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# Exposure to physical and sexual violence, mental health and help-seeking behaviors among Norwegian Adolocesent: A cross-sectional study using data from Ungvold, 2015

Master's thesis in International Social Welfare and Health Policy

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Abstract

This thesis is written with consideration of adolescents' mental health by looking at the connections with help-seeking and two types of violence, physical and sexual. The purpose was to investigate the association between violence and mental health and the association between help-seeking and mental health. It was also my goal to investigate the prevalence of help-seeking behaviors among adolescent victims of violence, the prevalence of physical and sexual violence as well as gender difference in all the variables as mentioned above.

The associations between the various variables above were studied using quantitative data from the Ungvold data survey in 2015 undertaken by the Norwegian Institute for Research on Childhood, welfare, and Aging (NOVA). The study had 5350 respondents from final year high school students in Norway.

The results of the study show that adolescents with experience of physical and sexual violence reported lower levels of mental health. The results also show that victims of both violence who sought help reported more mental health problems than their counterparts who did not seek help. The results further indicated that the prevalence of both physical and sexual violence and help-seeking behaviors among Norwegian adolescents was low. Furthermore, the results indicated that females reported higher levels of violence victimization, help-seeking behavior, and mental health problems than males. Lastly, the results show that adolescents mental health problem is highly associated with physical violence than sexual violence and that sexual violence also elicited more help-seeking behaviors than physical violence.

I discussed the results of this thesis within the frameworks of social risk management proposed by Holzmann and Jørgensen (2001).

This study's results contribute to increasing knowledge about some of the factors that can be considered as health promotion when dealing with adolescents' mental health. This knowledge is essential for social work when considering measures to promote adolescent's mental health.

# Preface

It all started with Simon Invær, an associate professor of health policy at OsloMet University, who, one day after class, having told him my aspirations in life, got inspired and led me directly to Randy Wærdahl, the then coordinator of International Health Policy Program at OsloMet University. She, the reception exceptionally welcomed me, and the conversations that transpired I still remember up till now. Right in her office, she called Åsmund Hermansen, who was the associate professor of quantitative methodology. Åsmund was gracious to me and strongly agreed that he could offer help for me to assist him in quantitative methodology. Know and behold, in my second year in the master's program, through his recommendation I was hired as a teaching assistant in quantitative methodology and worked closely with Åsmund, to which I see as the greatest privilege to have apart from the privilege to have life and to come from a loving family!

During the master thesis preparation, as I was searching for topics, I discussed with Einar Øverby, the professor of Social Risk Management, who also recommended me to NOVA. During this same time, Åsmund Hermansen also sent a recommendation of me to NOVA to be considered to write my thesis with violence in the close family project. I am super grateful to Einar and Åsmund for such helpful recommendations.

It was Åsmund who led me to Lars Røar Frøyland, a Ph.D. student at NOVA, to discuss with me about my master's thesis. It was one of the greatest moments in my life to meet Lars, who got involved in every area of this thesis. Through their recommendations, I was offered a scholarship from NOVA, who provided money, coffee, fruits, and office to help me do quality work. Whiles in my office, I met so many students and workers at NOVA who have been amazingly kind to me and offered all kinds of help to me. Obviously, I couldn't have had any better; indeed, I've had the best! I'm especially thankful to NOVA for what they have done to me, and to Lars, who has been incredibly supportive in my master thesis.

Again, I'm eternally grateful to both Åsmund and Lars for their time and directions they gave me, reading through every area of this thesis every now and then!

I must be grateful and thankful to my family and friends: especially my mother and brothers, my daddy in Ghana, Professor Osafo Adu, who have given me the love, support, and warmth to go through life challenges.

I am very grateful to Vyda Mamley Hervie, who has been a friend and a sister. Her advice was very helpful to me in many ways.

I am of the enormous optimism that this will not end here but will go on to lead me into more advanced areas of study. I hope to give back to others what I have received!

When I consider how things have unfolded, Åsmund calls this randomness, but as much as I agree with him as it applies to statistics, I look back at my life, and I see its not just randomness but more so orchestrated. I can now see that every piece of my life can perfectly fit into another piece to make a holistic whole. Everything I have been through, whether good or bad, I understood that indeed, the steps of a good man are ordered by the lord. I have reflected upon many things that seemingly did not make sense in my life. Some of them were very painful; others were hard to bear; some of them were frightening because I had uncertainty about what was going to come out of it. I bathe my soul on the word that I heard that every single thing in my life is not distraughtly composed, but in fact, has been carefully orchestrated. I got this deep in my spirit that whether things go good or bad, I armed myself with the word that nothing just happens. Thank you, God, for heavenly direct access into your heavenly blessings!

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# CHAPTER 1: INTRODUCTION

## 1.1. Background

Mental health amongst adolescents is on the decline, especially among girls (Collishaw, Maughan, Goodman, & Pickles, 2004). This evidence is shown by increases in depression ailments, anxiety, stress, and loneliness reported by young people. Norway is not exempted from this trend, as new figures from the Young Data survey show an increase in adolescents' poor mental health (Bakken, 2017). The decrease in adolescent's mental health has implications for the individual young people and society in general. The estimation of the cost of anxiety disorders alone in the USA in 1990 is 42.3 billion dollars or 1,542 dollars per sufferer (Greenberg et al., 1999). The cost of mental health problems is not only in monetary terms but also in reducing the quality of life and productivity, especially in areas of absenteeism. This study can contribute to widespread awareness and recognition of risk factor of adolescents' mental health

Throughout adolescence, a lot of adolescents separate from their parents, form an autonomous identity, make decisions regarding education and vocation, form close relationships; all of these processes have significant long-term effects on the individual (Debra Rickwood, Deane, Wilson, & Ciarrochi, 2005). If, for example, educational and vocational attainments are interrupted by a mental health problem, prospects in adulthood can be negatively affected. One of the fundamental areas to adolescents' mental health and wellbeing is their help-seeking behaviors for violence victimization. (Debra Rickwood et al., 2005). As they put it "unless effective mental health resources can be found for young people, in terms of services and focus of support that they will use and meet their needs, mental health problems will remain a substantial obstacle to improved wellbeing for young people" (Debra Rickwood et al., 2005).

Improving adolescent's mental health can be seen as a barometer of society's effort in enhancing adolescent's well-being and life chances. The comparison of extensive scale surveys of 15/16-year-olds at each time shows rises for problems such as depression and anxiety Collishaw et al. (2004). The study above shows that in general, young people of today have emotional and behavioral problems that are significantly higher than it was in the 1970s and 1980s.If we look at health service use, for example, many researchers have reported a steep increase in adolescent's service use for depression and anxiety, including help-seeking from the General Practitioner (GP) (Collishaw, Goodman, Ford, Rabe-Hesketh, & Pickles, 2009). Hagell (2012) reported that in the USA, the number of visits to doctors by adolescents who were depressed

increased more than double from 1.4 million in 1995-1996 to 3.2 million in 2001-2002, and anti-depressant prescriptions have had a substantial increase in the past decades. Changes in population prevalence of anxiety and depression may partly explain this increase in service use among adolescents.

Epidemiological studies comparing English teenagers in 2006 (sampled from the health survey England) and in 1986 confirmed an increase in symptoms of anxiety and depression (Collishaw, Maughan, Natarajan, & Pickles, 2010). In Scotland, the trend is still the same; the population of young people meeting the established "case criteria" for General Health Questionnaire (GHQ-12), almost doubled for boys and more than double increased for girls between 1987 and 2006 (Sweeting, West, Young, & Der, 2010). Other studies from European countries are consistent in this trend. For example, Sourander et al., 2004 reported that in Sweden, Iceland, Norway, Finland, the Netherlands, and Greece all found increased self-reported adolescents' symptoms of depression and anxiety since 1980.

Studies suggest that trends in adolescents' emotional and conduct problems differ for boys and girls. This is important to investigate because they highlight that boys and girls are maybe differentially susceptible to different kinds of the environmental risk factor of mental health. In this thesis, most of the literature that I have reviewed show that comparing self-report symptoms, increases in emotional problems are more pronounced for girls than boys (Sweeting & West, 2003). A Norwegian study conducted by the University of Oslo also found the same trend (karevold 2008). The paradox is that we are more healthy, wealthy, and comfortable today than at any time in the past (Twenge, Joiner, Rogers, & Martin, 2018). However, adolescents' mental health depreciation is still on the rise. In this thesis, I take a rather selective look at one specific area of concern, which might be necessary for mental health, violence. I also look at how health service centers, thus help-seeking behavior of adolescents, might be relevant in understanding the association between violence and mental health.

Research shows that being exposed to violence is a known risk factor for mental health problem (Stansfeld et al., 2017), and many adolescents who experience violence will, therefore, require some help. To provide victims of violence with a possible way of dealing with potential mental health problems, the society must give sufficient help-seeking services for victims, and the victims, in turn, be willing to use these services. Moreover, using help-seeking services could be related to the level of mental health problems experienced by the victims. For example,

social support was significantly associated with the recovery from prior post-traumatic stressed disorder (Dai et al., 2016)

However, even though seeking help could be related to an improvement of mental health, it could also be that those who seek help are those who experience the most problems or those who are able to recognize that their victimization exceeds their ability to handle by themselves, and maybe also have the most severe experiences with violence. I review the literature in this area on page 13 of this thesis.

This master thesis *aims to examine the association between violence and mental health, sources, and prevalence of help-seeking, violence and the association between help-seeking and mental health to increase knowledge about adolescent help-seeking behavior and mental health*. When individuals face challenges such as violence or experience painful emotions such as anxiety and depression, they may seek out help such as professional health services for comfort, advice, and help with problem-solving. Receiving support is a protective factor for individuals across the lifespan. For example, (P. A. Thoits, 2011; Uchino, 2006) reported that positive perceptions of social support predict better psychological and physical health and has been shown to buffer individuals against negative effects of stressful events (Hammack, Richards, Luo, Edlynn, & Roy, 2004; P. A. Thoits, 2011).

Psychological and Sociological pieces of literature are reviewed to explore the help-seeking behaviors of adolescents to understand the developmental and social complexities that surround the adolescent. To frame the quantitative data analysis and how adolescents experience certain domains of their lives, the developmental and the behavioral service use theories are used as a theoretical frameworks. The data material in this thesis is pulled from the Ungvold 2015 survey. Consequently, the data reflects the experiences and perspectives of the youth, their relationship with parents, and help-seeking behaviors. This provides the opportunity to gain insight into how adolescents perceive their mental health, their violence experiences, and help-seeking practices.

### 1.1. Thesis outline

After the introduction in chapter one, the study continues with the review of literature, which discusses associations between the various variables in the study, particularly scientific literature on violence and mental health and help-seeking and mental health. This review of

past studies helped in identifying relevant theories for the discussion of the results and finding gaps that helped in setting out the aims and hypotheses of this study.

Chapter three discusses two theories used in discussing the results of this study. It also introduces a risk management framework that is used to discuss a suggested intervention. In chapter four, formal aims and hypotheses are presented, while chapter five outlines the applied statistical test and relays the origins and creation of the variables. Results of univariate, bivariate, and multivariate analyses are presented in chapter six. Chapter seven interprets and discusses results, implications, a suggestion for future research and limitations. Chapter eight provides a conclusion for the study.

