,
and the girls in the study were more likely to become angry. Andover, Pepper and Gibb
(2007) reported that young women with a history of engaging in ISI behaviors “reported
significantly less use of problem-solving strategies” (p. 242) and less use of social
support than young women without a history of engaging in ISI behaviors. Young men
and women who had a history of engaging in ISI behaviors used more avoidance rather
than problem-solving as a coping mechanism in times of stress (Andover et al.).

In their study Evans, Hawton and Rodham (2005) concluded that it was unclear if
adolescents with ISI behaviors recognized how serious their problems were. In their
study, 25% of the adolescents who engaged in ISI behaviors did not think they had a
serious problem. This researcher speculated that if a student does not think they have a
serious problem they will be less likely to seek help. Of those students who had engaged
in ISI behaviors, 20% reported that no one knew of the behaviors.
ISI is a secretive behavior; persons who engage in ISI behaviors typically feel shame, guilt and social stigma about their behaviors (Turner, 2002). Individuals who engage in ISI behaviors usually successfully hide their cuts, burns, scars etc. from others for months or years (Turner). Although the secretive nature and social stigma of ISI behaviors has not been explicitly researched as a barrier to professional help-seeking it is feasible that it hinders persons from seeking professional help.

Theory of Help-Seeking among Those with ISI

The central question in this study is based on research showing that those persons who engage in ISI behaviors seek less professional help for their problems. The aim is to study whether the barriers to professional help-seeking in persons who engage in ISI behaviors are based on intrinsic barriers that parallel specific functions of ISI. Specifically, are barriers to professional help-seeking in those who engage in ISI related specifically to low emotional self-disclosure, use of experiential avoidance, and low feelings of self-compassion?

The following three sections consist of a three-part theory of the barriers to professional help-seeking for those individuals who engage in ISI behaviors. Each of the three subsequent sections will explain how a function of ISI may also serve as an intrinsic barrier to help-seeking. Below is a figure of the Three-Part Theory and Mediation Model that will be explained in the following three sections.
Low Emotional Self-Disclosure

Self-disclosure is commonly defined as a process of sharing personal feelings, thoughts, attitudes and beliefs with others (Vogel & Wester, 2003). Emotional self-disclosure is defined as sharing emotions with others, regardless of who the person is.

Studies show that persons who engage in ISI behaviors are less likely to talk with others in times of distress (Andover, Pepper & Gibb, 2007; Evans, Hawton & Rodham, 2005). Andover et al. specifically showed that women with a history of engaging in ISI behaviors were less likely to turn to social supports in times of stress (controlling for psychological distress in comparison group). Evans et al. reported that those adolescents who engaged in ISI behaviors had less people they felt they could talk to, and that these results were increasingly true for those adolescents who had engaged in ISI behaviors.
multiple times. Vogel and Wester (2003) found that persons who report less comfort with self-disclosure typically have a less favorable attitude toward help-seeking.

One function of engaging in ISI behaviors is to have an outlet for negative emotions such as anger, sadness and tension (Ross & Heath, 2002), escape from anguish (Hawton & James, 2007), and relieve guilt, loneliness and self-hatred (Gratz, 2006). Gratz discusses the possibility of engaging in ISI behaviors as a way to express emotions, albeit, in a maladaptive way. Gratz also discussed the possibility of the inability to express emotions as a contributing factor to sustaining ISI behaviors. Laye-Gindhu and Schonert-Reichl (2005) reported that negative emotions were the most common emotions felt before engaging in ISI behaviors, and that afterward those who engage in ISI behaviors felt relief from negative emotions, but also guilt, shame and disgust about their behaviors.

As mentioned above, research has shown that one way that people who engage in ISI behaviors deal with their distressing emotions is by using the ISI behaviors as a way of coping (e.g. Ross & Heath, 2002; Gratz, 2006). The research discussed above has also shown that people who engage in ISI behaviors are less likely to share their distress with others (Andover, Pepper & Gibb, 2007; Evans, Hawton & Rodham, 2005). If persons who engage in ISI behaviors are less likely to talk with others in times of distress and are using the ISI behaviors as a coping mechanism for distress – then the chance that they seek professional help for their distress seems unlikely. In other words, people with low emotional self-disclosure are likely to have a build-up in unresolved negative emotions. They avoid discussing these emotions with others and therefore resort to behaviors such as ISI to cope. Therefore, this study hypothesizes that one barrier for those persons who
engage in ISI behaviors is low emotional self-disclosure and consequently, persons who engage in ISI behaviors are less likely than those who do not engage in ISI behaviors to seek professional help.

Use of Experiential Avoidance

Experiential avoidance is defined as “the phenomenon that occurs when a person is unwilling to remain in contact with the particular private experiences (e.g. bodily sensations, emotions, thoughts, memories, behavioral predispositions) and takes steps to alter the form or frequency of these events and the contexts that occasion them” (Hayes, Wilson, Gifford, Follette & Strosahl, 1996, p. 1154). In essence, experiential avoidance is when a person tries to avoid or escape from unpleasant internal experiences.

Skegg (2005) found that one of the reasons for engaging in ISI behaviors is to escape or be distracted from unwanted emotions; Linehan (1993) described engaging in ISI behaviors as an escape from “an intolerable and unsolvable life” (p.15). Hawton and James (2007) described some possible functions for engaging in ISI behaviors as an “escape from unbearable anguish” or “escape from a situation” (p. 891) and Andover, Pepper and Gibb (2007) found that persons who engaged in ISI behaviors used significantly more avoidance to deal with stress than did persons who did not engage in ISI behaviors. Engaging in ISI behaviors is a way of taking care of a problem, or of emotional distress, “Despite its obvious negative consequences, DSH /deliberate self harm/ is quite functional on a certain level, as it may be exceedingly effective at terminating unwanted emotional states.” (Chapman, Gratz & Brown., 2006, p. 374). In conclusion then, research suggests that engaging in ISI behaviors is a form of engaging in experiential avoidance.
Chapman, Gratz and Brown (2006) put forth a specific model for understanding ISI in terms of experiential avoidance. They hypothesized that a stimulus will elicit a distressing emotional response, the person (who engages in ISI behaviors) feels high emotion intensity, has a difficult time regulating the emotions when aroused, has poor emotion regulations skills and has poor distress tolerance. Therefore, the solution to the distressing emotion is to avoid dealing with it. Engaging in ISI reduces the emotional distress and results in temporary relief, i.e. resulting in negative reinforcement, which may lead ISI behaviors to become a chronic response to emotional stimulation.

ISI has been found to reduce psychophysiological arousal in individuals who engage in the behavior (Brain, Haines & Williams, 1998; Brain, Haines & Williams, 2002) and hence engaging in ISI allows the individual to feel less tension, pain and distress. The reason for using ISI behaviors to reduce emotional stress may vary. The behaviors may be due to deficits in effective and adaptive coping skills (Evans, Hawton & Rodham, 2005; Linehan, 1993), or because of difficulty with impulse control (see Brain, Haines & Williams, 1998).

At this time, no research has been conducted about a relationship between experiential avoidance and lack of help-seeking during psychological distress. However, Rüsch et al. (2007) found that experiential avoidance significantly predicted drop-out rates from an inpatient Dialectical Behavior Therapy group. Those persons who dropped out of the therapy group before it was completed had higher baseline levels of experiential avoidance (as measured by the Acceptance and Action Questionnaire). The researchers discussed the possibility that experiential avoidance “may be a major obstacle for successfully engaging in psychotherapy” (p. 498).
Clearly, researchers have shown that engaging in experiential avoidance (in the form of engaging in ISI behaviors) is one way of coping with emotional distress. It seems then, that persons who engage in ISI behaviors are avoiding their distress and dealing with it in maladaptive, potentially dangerous and self-destructive ways instead of using adaptive coping skills. Persons who avoid distressing emotions are most likely less willing and/or less able to confront and share their distress to work on it in adaptive ways, which are tasks that are often required in therapy. Therefore this study hypothesizes that one barrier for those persons who engage in ISI behaviors is the use of experiential avoidance as a coping skill in times of emotional distress and consequently, persons who engage in ISI behaviors are less likely than those who do not engage in ISI behaviors to seek professional help.

*Low Feelings of Self-Compassion*

Self-compassion is defined as

“being touched by and open to one’s own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one’s own suffering and to heal oneself with kindness. Self-compassion also involves offering nonjudgmental understanding of one’s pain, inadequacies and failures, so that one’s experience is seen as a part of the larger human experience” (Neff, 2003a, p.87).

In short, the construct of self-compassion has three parts: being kind and understanding toward the self, feeling connected with others instead of isolated, and not over-identifying with internal pain (Neff, 2003b).
Research has found that persons who engage in ISI behaviors experience a variety of painful feelings such as self-hatred, sadness, anger (Ross & Heath, 2002), guilt, loneliness, depression (Gratz, 2006), anguish (Hawton & Jones, 2007) and dissociation (Skegg, 2005). Research has also found that they feel the need to punish themselves/take out the emotional distress on themselves as a way to deal with the pain (Ross & Heath; and as previously noted in Use of Experiential Avoidance section). Person’s who engage in ISI behaviors may have a history of abuse and interpersonal problems (Skegg), school or work issues, bullying, substance abuse and low self-esteem (Hawton & James, 2007) – all of which may affect the way they feel about themselves and the world around them.

Neff (2003a) discussed the possible connection between self-compassion and mental health. She writes:

“individuals who are self-compassionate should evidence greater psychological health than those with low levels of self-compassion, because the inevitable pain and sense of failure that is experienced by all individuals is not amplified and perpetuated through harsh self-condemnation” (p. 93).

Individuals who are self-compassionate are caring toward themselves, and understanding of themselves; therefore they do not believe that their pain, distress and failures are a representation of who they are, but an example of their connectedness with others. Leary, Tate, Adams, Allen and Hancock (2007) described self-compassion as caring for oneself. Therefore it would seem that self-compassionate people are unlikely to engage in self-destructive and self-damaging behaviors.
To date, no studies have conducted research on ISI and self-compassion. Persons who engage in ISI behaviors try to avoid or disconnect from their feelings (e.g. Skegg, 2005), and the behaviors they engage in are not acts of kindness toward the self. Instead of acting in self-compassionate ways persons who engage in ISI behaviors are acting in self-damaging ways. Therefore this study hypothesizes that one barrier for those persons who engage in ISI behaviors is low self-compassion, and consequently, persons who engage in ISI are less likely than those who do not engage in ISI behaviors to seek professional help.

**Exploratory Component**

This study also has an exploratory component. Additional aims of this study are: 1) to explore which barriers are more common in those persons who have at some point engaged in ISI behaviors compared to those who have not engaged in ISI behaviors, and 2) to compare those persons who have engaged in ISI behaviors and have sought help with those persons who have engaged in ISI behaviors and have not sought professional help on several variables. It is possible that the main hypotheses will not be found to be significant, but exploratory hypotheses will allow for a broader look and a place to start further research of what the barriers to professional help-seeking are for persons who have engaged or currently engage in ISI.

The purpose of this part of the exploratory component is to study general barriers to professional help-seeking as well as general attitudes toward professional help-seeking in those individuals who have engaged in ISI behaviors and those who have not engaged in ISI behaviors but endorse psychological distress. Information found here may serve as a guide for future research in terms of differences in barriers to professional help-seeking
in those who have and those who have not engaged in ISI behaviors yet endorse psychological distress.

This study hypothesizes that the barriers to professional help seeking in those persons who engage in ISI and have not sought professional help will be different than the barriers to professional help seeking endorsed by those persons who have engaged in ISI but sought help. If the sample of students is large enough, i.e. if the statistics have enough power, it would be interesting to see if there are differences in general barriers as well as in general attitudes toward professional help-seeking between those persons who have engaged in ISI and have not sought help versus those who have engaged in ISI and have sought professional help. Results here may suggest some differences in the dynamics of ISI for those persons who have or have not sought professional help for their ISI behaviors.

This study also hypothesizes that those persons who have engaged in ISI but have not sought professional help will rate: a) lower on emotional self-disclosure, b) higher on experiential avoidance and c) lower on self-compassion than those persons who have engaged in ISI but have sought professional help. Again, if the sample of students is large enough, i.e. if the statistics have enough power, it would be interesting to find out if there are differences in the specific barriers considered in the central aim of the study between those persons who do or have engaged in ISI and have not sought professional help versus those who do or have not engaged in ISI and have sought professional help.
Chapter II

Rationale and Hypotheses

Intentional self-injury has become an increasingly common behavior among adolescents and young adults. There are a variety of reasons why people may engage in ISI behaviors, the behavior may serve as a way to relieve stress, punish the self (Ross & Heath, 2002), avoid negative emotions (Skegg, 2005) and/or as a way to escape from anguish or a particular situation (Hawton & James, 2007). Regardless of the reason for engaging in ISI behaviors, the behavior itself is indicative of psychological distress. ISI behaviors are particularly concerning as persons who engage in them may become trapped in a self-perpetuating cycle of ISI (Brain, Haines & Williams, 1998) where the ISI behavior escalates (Favazza, 1989).

Research has shown that approximately half of the persons who engage in ISI behavior do not seek professional help (Whitlock, Eckenrode & Silverman, 2006). Moreover, research has shown that persons who engage in ISI behavior seek professional help less often than do those persons who have not engaged in ISI but report psychological distress (Evans, Hawton & Rodham, 2005). However, to date, research is unclear of the reasons for these findings. This study aims to explore some of the possible reasons why persons who engage in ISI behaviors do not seek professional help as often as persons who endorse psychological distress and do not engage in ISI behaviors.

As previously discussed, research has shown that persons who engage in ISI behaviors deal with distressing emotions by using the ISI behaviors as a way of coping (e.g., Gratz, 2006; Ross & Heath, 2002). Persons who engage in ISI behaviors are less
likely to share their distress with others (Andover, Pepper & Gibb, 2007; Evans, Hawton & Rodham, 2005). Hence, persons who are less likely to share their distress with others (low emotional self-disclosure) are less likely to seek professional help. Engaging in experiential avoidance is another way of coping with emotional distress (Chapman, Gratz & Brown, 2005), and for those who engage in ISI behaviors, engaging in the behavior is one way of avoiding or escaping from psychological distress. Hence, persons who engage in ISI behavior are more likely to endorse experiential avoidance and therefore less likely to seek professional help. Also, persons who engage in ISI behaviors are acting in self-damaging ways – in part they express their distress by injuring themselves and are therefore not acting in a self-compassionate way. Hence, persons who engage in ISI behaviors will endorse less self-compassion and therefore also seek professional help less often.