# CHAPTER 2: LITERATURE REVIEW

## 2.1. Association between violence and mental health

The violence that adolescents are exposed to includes both direct experiences of physical, sexual, and emotional abuse, as well as indirectly witnessing it. In this thesis, the violence understudy is direct physical and sexual. The World Health Organization in 2010 reported that about 25% to 50% of all children in the world had been physically abused (WHO, 2010).

According to Gershoff and Grogan-Kaylor (2016), children who are abused by sexual violence are more likely to develop long term behavioral problems as well as symptoms of trauma.
Physical violence, on the other hand, has also been found to be associated with mental health problems. Lambert, Copeland-Linder, and Ialongo (2008) studied community violence and antisocial behavior and reported that childhood physical abuse was associated with adolescent's suicidal ideations and attempts. In this thesis, physical violence was measured from only parents and stepparents. This makes it more important to review physical abuse by a close relative, such as parents. According to Edwards, Freyd, Dube, Anda, and Felitti (2012), violence against adolescents that was perpetrated by a caretaker is more likely to develop into harmful trauma symptoms than children whose victimization was committed by a stranger. Kisiel et al. (2014), explains that because the victimization is likely to start early in life if the perpetrator is a close relative, there is the likelihood that the abuse will continue. Freyd (1994), explaining the harmful trauma adolescents go through when a parent perpetrates victimization, explains that the relationship between the victim and the perpetrator will affect how the abuse will remember the experience. Because the child depends on the parents and wants to protect their relationship they often blame themselves.

A study indicates that adolescents who experience childhood sexual abuse are at increased risk of suffering a variety of health-related problems such as depression and anxiety (Jumper, 1995). One can imagine that if these sources of violence are from the child's caregivers such as parents, reporting will be shallow, and the likelihood that the abuse will continue. This is because children depend on adults such as parents to report abuse to child-welfare services and the police. What these two types of violence shares, based on the literature that I have reviewed so far are their potential for life-long consequences, which include mental health problems.
The literature shows that although boys experience sexual assault (Du Mont, Macdonald, White, & Turner, 2013; McDonald & Tijerino), it is girls who continue to disproportionately

be impacted WHO (2013). Unfortunately, both the violence that adolescents experience and its consequences are usually hidden from view (Hillis, Mercy, Amobi, & Kress, 2016). This is because violence such as sex is often carried out in places where it is unlikely to be witnessed, and victims rarely come into contact with official agencies, and therefore, many consequences do not become obvious until many years after the exposure. This may have huge mental health consequences.

In the following paragraphs, I argue that it is not people who have mental health problems that commit violence, but rather it is violence that is likely to lead to mental health problems.
Mental illness and violence remain inextricably intertwined. The relationship between mental illness and violence has been shown to be more complex than initially suspected. Researchers reanalyzing the NESALC (National Epidemiological Survey on Alcohol and Related Conditions) data have confirmed that mental illness and violence are related through the accumulation of risk factors of various kinds, for example historical factors such as past violence, juvenile detention, physical abuse, clinical factors such as substance abuse, perceived threats, dispositional such as age, sex, and contextual factors such as recent divorce, unemployment (Hasin & Grant, 2015).

According to Varshney, Mahapatra, Krishnan, Gupta, and Deb (2015), those with mental illness make up a small proportion of violent offenders. Results from other studies are uniformly coherent, that mental health problems far from explaining all the variations in violence. Specifically, the attributable risk of mentally ill individuals committing violence ranges approximately between less than 1% and 5% (Fazel & Grann, 2006; Swanson, 1994). However, studies about mental health varied a great deal. Fazel et al. (2009), in their meta-analysis, found that the attributable risk of schizophrenia associated with the number of crimes varied between 3,2% and 9.9%. The findings of the association between mental health and violence are mixed and inconclusive. Some studies report a positive association between mental health problems and violence; others say no association, and even where there is an association, other factors were involved.

There are many forms of mental health problems which are not predictive of interpersonal violence, example, depressive symptoms without Psychotic symptoms and anxiety disorders (Arseneault, Moffitt, & Caspi, 2000; Elkington, Bauermeister, Santamaria, Dolezal, & Mellins, 2015; Sourander et al., 2007). But some studies show that only a few mental health problems

predict violence. For example, some studies found an association between schizophrenia, psychosis, and violence (Arseneault et al., 2000). Other studies show that the majority of individuals who have schizophrenia or other forms of psychosis do not commit violence and that the cross-sectional relationship found between them is weak (Swanson, McGinty, Fazel, & Mays, 2015). The incidence of violence was higher for people with severe mental illness but only significantly so for those with co-occurring substance abuse. Mental illness alone did not predict future violence, and it was associated instead with historical factors such as past violence, juvenile detention, physical abuse, parental arrest record as well as Clinical factors such as substance abuse, perceived threat. Dispositional factors such as age, sex and income, and contextual factors such as recent divorce, unemployment, and victimization were all involved.

Elbogen and Johnson (2009) concluded that Schizophrenia and bipolar disorders were only predictors of violence in conjunction with substance use. The above studies reviewed show that it is violence that is more likely to lead to mental health problems such as depression and anxiety but not mental health problems that lead to violence.

According to Ahonen, Loeber, and Brent (2017), when considering expert's opinions on the association between mental health and violence, most experts about 66% of them mentioned that substance abuse and alcohol are the primary problems either as a cause or co-occurring with other disorders. The authors maintained that there is no precise predictor of violence associated with mental health problems besides substance use disorder (Ahonen, Loeber, & Brent, 2017).

Therefore, it is much easier looking at the studies above (Ahonen et al., 2017; Swanson et al., 2015) to predict that people with mental health illness, independent of other factors, will not commit violence.

Given the studies presented above, individuals with a mental disorder are only responsible for a small fraction of all violence committed. This means that an overwhelming majority of all violence is committed by individuals with no history of mental illness. Even if a mentally ill individual commits violence, usually, the violence is directed towards a family member or another person close to them than at a stranger (Taylor & Gunn, 1999). Thus, it's rare that someone with a mental illness commits community violence, and compared to non-mentally disordered community offenders, they are comparatively much less of a threat to public safety. Thus, the majority of individuals with mental illness do not contribute a danger to strangers or

the public at large. However, Symptoms associated with mental illness such as disorganized thought processes, impulsivity, and poor planning and problem-solving can compromise one's ability to perceive risks and protect oneself and make them not vulnerable to physical and sexual assaults.

Consequently, if we want to understand the link between violence and mental illness, we need to consider the association it has with other variables. In this master thesis, many I focused on violence and mental health, help-seeking and gender. My aim was to investigate the prevalence of violence among adolescents, prevalence of help-seeking behavior and the association between help-seeking and mental help, therefore, other variables such as alcohol abuse were not included in this study.

## 2.2. The landscape of help-seeking

According to Ashley and Foshee (2005), in general, the help-seeking behavior of adolescents related to violence is mainly unexplored. They found that 60% of victims of their sample did not seek help for violence, and most of the victims who sought help chose family and friends rather than professionals. Even when there are available effective treatments, only a third of individuals with diagnosable mental health problems seek formal help (Alonso et al., 2004).

Help-seeking behavior can bring young people into contact with a range of essential resources with the potential to reduce the likelihood of poorer psychosocial outcomes. According to the developmental theory employed in this study, social support and its related health outcomes should take into thought clear precursor processes that are related to measures of support over time (Uchino, 2006). Such a view highlights the need to distinguish measures of perceived and received support and its links to more specific violence and stages of development. Those who seek help should ideally find help or support. This support can be actual or perception that one is cared for, has assistance available, and that one is part of a supportive social network. These sources of help can be emotional, informational, or companionship; tangible and intangible (A. M. Williams, 2016)

Given the positive links between support and health outcomes (P. A. Thoits, 2011; Uchino, 2006), some writers reported that positive perceptions of social support predict better psychological and physical health. This positive link between social support and mental health has been shown to shield individuals against adverse effects of stressful events (Hammack,

Richards, Luo, Edlynn, & Roy, 2004; P. A. Thoits, 2011). It becomes critical to examine factors responsible for this link between social support and health outcomes. The distinction between received support and perceived support is essential as perceived support has been more consistently related to beneficial health outcomes than received support (Rappaport, Seidman, & Barrera, 2000).

Differences exist between perceived and received support, individuals with positive early family environments (parental support, less conflict) develop favorable psychological profiles, such as perceived support (Shaw, Krause, Chatters, Connell, & Ingersoll-Dayton, 2004). These favorable profiles, in turn, are associated with positive health outcomes through healthy behavioral choices and cooperation with the medical regimen (Dimatteo, 2004). This means that the point or the time when support is received can influence psychological changes such as one's self-esteem or control (Gleason, Iida, Shrout, & Bolger, 2008). This also means that support needs to be relatively stable over time for it to influence health outcomes. According to Sarason, Sarason, and Shearin (1986), social support that affects health outcomes is durable and has its roots in early parent-child interactions. Familial interactions include processes such as caring, affection, and positive involvement that sets the basis for supportive relational schemas.

This study examines received support, which is a situational factor that is sought or provided in direct response to stress (Barrera, 2000). Thoits (1986) reports that this type of support seeking is a potential resource for victims of violence necessary for coping. However, Berg and Upchurch (2007) said that its effectiveness might depend heavily on the context. This is consistent with the matching hypothesis of support, which predicts that stress-buffering is most effective when the type of support matches the needs and challenges of stressful events (Duggan, 2019). Duggan's (2019) argument is that the person seeking for support/help has a goal and that the support would only be beneficial if the support provider can understand such goals and appropriate response. Thus, received support can have either positive or negative consequences, depending on the context. This idea suggests that the type of support received in a particular stress context is important and may be responsible for some conflicting findings of received support. If there are instances under which received support is less effective, the possible explanations are one, those who receive assistance are actually under more severe stress. This implies that researchers need to follow up on the effects of received support over long periods of time because it is over time that received support eventually help one resolve the stressor.

The second reason why received support may sometimes fail according to Bolger, Zuckerman, and Kessler (2000), is related to the provider of the support. Anxiety on the part of the support provider may interfere with the retrieval of effective coping skills. People interacting with someone undergoing such stressful events feel anxious about these interactions because they would not want to do or say anything that would upset the individual. This anxiety makes it difficult to be an effective support provider as individuals may slip into more automatic modes of support provider that may then be viewed as unhelpful. Lastly, support may not be beneficial because it is sometimes associated with drop-in self-esteem or threat to one's sense of independence (Bolger et al., 2000). Because of this Bolger et al. (2000) argued that the best forms of support might be acts that are not noticed by the recipient as support. Support, therefore, must be prioritized to develop and refine prevention or intervention efforts for those most affected.

As applies to this study, D. Rickwood and Thomas (2012) define help-seeking as an adaptive coping process, which is the attempt to obtain external assistance to deal with the mental health concern. According to Boldero and Fallon (1995), some types of problems are more likely to promote help-seeking behavior than others, and different sources of help are deemed more appropriate for particular kinds of issues. They cited that relationship problems are often discussed with friends, personal problems with parents, and educational problems are more likely to be taken to teachers.

### 2.3. Informal help-seeking

Informal help-seeking, according to Allen and Badcock (2003), can provide a critical adaptive coping advantage if it is provided within an appropriately resourced social networks. However, other studies report that the perceived need to seek informal help without the availability of social support is likely to result in the severity of an individual emotional or health decline being compounded (Reavley, Jorm, & Morgan, 2017). Reliance on friends as the main form of support is potentially coupled with both positive and negative consequences. Friends can provide emotional support, advise information on how to handle abuse, help define behaviors as abusive. According to Reavley et al. (2017), members and the general public have rated the helpfulness of informal help from friends and family more highly than professionals. But of course, historically, friends and families have played key roles in caregiving, especially when

it comes to people with mental health problems. Surely, one can see that the social distance between the person with the mental health problems and the informal helper is not so great. Thus there is a more significant agreement about the perception of the problem and how it might be handled. However, informal help is difficult to evaluate because it happens spontaneously.

However, friends who are not trained and have not acquired specific skills are not equipped to deal with some situations, they may fear the abuser, be victimized themselves, or blame victims. Watson'sWatson's (2001) 's study of high school student's responses to dating violence found that the most frequently reported forms of action were informal help-seeking primarily from friends and parents. Stets and Pirog-Good (1989) found that individuals who are abused are more likely to confide in friends who may be less likely to react negatively than other people in their social networks, for example, parents. Some adolescents also reported that even with friends, they have to be careful about whom they confide in for fear that people might leak sensitive information that could embarrass them. Survivors of victims also seek help from family members other than friends. Among family members, most seek help from mothers but not fathers. In fact, many adolescents report that they do not feel close enough to their fathers to discuss sensitive issues such as sexual violence.

## 2.4. Formal help-seeking

Formal help service providers are well-positioned to assist victims in their recovery through the provision of services that address the physical and mental health consequences of the violence (WHO, 2013). This is because, according to the WHO (2013), they are uniquely positioned to act as a gateway, providing referrals to counseling, social, and legal services. Formal help service providers not only assist the survivor in accessing medical care, providing them with resources, particularly those that focus on coping with the aftermath of the violence and encouraging them to see a counselor or other mental health professionals. They also help in clarifying misconceptions about the violence and assessing safety.

Some of the studies I reviewed suggest that those who disclose their violence experience to health-care providers in an attempt to receive help, frequently receive inappropriate responses (Borja, Callahan, & Long, 2006). Mazza, Dennerstein, and Ryan (1996) found that 53% of victims of sexual violence in their study did not even disclose because they did not think it will

be relevant to their consultation. This is because Alaggia (2010), explains that disclosing or seeking help for violence victimization is a process where the victim makes several judgments before seeking help. Many factors could stop the adolescent victim from seeking help.

However, Golding, Siege, Sorenson, Burnam, and Stein (1989) reported that survivors are more likely to tell their physicians if the sexual assault involved penetration, physical or psychological assaults or if they identified having experienced emotional consequences. According to Ocampo, Shelley, and Jaycox (2007), formal support is least likely to be sought out among adolescents. About 84% of adolescents in their study did not seek help from formal sources, including school personnel, social services, police, or medical care. Ocampo et al. (2007) found that only 8% of high school students in their study used formal sources of help, such as teachers and counselors, when violated. Adolescents fear that help-seeking creates consequences that are deemed unfavorable to them, for example, victim status known to others. This low help-seeking rate makes it difficult for formal helpers to intervene to protect victims from mental health and safety issues that might arise after violence. Foshee et al. (1996) also found that adolescents are less likely than an adult to seek help from service providers because they fear that they would be blamed for the abuse and that information would not be held in confidence.

In terms of how helpful adolescents think various sources of formal help-seeking would be, Ocampo et al. (2007) reported adolescents saw informal sources of help as most beneficial. The percentage of adolescents who report that police, lawyers, counselors would be helpful was lower; they ranked friends as most beneficial. In terms of how likely adolescents would use sources of formal help, it was the same pattern. Most even ranked sources of formal help as more helpful than they would be likely to seek help, indicating a possible reluctance to seek formal help from problems relating to violence (Ocampo et al., 2007).

Generally, people do not trust and do not feel close to the adults in professional roles such as Doctors, counselors, Teachers in their lives (Debra Rickwood, Deane, Wilson, & Ciarrochi, 2005). There is the need to feel close to and trust the person they will tell and believe that the person understands them (Ocampo et al., 2007; Debra Rickwood et al., 2005). Victims who speculated they might confide in a teacher also clarified that it would have to be a teacher they felt close to and not just any teacher (Ocampo et al., 2007). Although medical professionals, lawyers, and the police are in professions that are likely to be of help to adolescents victims of

violence, victims stated that they would not be possible to seek help from these sources because of embarrassment (Debra Rickwood et al., 2005). Others feel that the police would not take their complaint seriously because they are just teenagers and stated that unless they had physical evidence that indicated that they had been abused, the police were unlikely to do anything about it.

Brown et al. (2014) did a study on formal and informal help for mental health problems in a community of psychiatric morbidity in London. They found that participants who scored above the threshold of the CIS-R (Revised Clinical Interviewed Schedule), any primary diagnosis, a depression diagnosis, suicidal ideation, longstanding illness, functional limitations, and poor perceived health were more likely to seek formal help than informal help. Participants who scored above the threshold on the CIS-R were more likely than those below the threshold to seek formal help, as well as informal help. Bebbington et al. (2000) reported that the severity of the mental health problem is the most consistent factor of formal help-seeking. Oliver, Pearson, Coe, and Gunnell (2005) found that there is a significant relationship between the severity of mental health problems and formal help-seeking. Individuals diagnosed with depression and suicidal ideation tended to be more likely to seek formal help (Brown et al., 2014). Participants with the longstanding illness also were more likely to seek formal help, and in some cases, they also sought informal help. Those participants reporting functional limitations due to emotional health and activities in daily living also indicated increase use of both formal and informal sources of help (Brown et al., 2014). The above studies support the behavioral service use theory that is applied in this study. One component of this theory is the level of need, which explains that a severe problem such as severe depression or anxiety is needed for victims to seek help.

In their study Debra Rickwood et al. (2005), informal help-seeking increased in participants who had a good family and close friend relationships-indicated as having someone to talk to. Equally, participants who did not indicate having a good family and close friend relationships tended to seek formal help (Brown et al., 2014). Adolescents were more likely to seek informal help than older adults (Debra Rickwood et al., 2005). Males were also less likely than females to seek help, both formal and informal (Debra Rickwood et al., 2005). Statistically, for the whole sample of their study (Debra Rickwood et al., 2005), informal help was sought twice as frequently (36.1%) as formal help (17.5%). Out of those who sought formal help, the majority of them also used informal help (69.3%), but most victims who sought informal help (65.1%) did not use formal help (Debra Rickwood et al., 2005). When they selected for victims only,

40.1% had sought formal help, but three-quarters of 40.1% had also sought informal help, indicating that only 10% of the victims sought formal help only.

## 2.5. Help-seeking and mental health

In their study, Rizo, Givens, and Lombardi (2017), a systematic review of coping among heterosexual female intimate partner violence survivors in the US with a focus on conceptualization and measurement of coping, found that greater help-seeking was positively associated with psychological abuse and threats, the number of incidents, violence severity, harassment and social support. The odds of a survivor seeking help were increased by violence severity. The support that youth seeks varies across gender, type of violence and severity of the violence (Satyen, Rogic, & Supol, 2018)

According to (Frazier, 2000), most in need of mental health service rarely contact such agencies. They only later become willing to consider seeking help when they can no longer suppress their distress, or their symptomatology gets worse. Ullman and Brecklin (2002) found that those assaulted in both child and adult life phases also reported more additional traumatic life events and a greater likelihood of post-traumatic stress disorder and more mental help-seeking than those in one life phase only. New and Berliner (2000), being a victim of sexual assault and having post-traumatic stress disorder diagnosis were related to mental health service use. Roy-Byrne, Berliner, Russo, Zatzick, and Pitman (2003), showed that those victims who perceived life threat during the crime sought counseling (seeking help). Millar, Stermac, and Addison (2002), women experiencing severe attacks were more likely to seek treatment immediately. Golding, Siege, Sorenson, Burnam, and Stein (1989), found that those victims who were more upset at the time of the assault were more likely to disclose to a mental health professional. A common denominator amongst all these studies (Frazier, 2000; Golding et al., 1989; Millar et al., 2002; New & Berliner, 2000; Rizo et al., 2017; Roy-Byrne et al., 2003; Satyen et al., 2018; Ullman & Brecklin, 2002) is that victims who seek help are a selection of severe violence and or severe mental distress.

Because there is a discrepancy between the victim's mental health needs and lack of help-seeking behavior or service use, I want to look at what influences help-seeking behavior among young people. According to Liao, Rounds, and Klein (2005), the most consistent factors that influence professional help-seeking behavior among adolescents are attitudes and beliefs

towards professional help. Vogel, Wester, Wei, and Boysen (2005) also found stigma to be an important factor to be associated with low professional help-seeking among adolescents. But other authors ask about the magnitude of these associations. This leaves inconsistencies in the field as to what exactly influences low help-seeking behavior among adolescents. Victims of violence go through processes in order to seek professional help. Of course, the first process to seek professional help is to recognize that 'something is significantly wrong'. Nonetheless, many victims have had reservations about and delayed seeking professional help because of the expectation that the services would not be helpful.

In this light, Nam et al. (2013) acknowledged that there is a need for further quantitative evaluations of psychosocial variables that can potentially influence professional help-seeking behavior among young people. This will not only help improve the understanding of young people's help-seeking behavior but also potentially highlight factors that help-service givers can target to encourage young people to seek professional help. For adolescents to successfully go through the developmental stages or to meet the developmental challenges in today's world, they require resourceful relationships and activities socially organized within a network of significant others and institutional agents distributed throughout the family, school, neighborhood, and community (Stanton-Salazar, 2011).

Mental health services emerged as a crucial part of college student support, especially so because of higher levels of psychological distress reported by young people (Eisenberg, Golberstein, & Gollust, 2007); Royal College of Psychiatrist, 2011). Students who reported higher psychological distress also reported a reduction in distress and anxiety and increased coping as they received mental health services (Eisenberg et al., 2007). The depressed woman also reported that their confidence had increased as a result of the information they received (Royal College of Psychiatrist, 2011).
But as noted earlier in this thesis, young people are reluctant to access this professional support, despite the reported benefit of service utilization. Victims appear to have different forms of informal support that they call upon before thinking of professional help. Some of these supports are self-help, such as the use of the internet as well as family and friends.