In light of the theory discussed in the previous section, this study hypothesizes that:

1. Those persons who engage in ISI will seek professional help less often for their psychological distress than will those who have psychological distress and do not engage in ISI.

1.1.) Those persons who engage in ISI are measured by one or more affirmative responses on the DSHI (if someone has engaged in ISI they are affirmative for psychological distress irregardless of differing self-report).
1.2.) Those persons who have psychological distress and do not engage in ISI are measured by affirmative answers on questions 1 and/or 3 on the PDQ as well as not endorsing ISI behavior on the DSHI.

– The comparison here is between those described in (1.1) and those described in (1.2) on questions 2, 2a, 4 and 4a on the PDQ.

2. Those persons who have engaged in ISI will have lower emotional self-disclosure than those who have psychological distress and do not engage in ISI.

– The comparison here is between those described in (1.1) and those described in (1.2) on the ESDS. The higher the score on the ESDS the more willing the person is to disclose emotions.

3. Those persons who have engaged in ISI will have higher use of experiential avoidance than those who have psychological distress and do not engage in ISI.

– The comparison here is between those described in (1.1) and those described in (1.2) on the AAQ. The higher the score on the AAQ the more the experiential avoidance the person is endorsing.

4. Those persons who have engaged in ISI will have higher rates of endorsing that they typically have less self-compassion than those who have psychological distress and do not engage in ISI.

– The comparison here is between those described in (1.1) and those described in (1.2) on the SCS. The higher the score on the SCS the more self-compassionate the person is.
A mediational model is also predicted. For a figure of the three-party theory and mediation model, see page 20. Therefore, secondary hypotheses are that:

5. Emotional self-disclosure will be positively related to help-seeking behavior.
   - Scores on the ESDS will be positively correlated with questions 2, 2a, 4 and 4a on the PDQ.

6. Experiential avoidance will be negatively related to help-seeking behavior.
   - Scores on the AAQ will be negatively correlated with questions 2, 2a, 4 and 4a on the PDQ.

7. Self-compassion will be positively related to help-seeking behavior.
   - Scores on the SCS will be positively correlated with questions 2, 2a, 4 and 4a on the PDQ.

8. The relationship between ISI and help-seeking behavior will be mediated by emotional self-disclosure, experiential avoidance, and self-compassion.
   - Follows from above Hypotheses 2 through 7.
Chapter III

Methods

Participants

Participants in this study are approximately 500 undergraduate students at Xavier University (mid-sized, private Catholic university in the Midwest). They will be recruited through the participant pool during the course of two and a half semesters (the later half of spring 2009 through spring 2010) at Xavier University and are therefore all students in undergraduate psychology courses. Participants will be both male and female, and for their participation they receive credits in their psychology classes.

A power analysis was conducted in order to determine how many students would be needed in the study. The power analysis was conducted with the general power analysis program, G*Power 3.0.10, created by Erdfelder, Faul and Buchner (1996). It is difficult to determine the percentage of participants who will endorse having engaged in ISI behaviors, research in the past has reported varying percentages. For instance, Whitlock, Eckenrode and Silverman (2006) found that 17% of their undergraduate sample had engaged in ISI behavior at some point in their life; Ross and Heath (2002) found that 10% of high school adolescents had engaged in ISI behavior at some point in their life. So as not to over-estimate the amount of students who will endorse having engaged in ISI behavior, it is expected that approximately 10% of the participants in the study will endorse having engaged in ISI behavior at some point. If approximately 10% of the participants endorse that they have engaged in ISI behavior at some point in their life, the study needs a total of 500 participants to obtain 50 participants who have engaged in ISI.
With this number of participants, the study will be powered to detect a medium effects size of .49 at an alpha level of .05.

*Measures*

*Psychological Distress Questionnaire (PDQ)*. Psychological distress and professional help-seeking are measured by the Psychological Distress Questionnaire (PDQ). This questionnaire was adapted from questions originally developed by Evans, Hawton and Rodham (2005) in a broader set of questionnaires. The questions were adapted to fit the needs of this study.

The purpose of the original questions was to obtain the participants’ opinions about having experienced psychological distress in the past year, if they felt help was needed for that distress as well as if they had sought help for those problems. Important here was that the researchers did not define psychological distress, instead, because psychological distress is a subjective concept they allowed the participants to draw their own conclusions. No statistics are available for the specific questions on the original questionnaire.

The questionnaire was adapted in that professional help-seeking was defined and the questions were split into asking about specific time frames for having had a serious personal, emotional, behavioral or mental health problem as well as having sought help in that specific time frame (in the original questions no time frame was specified). Because there may be participants of the study who have sought professional help without feeling that they had a serious personal, emotional, behavioral or mental health problem, two additional questions to address this were added (questions 2a and 4a). The current questionnaire (see Appendix A) consists of six self-report items that ask the participants
to respond Yes/No to “/In a certain time frame/ have you had a serious personal, emotional, behavioral or mental health problem for which you thought professional help was needed?” as well as “Did you seek professional help at that time?” Participants are also asked if they have sought professional help without feeling that they had a serious problem in each of the two time frames (the past 12 months, prior to the past 12 months).

*Deliberate Self-Harm Inventory (DSHI)*. The Deliberate Self-Harm Inventory (DSHI), developed by Gratz (2001), is a behaviorally based, self-report measure of deliberate self-harm (see Appendix A). The DSHI has high internal consistency, .82, an adequate test-retest reliability score of .68 (p<.001). Participants who endorsed self-harming behaviors during the first and second test-administration were highly correlated (r=.92, p<.001). In a study conducted by Gratz in 2006 internal consistent was found to be .81. Fliege et al. (2006) conducted a study in which they investigated three assessment tools for ISI behaviors, two of which were self-report measures. Results here showed that the DSHI had good reliability (cronbach’s alpha at .81 and split-half reliability at .78). The DSHI has been significantly correlated with other measures of self-harm and a measure of borderline personality organization (Gratz, 2001). For purposes of developing the DSHI, Gratz defined deliberate self-harm (or intentional self-injury, ISI) “as the deliberate, direct destruction or alteration of body tissue without conscious suicidal intent, but resulting in injury severe enough for tissue damage (e.g. scarring) to occur” (p.255).

The DSHI consists of 17 behaviorally based items, e.g. Have you ever intentionally (i.e. on purpose) cut your wrists, arms or other area(s) of your body (without intending to kill yourself)? Yes/No. For each affirmative answer, participants are asked to respond to
four follow up questions. The follow up questions are aimed to find out more about the behavior the participant has endorsed, i.e. how old the person was when they started, how many times they have done the behavior, how many years they have been doing it and if the behavior has ever resulted in some sort of medical treatment.

One specific limitation with this measure is that the measure does not account for persons who have engaged in ISI behaviors without the conscious intent to harm themselves, i.e. those persons who have engaged in the behaviors while in a dissociated feeling state. There may be some individuals who have engaged in ISI behaviors but because they do not feel that they engaged in the behaviors with the intent to harm the self they will not endorse the behaviors. Another limitation is that the definition of ISI that was used by Gratz (2001) in the development of the inventory does not take into account types of ISI behaviors that do not cause tissue damage. However, it seems that the last question may be attempting to correct for this as it asks the participants if they have “done anything else to hurt yourself that was not asked about in this questionnaire” and if participants answer yes, they are asked “What did you do to hurt yourself?”.

*List of Barriers.* The List of Barriers was taken from results of a large study by Hornblow et al (1990) and adapted minimally for the purposes of this study (see Appendix A). In the epidemiology study by Hornblow et al., researchers conducted interviews with persons about utilization of mental health services. Each participant was asked “Some people don’t see a doctor or other professional about emotional or mental problems or problems with drugs or alcohol when perhaps they should. Was there ever a time when you decided not to see a doctor or professional even when your family or you yourself, thought you should?” (p.415). Fifteen common barriers to professional help-
seeking emerged, and these barriers form the basis of the current research study’s List of Barriers. The list of barriers was minimally adapted as this researcher added one potential barrier to the list, namely “You felt like you were taking care of the problem yourself”. The reason for adding this statement to the questionnaire was that for individuals who engage in ISI behaviors engaging in the behaviors themselves may serve as a way of taking care of the problem/psychological distress, therefore, in essence, engaging in ISI behaviors may serve as self-help (Favazza, 1989). The list of barriers is not a list that has been used as a questionnaire; therefore there is no statistical information available.

In the current List of Barriers participants are asked if any of the following statements have ever been barriers for them in seeking professional help, or, if they think the statements would be barriers for them in seeking professional help. Professional help is defined (see Appendix A). Some examples of barriers are “You thought it was something you were strong enough to handle alone” and “You thought the problem would get better by itself”. Participants answer each statement with Yes or No.

*Attitudes toward Seeking Professional Psychological Help Scale (ATSPPHS).* The Attitudes toward Seeking Professional Psychological Help Scale (ATSPPHS) measures a person’s general attitude toward seeking professional help for psychological disturbances (Fischer & Turner, 1970; see Appendix A). Factor analyses on the scale revealed four dimensions: recognition of need for psychological help, stigma tolerance, interpersonal openness, and confidence in mental health professionals. The internal reliability on the original sample was .86; the test-retest reliability was between .73 and .89 depending on the amount of time between testing. Vogel and Wester (2003) utilized the ATSPPHS in their study of college students; these researchers report an internal consistency validity of
.90. Fischer and Turner found that the scale was able to discriminate between those individuals who had and had not sought professional help.

The scale consists of 29 statements that participants are asked to rate on a four-point Likert scale (3 – agree, 2 – somewhat agree, 1 – somewhat disagree, 0 – disagree), an example of a statement is “Although there are clinics for people with mental troubles, I would not have much faith in them”. The questionnaire was minimally adapted for purposes of this study; the changes made were due to the outdated nature of some of the terms on the original scale. The term “mentally ill” was changed to “psychological problems”, the term “psychiatric patient” was changed to “mental health client”, “psychiatrist” was changed to “mental health professional” and “he” was changed to “he/she”.

The responses to the questionnaires are summed and the higher the sum of the scores the more positive the participants attitude is toward professional help-seeking. Disagree corresponds with a score of 0, somewhat disagree corresponds with a 1, somewhat agree corresponds with a score of 2 and agree corresponds with a score of 3.

*Emotional Self-Disclosure Scale (ESDS)*. The Emotional Self-Disclosure Scale (ESDS) measures how willing a person is to discuss specific emotions with other people (Snell, Miller & Belk, 1988; see Appendix A). The purpose of the ESDS is to see how willing people are to discuss certain emotions with different persons in their life (i.e. female friends, male friends, and spouse/lovers). The psychometrics on the ESDS were found to be reliable, that is, the five questions for each of the eight emotions were found to reliably measure the specific emotions (the measure of internal reliability ranged from .83 to .95). Vogel and Wester (2003) utilized six of the eight emotions on the scale in
their study and found that coefficient alphas were high (depression was .91, happiness, jealousy, anxiety and anger were all .92, and fear was .94). Snell, Miller and Belk have also showed that test-retest reliability over a 12-week period where somewhat stable (depending on the person the participant was disclosing to).

The ESDS consist of 40-items measured on a five-point Likert scale (1 – Not at all willing to discuss this topic, 5 – Totally willing to discuss this topic). The 40-items are split into eight groups of five questions aimed to measure each of eight distinct emotions (depression, happiness, jealousy, anxiety, anger, calmness, apathy and fear). For the purposes of this study the scale was adapted and participants are only asked to rate how willing they are to discuss the “following times” with other persons as opposed to being asked multiple times regarding different persons. For this study there is no need for a distinction between whom the participants are willing to disclose emotional information to, the purpose here is to study if persons who engage in intentional self-injury overall are less willing to disclose emotional information.

The responses to the feeling states are summed for each of the eight emotions, the higher the score the more willing the person is to disclose that particular emotion (the answers are scored between from 1 point for Not at all willing to discuss the topic to 5 points for Totally willing to discuss the topic). Participants may also be compared on their overall sum of scores in terms of sharing any of the type of emotions with others.

_Acceptance and Action Questionnaire (AAQ)_ The Acceptance and Action Questionnaire (AAQ) is a general measure of experiential avoidance and was created by Hayes et al. (2004; see Appendix A). The AAQ has an adequate internal consistency alpha of .70 and test-retest reliability of .64 at four months. The AAQ has been compared
to a measure of avoidant coping (White Bear Suppression Index); convergent validity was between .44 and .50. The AAQ correlated well with specific types of mental health concerns such as depression, anxiety, social phobia, anxiety sensitivity and post-traumatic stress symptoms as well as measures of general mental health. Boelen and Reijntjes (2008) studies the reliability and validity of the Dutch 9-item AAQ. Results here showed that high AAQ scores were significantly associated with psychopathology and maladaptive coping strategies, among others.

The AAQ is a 9-item questionnaire; participants are given statements that they are asked to rate on a seven-point Likert scale (1 – Never true, 4 – Sometimes true, 7 – Always true). An example of a statement is “I am able to take action on a problem even if I am uncertain what is the right thing to do”. The questionnaire was not adapted for purposes of this study.

For purposes of scoring, responses to statements 1, 4, 5 and 6 are reversed; the responses to statements are then summed (1 point to Never true, 7 points to Always true). The higher the score the more experiential avoidance the participant endorses.

Self-Compassion Scale (SCS). The Self-Compassion Scale (SCS) measures two subscales in each of three basic components of self-compassion: self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus over-identification (see Appendix A). The SCS was developed by Neff (2003b) and has a Cronbach’s alpha coefficient of .92. Her goal with creating the scale was to create a measure that would measure self-compassion as an overarching construct.

The scale consists of 26 self-report statements, and participants are asked to rate their responses on a five-point Likert scale (1 – Almost never, 5 – Almost always). An
example of a statement is “I’m disapproving and judgmental about my own flaws and inadequacies”.

The responses to the statements are summed for each of the two subscales in each of the three components of self-compassion. The self-judgment, isolation and over-identification subscales are reverse scored. The means of the subscales are then calculated and summed to form one overall score of self-compassion. The higher the summed score the more self-compassion is endorsed by the participant.