## 2.6. Adolescents and help-seeking behavior

According to Debra Rickwood, Deane, Wilson, and Ciarrochi (2005, p. 10), *"Help-seeking is not simply a process of identifying a need, deciding to seek help and carrying out that decision. At each of these decision points, factors intervene to prevent the progression of the help-seeking process: need may not be identified; if identified, the need may not be translated into intention; and intention does not always lead to behavior".* Adolescents in particular do not seek help because of the believe that they can resolve their problems, be it physical, emotional, or psychological is an important factor related to help-seeking (Gary et al., 2001). The authors remarked that in many cases, adolescents might have an exaggerated sense of their ability to cope with problems and risks. Some adolescents, by virtue of being resilience, defy the odds, and react positively to stressful life events. According to Gary et al. (2001), help-seeking and coping are learned behaviors. Adolescents observe and internalize the ways their parents and other significant adults around them cope with stress and in which situation they tend to seek help. If an adolescent has had a negative experience in seeking help, such as abuse of trust, he or she may be reluctant to seek help in the future. According to (Frydenberg, 1997), young people who turned to social support such as persons or institutions in times of need lost trust because of the ways those persons and institutions responded to their needs, in judgemental terms. They do this by betraying their confidence, offering advice instead of listening, or rejecting or ridiculing the young person. In Newton (2000)'s study adolescent confirmed that they preferred traditional healers and private health practitioners because their past experiences with formal service givers they were scolded for being sexually active. This issue of mistrust is the reason why Debra Rickwood et al. (2005) suggested that one most important factor in the help-seeking process is the availability of established and trusted relationships. It is for these trusted relationships that victims of violence prefer friends and family than formal help-seeking sources for personal and emotional problems (Debra Rickwood et al., 2005)

A study done by King and Woollett (1997) suggested that seeking help for victimization by violence or depression are often highly stigmatizing in many cultural settings. Seeking help for such needs is perceived as a sign of weakness or personal inadequacy. In their study, (King & Woollett, 1997), found that only 31% of men who have been victims of sexual violence sought help for their victimization. The authors explained that the reason was mainly because of the highly taboo nature of the problem and issues of self-blame. Debra Rickwood et al. (2005) reported that negative beliefs about counseling mediated the help negation effect for seeking help from mental health professionals. The authors suggested that if we change beliefs about counseling, we may influence help-seeking behavior. Knowledge of the available services, of

what to expect from a particular source of help, and understanding of when to seek help for oneself and others are important to help young people seek help (Debra Rickwood et al., 2005). Many adolescents do not have past experience with professional help, and for this reason, they may base their understanding on inaccurate media stereotypes. Many adolescents may not be aware of the services that are available to them. According to Debra Rickwood et al. (2005), few adolescents have adequate information regarding the signs of mental help problems in themselves and to recognize when there is the need to call on professional help.

So far, this chapter has discussed the findings of past studies, which show that various factors, such as gender, violence victimization, and help-seeking behaviors of adolescents are associated with their mental health. By implication, it has informed the choice of the theories that are useful in discussing the results of this study and also helped in setting the aims and hypotheses of this study. The literature has shown that a successful intervention in adolescents' violence and mental health needs to have a broader scope. Following this, a suggested intervention and theoretical frameworks for this study have been discussed in the next chapter.

# CHAPTER 3: THEORETICAL FRAMEWORKS

In this chapter, I establish the theoretical principles for this study. I have considered two theories that will provide me the academic background for analyzing the data used in this master thesis. The two theories accordingly will help me make sense of the results from the various statistical analyses conducted in this study. They will also together provide an opportunity for me to add to the knowledge that these theories help me understand and at the same time, offers a chance for me to underline "novel" understanding that is not comprehensively addressed by the two approaches. I took a clue from an argument made by Fink (1968), that to put attention on a particular phenomenon will result in ignoring some other truths which are essential for an adequate understanding of that phenomenon. This implies that focusing only on one theory may not be enough to the degree that it is not informed by comparing it with other types (Fink, 1968, p.413). Because of this, I discuss the results of this thesis through the lenses of two theories, the main theory and a supplementary theory. The two theories are the developmental and behavioral theory of health service use. These two theories are particularly crucial for this thesis mainly because I look at the association between violence and mental health among adolescents, which the developmental theory explains. I also look at help-seeking behavior among adolescents, which is explained through the behavioral theory of health service use.

## 3.1.Developmental theory as a theoretical framework of reference

Developmental theory is used in this study to explain the impact of the independent variable violence on the dependent variable mental health so that the relationship between violence and mental health can be better understood. Thus, highlighting the vital role violence play in increasing the risk of mental health problems. The developmental theory tries to explain why an adverse life event occurred in childhood can lead to health problems in adulthood.

The appreciation that an individual's lives are induced by their dynamic past circumstance, that the study of human development should apply to processes across the life span, the idea that changing lives alter developmental routes. According to (Elder, 1998) this idea started somewhere in the late 1920s, the life stories of the adolescents of the great depression noted numerous changes of residence and jobs. And as such, a child who is in economically poor family appeared older than his age nonetheless claimed his lively spirit when family income enhanced.

Such events helped drew attention to ways of thinking about social change, life pathways, and life-threatening events such as violence and their significant impact on the development of the individual.

The theory has it that all life choices are conditional on the opportunities and restrictions of social structure and culture. These conditions are believed to contrast children who grow up in socially desirable and protective homes than children who grow up in violence and conflict at home. Most times, their effects are felt in later life and some cases lasting.

According to (Elder, 1998), this theory of development is valuable in showing us the effects of retrospective life history or past events on present lives. The fundamental principles of this theory are recent events, interdependent beings, and human agency. Past events relate to the idea that the effects of violence experienced during childhood can permeate adult development. Interconnected lives also refer to the notion that development is in stages and are linked together, that a disruption in one phase will affect the successful development of another phase. The human agency, on the other hand, relates the idea that individuals make choices and adaptations within available options and constraints (Hutchison, 2011).

According to Coker, McKeown, and King (2000), physical and sexual violence can interfere with the development of secure attachment within the caregiving system. The authors speculate that violence results in the loss of core capacities for self-regulation and interpersonal relatedness. Children exposed to violence often experience lifelong problems that place them at risk for individual violence and cumulative impairments.

Stage two, the child understands differentiation from others, but still pursues mainly selfish goals, and therefore can't take the perspectives of others. Stage three, Young people at this stage are fully socialized adults, who look to the others-the community, family, the organization as sources of values and self-worth. They recognize that others have a different point of view, but they are entangled in the roles and relationships around them and tend to avoid conflict for fear that it will lead to loss of esteem either for themselves or for others. Stage 4, individuals have developed a value system that is truly theirs- a strong individualized point of view. Stage 5, as leaders, people here are opened to ambiguities, most able to perceive and hold polarities in tension, and most concerned with larger systems-not just the corporation but also the country or the world. The theory assumes that without any disruptions and significant changes, this should be how human beings develop.

Anything that disrupts the progressive development of these stages is likely to cause a problem such as depression and anxiety. For example, a borderline personality disorder is a developmental failure, stemming from the inability to separate an individual from one's mother and become an autonomous person.

The theory focuses on the meaning and meaning-making processes across the life span.
The theory is constructive according to McCauley, Drath, Palus, O'Connor, and Baker (2006) because it deals with the person's understanding and interpretations of experiences. This constitutes the way a person makes meaning of an experience. It is developmental in the sense that it is concerned with how those constructions and experiences grow more complex over time (McCauley, Drath, Palus, O'Connor, & Baker, 2006). According to McCauley et al. (2006), it assumes an ongoing process of development in which subjectively different meaning systems develop, both as a natural unfolding as well as in response to the limitations of existing ways of making meaning. Each meaning system is more complicated than the previous one in the sense that it is capable of including, separating among, and adding a more different range of experience. The psychologist Jean Piaget (1954) referred to this as genetic epistemology, that is, the genesis or successive development of the ability for rational thought in the developing child. According to Piaget, ideas are actively constructed by the individual in response to the need to understand the world. When conflicts such as violence arise in the individual's current ways of understanding the world, they recreate how they know the world to eliminate the inconsistencies.There is general support within the lifespan development literature that there are essential patterns in the ways adults mature such that earlier methods of meaning-making are integrated into more comprehensive and complex later ways (Michael, 2005).

The developmental theory posits that experiences during childhood are critical to adult modification. The childhood development task from infancy to adolescent are organized in an ordered manner and are integrated. Each new development stage is linked to the successful completion of the previous stages (Cicchetti & Lynch, 1995). What this means is that childhood developmental task is critical, and therefore, any disturbance has the potential to cause adverse and profound long-term effects. The stage of development in which the violence occurred determines the child’s cognitive appraisal and symptoms expression (Finkelhor, 1995). If the child cognitively judges the event, abuse as harmful as perceived physical damage, and or negative assessment of the self and others, it can lead to adult depression and anxiety

(Spaccarelli, 1994). Again, if because of the violence, certain developmental stages are not completed successfully due to the disruptive effect of the violence, it will lead to difficulties in completing subsequent ones. These difficulties are more likely if the victim does not receive any support or help (Finkelhor, 1995). Briere (1992) has documented empirical support to the disruptive effects of violence on development. He found out that abused children are traumatized during the most critical period of their lives when there are no effective coping mechanisms. This means that help-seeking behavior from within and outside the family becomes essential to adolescent's mental health in the events of violence.

### 3.2. The behavioral theory of service use

The second theory of this thesis used as supplementary is the behavioral theory of health service use. This theory is useful for understanding the factors that influence adolescents' help-seeking behavior. Andersen (1995) proposed three interdependent models that describe the features of people who seek help. These three components are predisposing factors, enabling factors, and the level of need. According to Andersen (1995), predisposing factors are usually demographics such as age and gender and health care beliefs such as attitudes about health and health services. Enabling factors, on the other hand, as explained by Andersen (1995) are availability and accessibility to services such as transportation.

The level of need explains that the severity of a problem such as victimization or a mental health problem such as depression or anxiety that the individual adolescent experience also determines the likelihood that he or she will seek help. This model is used in this study to investigate the help-seeking behaviors of adolescents who are victims of physical and sexual violence. Many studies have reported that gender is an essential factor that affects the help-seeking behaviors of adolescents and in some cultures whether the adolescent gets help or not even if they seek out for help (Barker & Adelman, 1994). Females, for example, are more likely to seek help than males (Barker & Adelman, 1994; Newell-Withrow, 1986). Accessibility is an essential factor that is considered when looking at the help-seeking behaviors of adolescents. Barker and Adelman, 1994, reported that an excellent supportive relationship between adolescents and family members as well as significant others, such as teachers, could predict adolescents' help-seeking behaviors. A severe problem such as physical or sexual violence or mental health problems such as depression or anxiety is associated with higher help-seeking behaviors among adolescents (Cohen & Hesselbart, 1993; Cohen, Kasen, Brook, & Struening, 1991; Saunders,

Resnick, Hoberman, & Blum, 1994; Wu et al., 2001). The presence of more than one disorder in the same person further increases the likelihood of help-seeking (Zima et al., 2000)

### 3.3 Development of health policy: a suggested intervention

Social risk management:(Holzmann & Jørgensen, 2001)

This thesis is written within the field of International Social Welfare and Health Policy in social work. One of the goals is to influence social policy through the results of this thesis. I discussed the results of this thesis within the framework of social risk management, proposed by Holzmann and Jørgensen (2001).

In this thesis, both physical and sexual violence were found to be risk factors associated with adolescents' mental health problems. I have reviewed some of the pieces of literature in the field of social welfare and health policy to find reasons why this framework is useful as an intervention.

Goodin (1986) defined one major feature of welfare states; its commitments to providing a certain range of goods and services to its citizens as a right. Barr (2001) explains that sources of welfare go beyond state activities, and the mode of delivery is diverse. The question is welfare for what? The answer is welfare to solve social problems, and a classic example is physical and sexual violence against adolescents and their subsequent mental health issues.

Nobody is wise, patient, and knowledgeable enough to be fully responsible for making the right decisions for his or her health (Banerjee & Duflo, 2012). The difference between adolescents who are at less risk of violence and those who are at high risk of violence is the many things that those who are at less risk take as given (Banerjee & Duflo, 2012). They live in communities where laws work and are enforced; they go to schools where they are taught how to socialize and gain knowledge about awareness of violence, they have parents who are protective and where unfortunately they eventually become victims, they have governments who take care of them through so many social institutions. They rarely need to draw upon their limited endowment of self-control. A civilized society cannot allow a child's right to a normal childhood, free from violence to be held hostage by their parents' whims and greed (Banerjee & Duflo, 2012).