Limitation. One concern about the use of the last three questionnaires, the ESDS, the AAQ and the SCS is that there may be some multicollinearity between measures which needs to be controlled for in the analysis.

Procedure

The proposed study will be reviewed by Xavier University’s Institutional Review Board (approved on 23 April 2009). When approved, undergraduate students at Xavier University (participant pool members) will be able to read an announcement about the study on the participant pool bulletin board. The announcement will contain limited information about the study, state that participation in the study is anonymous and have paper-tags with the web-address for the study for participants to take.

When entering the acquired survey web-address into their web-browser participants will be taken directly to the informed consent portion of the internet-based survey (SurveyMonkey). Participants read the informed consent and opt to either consent or not consent to participate in the study by answering “Yes” or “No” to the statement at the bottom of that page. The number of persons who opt to continue (respond “Yes”) or discontinue (respond “No”) with the survey will be tallied. Participants who opt to
consent to participating in the survey will then be prompted to fill in their gender and age, and will then be prompted to answer seven self-report measures: the PDQ, DSHI, List of Barriers, ATSPPHS, ESDS, AAQ and the SCS. After completing the seven questionnaires students will be prompted to enter their name, class and professor in a separate survey. The identifying information is collected for purposes of awarding credit only and the identifying information is in no way linked with the original survey responses. Upon completion of the survey participants are again made aware of where they can turn for free counseling services as well as where to turn if they have questions regarding the study or about their rights as research participants as well as where to turn for free counseling services (see Appendix C for Debrief statement).

The survey responses gathered is completely anonymous and will be stored in a database. The information that is gathered for purposes of awarding credit for participation (i.e. name, class and professor) are stored in a separate database in which there is no link to the survey responses.

Due to the length of the survey (approximately 40-45 min total) it is possible that participants may become fatigued toward the end of the survey and start filling in answers at random. In order to control for this the orders of the questionnaires in the survey will be changed after (approximately) every 50 participants have completed the survey.

For the analysis, participants who are older than 25 years of age will be discarded as these participants would most likely be considered untraditional undergraduate students. Participants will then be divided into four groups based on responses to the Psychological Distress Questionnaire (PDQ) and the Deliberate Self-Harm Inventory (DSHI; see
measures section for descriptions). The first group (group 1) consists of those persons who have engaged in ISI behaviors, as evidenced by one or more affirmative responses on the DSHI. The second group (group 2) consists of those persons who have psychological distress but do not engage in ISI behaviors. This group consists of those persons who endorse having had psychological distress on the PDQ as well as non-affirmative answers on all questions on the DSHI. The third group is a subgroup of the first group (group 1a). This group consists of those persons who have engaged in ISI behaviors and have sought professional help. This group consists of persons who give one or more affirmative answers on the DSHI as well as endorse having sought professional help on the PDQ. (This group is specific to the exploratory component of the study). Finally, the fourth group is also of a subgroup of the first group (group 1b). This group consists of those persons who have engaged in ISI behaviors and have not sought professional help. This group consists of persons who give one or more affirmative answers on the DSHI as well as endorse not having sought professional help on the PDQ. (This group is also specific to the exploratory component of the study).
Chapter IV

Proposed Analyses

Study participants will be grouped into four groups (with those participants older than 25 years of age discarded); the first two groups will be the main focus for analysis on the central four hypotheses. The first two groups are group 1 (those persons who have engaged in ISI behaviors) and group 2 (those persons who have psychological distress but do not engage in ISI behaviors). Group 1a (those persons who have engaged in ISI behaviors and have sought professional help) and group 1b (those persons who have engaged in ISI behaviors and have not sought professional help) are central to the exploratory component of the study.

Analysis begins with a non-parametric test to compare group 1 and group 2 (independent variables, categorical) on seeking professional help (dependent variable, categorical). For hypotheses 2 through 4 primary analyses will consist of a MANOVA, i.e. calculating the difference between categorical independent variables (two groups) on various continuous dependent variables (three measures). Here, the independent variables are group 1 and group 2 while the dependent variables are the scores on the ESDS, AAQ and the SCS. The MANOVA will reveal if there is a difference in ESDS, AAQ, and SCS scores between group 1 and group 2. If the results of the MANOVA are significant, post hoc tests (one-way ANOVAs for each dependent variable) are conducted. If, in turn, the post hoc tests are significant, Tukey tests reveal the direction of significance. Data will also be examined in terms of differences between genders; typically women are more likely to engage in ISI behaviors than men (as previously discussed in Chapter 1).
Hypotheses 5 through 8 will be tested using a mediational model, as described by Baron and Kenny (1986), and further used by Murrell, Salsman and Meeks (2004). In short, using the mediational model to guide statistic analysis of hypotheses 5 through 8 is a way in which to test if emotional self-disclosure, experiential avoidance, and self-compassion are part of the reason for why persons who engage in ISI seek less professional help than those who do not engage in ISI but endorse psychological distress.

In order for mediation to occur the independent variable (engaging in ISI) has to account for changes in each of the mediators (emotional self-disclosure, experiential avoidance, and self-compassion; Baron & Kenny). In turn, the mediators have to account for part of the change in the dependent variable (professional help-seeking). The mediators mediate the relationship if a previous significant relationship between the independent and dependent variables becomes smaller when the mediator is controlled for; the smaller the relationship between the independent and dependent variables – the stronger the mediator (Baron & Kenny). Specifically in this study, it is expected that emotional self-disclosure, experiential avoidance and/or self-compassion will mediate the relationship between engaging in ISI behavior and seeking professional help.

For the exploratory component a 2x2 (psychological distress with ISI or without ISI x did or did not seek help) ANOVA will be conducted. Group 1 and group 2 will be compared on their responses to the List of Barriers (categorical variables; therefore a non-parametric test) and ATSPPHS scale [(continuous variable)(to control for type I error the comparison between group 1 and group 2 on the ATSPPHS may be added to the MANOVA in the primary part of the analysis above)]. The final part of the exploratory component will be analyzed with the use of a MANOVA, the independent variables are
group 1a and group 1b (categorical variables) while the dependent variables are scored on the ESDS, AAQ and the SCS (continuous variables).

Several analyses will be run on the data collected, therefore it is crucial to control for Type I error as well as control for multicollinearity between variables (specifically in the mediational model, regression analysis). By combining the analysis for several hypotheses into one MANOVA chances of Type I errors occurring are lessened.
References


Appendix A

Instruments Used

The Psychological Distress Questionnaire (PDQ) was adapted from questions used by Evans, Hawton and Rodham, 2005. This questionnaire has not been published but the original questions can be found in the aforementioned article.

The Deliberate Self-Harm Inventory (DSHI) is protected by copyright so it is not reproduced in this document. The questionnaire can be found in the article by Gratz, 2001.

The List of Barriers was adapted from an original list of barriers created by Hornblow, Bushnell, Wells, Joyce, and Oakley-Browne, 1990. The List of Barriers is protected by copyright and is therefore not reproduced in this document. The list can be found in the aforementioned article.

The Attitudes toward Seeking Professional Psychological Help Scale (ATSPPHS) is protected by copyright so it is not reproduced in this document. The scale can be found in the article by Fischer and Turner, 1970.

The Emotional Self-Disclosure Scale (ESDS) is protected by copyright so it is not reproduced in this document. The scale can be found in the article by Snell, Miller and Belk, 1988.

The Acceptance and Action Questionnaire (AAQ) is protected by copyright so it is not reproduced in this document. The questionnaire can be found in the article by Hayes, Wilson, Gifford, Follette and Strosahl, 2004.

The Self-Compassion Scale (SCS) is protected by copyright so it is not reproduced in this document. The scale can be found in the article by Neff, 2003b.
Appendix B

Informed Consent

You are being given the opportunity to volunteer to participate in a project conducted through Xavier University. This study is being conducted by a Doctoral candidate in the Clinical Psychology graduate program at Xavier University and through the Department of Psychology.

Please click next to read the Informed Consent form.

[Next]

INFORMED CONSENT

Purpose
The purpose of this study is to research plausible barriers to seeking professional help.

Why subject was selected
You were selected to participate because you are an undergraduate student.

Procedures
If you agree to participate in this study you will be prompted to complete seven questionnaires. The questionnaires will ask you questions about psychological distress and if you have engaged in harmful behaviors (for example, have you ever intentionally (i.e. on purpose) carved pictures, designs, or any other marks into your skin) at some point in your life. If you have engaged in these behaviors you will be asked more information about those behaviors (for example, how many times have you done this and has this behavior ever resulted in hospitalization or injury severe enough to require medical treatment). You will also be asked about your attitudes toward professional help-seeking (for example, a person with strong character can get over mental conflicts by himself/herself, and would have little need of a mental health professional), you will be asked what you perceive may be possible barriers for you in doing so (for example, you thought the problem would get better by itself) as well as how willing you are to discuss your emotions with others (for example, emotions such as feeling depressed, feeling afraid, feeling indifferent, etc.), how likely you are to avoid certain types of things (for example, if I could magically remove all the painful experiences I’ve had in my life, I would do so) and questions about your self-compassion (for example, I’m disapproving and judgmental about my own flaws and inadequacies). The questionnaires vary in length and will take you approximately 40 minutes to complete.

Associated Risks
There is minimal risk involved in participating in this study. In this study you will be asked to answer specific questions about your personal history with harmful behaviors. If you feel that you may be at risk of engaging in harmful behaviors, or you do not want to continue with this study, know that you do not have to participate and that you may
withdraw from the study at any time. If you feel distress at any point in time during or after the study counseling services are available free of charge to full time Xavier students at the Psychological Services Center (745-3531) and the Health and Counseling Center (745-3022).

Associated Benefits
There are no personal benefits for you for participating in this study, other than course credit that your professor might provide.

If you choose to participate in the study you will be prompted to give your name, class and professor at the end of the study. Gathering this information is solely for purposes of awarding you credit for your participation. The identifying information that you give will in no way be linked with your responses to the questionnaires, nor will it be saved on the same database.

Refusal to participate in this study will have NO EFFECT ON ANY FUTURE SERVICES you may be entitled to from the University. You are FREE TO WITHDRAW FROM THE STUDY AT ANY TIME, OR TO NOT PARTICIPATE, WITHOUT PENALTY.

If you have any questions at any time during the study, you may contact Sofie Shouse at asofie.shouse@gmail.com or at 312-1647. You may also contact her dissertation chair and licensed psychologist, Dr. Nicholas Salsman at 745-4289. Questions about your rights as a research subject should be directed to the Xavier University’s Institutional Review Board at (513) 745-2870.

(The contact information and information about counseling services will be available at the end of the questionnaires as well.)

Thank you,
Sofie Shouse, MA

* I have been given information about this research study and its risks and benefits and have been given the information about where to direct any questions or concerns I may have.
By answering Yes below, I indicate that I have read and agreed to the conditions above and that I freely give my consent to participate in this research study.

[ ] Yes                    [ ] No (this choice will end the study)
Appendix C

Debrief

To receive credit for your participation please click on the link below:

Click Here to Enter Information to Receive Credit

Thank you for your time!

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If you feel distress at any point in time during or after the study counseling services are available free of charge to full time Xavier students at the Psychological Services Center (745-3531) and the Health and Counseling Center (745-3022).

If you have any questions you may contact Sofie Shouse at asofie.shouse@gmail.com or at 312-1647. You may also contact her dissertation chair and licensed psychologist, Dr. Nicholas Salsman at 745-4289. Questions about your rights as a research subject should be directed to the Xavier University’s Institutional Review Board at (513) 745-2870.
Chapter V: Dissertation

Abstract

The purpose of this study was to examine if barriers to professional help-seeking in college students who reported having engaged in intentional self-injury (ISI) differed from college students who endorsed psychological distress but had not engaged in ISI. Participants were 452 undergraduate students at a mid-sized, private Catholic university. It was hypothesized that students who had engaged in ISI would endorse lower emotional self-disclosure, more use of experiential avoidance and lower feelings of self-compassion than those who endorsed psychological distress but had not engaged in ISI. In turn, each of the three variables was hypothesized to be related to less professional help-seeking. Psychological distress, ISI, help-seeking and the three variables were measured through self-report on several scales. Results showed that engaging in ISI was not significantly predictive of professional help-seeking. However, linear and logistic regression analysis showed that persons who engaged in ISI were significantly less likely to share emotions with others and endorsed significantly less self-compassion than those who endorsed psychological distress but had not engaged in ISI. Contrary to the hypothesis, results also showed that persons who endorsed more experiential avoidance had sought help more often than those who endorsed less experiential avoidance. The implications of the current findings, as well as suggestions for future research, are discussed.
Intentional Self-Injury as a Barrier to Help-Seeking in a College Population

It may be hard to understand and even scary to think that people engage in hurting their own bodies; nonetheless, intentional self-injury (ISI) is a major problem. ISI is defined as any type of behavior that is self-inflicted with the intent to harm the self without intent to die (Andover, Pepper & Gibb, 2007; De Leo & Heller, 2004; Evans, Hawton & Rodham, 2005). Rates of college students who engage in ISI behaviors are alarmingly high. For example, in a study by Whitlock, Eckenrode and Silverman (2006), 17% of college students had engaged in ISI behaviors at some point in their life while Gratz (2001) reported that 33% of her undergraduate sample had engaged in ISI. Additionally, recent findings indicated that, among high school adolescents 17% had intentionally self-injured at some point in their life (Whitlock, Eckenrode, & Silverman, 2006). Findings also indicated rates of ISI among adolescents and college students are increasing over time (Ross & Heath, 2002). The aim of this study was to examine why people who engage in ISI behaviors do not seek professional help equally often as other people in psychological distress.

In their study, Ross and Heath (2002) found that adolescents who have engaged in some type of ISI behavior struggled with more significant feelings of anxiety and depression than adolescents who have not engaged in ISI behaviors. ISI is associated with a variety of clinical disorders such as substance abuse disorders, eating disorders, posttraumatic stress disorder, anxiety disorders, impulse-control disorders, dissociative disorders, mood disorders, schizophrenia and borderline personality disorder (Suyemoto, 1998; Turner, 2002). Persons who engage in ISI behaviors are more likely to have: either considered or attempted suicide, been abused (Whitlock, Eckenrode & Silverman, 2006),
been emotionally neglected (Gratz, 2003) and are more likely to have affective and interpersonal problems (Laye-Gindhu, Schonert-Reichl, 2005). Laye-Gindhu and Schonert-Reichl reported that, among a sample of adolescents, those adolescents who engaged in ISI behaviors exhibited more maladjustment in “emotional distress, antisocial behavior, anger control issues, anger discomfort, and negative self-esteem” (p. 453) compared to adolescents who had not engaged in ISI behaviors, and that 83% of those adolescents who engaged in ISI behaviors reported suicidal ideation (compared to 29% of those who did not engage in ISI behaviors). The researchers also found that significantly more adolescents who engaged in ISI behaviors (26%) had attempted suicide (compared to 6% of adolescents who had not engaged in ISI behaviors).

Individuals may engage in ISI for a number of reasons. Gratz (2003) reviewed empirical and theoretical literature about risk factors for engaging in ISI and suggest a number of functions of engaging in ISI. Those functions included relieving upsetting feelings such as anger, tension, guilt, loneliness and self-hatred; providing a sense of control and safety, and to relieve cognitive distress. Skegg (2005) studied a variety of literature about suicide and self-injury and reported that self-injury can be a distraction from painful feelings, a way to decrease dissociative symptoms, block upsetting memories and communicate stress to others. Gratz (2006) found that persons who engage in ISI had a difficult time expressing emotions in adaptive ways, and concluded (2003) that reasons for engaging in ISI are multifaceted and that engaging in ISI may serve many functions simultaneously.

**Barriers to Professional Help-Seeking**

In general, less than one-third of persons with mental disorders seek professional help (Andrews, Issakidis & Carter, 2001). Eisenberg, Golberstein and Gollust (2007)
found that between 34-84% (depending on the disorder) of college students suffering from anxiety or depression did not receive help. Evans, Hawton and Rodham (2005) found that 53% of men and 42% of women who engaged in intentional self-injury who felt the need for help due to a serious personal, emotional, behavioral or mental health problem avoided seeking help, while only 33% of men and 29% of women who had not engaged in ISI behaviors avoided seeking help though they felt help was needed. The researchers also found that 27% of men and 30% of women who engaged in ISI did not feel the need to seek help.

Several studies have researched barriers to professional help-seeking in a variety of populations, both clinical and non-clinical. Clarke (2007) discussed external barriers as those barriers that are related to how available, how affordable and how accessible services are. Intrinsic, or attitudinal, barriers to professional help-seeking have to do with the specific attitudes and inherent qualities, as well as the thoughts and feelings of the individual (Cachelin & Streigel-Moore, 2006; Clake, 2007; Hornblow, Bushnell, Wells, Joyce, & Oakley-Browne, 1990). This study focuses on intrinsic barriers to treatment, rather than external barriers. College students often (and in this case do) have free treatment available to them, as well as knowledge of on-campus mental health resources, thus removing some of the main extrinsic barriers.

Several groups of researchers have examined help-seeking (both formal and informal) and barriers to help-seeking specifically in adolescents and young adults (e.g., Moskos, Olson, Halbern & Gray, 2007; Nada-Raja, Morrison & Skegg, 2003; Wisdom, Clarke & Green, 2006). Adolescents face several barriers that adults may not; for instance, adolescents likely want to feel autonomous, e.g., “wanting the involvement and guidance of parents and providers, but the freedom and autonomy to make decisions on
their own” (Wisdom, Clarke & Green, 2006, p.141). Furthermore, Evans, Hawton and Rodham (2005) found that adolescents who engage in ISI behaviors seek professional help less often than those who endorse feeling psychological distress and do not engage in ISI behaviors. Nada-Raja, Morrison and Skegg (2003) found that 54% of a group of persons who had engaged in ISI behaviors had not sought help (professional or other help).

Why do persons who engage in ISI behaviors seek help less often than those who do not engage in ISI behaviors? Nada-Raja, Morrison and Skegg (2003) reported that 83% of their sample of young adults who had engaged in ISI behaviors but had not sought professional help did not believe they needed to seek help; 39% did not seek help due to attitude related barriers; approximately 11% due to practical barriers; and approximately 7% due to fear of stigma. Researchers have found that those adolescents who had engaged in ISI behaviors talked less about their problems with others than did adolescents who did not engage in ISI behaviors (Evans, Hawton & Rodham, 2005).

When comparing adolescents who have engaged in ISI with adolescents who have not engaged in ISI (school sample) the adolescents who deliberately self-harmed were more likely to isolate themselves from others when they were upset.

The purpose of this study was to examine the barriers to professional help-seeking among college students who engage in ISI behaviors – few studies have done so. Existing research indicates that persons who engage in ISI behaviors present less for professional help than do those persons who are in psychological distress but do not engage in ISI behaviors (e.g., Evans, Hawton & Rodham, 2005). The aim of this study is to examine whether the barriers to professional help-seeking in persons who engage in ISI behaviors are based on intrinsic barriers that parallel specific functions of ISI. In particular, are
barriers to professional help-seeking in those who engage in ISI related specifically to low emotional self-disclosure, use of experiential avoidance, and low feelings of self-compassion? With more understanding professionals may be able to engage and help this population seek help in their suffering.

Theory of Help-Seeking among Those with ISI

Figure 1 describes a Three-Part Theory and Mediation Model of help-seeking among those who do and do not engage in ISI.

![Diagram of Theory of Help-Seeking among Those with ISI]

*Figure 1.* Three-Part Theory and Mediation Model of help-seeking behavior among those who reported having engaged in ISI and those who endorsed psychological distress and had not engaged in ISI.

Low *emotional self-disclosure*. Self-disclosure is commonly defined as a process of sharing personal feelings, thoughts, attitudes and beliefs with others (Vogel & Wester, 2003). Emotional self-disclosure is defined as discussing emotions with others (Snell, Miller & Belk, 1988). Vogel and Wester (2003) found that persons who report less comfort with self-disclosure typically have a less favorable attitude toward help-seeking.
Studies show that persons who engage in ISI behaviors are less likely to talk with others in times when they are distressed (Andover, Pepper & Gibb, 2007; Evans, Hawton & Rodham, 2005). Andover et al. specifically showed that women with a history of engaging in ISI behaviors were less likely to turn to social supports in times of stress than women who endorsed an equal amount of psychological distress but had not engaged in ISI. Evans et al. reported that those adolescents who engaged in ISI behaviors had less people to whom they felt they could talk, and that this effect was stronger among those adolescents who had engaged in ISI behaviors multiple times.

One function of engaging in ISI behaviors is to have an outlet for negative emotions such as anger, sadness and tension (Ross & Heath, 2002), escape from anguish (Hawton & James, 2007), and relieve from guilt, loneliness and self-hatred (Gratz, 2006). Gratz discussed the possibility of engaging in ISI behaviors as a way to express emotions, albeit, in a maladaptive way. Gratz also discussed the possibility that the inability to express emotions is a contributing factor to sustaining ISI behaviors. Laye-Gindhu and Schonert-Reichl (2005) reported that negative emotions were the most common emotions felt before engaging in ISI behaviors, and that afterward those who engaged in ISI behaviors felt relief from negative emotions, but also guilt, shame and disgust about their behaviors.

As mentioned above, research has shown that one way people who engage in ISI behaviors deal with their distressing emotions is by using the ISI behaviors as a way of coping (e.g., Gratz, 2006; Ross & Heath, 2002). The research discussed above has also shown that people who engage in ISI behaviors are less likely to share their distressing emotions with others (Andover, Pepper & Gibb, 2007; Evans, Hawton & Rodham, 2005). If persons who engage in ISI behaviors are less likely to talk with others in times of
ISI & HELP-SEEKING

distress and are using the ISI behaviors as a coping mechanism for distress – then the chance that they seek professional help for their distress seems unlikely. In other words, people with low emotional self-disclosure are likely to have a build-up in unresolved negative emotions. They avoid discussing these emotions with others and therefore resort to behaviors such as ISI to cope. This study hypothesizes that low emotional self-disclosure mediates the relationship between ISI and seeking professional help.

Use of experiential avoidance. Experiential avoidance is defined as “the phenomenon that occurs when a person is unwilling to remain in contact with the particular private experiences (e.g., bodily sensations, emotions, thoughts, memories, behavioral predispositions) and takes steps to alter the form or frequency of these events and the contexts that occasion them” (Hayes, Wilson, Gifford, Follette & Strosahl, 1996, p. 1154). In essence, experiential avoidance is when a person tries to avoid or escape from unpleasant internal experiences.

Research has suggested that engaging in ISI behaviors is a form of escaping from unwanted/intolerable emotions and/or situations (Hawton & James, 2007; Linehan 1993; Skegg 2005). Chapman, Gratz and Brown (2006) put forth a specific model for understanding ISI in terms of experiential avoidance. They hypothesized that when a stimulus elicits a distressing emotional response in a person who engages in ISI behaviors, the combination of feeling high emotional intensity with a difficult time regulating emotions, poor emotion regulations skills and poor distress tolerance, leads the person to try to deal with the distressing emotion by avoiding it. For a person who engages in ISI, engaging in ISI behavior reduces emotional distress and results in temporary relief, i.e. resulting in negative reinforcement, which may lead ISI behaviors to become a chronic response to emotional stimulation.
ISI & HELP-SEEKING

ISI has been found to reduce psychophysiological arousal in individuals who engage in the behavior (Brain, Haines & Williams, 1998 & 2002) and hence engaging in ISI allows the individual to feel less tension, pain and distress. The reason for using ISI behaviors to reduce emotional stress may vary. The behaviors may be due to deficits in effective and adaptive coping skills (Evans, Hawton & Rodham, 2005; Linehan, 1993), or because of difficulty with impulse control (see Brain, Haines & Williams, 1998).

At this time, no research has been conducted about a relationship between experiential avoidance and lack of help-seeking during psychological distress. However, Rüschi et al. (2007) found that experiential avoidance significantly predicted drop-out rates from an inpatient Dialectical Behavior Therapy group. Those persons who dropped out of the therapy group before it was completed had higher baseline levels of experiential avoidance (as measured by the Acceptance and Action Questionnaire; Hayes, Wilson, Gifford, Follette & Strosahl, 2004). The researchers discussed the possibility that experiential avoidance “may be a major obstacle for successfully engaging in psychotherapy” (p. 498).

Clearly, researchers have shown that engaging in experiential avoidance (in the form of engaging in ISI behaviors) is one way of coping with emotional distress. It seems then, that persons who engage in ISI behaviors are avoiding their distress and dealing with it in maladaptive, potentially dangerous and self-destructive ways instead of using adaptive coping skills. Persons who avoid distressing emotions are most likely less willing and/or less able to confront and share their distress to work on it in adaptive ways, which are tasks that are often required in therapy. Therefore, this study hypothesizes that one barrier for those persons who engage in ISI behaviors is the use of experiential avoidance as a coping skill in times of emotional distress. Consequently, persons who
engages in ISI behaviors are less likely than those who do not engage in ISI behaviors to seek professional help. This study hypothesizes that use of experiential avoidance mediates the relationship between ISI and seeking professional help.

**Low feelings of self-compassion.** Self-compassion is defined as

"being touched by and open to one’s own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one’s own suffering and to heal oneself with kindness. Self-compassion also involves offering nonjudgmental understanding of one’s pain, inadequacies and failures, so that one’s experience is seen as a part of the larger human experience" (Neff, 2003a, p.87).

In short, the construct of self-compassion has three parts: being kind and understanding toward the self, feeling connected with others instead of isolated, and not over-identifying with internal pain (Neff, 2003b).

Research has found that persons who engage in ISI behaviors feel the need to punish themselves/take out the emotional distress on themselves as a way to deal with the pain (Ross & Heath, 2002). However, to date, no studies have conducted research on ISI and self-compassion. Persons who engage in ISI behaviors try to avoid or disconnect from their feelings (e.g. Skegg, 2005), and the behaviors they engage in are not acts of kindness toward the self. Instead of acting in self-compassionate ways, persons who engage in ISI behaviors are acting in self-damaging ways. Therefore, this study hypothesizes that a barrier for those persons who engage in ISI behaviors is low self-compassion, and consequently, persons who engage in ISI are less likely than those who do not engage in ISI behaviors to seek professional help. This study hypothesizes that low self-compassion mediates the relationship between ISI and seeking professional help.
Hypotheses

In light of the theory discussed in the previous section, this study hypothesizes that:

1. Those persons who have engaged in ISI will seek professional help less often for their psychological distress than will those who have psychological distress and do not engage in ISI.

2. Those persons who have engaged in ISI will have lower emotional self-disclosure than those who have psychological distress and do not engage in ISI.

3. Those persons who have engaged in ISI will have higher use of experiential avoidance than those who have psychological distress and do not engage in ISI.

4. Those persons who have engaged in ISI will have higher rates of endorsing that they typically have less self-compassion than those who have psychological distress and do not engage in ISI.

A mediational model is also predicted (see Figure 1). Therefore, it is hypothesized that:

5. Emotional self-disclosure will be positively related to help-seeking behavior.

6. Experiential avoidance will be negatively related to help-seeking behavior.

7. Self-compassion will be positively related to help-seeking behavior.

8. The relationship between ISI and help-seeking behavior will be mediated by emotional self-disclosure, experiential avoidance, and self-compassion.

Exploratory Component

This study also has an exploratory component. Additional aims of this study are: 1) to explore which barriers are more common in those persons who have, at some point,
engaged in ISI behaviors compared to those who have not engaged in ISI behaviors, and
2) to compare those persons who have engaged in ISI behaviors and have sought help
with those persons who have engaged in ISI behaviors and have not sought professional
help on several variables. It is possible that the main hypotheses will not be found to be
significant, but exploratory hypotheses will allow for a broader look and a place to start
further research of what the barriers to professional help-seeking are for persons who
have engaged or currently engage in ISI.

The exploratory component will examine general barriers to professional help-
seeking as well as general attitudes toward professional help-seeking in those individuals
who have engaged in ISI behaviors and those who have not engaged in ISI behaviors but
endorse psychological distress. Information found here may serve as a guide for future
research in terms of differences in barriers to professional help-seeking in those who have
and those who have not engaged in ISI behaviors yet endorse psychological distress.

The exploratory component of this study also hypothesizes that those persons who
have engaged in ISI but have not sought professional help will rate: a) lower on
emotional self-disclosure, b) higher on experiential avoidance and c) lower on self-
compassion than those persons who have engaged in ISI but have sought professional
help.