According to Le Grand (2007), ruling politicians make direct and indirect decisions on the public risk management system through rules, regulations, economic incentives, information,

deliberation, and negotiation. Shang (2008), talks about the role of extended family in childcare, he maintained that the family is a risk management system. However, Banerjee and Duflo (2012), points out that parents do not always put their children's interest first and that the relationship between men and women in the family is not always harmonious. Le Grand (2007), talks of various attributes of good services; high quality, operationalized and managed efficiently, responsible to the needs and wants of users, accountable to the taxpayers, and equitable distribution. It assumes the idea that we must improve upon daily life. Thus the circumstances in which adolescents are born, grow, live, school, and age. McInnes and Lee (2006), remarked that human security is about freedom from fears and violence. This is strongly linked to the promotion of human rights; physical and sexual violence, if not properly managed, can affect the confidence of adolescents, and if the state must protect its citizens but fails to do so, then the social construct is broken. The solution, according to Weiss (1999, pp. 69-70), is "embedded paternalism; designing the working and the living environment so that people do not have to think consciously about making healthy behavioral choices." This will tackle general socio-economic, cultural, and environmental conditions.

The social risk management framework proposed by Holzman is designed to overcome several obstacles to providing safety for adolescents.

# CHAPTER 4: AIMS AND HYPOTHESES

## 4.1. Aims and Hypotheses

This study aims to examine the association between help-seeking and mental health among Norwegian adolescents. I also wish to explore the relationship between physical violence, sexual violence and mental health, prevalence, and sources of help-seeking among adolescents. This chapter starts with a section on operational definitions, followed by a description of the hypotheses in this study. A theoretical model on the hypothetical relationship between help-seeking, background factors, and mental health will be presented.

## 4.2.Operational definition

First of all, mental health in this study measured by using the Hopkins Symptoms Checklists. I believe that victims of physical and sexual violence will experience higher levels of mental health problems and that females will outnumber males in both victimization and mental health problems. This is basically based on some of the studies I reviewed above (Brown et al., 2014; King & Woollett, 1997; Debra Rickwood et al., 2005).

Second, Help-seeking, as used in this thesis, is similar to the definition by Unrau and Grinnell (2005), "a request for assistance from formalized or institutional services to resolve emotional, behavior or health problems."

In this thesis, the ungvold survey measured help-seeking from victims who sought help from a formal source after physically or sexually violated. In this thesis, I considered Crisis center, Family counseling, Lawyer, Police, Family doctor, Emergency room, Dentist, Health service for young people, BUP, Psychologist/Psychiatrist, Child welfare, Barnehus, and Teacher/counselor at school as formal sources.

Third, violence as defined by Krug and World Health (2002) is the '*intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either result in or has a high likelihood of resulting in injury, death, psychological harm*, maldevelopment or deprivation. The definition includes threats, intimidation, neglect, and abuse, whether physical, sexual, or psychological, as well as acts of self-harm and suicidal behavior. In this thesis, violence referred to the victim, who is an

individual student in their final year of secondary school in Norway, who has experienced physical or sexual abuse.

Physical abuse is where the victim receives physical force which causes, or could cause harm. Sexual abuse is where the victim receives force or manipulations into unwanted sexual activity without their consent or against their will.

## 4.3. Hypotheses of the study

As this is a quantitative study of factors associated with self-report symptoms of mental health, hypotheses have been tested through multiple regression, a correlational method that examines the associative strength between variables**.** Based on the literature reviewed above, I expect violence and help-seeking to be negatively associated with mental health. Specifically, adolescents who experience violence (physical or sexual) will report higher mental health decline than adolescents who have no experience of violence. Also, adolescents who seek formal help will report higher levels of mental health problems than adolescents who did not seek help after being victimized. Based on the literature reviewed, I also expect females to report higher levels of violent victimization than their male counterparts.

Hypothesis 1: Victims of violence will experience higher levels of mental health problems than non-victims.

Hypothesis 2: Females will experience a higher prevalence of violent victimization than their male counterparts.

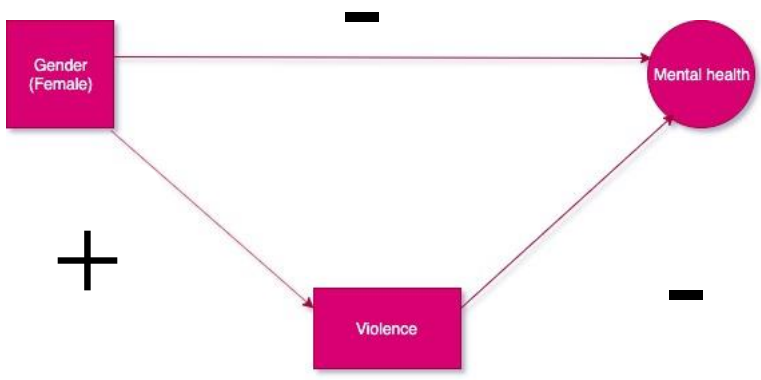



Figure 1. Hypotheses 1 and 2

Fig1 above explains the relationship between the variables as intended in the hypotheses above. The positive (+) relationship between gender and violence is intended to mean that more females will experience higher violence prevalence than males. The negative (-) relationship between violence and mental health is designed to suggest that more violence victimization is believed to lead to less mental health. The relationship between gender and mental health is a logical deduction from the two hypotheses, that if females will have a higher prevalence of violence, and if violence is negatively associated with mental health, then females will experience higher mental health problems than males, hence the negative (-) relationship between gender and mental health.

Hypothesis 3: Help-seeking is negatively associated with mental health, Specifically
Victims of violence who seek help will report more mental health problems than victims who did not seek help
Hypothesis 4: Females will have a higher prevalence of help-seeking behavior than males

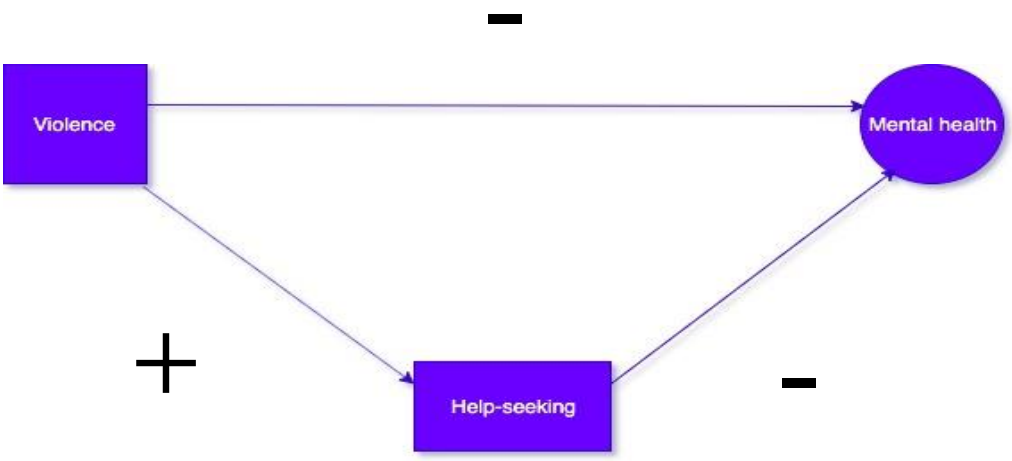



Figure 2. Hypotheses 3 and 4

Hypothesis 5: Females will experience higher prevalence of help-seeking than males

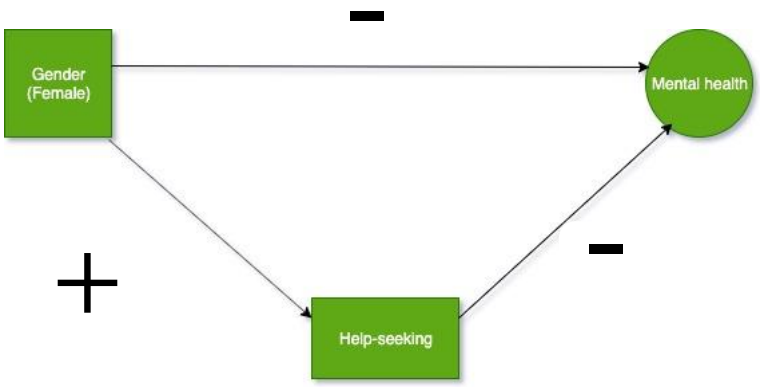



Figure 3. Hypothesis 5

Girls are more likely to report symptoms of depression, so gender is a crucial variable to account for (Smokowski, Evans, Cotter, & Guo, 2014)

Fig 2, explains the relationship between the variables in hypothesis 3 and 4. The relationship between violence and help-seeking is positive (+), intended to mean that higher prevalence of violence will lead to a higher prevalence of help-seeking and that females will report a higher prevalence of help-seeking than males.

Fig 3 illustrates the meaning of hypothesis 5. The relationship between help-seeking and mental health is negative (-), in that people who seek-help will report higher scores on mental health problems than those who did not seek help.

It should be emphasized that the causal diagram is a simplified depiction of the dynamics between the variables. The current study is not equipped to established causality and direction of relationships, only association between the included factors. Consequently, the direction of the influence may go both ways. That is, mental health may influence the independent variables, and the independent variables may influence mental health.

From the previous chapter, I retain the understanding that development occurs in stages, and that what happens at every stage of development can affect adolescents' mental health, and that adolescents are particularly vulnerable. Thus, the developmental theory is useful to provide a framework for discussion of mental health from the perspective of violence in close relationships.

Even though this thesis is a cross-sectional study and its unable to explain the changes in mental health over time, it can shed light on the social correlates of mental health and the relative importance of these factors to it.

# CHAPTER 5: METHODOLOGY

## 5.1. Data and Methods

This study exhibits a cross-sectional design employing existing survey data. The purpose of the design is to measure the associations between violence and mental health and help-seeking, as well as to control for background characteristics.
In the first section of this chapter, I will describe the origin of the data material, as well as the specifics of the questionnaire and data collections. Next follows a description of measures and their characteristics, including an account of the data preparation procedures. The final section will relay the selection of statistical tests and analysis for this study and discusses these choices.

## 5.2. Ungvold Survey

The survey was conducted among students in the last year of senior high schools in Norway (Mossige, Huang, & Dalby, 2017). The purpose of the survey was designed to assess the prevalence of offenses and violence committed against children and adolescents (Mossige et al., 2017). The UngVold survey has been conducted twice, 2007 and 2015. In this master thesis, I make use of the 2015 data, which was a continuation of the 2007 survey. In 2007, 67 high schools participated in the survey (Frøyland & von Soest, 2018). To obtain a nationally representative sample, Statistics Norway included every school in the country in the pool from which participant schools were selected (Mossige and Stefansen, 2016). The sample was stratified according to geographical region, and each school's sampling probability was proportional to the number of students enrolled in the school, thereby ensuring that the possibility of selection was equal for all students in Norway (Frøyland & von Soest, 2018). For the 2015 survey, the same schools as in 2007 were invited to participate in the study. Of the 67 original schools, 41 agreed to participate, five had been closed down or merged with other schools in the sample. Of the remaining 21 schools that refused participation in 2015, 8 were replaced with schools from the same strata as the original school. It was not necessary to replace all schools that refused participation to obtain the desired number of participants, so the remaining 13 schools were not replaced by a new school. All third-year students were invited to complete a questionnaire on an individual computer during school hours with a teacher present in class.