Method

Participants

Participants were undergraduate students at a mid-sized, private Catholic university
in the Midwest recruited through the University’s participant pool during the course of
three and a half semesters to participate in this study. All participants were students in
undergraduate psychology courses. For their participation, students received credits in
their psychology classes. 479 individuals initially completed the measures. The total number of students who fit inclusion criteria (gave consent and were between the age of 18 and 25) was 452 (i.e., 94% of individuals who completed the measures). Participants consisted of 161 men and 290 women (one person neglected to identify gender). The mean age of the sample of participants used was 19.93 years ($SD=1.29$).

Participants were divided into two groups depending on if they had: 1) reportedly engaged in ISI ($n=131$, 28% of the sample) or 2) had not engaged in ISI but endorsed psychological distress at some point in their life (either prior to or during the past 12 months; $n=137$, 30% of the sample). Participants who reported having engaged in ISI were not asked about psychological distress as it was assumed that engaging in ISI was indicative of some type of psychological distress. Of the 452 students in the total sample, 184 or 40% of students had neither engaged in ISI nor endorsed psychological distress. Of the 131 students who had engaged in ISI, 78 or 59% had at some point sought professional help while 53 or 40% had not. Of the 137 students who endorsed having experienced psychological distress at some point in their life but had not engaged in ISI, 45 or 32% had sought professional help while 92 or 67% had not. A total of 170 students (regardless of engaging in ISI or psychological distress) had at some point in their life sought professional help (see Table 1 for descriptive information on the various groups).

**Measures**

**Psychological Distress Questionnaire (PDQ).** Psychological distress and professional help-seeking was measured by the Psychological Distress Questionnaire (PDQ; see Appendix A). This questionnaire was adapted from questions originally developed by Evans, Hawton and Rodham (2005) in a broader set of questionnaires. No psychometric statistics are available for the specific questions on the original
questionnaire. The questions were adapted to fit the needs of this study. In the original questionnaire no definition of professional help-seeking was given nor did the researchers inquire about help-seeking prior to the past 12 months. In the current study, professional help-seeking was defined as seeking help from a professional in the mental health or medical services fields, i.e. a counselor, psychologist, psychiatrist, medical doctor or nurse. Additionally, questions were added so as to inquire about help-seeking prior to the past 12 months for having had a serious personal, emotional, behavioral or mental health problem.

The questionnaire consists of six self-report items that ask the participants to respond yes or no to the question “/In a certain time frame, i.e. in the past 12 months or prior to the past 12 months/ have you had a serious personal, emotional, behavioral or mental health problem for which you thought professional help was needed?” When they responded yes, participants also answered the follow up question, “Did you seek professional help at that time?” Participants were also asked if they had sought professional help without feeling that they had a serious problem in each of the two time frames (i.e., the past 12 months, prior to the past 12 months). Two additional questions were added to the questionnaire (i.e., questions 2a and 4a). These questions were added to measure those who may have sought professional help without feeling that they had a serious personal, emotional, behavioral, or mental health problem. No summative score was collected from this scale; rather, data collected from the PDQ was used to identify persons who endorsed having experienced psychological distress and/or engaged in professional help-seeking. Those individuals who answered in the affirmative to having experienced psychological distress were identified as persons having psychological
distress. Those individuals who answered in the affirmative to having sought professional help were identified as persons who had sought professional help.

**Deliberate Self-Harm Inventory (DSHI).** The Deliberate Self-Harm Inventory (DSHI), developed by Gratz (2001), is a behaviorally based, self-report measure of deliberate self-harm (see Appendix A). The DSHI has high internal consistency, .82 and an adequate test-retest reliability score of .68 (p<.001). The DSHI has been shown to be significantly positively correlated with other measures of self-harm and a measure of borderline personality organization (Gratz, 2001). For the purposes of developing the DSHI, Gratz defined deliberate self-harm (or intentional self-injury, ISI) “as the deliberate, direct destruction or alteration of body tissue without conscious suicidal intent, but resulting in injury severe enough for tissue damage (e.g. scarring) to occur” (p.255).

The DSHI consists of 17 behaviorally based items, e.g., “Have you ever intentionally (i.e., on purpose) cut your wrists, arms or other area(s) of your body (without intending to kill yourself)?” Participants answered either “yes” or “no”. For each affirmative answer, participants were asked to respond to four follow up questions. The follow up questions ask more about the behavior the participant has endorsed, i.e., how old the person was when he or she started, how many times he or she have done the behavior, how many years he or she have been doing it and if the behavior has ever resulted in some sort of medical treatment. No summative score was calculated for this scale; rather, data collected from the DSHI was used to identify persons who had engaged in ISI behaviors. Those individuals who answered affirmative to one or more of the DSHI questions were identified as persons who had engaged in ISI. Those individuals who
endorsed no affirmative answers to the DSHI questions were identified as persons who had not engaged in ISI.

**List of Barriers.** The List of Barriers was taken from results of a large study by Hornblow et al (1990; see Appendix A). In the epidemiology study by Hornblow et al., researchers conducted interviews with persons about utilization of mental health services. Fifteen common barriers to professional help-seeking emerged, and these barriers form the basis of the current research study’s List of Barriers. The list of barriers is not a list that has been used as a questionnaire; therefore, there are no psychometric statistics available. The list of barriers was minimally adapted as this researcher added one potential barrier to the list, namely “You felt like you were taking care of the problem yourself”. The reason for adding this statement was that engaging in ISI behaviors may be viewed by those engaging in the behaviors as a way of taking care of the problem/psychological distress without the need of any help (Favazza, 1989). Participants responded to items on the list of barriers asking if the items had ever been barriers for them in seeking professional help, or, if they thought the items would be barriers for them in seeking professional help. Some examples of barriers are “You thought it was something you were strong enough to handle alone” and “You thought the problem would get better by itself”. Participants answered each statement with Yes or No. No summative score was calculated for this scale; rather, participants were compared on each affirmative answer to the barriers.

**Attitudes toward Seeking Professional Psychological Help Scale (ATSPPHS).**
The Attitudes toward Seeking Professional Psychological Help Scale (ATSPPHS) measures a person's general attitude toward seeking professional help for psychological disturbances (Fischer & Turner, 1970; see Appendix A). Factor analyses on the scale
revealed four dimensions: recognition of need for psychological help, stigma tolerance, interpersonal openness, and confidence in mental health professionals. The internal reliability on the original sample was .86; the test-retest reliability was between .73 and .89 depending on the amount of time between testing (testing was completed at intervals between five days and two months). Vogel and Wester (2003) utilized the ATTSPPHS in their study of college students; these researchers reported an internal consistency of .90. Fischer and Turner found that the scale was able to discriminate between those individuals who had and had not sought professional help.

The scale consists of 29 statements that participants are asked to rate on a four-point Likert-type scale (3 – “agree”, 2 – “somewhat agree”, 1 – “somewhat disagree”, 0 – “disagree”). An example of a statement is “Although there are clinics for people with mental troubles, I would not have much faith in them”. The questionnaire was minimally adapted for purposes of this study; the changes made were due to the outdated nature of some of the terms on the original scale. The term “mentally ill” was changed to “psychological problems”, the term “psychiatric patient” was changed to “mental health client”, “psychiatrist” was changed to “mental health professional” and “he” was changed to “he/she”.

The responses to the questionnaires were summed and the higher the sum of the scores, the more positive the participants attitude was toward professional help-seeking. The range of possible scores was zero to 87.

**Emotional Self-Disclosure Scale (ESDS).** The Emotional Self-Disclosure Scale (ESDS) measures how willing a person is to discuss specific emotions with other people such as female friends, male friends, and spouse/lovers (Snell, Miller & Belk, 1988; see Appendix A). The ESDS consists of 40-items measured on a five-point Likert-type scale
ISI & HELP-SEEKING

(1 – “Not at all willing to discuss this topic”, 5 – “Totally willing to discuss this topic”).

The 40-items are split into eight groups of five questions aimed to measure each of eight distinct emotions (depression, happiness, jealousy, anxiety, anger, calmness, apathy and fear). The eight emotion subscales of the ESDS were found to be reliable, with internal reliability ranging from .83 to .95. For the purposes of this study the scale was adapted to reflect how willing participants were to discuss emotions with people in general. There is no need for a distinction between whom the participants are willing to disclose emotional information to since the purpose of this study is to examine if persons who engage in intentional self-injury are less willing to disclose emotional information overall.

The responses to the eight feeling states were summed for each of the eight emotions, the higher the score the more willing the person was to disclose that particular emotion. Participants were compared on their overall sum of scores on all eight feelings states. The range of possible scores was 40 to 200.

Acceptance and Action Questionnaire (AAQ). The Acceptance and Action Questionnaire (AAQ) is a general measure of experiential avoidance and was created by Hayes et al. (2004; see Appendix A). The AAQ is a 9-item questionnaire; participants are given statements that they are asked to rate on a seven-point Likert scale (1 – “Never true”, 4 – “Sometimes true”, 7 – “Always true”). An example of a statement is “I am able to take action on a problem even if I am uncertain what is the right thing to do”. Several items are reverse scored and the responses to statements are summed. The higher the score the more experiential avoidance the participant endorsed. The AAQ has an alpha of .70 and test-retest reliability of .64 at four months. The AAQ has been compared to a measure of avoidant coping (White Bear Suppression Index); evidence of convergent
validity was established with correlations between .44 and .50. The range of possible scores was nine to 63.

**Self-Compassion Scale (SCS).** The Self-Compassion Scale (SCS) was created to measure self-compassion as an overarching construct and was created by Neff (2003b; see Appendix A). The SCS measures six paired subscales of self-compassion: self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus over-identification. The scale consists of 26 self-report statements, and participants are asked to rate their responses on a five-point Likert-type scale (1 – “Almost never”, 5 – “Almost always”). An example of a statement is “I’m disapproving and judgmental about my own flaws and inadequacies”. The responses to the statements were summed for each of the six pairs of subscales of self-compassion. The self-judgment, isolation and over-identification subscales were reverse scored. The means of the paired subscales were calculated and summed to form one overall score of self-compassion (as described by Neff). The higher the summed score the more self-compassion was endorsed by the participant. The range of possible scores was zero to 30. The SCS has a Cronbach’s alpha coefficient of .92.

**Procedure**

Approval was received from a university IRB (see Appendix B) and approval was extended on June 29th, 2010 (see Appendix C). Participants where recruited through a university undergraduate participant pool; therefore, all were students in an undergraduate psychology class. All data were collected using SurveyMonkey (Finley & Finley, 1999) and then downloaded in Microsoft Excel format (2007). SurveyMonkey is a service that allows users to create and manage surveys as well as collect responses online. Users are then able to download the responses collected in various forms. From
Microsoft Excel, data were transferred to SPSS in which all analyses were completed. For the purpose of awarding participants credit for participation, participants entered identifying information into SurveyMonkey; however, all identifying information was stored in a separate file and was, therefore, not connected to their survey answers.

Unfortunately, a survey glitch was found after having gathered data from 186 participants. When adding the SCS to SurveyMonkey, the researcher had unintentionally entered only the first 16 out of 26 questions. Once the problem was found, it was immediately corrected and the rest of the participants answered all 26 questions. The Dissertation Committee was notified and the researcher was advised to continue gathering data. When all data were gathered, the researcher was instructed to run analyses on the SCS comparing the data from those participants who had answered the first 16 questions to those who had answered the entire SCS. The purpose would be to determine whether the data from the first 186 participants could be used in the statistical analysis for hypothesis testing (this is further discussed in the Results section).

**Results**

Correlations among the three mediational variables (ESDS, AAQ and SCS) as well as the ATSPPHS variable (for exploratory analysis) are displayed in Table 2. The table shows that most of the variables – namely, the ESDS and AAQ, the ESDS and the SCS, the ESDS and the ATSPPHS, the AAQ and SCS, and the AAQ and the ATSPPHS – are significantly correlated ($p = .000$, .001 and .004 respectively) meaning that there is a high degree of overlap between the measures.

Mean and standard deviation scores were calculated for each of the ESDS, AAQ, SCS and ATSPPHS scales so as to compare these scores to the normative means and standard deviations for each scale. Regrettably, the ESDS did not have a normative mean
or standard deviation score for the scale when used as a whole (as opposed to split into
subscales; Snell, Miller & Belk, 1988). Table 3 includes means and standard deviation
scores of the measures used in this study as well as available normative means and
standard deviations. Scores in this study do not appear to differ from the normative
scores on the AAQ (Hayes et al., 2004) nor the SCS (Neff, 2003). However, scores on the
ATSPPHS are somewhat lower than the reported normative scores (Fischer & Turner,
1970).

The primary analysis, a mediational analysis using methodology described by
Baron and Kenny (1986), examined whether the relationship between the independent
variable and the dependent variable was mediated by one or more of three potential
mediational variables. In order for mediation to occur, the independent variable
(engaging in ISI) has to account for changes in each of the mediators (emotional self-
disclosure, experiential avoidance, and self-compassion). In turn, the mediators have to
account for part of the change in the dependent variable (professional help-seeking). The
mediators mediate the relationship if a previous significant relationship between the
independent and dependent variables becomes smaller when the mediator is controlled
for; the smaller the relationship between the independent and dependent variables, the
stronger the mediator (Baron & Kenny).

The first hypothesis was that those persons who reported having engaged in ISI
would seek professional help less often for their psychological distress than would those
who endorsed having psychological distress and had not engaged in ISI and was tested
through the use of a logistic regression. Results were not significant; of the 131 persons
who had engaged in ISI, 59.5% sought help and of the 137 persons who endorsed
psychological distress but had not engaged in ISI, 67.1% had sought help ($\beta = -.33$, $p =$
.197). Since there is not a significant relationship between ISI and professional help-seeking, the mediational model hypothesized in hypothesis number eight is not supported. Nonetheless, the results of each of hypotheses two through seven as well as the exploratory component are still of interest.