## 5.3. Physical violence

In this study, Physical violence was measured by violence from mother/stepmother and father/stepfather. It should be noted; therefore, that physical violence in this study are those committed by parents and stepparents only. The scale for physical violence in this study was an adoption from the Conflict Tactics Scale developed by Straus 1974. The original scale has four sections; parent-child (scale 1), partner-child (scale 2), partner-partner (scale 3) and parent-partner (scale 4). Each section contains 20 items, making 80 items for the whole scale.

In the ungvold survey only 11 out of 20 items from scale 1 (parent-child) for data collection. The purpose of the original scale as it pertains to this study was to explore intra-family conflict and violence. It assesses how parents react in conflict with the child, such as trying to discuss an issue calmly, yelling at, insulting the child, or hitting the child. Out of the 11 items adopted in the ungvold survey, I used only eight items for this study, ignoring the first three items (yelled at, scolded you, and insulted/humiliated you). This was based on my assessment that the above three items from the scale were not enough to warrant help-seeking behavior from adolescents. It will be challenging for a child who has been yelled at or humiliated by a parent to seek help from professional service givers.

Originally the items are rated on a seven-point scale, ranging from 0=never to 6=almost every day. But, in the ungvold survey, it was further adopted to 6 points scale ranging from 6=daily, 5=weekly, 5=monthly, 3=few times, 2=once, and 1=never. The standard instruction for the conflict tactic scale asks what happened in the previous year. However, in the Ungvold survey, the physical violence scale had the introduction question “have your mother/stepmother ever done any of the following against your will?” Example of the questions included “threw, hit or kicked something” “threatened you vith violence”, “pushed you or shook you violently”, “slaped you”. The conflict tactic scale is scored by adding the midpoints for response categories chosen by the participants.

Reliability and internal consistency have been showed by Straus (1990) to be 0.79. I computed the Cronbach's alpha for the eight items used in this study, and I found reliability to be very high at 0.90. The difference partly because the scale has been adopted in both the response categories and the number of items. However, this does not affect the validity and reliability of the scale, as it even shows a higher coefficient for Cronbach’s alpha. According to Brown, Wilding, and Culter (1991), reliability does not depend on the number of response categories.

This adaptation was necessary because this scale was used in Norwegian culture, and it was useful to modify it to fit the new setting. I computed a mean score for both father/stepfather and mother/stepmother scale. I dichotomized those who reported no to victimization and those who reported at least one act of victimization. Therefore, I had victims as one group and non-victims as another group.

## 5.4. Sexual violence scale

UngVold adopted a sexual violence scale from a Swedish study called SAM 2000 (Priebe, 2009). They have also been used in previous NOVA studies (Østersjøundersøkelsen in 2004 and UngVold 2007). The name of the scale was Adolescents' Sexuality – Attitudes and Experiences (Ungdomars sexualitet – attityder och erfarenheter). The questionnaire was developed for The Baltic Sea Regional Study on Adolescents' Sexuality. It consisted of 65 questions covering the following issues: (i) sociodemographic data and background, (ii) consensual sexual experiences, (iii) sexual abuse experiences, (iv) sexually coercive behavior, (v) sexual attitudes, (vi) use of pornography and (vii) experiences of sexual exploitation (to sell sex for remuneration). The questionnaire was based on a Norwegian survey of young people's attitudes towards sexuality and sexual abuse (Mossige, 2001). The revised version was constructed in Swedish and Norwegian and translated into English. Several questions, especially those about sexual coercion of others and sexual exploitation, were developed especially for the revised version. Several questions, either used by Mossige (2001) or included in the revised version, came originally from other surveys, mainly about young people's sexuality or experiences of sexual abuse, or other instruments and scales. The studies that contributed questions were: SAM 73-90 (Edgardh, 2001) and SAM 2000 (Priebe, 2009).

In the ungvold survey, out of the 65 items 20 were used for the study, But in ungvold survey, the perpetrator was not limited to only parents and step-parents but included everybody. In the Ungvold survey, they experimentaly assigned respondents to two versions of the instrument. Each respondent answered 9 or 11 items depending on which version of instrument you find yourself. In the questionnaire the two versions had the same introduction question: Before/after the age of 13, have you been subjected to any of the following against your will?. Example of the questions were "forced or threatened you to have oral sex", "you have had sexual intercourse", "You have had oral sex".
The answers had three options: "no,never", "yes, once" and "yes, several times".

According to Heinskou, Skilbrei, and Stefansen (2019), the randomization was purported to reach balance across demographic variables such as gender and age. In this thesis, I did not distinguish between experiences of sexual violence before and after 13 years of age. I dichotomized sexual violence into two groups. One group was respondents who answered "no,never", they were given the value 0 and were called non-victims of sexual violence. The other group was the respondents who answered the question "yes, once" and "yes, several times", they were both given the value 1 and were called victims of sexual violence. I computed the chronbach's alpha for this variable and found it to be very high, 0.91.

## 5.5. Help-seeking

According to D. Rickwood and Thomas (2012), formal help-seeking is assistance from professionals who have a legitimate and recognized role in providing relevant advice, support, and treatment. This type of help-seeking is diverse and includes a wide range of professionals, such as specialists, generalists, and primary health care providers. It also includes nonprofessionals such as teachers, clergy, community, and youth workers. A distinction between health care service providers and none health care service providers has to take the dimension of 'treatment-seeking' (D. Rickwood & Thomas, 2012), to mean seeking help from specific health treatment professionals.

According to D. Rickwood and Thomas (2012), there are currently no psychometrically sound measures that are routinely used. Consequently, each study done on help-seeking adopted an idiosyncratic range of sources of professionals. In the ungvold survey, NOVA also used sources of help from professionals that are useful in the Norwegian context. There are essential components of help-seeking that are usually captured in the measurement, such as time context, sources of help, and types of problems (Debra Rickwood, Deane, Wilson, & Ciarrochi, 2005). Because help-seeking is a process, it is important to be able to assess changes over time, including past and recent behaviors, as well as future behavioral intentions. Secondly, it is important to measure help-seeking from a variety of sources, such as informal or formal. Thirdly, the measure needs to be adaptable to different types of mental health and other problems. In the Ungvold survey, NOVA assessed both the general help-seeking, which has future help-seeking intentions as well as actual help-seeking behavior. In this study, I used only

the actual help-seeking questionnaire because it was tailored to a specific type of help, help when physically violated, and help when sexually violated. Therefore, this study only assesses actual help-seeking behaviors among Norwegian adolescents. The actual or recent help-seeking is measured by listing a number of potential help sources and asking whether or not help has been sought from any of the sources during a specified time for a specified problem. In the ungvold survey, the specified time period was not limited, and the specified and the specified problem was physical and sexual violence. According to Debra Rickwood et al. (2005), the specified sources of help listed, the time period specified, and the type of problem can all be modified to be appropriate to the particular research objectives.

Formal help-seeking in this study was divided into two; help-seeking for physical violence and help-seeking for sexual violence. For example, "If you have been subjected to sexual abuse (eg, rape, attempted rape, embezzlement), have you been in contact with any of these bodies as a result. It also asked the question 'if you have been subjected to physical abuse example hit, have you been in contact with any of these bodies as a result? Examples of the bodies listed as a source of formal help-seeking included crisis center, police, psychiatrist/psychologist, a teacher at school, and others. In both physical and sexual violence help-seeking, I coded the response into dichotomous variables, where those who did seek help from at least one of the listed sources were given a value of 1 and those who did not seek help but were equally victimized were given a value of 0. This indicates that I measured formal help-seeking irrespective of the source of help. A victim could think that the crisis center has more impact on mental health than the family doctor, for example, but I didn't look at that, although in the descriptive statistics, one could see that victims used some sources of help more often than others.

### 5.6. Mental health

The dependent variable in this study, mental health is captured by a composite measure of the Hopkins symptoms Checklist 25 (HSCL-25). The Hopkins Symptoms Checklist (HSCL-25) is widely used for both clinical and epidemiological purposes of measuring psychological distress among adolescents and adults (Kleppang & Hagquist, 2016). This scale is appropriate for this study because this study aims to examine the association between violence and Psychological distress (operationally defined as mental health). According to Kleppang and Hagquist (2016), the scale shows good reliability on the whole, and it works well. The Hopkins Checklist was

originally intended to study the efficacy of psychotropic drugs and had questions relating to the symptomatic behavior of outpatients in adult populations. The scale is currently available in different versions and used in studies of adults and adolescents in general populations. The HSCL-25, which is used in this study, is considered to tap information about general psychological distresses. The HSCL-25 has been evaluated for adults and adolescents using factor analysis (Glaesmer et al. 2014) and the outcome from self-reports have been compared with diagnostic interviews (Sandanger et al., 1999) and other instruments.

In the Ungvold survey, mental health among adolescents were measured with an introductory question “have you been bothered by any of the following during last week? Example of the questions were “suddenly scared for no reason”, “feeling anxious”, “nervousness, internal disorder”, “feeling stiff or tense” and “attack of fear or panic”. Respondents had to choose among four options, “do not bothered at all”, “a little bothered”, “pretty much bothered” and “very much bothered”. This is strictly an ordinal scale but in this thesis it was used as if an equal interval.

### 5.7. Data analysis

All data analysis and preparation were conducted in IBM SPSS statistic version 25 for Mac. Univariate, bivariate, and multivariate analysis was applied to the data and variables in this study. Univariate analysis was conducted for descriptive information, and a correlational analysis was used to establish the relationships between variables pairwise.

The hypotheses in this master thesis were tested using Multiple Linear regression analysis.

In the following sections, each statistical test used in this study will be individually elaborated on, and the process of analysis will be described. The background and rationale for this thesis will also be addressed.

#### 5.7.1. Bivariate analysis: Pearson Correlation

Because the independent variables in the current study are dichotomous, and the dependent variable is used as if it's at the interval level, although strictly speaking, it's at ordinal; the preferred method is correlational analysis. The bivariate correlation coefficient used in this analysis is Pearson's r, which is commonly used when variables are continuous or dichotomous.

Pearson's r varies between -1 and 1, where 0 means that the variables are not related at all, -1 signifies a perfect negative relationship, and 1 reflects a perfect positive correlation. Another important output of a statistical test, including correlational analysis, is the statistical significance, or P-value, of the result. What it means is how likely it is that you would have gotten your result if the null hypothesis was correct. So with a null hypothesis stating that there is no relationship between two variables in the population for example, between mental health and help seeking, a p-value of .05 means that there is a 5% chance that you have found an association between the variables even though the actual truth is that there is no relationship between them in the population.

### 5.7.2. Multivariate analysis: multiple linear regression

Multiple linear regression analysis was conducted to test the hypotheses that victims of violence who seek help will experience a positive association with mental distress and that females correlate more strongly with mental distress than do their male counterparts.
Linear regression is used to predict an outcome variable based on a predictor variable by examining the pattern of the data and fitting to its statistical model in the form of the regression line (Field, 2009).