Linear regression was used to test hypotheses two through four. More specifically, for hypothesis two, it was found that persons who reported having engaged in ISI reported that they were less likely to share their emotions with others (score lower on the ESDS) than those who endorsed psychological distress but had not engaged in ISI ($\beta = .15, p = .017$). For hypothesis three, it was found that persons who reported having engaged in ISI did not report having higher experiential avoidance (score higher on the AAQ) than persons who endorsed psychological distress but had not engaged in ISI ($\beta = -.06, p = .311$). Finally, for hypothesis four, it was found that persons who reported having engaged in ISI reported being significantly less self-compassionate (score lower on the SCS) than those who endorsed psychological distress but had not engaged in ISI ($\beta = .18, p = .049$; statistic calculated with only those individuals who had answered all 26 questions of the SCS, potential $n$ of 266). SCS statistics were somewhat complicated by the fact that 186 participants only answered the first 16 items of the SCS (researcher error when entering questionnaires into SurveyMonkey). Data on the SCS from these participants ($n = 186$) were discarded.

For hypothesis five through seven, logistic regression was used. For hypothesis five, it was expected that those persons who endorsed being less willing to share their emotions with others (lower score on the ESDS) would have sought professional help less often than those who endorsed being more willing to disclose emotions to others; results were not significant ($\beta = -.002, p = .665$). For hypothesis six, it was found that
persons who endorsed being more avoidant (higher AAQ score) reported having sought professional help significantly more often than those who endorsed being less avoidant ($\beta = -0.04, p = 0.043$); this was in the opposite direction of the hypothesis. Regarding hypothesis seven, it was found that persons who endorsed being more self-compassionate did not report seeking help more often than individuals who endorsed being less self-compassionate ($\beta = 0.03, p = 0.410$). See Table 4 for a description of all primary analysis hypotheses and findings.

**Exploratory Analyses**

For the exploratory component of the analysis, the aims included: 1) to compare those persons who reported having engaged in ISI behaviors and had sought help with those persons who reported having engaged in ISI behaviors and had not sought professional help on the ESDS, AAQ and SCS, and 2) to compare persons who reported having engaged in ISI and those who had endorsed psychological distress but had not engaged in ISI on attitudes toward and barriers to professional help-seeking. In addition, statistics including all participants who were between the ages of 18 and 25 (including those individuals who neither engaged in ISI nor endorsed having psychological distress) were calculated on the correlation between scores on the ESDS, AAQ and ESDS with professional help-seeking.

It was hypothesized that persons who reported having engaged in ISI and had not sought help ($n = 53$) would report being less willing to share emotions (lower score on the ESDS), more avoidant (higher score on the AAQ) and less self-compassionate (lower score on the SCS) than those persons who also reported having engaged in ISI but had sought professional help ($n = 78$). Results showed that among those persons who reported having engaged in ISI, there was no significant relationship between help-seeking and
ESDS scores ($\beta = .06, p = .491$). Contrary to expectations, among individuals who reported having engaged in ISI, those who had not sought help reported being significantly less avoidant ($\beta = -.33, p = .000$) than those who reported having engaged in ISI and had sought help. Also contrary to expectations, among individuals who reported having engaged in ISI, those who had not sought help reported being significantly more self-compassionate ($\beta = .34, p = .000$). One possible explanation for these results is that those individuals who reported having engaged in ISI and had not sought help may be those individuals who engage in less, or less severe, forms of ISI. To explore this, a table of the frequencies of ISI among all those who reported having engaged in ISI, those who reported having engaged in ISI and had sought help, and lastly, those who reported having engaged in ISI and had not sought help was created (see Table 5). The table suggests that persons who reported having engaged in ISI and had not sought help endorsed engaging in less kinds of ISI. A series of chi-square analyses were completed to test if any of the types of ISI were endorsed significantly more or less by those who reportedly had or had not sought professional help (see Table 6). Persons who reported having engaged in ISI and had sought help endorsed significantly more cutting ($\chi^2 = 10.98, p = .001$), scratching enough for scarring or bleeding ($\chi^2 = 12.85, p = .000$), and having bitten the self so that the skin broke ($\chi^2 = 8.16, p = .004$) than those persons who had engaged in ISI but had not sought help. Those who reported having engaged in ISI and had not sought help had no forms of ISI that they engaged in more frequently than those who reported having engaged in ISI and had sought help.

To find out if scores on the ESDS, AAQ and SCS were in any way predictive of professional help-seeking, a logistic regression was run between the ESDS, AAQ and SCS, and professional help-seeking. The sample consisted of all 452 participants. No
significant relationship was found between scores on the ESDS and help seeking ($\beta = .00$, $p = .916$). However, those individuals who reported less avoidance (lower AAQ score) and those individuals who reported more self-compassion (higher SCS score) sought significantly less help ($\beta = -.63$, $p = .000$; $\beta = .12$, $p = .000$, respectively).

An independent samples t-test was completed to compare those who reported having engaged in ISI with those who reported not having engaged in ISI ($n = 131$ and $n = 297$, respectively) on attitudes toward help-seeking (score on the ATSPPHS). Results showed no significant difference in ATSPPHS scores between the two groups ($t(426) = .49$, $p = .625$), indicating that attitudes toward professional help-seeking do not vary between individuals who reported having engaged in ISI and those who reported they had not. Similarly, scores on the ATSPPHS did not vary between persons who reported having engaged in ISI ($n = 131$) and those who endorsed psychological distress but had not reported engaging in ISI ($n = 136$; $t(265) = -.56$, $p = .575$).

A series of chi-square analyses were completed to compare those who reported having engaged in ISI with those who had endorsed psychological distress but reported not having engaged in ISI on the List of Barriers to seeking professional help (see Table 7 for affirmative answers and percentages of individuals who endorsed various barriers; see Table 8 for chi-square analysis). Results of the chi-square analysis showed that those who endorsed psychological distress but had not reported having engaged in ISI were significantly more likely to endorse feeling like they should be strong enough to handle the problem themselves ($\chi^2 = 5.23$, $p = .022$) and that they felt they were taking care of the problem themselves ($\chi^2 = 4.89$, $p = .027$) compared to those who reported having engaged in ISI. Those persons who reported having engaged in ISI were significantly more likely to endorse being afraid of the treatment they would receive ($\chi^2 = 9.24$, $p =$
.002) and having a member of the family who had objected ($\chi^2 = 3.91, p = .048$) than those who endorsed psychological distress but reported not having engaged in ISI.

**Discussion**

As previously stated, the purpose of this study was to examine if the relationship between ISI and professional help-seeking is mediated by low emotional self-disclosure, use of experiential avoidance, and low feelings of self-compassion. A sample of persons who reported having engaged in ISI was compared to a sample of persons who endorsed psychological distress but reported not having engaged in ISI. Figure 2 shows the three significant relationships found.

![Diagram](image)

*Figure 2. Results of the Three-Part Theory and Mediation Model of help-seeking behavior among those who reported having engaged in ISI and those who endorsed psychological distress and had not engaged in ISI.*

The first step of the mediational analysis (the relationship between engaging in ISI and professional help-seeking) was non-significant and therefore this study did not establish emotional self-disclosure, use of experiential avoidance, nor feelings of self-
compassion as mediators in the relationship between reportedly engaging in ISI behaviors and professional help-seeking. This non significant finding is contrary to findings by Evans, Hawton and Rodham (2005). Some possible reasons for the differing results may be the age of the sample (Evans, Hawton and Rodham researched adolescents who may, or may not, be more hesitant to seek help than young adults) as well as the time frame for having engaged in ISI behaviors (Evans, Hawton and Rodham researched only incidences of ISI in the past year). However, because hypotheses two through seven were still of interest, non-significant results in the first step of the statistics did not invalidate the study as a whole.

As hypothesized, those persons who reported engaging in ISI scored significantly lower on the ESDS than those who endorsed psychological distress but reported not having engaged in ISI (a in figure 2). These results are consistent with findings by Andover, Pepper and Gibb (2007) and Evans, Hawton and Rodham (2005) and add credibility to previous finding that persons who engage in ISI are less likely to talk with others about how they are feeling.

There was a statistically significant relationship between reportedly having engaged in ISI and low self-compassion (b in figure 2). However, contrary to the hypothesis, persons who endorsed being more self-compassionate had sought help less often than those who endorsed being less self-compassionate. This may be explained by the assumption that people who endorse more self-compassion experience less pathology due to being more caring toward themselves. This phenomenon was noted by Neff (2003a); who described “this supportive attitude toward oneself should be associated with a variety of beneficial psychological outcomes, such as less depression, less anxiety, less neurotic perfectionism, and greater life satisfaction” (p. 93). Even in those persons who
endorsed psychological distress, endorsing more self-compassion was related to less help-seeking and therefore may be related to less overall pathology.

High experiential avoidance was hypothesized to be significantly related to both reportedly engaging in ISI and less professional help-seeking but results were not consistent with either of these hypotheses. There was no significant relationship among ISI behaviors and experiential avoidance. Furthermore, those persons who endorsed higher experiential avoidance reported seeking treatment more often than those who endorsed less experiential avoidance (c in figure 2). One possible explanation for this may be that those individuals who endorsed higher experiential avoidance were also suffering from more psychological distress and were therefore seeking professional help more often due to the severity of their pathology as opposed to the specific dynamics (avoiding unpleasant internal experiences) of their pathology. Interestingly, Rüsch at al. (2007) has found that high experiential avoidance predicted drop-out rates for an inpatient Dialectical Behavior Therapy group, suggesting that high levels of experiential avoidance may play a role in therapy attrition. Further study of the relationship between higher experiential avoidance and severity of pathology as well as therapy attrition to gain a better understanding of the role of experiential avoidance in mental health concerns and treatment seems warranted.

Overall, individuals who reported not having sought professional help for any type of problem, were significantly less avoidant of unpleasant internal experiences, and were significantly more self-compassionate than those who reported having sought professional help. Both characteristics (less avoidant of internal experiences and more self-compassionate) appear to be descriptors of well-adapted and psychologically healthy people. Furthermore, when persons who reported having engaged in ISI and had sought
help were compared to those who reported having engaged in ISI and had not sought help, 
the same results were found. Namely, that the persons who reported having engaged in 
ISI and had not sought help appeared less avoidant of internal experiences and more self-
compassionate than those who reported having endorsed engaging in ISI and had sought 
help. These results suggest that those individuals who reported having engaged in ISI and 
had not sought help had less severe pathology and are, therefore, also less likely to seek 
professional help for problems.

As an element of the exploratory component of the study, participants’ attitudes 
toward help seeking and perceived barriers to seeking help were examined. Attitudes 
toward professional help-seeking were found not to vary between individuals who 
reported having engaged in ISI and those who had not (with or without psychological 
distress); nor did attitudes toward professional help-seeking vary between those who 
reported having engaged in ISI and those who endorsed psychological distress. 
Therefore, the data do not support a model in which the attitudes toward professional 
help-seeking in participants who reported having engaged in ISI behaviors affect their 
decision to seek or not seek professional help more so than individuals who had reported 
not having engaged in ISI behaviors.

However, and somewhat contrary to the finding that attitudes toward professional 
help-seeking do not appear to differ between those who reported having engaged in ISI 
and those who reported they had not, some of the barriers endorsed were significantly 
different. For instance, persons who reported having engaged in ISI behaviors reported 
being more afraid of what kind of treatment they may receive. Examining why people 
who reported having engaged in ISI were wearier of the kind of treatment they would 
receive is of interest for future study. Persons who reported not having engaged in ISI but
endorsed psychological distress were significantly more likely to feel that they should be
strong enough to handle the problem themselves and that they feel they are taking care of
the problem than those who reported having engaged in ISI.

A limitation of this study is the fact that the AAQ, SCS, ESDS and ATSPPHS
correlate (see Table 2) and are, therefore, measuring some of the same constructs. For
instance, the construct that is measured by the AAQ is significantly negatively correlated
to the construct that is measured by the ESDS, the construct that is measured by the SCS
and the construct that is measured by the ATSPPHS. It appears that some level of (low)
emotional self-disclosure and (low) self-compassion is accounted for by (high) scores on
experiential avoidance. Given previous results, it is plausible that the unifying construct
that is measured by all the above scales is psychopathology. This might suggest that the
experiential avoidance scale is such a broad construct that it cannot be adequately
separated from the other constructs in this study.

Another limitation of this study is that multiple regressions and chi-square analyses
were conducted without controlling for Type I error. Because aspects of this study were
exploratory in nature, and correcting for Type I error would have rendered most
significant findings non-significant, this researcher felt using a Bonferroni correction
would have been too conservative of a measure. Therefore, it is important to keep in
mind that this study may have found some false positive results in both the primary and
exploratory analyses.

A further limitation is that there may have been some degree of self-selection or
selection-bias in terms of students who chose to, or chose not to, consent and participate
in the study because of the explicit nature of the informed consent. It is plausible that
individuals who had engaged in ISI behaviors chose specifically to complete, or not
complete, the set of questionnaires after reading the informed consent. If students did not endorse “Yes” or “No” at the bottom of the informed consent screen this researcher has no way of knowing how many students read the informed consent and decided not to continue with the survey.

Further limitations are that this study did not take into consideration the time at which a person had experienced psychological distress. The sample may have been smaller and the findings different if only persons who reported having engaged in ISI or endorsed psychological distress in the past year had been analyzed. In those persons who reported engaging in ISI or experiencing psychological distress in the past year the ISI and psychological distress may still be effecting them; whereas, those persons who reported having engaged in ISI or experienced psychological distress prior to the past 12 months may no longer be effected by the ISI or distress. Future research may therefore consider differentiating between psychological distress in the present versus past tense. Moreover, the results in this study may not be generalizable to the public as a whole because all participants were undergraduate students at a private, Catholic university in the Midwest. Additionally, research that takes into consideration ethnicity/race as well as other age groups would also be of interest.

Overall, while the number of research studies about various aspects of ISI continue to increase, few researchers have examined the relationship between ISI and professional help-seeking, and even fewer (if any) have studied why those who engage in ISI seek professional help less often. This particular study has aimed to add some insight into why those who engage in ISI seek professional help less often by hypothesizing a theory that connects various constructs within ISI pathology with barriers to help-seeking. This research study has therefore added more wealth and depth to the study of ISI and help-
seeking in general, and the relationship between ISI behaviors and help-seeking in particular.
References


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### Table 1

**Descriptive Statistics for Sample**

<table>
<thead>
<tr>
<th>Sample</th>
<th>Total (%)</th>
<th>Women (%)</th>
<th>Men (%)</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total sample</td>
<td>452* (100)</td>
<td>290 (64)</td>
<td>161 (36)</td>
<td>Mean 19.93</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SD   1.29</td>
</tr>
<tr>
<td>No ISI &amp; no psych distress</td>
<td>184 (41)</td>
<td>102 (55)</td>
<td>82 (45)</td>
<td>Mean 19.77</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SD   1.21</td>
</tr>
<tr>
<td>Psych distress but no ISI</td>
<td>137 (30)</td>
<td>112 (82)</td>
<td>25 (18)</td>
<td>Mean 20.06</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SD   1.32</td>
</tr>
<tr>
<td>Endorsed ISI</td>
<td>131 (29)</td>
<td>78 (60)</td>
<td>53 (40)</td>
<td>Mean 20.04</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SD   1.35</td>
</tr>
<tr>
<td>ISI and sought help</td>
<td>78 (60)</td>
<td>50 (64)</td>
<td>27 (35)</td>
<td>Mean 20.27</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SD   1.37</td>
</tr>
<tr>
<td>ISI but not sought help</td>
<td>53 (40)</td>
<td>26 (49)</td>
<td>27 (51)</td>
<td>Mean 19.70</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SD   1.25</td>
</tr>
</tbody>
</table>

*One person did not endorse gender.
Table 2

*Intercorrelations between Variables*

<table>
<thead>
<tr>
<th>Variable</th>
<th>ESDS</th>
<th>AAQ</th>
<th>SCS</th>
<th>ATSPPHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESDS</td>
<td>--</td>
<td>-.19**</td>
<td>.14**</td>
<td>.16**</td>
</tr>
<tr>
<td>AAQ</td>
<td>--</td>
<td>--</td>
<td>-.60**</td>
<td>-.19**</td>
</tr>
<tr>
<td>SCS</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>.08</td>
</tr>
<tr>
<td>ATSPPHS</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

** p<.01 (2-tailed)
### Table 3

**Descriptive Statistics for the ESDS, AAQ, SCS and ATSPPHS**

<table>
<thead>
<tr>
<th>Scale</th>
<th>Mean (SD)</th>
<th>Normative Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESDS</td>
<td>137.22 (28.93)</td>
<td><strong>--</strong>*</td>
</tr>
<tr>
<td></td>
<td>but no ISI</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(n = 265)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total Sample</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(n = 436)**</td>
<td></td>
</tr>
<tr>
<td></td>
<td>139.31 (29.14)</td>
<td></td>
</tr>
<tr>
<td>AAQ</td>
<td>35.23 (6.97)</td>
<td>Women: 37.3 (7.9)(^a)</td>
</tr>
<tr>
<td></td>
<td>(n = 266)</td>
<td>Men: 34.7 (7.8)(^a)</td>
</tr>
<tr>
<td></td>
<td>Total Sample</td>
<td>Caucasian: 32.9 (6.9)(^b)</td>
</tr>
<tr>
<td></td>
<td>(n = 430)**</td>
<td>Non-Caucasian: 34.5 (6.8)(^b)</td>
</tr>
<tr>
<td></td>
<td>33.95 (6.73)</td>
<td></td>
</tr>
<tr>
<td>SCS (all 26)</td>
<td>16.93 (3.38)</td>
<td>Women: 17.72 (3.74)(^c)</td>
</tr>
<tr>
<td></td>
<td>(n = 120)</td>
<td>Men: 18.96 (3.64)(^c)</td>
</tr>
<tr>
<td></td>
<td>Total Sample</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(n = 196)**</td>
<td></td>
</tr>
<tr>
<td></td>
<td>17.83 (3.55)</td>
<td></td>
</tr>
<tr>
<td>ATSPPHS</td>
<td>45.01 (7.18)</td>
<td>Women: 63.2 (11.4)(^d)</td>
</tr>
<tr>
<td></td>
<td>(n = 267)</td>
<td>Men: 56.1 (11.8)(^d)</td>
</tr>
<tr>
<td></td>
<td>Total Sample</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(n = 428)**</td>
<td></td>
</tr>
<tr>
<td></td>
<td>44.47 (8.10)</td>
<td></td>
</tr>
</tbody>
</table>

---

**---**Normative data available for ESDS subscale as opposed to the total score (Snell, Miller & Belk, 1988)

**---**The sample n does not equal 452 due to missing values

\(^a\) Based on a clinical sample (Hayes et al., 2004)

\(^b\) Based on a non-clinical undergraduate sample (Hayes et al.)

\(^c\) Based on non-clinical undergraduate sample (Neff, 2003)

\(^d\) Based on a non-clinical college sample (Fischer & Turner, 1970)
### Table 4

**Hypotheses and Findings Comparison**

<table>
<thead>
<tr>
<th>Hyp.</th>
<th>Hypothesized Relationship</th>
<th>True Relationship</th>
<th>Regression</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>ISI, &lt;help-seeking</td>
<td>No relationship</td>
<td>$\beta = -.33; p = .197$</td>
</tr>
<tr>
<td>2</td>
<td>ISI, &lt;ESDS score</td>
<td>ISI, &lt;ESDS</td>
<td>$\beta = .15; p = .017^*$</td>
</tr>
<tr>
<td>3</td>
<td>ISI, &gt;AAQ</td>
<td>No relationship</td>
<td>$\beta = -.06; p = .311$</td>
</tr>
<tr>
<td>4</td>
<td>ISI, &lt;SCS</td>
<td>ISI, &lt;SCS</td>
<td>$\beta = .18; p = .049^{**}$</td>
</tr>
<tr>
<td>5</td>
<td>&lt;ESDS, &lt;help-seek</td>
<td>No relationship</td>
<td>$\beta = -.002; p = .665$</td>
</tr>
<tr>
<td>6</td>
<td>&gt;AAQ, &lt;help-seek</td>
<td>&gt;AAQ, &gt;help-seek</td>
<td>$\beta = .04; p = .043^*$</td>
</tr>
<tr>
<td>7</td>
<td>&gt;SCS, &gt;help-seek</td>
<td>No relationship</td>
<td>$\beta = .03; p = .410$</td>
</tr>
<tr>
<td>8</td>
<td>Relationship between ISI &amp; help-seeking is mediated by ESDS, AAQ &amp; SCS</td>
<td>Analysis not possible</td>
<td>-</td>
</tr>
</tbody>
</table>

*Note.* The Hypothesized Relationship column corresponds with the hypothesized relationship between the two variables in that column (e.g., for hypothesis 1 it was hypothesized that persons who engaged in ISI would have sought less help). The True Relationship Direction column corresponds with what the actual, statistical relationship between the two variables in that column was (e.g., for hypothesis 1, persons who engaged in ISI had sought less help than those who had not engaged in ISI).  
* $p < .05$  
*a* Did not use the 186 participants who only answered the first 16 items.
Table 5

*Frequencies of Different Types of ISI Endorsed*

<table>
<thead>
<tr>
<th>Type of ISI</th>
<th>All who engaged in ISI (n=131)</th>
<th>ISI &amp; sought help (n=78)</th>
<th>ISI &amp; not sought help (n=53)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) cutting</td>
<td>60</td>
<td>45</td>
<td>15</td>
</tr>
<tr>
<td>2) burned w/cigarette</td>
<td>13</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>3) burned w/lighter or match</td>
<td>13</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>4) carved words into skin</td>
<td>14</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>5) carved pictures, designs or other marks</td>
<td>15</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>6) scratched enough for scarring or bleeding</td>
<td>46</td>
<td>37</td>
<td>9</td>
</tr>
<tr>
<td>7) bit self so that skin broke</td>
<td>11</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>8) rubbed sandpaper on body</td>
<td>4</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>9) dripped acid on skin</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10) used bleach, comet or oven cleaner to scrub skin</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>11) stuck sharp objects into skin (e.g. needles, pins)</td>
<td>21</td>
<td>13</td>
<td>8</td>
</tr>
<tr>
<td>12) rubbed glass into skin</td>
<td>5</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>13) broken own bones</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>14) banged head that caused a bruise</td>
<td>20</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>15) punched self that caused a bruise</td>
<td>20</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>16) prevented wounds from healing</td>
<td>15</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>17) anything else?</td>
<td>29</td>
<td>21</td>
<td>8</td>
</tr>
</tbody>
</table>
Table 6

Chi-square Analysis of Participants Who Endorsed ISI & Help-seeking and Participants Who Endorsed ISI & No Help-seeking on Type of ISI

<table>
<thead>
<tr>
<th>Type of ISI</th>
<th>ISI &amp; help</th>
<th></th>
<th>ISI &amp; no help</th>
<th></th>
<th>Chi-square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>1) cutting</td>
<td>45</td>
<td>33</td>
<td>15</td>
<td>38</td>
<td>10.98**</td>
</tr>
<tr>
<td>2) burned w/cigarette</td>
<td>11</td>
<td>67</td>
<td>2</td>
<td>50</td>
<td>3.65</td>
</tr>
<tr>
<td>3) burned w/lighter or match</td>
<td>9</td>
<td>69</td>
<td>4</td>
<td>49</td>
<td>.56</td>
</tr>
<tr>
<td>4) carved words into skin</td>
<td>11</td>
<td>67</td>
<td>3</td>
<td>50</td>
<td>2.36</td>
</tr>
<tr>
<td>5) carved pictures, designs or other marks</td>
<td>12</td>
<td>66</td>
<td>3</td>
<td>50</td>
<td>2.94</td>
</tr>
<tr>
<td>6) scratched enough for scarring or bleeding</td>
<td>37</td>
<td>41</td>
<td>9</td>
<td>44</td>
<td>12.85**</td>
</tr>
<tr>
<td>7) bit self so that skin broke</td>
<td>11</td>
<td>67</td>
<td>0</td>
<td>53</td>
<td>8.16*</td>
</tr>
<tr>
<td>8) rubbed sandpaper on body</td>
<td>1</td>
<td>77</td>
<td>3</td>
<td>50</td>
<td>2.04</td>
</tr>
<tr>
<td>9) dripped acid on skin</td>
<td>0</td>
<td>78</td>
<td>0</td>
<td>53</td>
<td>-</td>
</tr>
<tr>
<td>10) used bleach, comet or oven cleaner to scrub skin</td>
<td>1</td>
<td>77</td>
<td>1</td>
<td>52</td>
<td>.08</td>
</tr>
<tr>
<td>11) stuck sharp objects into skin (e.g. needles, pins)</td>
<td>13</td>
<td>65</td>
<td>8</td>
<td>45</td>
<td>.06</td>
</tr>
<tr>
<td>12) rubbed glass into skin</td>
<td>4</td>
<td>74</td>
<td>1</td>
<td>52</td>
<td>.90</td>
</tr>
<tr>
<td>13) broken own bones</td>
<td>0</td>
<td>78</td>
<td>0</td>
<td>53</td>
<td>-</td>
</tr>
<tr>
<td>14) banged head that caused a bruise</td>
<td>15</td>
<td>63</td>
<td>5</td>
<td>48</td>
<td>2.34</td>
</tr>
<tr>
<td>15) punched self that caused a bruise</td>
<td>11</td>
<td>67</td>
<td>9</td>
<td>44</td>
<td>.20</td>
</tr>
<tr>
<td>16) prevented wounds from healing</td>
<td>11</td>
<td>67</td>
<td>4</td>
<td>49</td>
<td>1.38</td>
</tr>
<tr>
<td>17) anything else?</td>
<td>21</td>
<td>57</td>
<td>8</td>
<td>45</td>
<td>2.56</td>
</tr>
</tbody>
</table>

* p < .05 (2-tailed).
** p < .001 (2-tailed).
Table 7

*Frequency and Percentage of Affirmative Answers to List of Barriers*

<table>
<thead>
<tr>
<th>Barrier</th>
<th>All (n=452)</th>
<th></th>
<th>Endorsed ISI (n=131)</th>
<th></th>
<th>Psych distress &amp; no ISI (n=137)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>%</td>
<td>Freq.</td>
<td>%</td>
<td>Freq.</td>
<td>%</td>
</tr>
<tr>
<td>1) Should have been strong enough to handle alone</td>
<td>322</td>
<td>71.2</td>
<td>99</td>
<td>75.6</td>
<td>116</td>
<td>86.6</td>
</tr>
<tr>
<td>2) Thought the problem would get better by itself</td>
<td>305</td>
<td>67.5</td>
<td>96</td>
<td>73.3</td>
<td>106</td>
<td>78.5</td>
</tr>
<tr>
<td>3) Family thought you should go but you didn’t think it was necessary</td>
<td>135</td>
<td>29.9</td>
<td>47</td>
<td>35.9</td>
<td>50</td>
<td>36.8</td>
</tr>
<tr>
<td>4) Didn’t think anyone could help</td>
<td>141</td>
<td>31.2</td>
<td>57</td>
<td>43.5</td>
<td>43</td>
<td>32.3</td>
</tr>
<tr>
<td>5) Were too embarrassed to discuss it with anyone</td>
<td>213</td>
<td>47.1</td>
<td>73</td>
<td>56.2</td>
<td>73</td>
<td>54.5</td>
</tr>
<tr>
<td>6) Were afraid of what your boss, friends, family or others would think</td>
<td>204</td>
<td>45.1</td>
<td>67</td>
<td>51.1</td>
<td>67</td>
<td>49.6</td>
</tr>
<tr>
<td>7) Hated answering personal questions</td>
<td>188</td>
<td>41.6</td>
<td>72</td>
<td>55.4</td>
<td>63</td>
<td>46.7</td>
</tr>
<tr>
<td>8) Couldn’t afford the bill</td>
<td>106</td>
<td>23.5</td>
<td>33</td>
<td>25.6</td>
<td>27</td>
<td>20.1</td>
</tr>
<tr>
<td>9) Didn’t know any place to go for help</td>
<td>109</td>
<td>24.1</td>
<td>36</td>
<td>28.1</td>
<td>29</td>
<td>21.5</td>
</tr>
<tr>
<td>10) Were afraid they would put you into hospital</td>
<td>75</td>
<td>16.6</td>
<td>28</td>
<td>21.5</td>
<td>21</td>
<td>15.7</td>
</tr>
<tr>
<td>11) Were afraid of the treatment they would give you</td>
<td>91</td>
<td>20.1</td>
<td>40</td>
<td>30.8</td>
<td>20</td>
<td>15.0</td>
</tr>
<tr>
<td>12) Didn’t have time</td>
<td>173</td>
<td>38.3</td>
<td>55</td>
<td>42.0</td>
<td>60</td>
<td>46.2</td>
</tr>
<tr>
<td>13) Hours were inconvenient</td>
<td>118</td>
<td>26.1</td>
<td>39</td>
<td>29.8</td>
<td>32</td>
<td>23.7</td>
</tr>
<tr>
<td>14) A member of your family objected</td>
<td>52</td>
<td>11.5</td>
<td>21</td>
<td>16.2</td>
<td>11</td>
<td>8.2</td>
</tr>
<tr>
<td>15) Didn’t have a way to get there</td>
<td>40</td>
<td>8.9</td>
<td>13</td>
<td>10.0</td>
<td>8</td>
<td>6.0</td>
</tr>
<tr>
<td>16) Felt that you were taking care of the problem yourself</td>
<td>287</td>
<td>63.5</td>
<td>87</td>
<td>66.4</td>
<td>106</td>
<td>78.5</td>
</tr>
</tbody>
</table>
Table 8