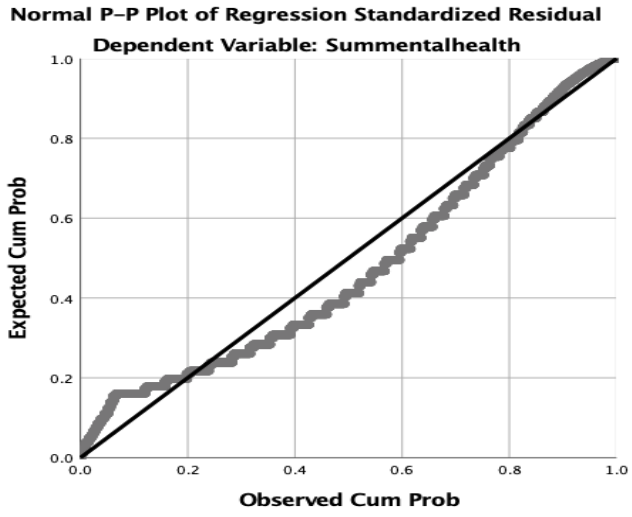
## 5.8. Tests assumptions

According to Ringdal (2013, p. 414), some prerequisites must be met to perform linear multiple regression analysis. Osbourne and Waters (2002) state that when these assumptions are not met the results are not trustworthy, resulting in type I and type II or under-estimation or over-estimation of significance or effect sizes. These violations of regression assumptions undermine the validity of results and the conclusions thereof. Because of this, I give some space in this study to discuss some assumptions and how I considered them for purposes of validity.
Osbourne and Waters (2002) explained that there are generally four types of assumptions that must be considered for regression analysis.

5.8.1. Normal distribution of errors

The first one is that the variables in the study should be normally distributed and that non-normally distributed variables, for example, highly skewed or kurtotic, or variables can distort relationships and significant tests. However, Williams, Grajales, and Kurkiewicz (2013), contended that the assumption of normality distribution of variables such as predictor and the response variables is a misconception. They recommended that it is rather the normal distribution of errors that should be considered for trustworthy of inferences. They added that this is very useful for small samples, but the significance of this normal distribution of errors becomes less in large samples. For a large sample such as this, about 4530 participants, a statistical test of normality is usually not recommended, because some of these tests (example, Z score tests, and Kolmogorov-Smirnov-test) are biased in support of large samples. When I visually inspected the p-p plot of regression standardized residuals as seen in table 1, however, I found the deviation to be minor and the distribution acceptable.

**Table 1. Normal p-p plot of regression standardized residuals**

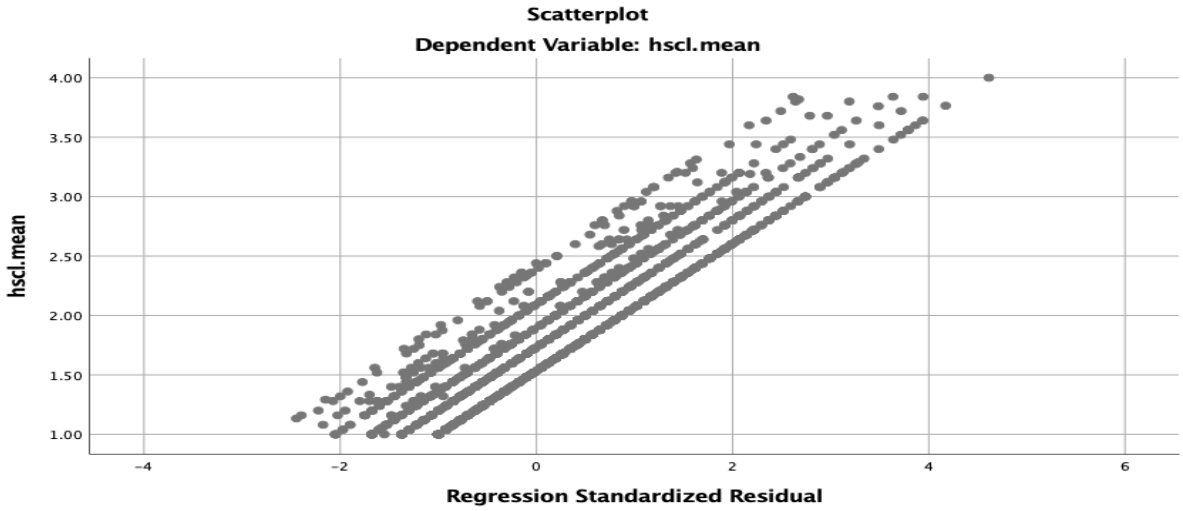



5.8.2. Homoscedasticity

The next assumption that I considered in this study is homoscedasticity. This assumption means that the variance in the residuals must be the same for all values in the independent variables, example, for respondents who report high levels of violence (physical and sexual) and low violence (Osbourne & Waters, 2002; Ringdal, 2013; Williams, Grajales, & Kurkiewicz, 2013). I investigated this assumption in this study by means of a residual diagram, which is shown

below in table 2. It can be seen that the points, which are the errors, are distributed evenly. Therefore, the assumption of homoscedasticity is met for this study.

**Table 2. Homoscedasticity scatterplot**




5.8.3. Multicollinearity

The third assumption I considered for this study is multicollinearity.
This is the presence of high correlations between the independent variables, sexual violence, physical violence, help-seeking after sexual violence, help-seeking after physical violence, and gender. I can take a look at these variables and see potential correlations, for example, between physical violence and sexual violence and also between help-seeking after sexual violence and help-seeking after physical violence. I can expect that there could be a positive correlation between physical violence and sexual violence; although they are different, there could be overlap. If adolescents experience sexual violence, there is a probability that they also experienced physical violence.

The table8 in the result section below provides the correlation between all the variables used in this study. We can see that the highest correlation was between help-seeking for physical violence, and sexual violence, .472, followed by help-seeking for physical violence, and sexual violence, .341. As with the case with many statistics, there is no agreed-upon value when interpreting correlations in terms of what is equal to multicollinearity and what is not. Popular cut-off scores would be 0.7, 0.8, and 0.9. In this study, none of the correlations is up to 0.7.
The variance inflation factor is one popular measure of multicollinearity (Cohen et al. 2003).

The table3 below shows the tolerance and variance inflation values for multicollinearity.
One requirement for tolerance is that the values need to be higher than 0.1, and or 0.2, that anything less than 0.1 or 0.2 in the tolerance will be considered multicollinearity. The acceptable values of variance inflation factor of 0.1 tolerance level are 10, and 0.2 is 5.
According to Christophersen (2009, p.161), multicollinearity can be excluded with tolerance values < 0.20 and the variance inflation factor (VIF) <5. The table below shows that all the tolerance values are greater than 0.20, and variance inflation is below 5, indicating the absence of multicollinearity.

**Table 3. Multicollinearity diagnostic**

| Independent variables | Tolerance | VIF |
|---|---|---|
| Physical violence | 0.953 | 1.050 |
| Help-seeking after physical violence | 0.738 | 1.355 |
| Help-seeking after sexual violence | 0.747 | 1.399 |
| Sexual violence | 0.793 | 1.261 |
| Gender | 0.936 | 1.069 |

5.8.4.Outliers

The fourth assumption I checked for this thesis is outliers. According to Williams, Grajales, and Kurkiewicz (2013), in some cases, the results of the regression analysis may be influenced by individual members of the sample that have highly significant values on one or more variables under analysis. According to Williams et al. (2013), this is not a problem in itself, nor necessarily a justification for excluding such cases. The problem, however, is if the values were wrongly entered through codings such as the typographical mistakes, or the result of the inclusion of a case that is not a member of the intended population, then the result of the regression analysis would obviously be harmfully affected. In this thesis, I visually checked all the values in the data view on the spss according to their upper and lower limits to be sure that

there were no extreme values that were wrongly entered. Because of the close-question questionnaire format used in the ungvold, data outliers are not an immediate concern in the current study. Moreover, the independent variables are dichotomous, thus further limiting the range of possible values.

### 5.8.5. Linearity

I also considered for this study was linearity between the dependent variable and the independent variables. When choosing linear regression as a method of analysis for this data, researchers should be sure that the relationship between the dependent variable and the independent variable is linear. In this study, this would translate into a linear relationship between violence and mental health. In other words, high levels of violence would lead to low levels of mental health and vice versa. If we knew this relationship to be non-linear, for example, both low and high levels of violence are associated with mental health, it would not be appropriate to use linear regression analysis. The choice of linear regression for this data in this study is supported by research literature showing support for a linear relationship between violence and mental health (Jumper, 1995; Vogel, Wester, Wei, & Boysen, 2005)

## 5.9. Missing data

When working with questionnaires, missing data is often referred to as “non-response”. That is; the data matrix contains slums where respondents have left questions blank. These non-responses are usually coded as ‘missing values’ and so excluded from the data analysis. For the sake of representativeness, it is still important to examine this attrition. It makes a difference whether the missingness is related to the variables in such a way that there exists a pattern of respondents who, for some reason, skip the question. If, for example, girls were more likely than boys to skip questions about sexual violence, the results would be skewed, such as sexual violence score for girls possibly could reflect a lower or higher value than actually exist in the sample, and by extension, the population.
In some cases, it is beneficial to conduct a structured attrition analysis to determine reasons for attrition, so that appropriate remedies can be applied (Almquist, Ashir, & Brännström, 2014).

In this study, the percentage of missing values was compared across all variables, including the sum score measures, violence, help-seeking, mental health. Help-seeking after sexual violence had a lot of missing values. This was because the respondents were split into two; a randomized half answered the questionnaire separately. Therefore, to avoid a large amount of missing in this thesis, I coded all those who have not ticked any help-seeking service as not having sought help.

## 5.10. Assessing the quality of the study

The discrepancy between the results of a study and the reality that is being described by the study is referred to as measurement error. In other words, the measured variable is equal to the true value plus the measurement error, which can be random or systematic. Random measurement errors affect the reliability of the data whiles systematic errors that researchers can control-affects the validity (Carmines, 1979)

The Norwegian institute for research on growing-up, welfare and ageing (NOVA) has processed the results from Ungvold survey and concluded that the data quality is very good, attributed mainly to large sample size **(**N=4,530) and high response rate (66%) from the schools (Frøyland & von Soest, 2018)

To account for and minimize measurement errors in the current study, as well as to evaluate the quality of measures used, the properties, reliability, and validity are considered.

Validity is addressed as external-including representativeness and internal-incorporating construct validity, face validity, and content validity. Although these properties are related to each other, I will, for the sake of order, address each of them separately as they pertain to this thesis.

### 5.10.1. External validity and representativeness

Broadly defined, validity refers to the extent to which a study measures what it sets out to measure (Ringdal 2013). The term has a range of research aspects and can be further subdivided into external and internal validity. External validity refers to the representativeness, or generalizability of the data. In order to discuss the results as they apply to groups of people larger than the actual sample (generalizing the results), the sample has to be representatives of these larger groups. A representative sample is a sample in which the distribution of respondents

across a particular variable (e.g., gender) reflects the distribution in the population (Ringdal, 2013)

In this thesis, the term population refers to students in the final year of high schools in Norway. Representativeness is often achieved by conducting probability sampling, in which subjects are randomly selected from a previously defined population pool (Ringdal, 2013). In the ungvold survey, respondents were experimentally randomized and assigned to different versions of some of the scales, for example the sexual violence scale to achieve balance across the various demographics, such as gender and age.