Chi-square Analysis of Participants Who Endorsed ISI and Participants Who Endorsed Psychological Distress but No ISI on List of Barriers

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Endorsed ISI</th>
<th></th>
<th>Psych distress &amp; no ISI</th>
<th></th>
<th>Chi-square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>1) Should have been strong enough to handle alone</td>
<td>99</td>
<td>32</td>
<td>116</td>
<td>18</td>
<td>5.23*</td>
</tr>
<tr>
<td>2) Thought the problem would get better by itself</td>
<td>96</td>
<td>35</td>
<td>106</td>
<td>29</td>
<td>1.00</td>
</tr>
<tr>
<td>3) Family thought you should go but you didn’t think it was necessary</td>
<td>47</td>
<td>84</td>
<td>50</td>
<td>86</td>
<td>.02</td>
</tr>
<tr>
<td>4) Didn’t think anyone could help</td>
<td>57</td>
<td>74</td>
<td>43</td>
<td>90</td>
<td>3.51</td>
</tr>
<tr>
<td>5) Were too embarrassed to discuss it with anyone</td>
<td>73</td>
<td>57</td>
<td>73</td>
<td>61</td>
<td>.08</td>
</tr>
<tr>
<td>6) Were afraid of what your boss, friends, family or others would think</td>
<td>67</td>
<td>64</td>
<td>67</td>
<td>68</td>
<td>.06</td>
</tr>
<tr>
<td>7) Hated answering personal questions</td>
<td>72</td>
<td>58</td>
<td>63</td>
<td>72</td>
<td>2.01</td>
</tr>
<tr>
<td>8) Couldn’t afford the bill</td>
<td>33</td>
<td>96</td>
<td>27</td>
<td>107</td>
<td>1.10</td>
</tr>
<tr>
<td>9) Didn’t know any place to go for help</td>
<td>36</td>
<td>92</td>
<td>29</td>
<td>106</td>
<td>1.59</td>
</tr>
<tr>
<td>10) Were afraid they would put you into hospital</td>
<td>28</td>
<td>102</td>
<td>21</td>
<td>113</td>
<td>1.50</td>
</tr>
<tr>
<td>11) Were afraid of the treatment they would give you</td>
<td>40</td>
<td>90</td>
<td>20</td>
<td>113</td>
<td>9.24*</td>
</tr>
<tr>
<td>12) Didn’t have time</td>
<td>55</td>
<td>76</td>
<td>60</td>
<td>70</td>
<td>.46</td>
</tr>
<tr>
<td>13) Hours were inconvenient</td>
<td>39</td>
<td>92</td>
<td>32</td>
<td>103</td>
<td>1.25</td>
</tr>
<tr>
<td>14) A member of your family objected</td>
<td>21</td>
<td>109</td>
<td>11</td>
<td>123</td>
<td>3.91*</td>
</tr>
<tr>
<td>15) Didn’t have a way to get there</td>
<td>13</td>
<td>117</td>
<td>8</td>
<td>126</td>
<td>1.46</td>
</tr>
<tr>
<td>16) Felt that you were taking care of the problem yourself</td>
<td>87</td>
<td>44</td>
<td>106</td>
<td>29</td>
<td>4.89*</td>
</tr>
</tbody>
</table>

*p < .05 (2-tailed).
Appendix A

Instruments Used

The Psychological Distress Questionnaire (PDQ) was adapted from questions used by Evans, Hawton and Rodham, 2005. This questionnaire has not been published but the original questions can be found in the aforementioned article.

The Deliberate Self-Harm Inventory (DSHI) is protected by copyright so it is not reproduced in this document. The questionnaire can be found in the article by Gratz, 2001.

The List of Barriers was adapted from an original list of barriers created by Hornblow, Bushnell, Wells, Joyce, and Oakley-Browne, 1990. The List of Barriers is protected by copyright and is therefore not reproduced in this document. The list can be found in the aforementioned article.

The Attitudes toward Seeking Professional Psychological Help Scale (ATSPPHS) is protected by copyright so it is not reproduced in this document. The scale can be found in the article by Fischer and Turner, 1970.

The Emotional Self-Disclosure Scale (ESDS) is protected by copyright so it is not reproduced in this document. The scale can be found in the article by Snell, Miller and Belk, 1988.

The Acceptance and Action Questionnaire (AAQ) is protected by copyright so it is not reproduced in this document. The questionnaire can be found in the article by Hayes, Wilson, Gifford, Follette and Strosahl, 2004.

The Self-Compassion Scale (SCS) is protected by copyright so it is not reproduced in this document. The scale can be found in the article by Neff, 2003b.
Appendix B

Xavier University IRB Letter of Approval

April 20, 2009

Ms. A. Sofie Shouse
726-D Ohio Pike
Cincinnati, OH 45245

Dear Ms. Shouse:

Thank you for responding to the IRB’s request for minor corrections to your protocol # 0585, “Barrier to Help-Seeking in a College Population”.

The reviewers found that the revisions you have submitted to be appropriate, and therefore your study is approved in the Expedited category. Approval expires April 22, 2010. A progress report, available at http://www.xavier.edu/irb/forms.cfm, is due by that date.

If you wish to modify your study, it will be necessary to obtain IRB approval prior to implementing the modification. If any adverse events occur, please notify the IRB immediately.

We appreciate all of your effort in getting this proposal submitted in a thorough manner and your patience through the approval process. We wish you success with your research!

Sincerely,

[Signature]

Kathleen J. Hart, Ph.D., ABPP
Interim Chair, Institutional Review Board

c: Nicholas Salsman, PhD
Xavier University, ML #6511

KH/dm
Appendix C

Xavier University IRB Approval Letter of Extension

June 29, 2010

Ms. A. Sofie Shouse
1064 Saddlebrook Dr.
Batavia, OH 45103

Dear Ms. Shouse:

Thank you for responding to the IRB’s request for minor corrections to your protocol.


An extension was approved until June 27, 2011. A progress report, available at http://www.xavier.edu/irb/forms.oftm, is due by that date if you plan to continue collecting data.

We wish you success with your research!

Sincerely,

[Signature]

Morell E. Mullins, Jr., Ph.D.
Chair, Institutional Review Board

c: Nicholas Solomon, Ph.D.
Xavier University, ML #5111
Appendix D

Informed Consent

You are being given the opportunity to volunteer to participate in a project conducted through Xavier University. This study is being conducted by a Doctoral candidate in the Clinical Psychology graduate program at Xavier University and through the Department of Psychology.

Please click next to read the Informed Consent form.

[Next]

INFORMED CONSENT

Purpose
The purpose of this study is to research plausible barriers to seeking professional help.

Why subject was selected
You were selected to participate because you are an undergraduate student.

Procedures
If you agree to participate in this study you will be prompted to complete seven questionnaires. The questionnaires will ask you questions about psychological distress and if you have engaged in harmful behaviors (for example, have you ever intentionally (i.e. on purpose) carved pictures, designs, or any other marks into your skin) at some point in your life. If you have engaged in these behaviors you will be asked more information about those behaviors (for example, how many times have you done this and has this behavior ever resulted in hospitalization or injury severe enough to require medical treatment). You will also be asked about your attitudes toward professional help-seeking (for example, a person with strong character can get over mental conflicts by himself/herself, and would have little need of a mental health professional), you will be asked what you perceive may be possible barriers for you in doing so (for example, you thought the problem would get better by itself) as well as how willing you are to discuss your emotions with others (for example, emotions such as feeling depressed, feeling afraid, feeling indifferent, etc.), how likely you are to avoid certain types of things (for example, if I could magically remove all the painful experiences I’ve had in my life, I would do so) and questions about your self-compassion (for example, I’m disapproving and judgmental about my own flaws and inadequacies). The questionnaires vary in length and will take you approximately 40 minutes to complete.

Associated Risks
There is minimal risk involved in participating in this study. In this study you will be
asked to answer specific questions about your personal history with harmful behaviors. If you feel that you may be at risk of engaging in harmful behaviors, or you do not want to continue with this study, know that you do not have to participate and that you may withdraw from the study at any time. If you feel distress at any point in time during or after the study counseling services are available free of charge to full time Xavier students at the Psychological Services Center (745-3531) and the Health and Counseling Center (745-3022).

Associated Benefits
There are no personal benefits for you for participating in this study, other than course credit that your professor might provide.

If you choose to participate in the study you will be prompted to give your name, class and professor at the end of the study. Gathering this information is solely for purposes of awarding you credit for your participation. The identifying information that you give will in no way be linked with your responses to the questionnaires, nor will it be saved on the same database.

Refusal to participate in this study will have NO EFFECT ON ANY FUTURE SERVICES you may be entitled to from the University. You are FREE TO WITHDRAW FROM THE STUDY AT ANY TIME, OR TO NOT PARTICIPATE, WITHOUT PENALTY.

If you have any questions at any time during the study, you may contact Sofie Shouse at asofie.shouse@gmail.com or at 312-1647. You may also contact her dissertation chair and licensed psychologist, Dr. Nicholas Salsman at 745-4289. Questions about your rights as a research subject should be directed to the Xavier University’s Institutional Review Board at (513) 745-2870.

(The contact information and information about counseling services will be available at the end of the questionnaires as well.)

Thank you,
Sofie Shouse, MA

*I have been given information about this research study and its risks and benefits and have been given the information about where to direct any questions or concerns I may have.
By answering Yes below, I indicate that I have read and agreed to the conditions above and that I freely give my consent to participate in this research study.
[ ] Yes

[ ] No (this choice will end the study)
Appendix E

Debrief

To receive credit for your participation please click on the link below:

Click Here to Enter Information to Receive Credit

Thank you for your time!

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If you feel distress at any point in time during or after the study counseling services are available free of charge to full time Xavier students at the Psychological Services Center (745-3531) and the Health and Counseling Center (745-3022).

If you have any questions you may contact Sofie Shouse at asofie.shouse@gmail.com or at 312-1647. You may also contact her dissertation chair and licensed psychologist, Dr. Nicholas Salsman at 745-4289. Questions about your rights as a research subject should be directed to the Xavier University’s Institutional Review Board at (513) 745-2870.
Appendix F

Summary

Title: Intentional Self-Injury as a Barrier to Help-Seeking in a College Population.

Problem. Rates of college students who engage in ISI behaviors are alarmingly high; for example, in a study by Whitlock, Eckenrode and Silverman (2006), 17% of college students had engaged in ISI behaviors at some point in their life. In general, less than one-third of persons with mental disorders seek professional help (Andrews, Issakadis & Carter, 2001). Furthermore, Evans, Hawton and Rodham (2005) found that adolescents who engaged in ISI behaviors sought professional help less often than those who endorsed feeling psychological distress and had not engaged in ISI behaviors. The aim of this study was to examine whether the barriers to professional help-seeking in college students who reported having engaged in ISI behaviors are based on intrinsic barriers that parallel specific functions of ISI. In particular, are barriers to professional help-seeking in those who engage in ISI related specifically to low emotional self-disclosure, use of experiential avoidance, and low feelings of self-compassion?

Method. Participants were 452 undergraduate students at a mid-sized, private Catholic university in the Midwest recruited through the University's participant pool. Participants consisted of 161 men and 290 women (one person neglected to identify gender). The mean age of the sample of participants used was 19.93 years (SD = 1.29). Participants were divided into two groups depending on if they: 1) had reported engaging in ISI (n = 131, 28% of the sample) or 2) had reported not engaging in ISI but endorsed psychological distress at some point in their life (n = 137, 30% of the sample). A series of linear and logistic regressions were completed to examine seven different hypothesis; the relationship between having engaged in ISI and help-seeking, having engaged in ISI and emotional self-disclosure (using the Emotional Self-Disclosure Scale, ESDS), experiential avoidance (the Acceptance and Action Questionnaire, AAQ), and self-compassion (the Self-Compassion Scale, SCS), as well as the relationship between emotional self-disclosure, experiential avoidance, and self-compassion with professional help-seeking.

Findings. The primary analysis, a mediational analysis using methodology described by Baron and Kenny (1986), examined whether the relationship between the independent variable and the dependent variable was mediated by one or more of three potential mediational variables. The first hypothesis (that those persons who reported having engaged in ISI would seek professional help less often for their psychological distress than would those who endorsed having psychological distress and had not engaged in ISI) was not significant and therefore the meditational model was not supported. It was found that persons who reported having engaged in ISI were significantly less likely to share their emotions with others (β = .15, p = .017) and significantly less self-compassionate (β = .18, p = .049) than those who endorsed psychological distress but had not engaged in ISI. It was also found that persons who endorsed being more avoidant had sought professional help significantly more often than those who endorsed being less avoidant (β = -.04, p = .043); this was in the opposite direction of the hypothesis.
Implications. Overall, while the number of research studies about various aspects of ISI continue to increase, few researchers have examined the relationship between ISI and professional help-seeking, and even fewer (if any) have studied why those who engage in ISI seek professional help less often. The non-significant finding between reportedly having engaged in ISI and professional help-seeking was contrary to findings by Evans, Hawton and Rodham (2005). However, the results that those persons who reported engaging in ISI scored significantly lower on the ESDS than those who endorsed psychological distress but reported not having engaged in ISI were consistent with findings by other researchers. Contrary to the hypothesis, those persons who endorsed higher experiential avoidance reported seeking treatment more often than those who endorsed less experiential avoidance - one possible explanation for this may be that those individuals who endorsed higher experiential avoidance were also suffering from more psychological distress and were therefore seeking professional help more often due to the severity of their pathology as opposed to the specific dynamics of their pathology.