Large studies sometimes assess the representativeness across many or all variables, disclosing discrepancies, to the reader. The large sample size (N=4,530) and high response rate 66% further contributes to the representativeness of the study. Accordingly, this yields a more than adequate effect size and allows for generalization to the students in the final year of high schools in Norway.

### 5.10.2. Internal validity

Early literature makes a distinction between internal and external validity. Whereas external validity is understood as representativeness, internal validity concerns the methodological structure and precedes within the study. That is, it tells us where our instruments and analyses, in fact, answer our research questions. Internal validity lies at the core of research quality, study with low internal validity yields equally invalid results or faulty conclusions. The ungvold questionnaire was piloted both in 2007 and 2015 to ensure, among others, the validity of the included questions. Considering the rigorous processes of data collection that was applied to the ungvold survey as discussed above, I argue that the various measurements actually measured their intended constructs. In this thesis, I did all analysis carefully considering my research questions, making sure that each analysis was based on the research question.

### 5.10.3. Reliability

Reliability refers to the consistency of a measure. In other words, it is the extent to which repeated measurements with the same group at same circumstance yields the same results (Field, 2009). To be deemed satisfactory in most research contexts, a measure must be both

valid and reliable. Not only does it have to be internally sound, yielding appropriate study conclusions, it also has to be repeatable.

Ringdal (2013) identifies three ways to test for reliability. First, general source assessment familiarizes the researcher with the data and quality of the data in question. In this study, the data quality was assessed by reading the questionnaires, as well as NOVA reports on collection and methods. I have found the methods to be thorough and well documented. Besides, there is integrity associated with the record of the Ungvold survey, as well as NOVA's long-standing involvement with regards to social research and survey development.

Another technique is to evaluate test-retest-reliability. This involves measuring the correlation between several assessments using the same measure. Although this is one of the best ways to measure reliability, it can be difficult to carry out practically. In the case of this thesis, it could mean redistributing the same questionnaire and run a correlation between, say, sexual violence from the first and second questionnaire (Ringdal, 2013). This is outside the possibility of this master thesis; consequently, test-retest- reliability is not assessed.

Third, and most applicable for this study, is the evaluation of internal consistency, or average correlation, between items within a composite measure. This assessment consists of a scale reliability test when it yields a value between 0 and 1 for the coefficient Cronbach's alpha α. The higher the alpha value, the higher the internal consistency of the measure. There is no standardized rule regarding acceptable values of Cronbach's alpha, and authors report different inclinations, but @=.7 is commonly regarded as the minimum acceptable value (Almquist, Ashir, & Brännström, 2014; Field, 2009)

When using Cronbach's alpha, some cautions should be noted. First, the alpha value, thus the interpreted reliability, increases as the number of items in a measure increases (assuming other factors are held constant). This can be problematic for scales with few (less than five) items, but the effect dissipates as items are added. In other words, increasing a scale from two to four items will yield a bigger change in the alpha value than would increasing a scale from eight to ten items (Carmines, 1979; Field, 2009). The measures developed in this study-physical violence, sexual violence, and mental health-contains had alphas 0.90, 0.91, and 0.95, respectively. These alpha levels indicate that various measures employed in this study are highly reliable.

## 5.11. Ethical considerations

Ethics refers to the dichotomy of right and wrong-moral and immoral. In research, ethics awareness serves several domains, of which I will mention two. First, ethical guidelines in research exist to protect persons from mental and physical harm. This involves consent and privacy, which in social sciences, are issues more than direct harm. Participants can give their informed consent before the study begins. This means before they can agree to participate, they must be informed about the nature and purpose of the study, of possible risks, and of their right to discontinue participation at any time. Their privacy must be protected by confidentiality practices so that their identity cannot latter be identified via the information they have provided (Ringdal, 2013).

There is always a chance of negative emotional reactions when encountering sensitive questions such as investigations about sexual violence and mental health. Therefore, information about where and whom counselor or health sister at school as well as the project leader, who is a psychology professor and clinical psychologist at the University of Oslo. The respondents could seek help from, both at the start of the survey and on the last page of the survey questionnaire (Mossige, Huang, & Dalby, 2017). Also, the schools were instructed to conduct the survey as they would have conducted an examination, to prevent answers to the highly sensitive questions being visible to other students in the class (Frøyland & von Soest, 2018)

Again, complying with the Personal Data Act (Act of 14 April 2000 No.31 relating to the processing of personal data), this survey was approved by the Norwegian Data Protection Authority (NSD), 39632, and also approved by Datatilsynet with the reference number 14/01407-5/EOL before the collection.

Regarding privacy and consent, the sampled schools were contracted to obtain permission to conduct the survey. The students at each school also gave their consent to participate in the survey after receiving clear written information of the themes and purpose of the study. The written information to both the schools and the students emphasized that it was voluntarily to participate, and all answers would be anonymous. The anonymity of the survey was further protected both at the schools and individual levels in a way that direct and indirect person-identification data was not requested (Mossige et al., 2017). Because the identity of respondents in the Ungvold survey 2015 cannot be traced, the data are not considered personal, and reporting to NSD is not required for this thesis. According to NOVA, Ungvold 2015 has been conducted

in accordance with current regulations on research ethics (NSD 2015). NOVA is not responsible for any analysis and interpretations that I make based on the data.

The second category of research ethics addressed here concerns less formal rules that provide researchers with guidelines for conduct and publication. Fabrication and Plagiarizing data are two examples of crucial misconduct in research, although the list of possible wrongdoings contains exclusion of data, researcher favoritism, selective publication, and other publication-related issues (Ringdal, 2013). The data processing procedures in this study have been consistent, and exclusion of data cannot be reported, aside from the questionnaire topics that fall outside of range constructs covered by the research question. I have no political, professional, or personal interest in the direction of the results, even though I have received funding for this study, there is no agreement as to the conclusions of this study. Ungvold is funded by the Ministry of Justice and Public Security. Questions of publication ethics will not be addressed as it lies beyond the scope and relevancy of this master thesis.

# CHAPTER 6: RESULTS

This chapter will present the results from the statistical analyses in this study. The purpose of this master thesis is to first explore sources of formal help for victims of sexual and physical violence and to explore the association between help-seeking and mental health as well as the association between physical violence and mental health. In this regard, I present descriptive statistics of sources and prevalence of formal help for young people who are victims of physical violence in table 1, and sources and prevalence of help for young people who are victims of sexual violence in table 2.

I present the result of the univariate analysis for the dependent variable, mental health. Table 4 presents a descriptive overview of the distribution of all independent variables on the dependent variable. Table 5 presents correlations for all variables under study, table 6, 7, and 8 present the results for multiple linear regression. The aim is to look at the most frequent sources of formal help for young people who are victims of physical violence.

## 6.1. Descriptive statistics: sources of help for physical violence victimization

The table below presents sources and prevalence of help when physically violated. The aim is to look at the most frequent sources of formal help for young people who are victims of physical violence. If you have been a victim of physical violence, have you as a result of the violence visited any of the following services?

**Table 4. Help seeking after Physical violence**

| **SOURCES OF HELP** | **VICTIMS** | |
|---|---|---|
| | N | % |
| Crisis Center | 7 | .6 |
| Family counseling | 17 | 1.5 |
| Lawyer | 11 | 1 |
| Police | 26 | 2.3 |
| Family Doctor | 23 | 2.1 |
| Emergency room | 15 | 1.3 |
| Dentist | 3 | .3 |
| Health Service for young people | 28 | 2.5 |
| BUP | 34 | 3 |
| Psychologist/Psychiatrist | 34 | 3 |
| Child Welfare | 21 | 1.9 |
| Teacher/counselor at school | 28 | 2.5 |
| Others | 8 | .7 |
| **Help-seeking** | **81** | **7.2** |
| **Did not seek help** | **1040** | **92.8** |
| **Total** | **1121** | **100** |

he table4 above presents sources and prevalence of help when physically violated. It should be noted; therefore, that table4 represents only victims of violence.

The most frequent sources of formal help-seeking for young people when physically violated are the Psychologist/Psychiatrist and BUP, each making 3% of the overall sources of help-seeking. Teachers at school, Health Services for young people, and the Police are the second most frequent sources of help-seeking for young people when physically violated, 2.5%, 2.5%, and 2.3%, respectively. Dentist and Crisis Center have the least frequent source of help-seeking, 0.3%, and 0.6%, respectively. A significant percentage of victims also uses Family Doctor (2.1%)

The percentage of victims who sought help is indicated by the bivariate analysis in table7, which is 7.2%, representing 81 victims. The larger percentage of victims, 92.8 representing 1040 adolescents, did not seek formal help.

### 6.2. Descriptive statistics: sources of help for sexual violence victimization

### Sources and prevalence of help when sexually violated

The table below displays the prevalence and sources of formal help-seeking for victims of sexual violence. The aim is to look at the most frequent sources of help for young people who are victims of sexual violence. It should be noted that the table shows only victims of violence and not the total sample. If you have been a victim of sexual violence, have you as a result of the violence visited any of the following services?

**Table 5. Help seeking after sexual violence**

| **SOURCES** | **VICTIMS** | |
|---|---|---|
| | N | % |
| Crisis Center | 11 | 1.2 |
| Family counseling | 7 | .7 |
| Lawyer | 16 | 1.7 |
| Police | 34 | 3.6 |
| Family Doctor | 29 | 3.1 |
| Emergency Room | 14 | 1.5 |
| Dentist | 1 | |
| Health service for young people | 40 | 4.3 |
| BUP | 37 | 3.9 |
| Psychologist/Psychiatrist | 61 | 6.5 |
| Child Welfare | 15 | 1.6 |
| Barnehus | 2 | .2 |
| Teacher/Counselor at school | 27 | 2.9 |
| Others | 28 | 3 |
| **Help seeking** | **117** | **12.4** |
| **Did not seek help** | **823** | **87.6** |
| **Total** | **940** | **100** |

The most frequent source of help for young people who are victims of sexual violence is the Psychologist/Psychiatrist making 6.5% of the overall sources of help for young people. Health Service for young people followed with 4.3% of the overall sources of help, then BUP, Police, Family doctor and Teacher at school with 3.9%, 3.6%, 3.1%, and 2.9%, respectively. Still, the least source of help for young people who are victims of sexual violence is Dentist and Crisis Center, with 0.1% and 1.2%, respectively. The number of adolescents who were victims of sexual violence and sought help was 117, as seen in table7 below, representing 12.4%. The larger number of adolescent victims 823, representing 87.6%, did not seek any form of formal help.

6.3. Descriptive statistics for mental health

**UNIVARIATE**

**Table 6. Descriptive statistics for the dependent variable (Mental Health)**

| Mental Health | N(missing) | Min | Max | Average | SD | Skewness | Kurtosis |
|---|---|---|---|---|---|---|---|
| | 4269(261) | 1 | 4 | 1.67 | .57 | 1.041 | .595 |

The purpose of the above Univariate table is to investigate how one variable, which is the dependent variable in this study, mental health, is distributed in the population, adolescents in Norway.

As described in the depended variable constructed as an index-based, that intends to capture adolescents' mental health status. From the table above, 4269 respondents are included in the index and that the average mental health status in the total selection is 1.67 on a scale of 1(do not bother at all/high mental health) to 4 (very much bothered/low mental health). The table also shows that the index has a disparity of 1.041, which indicates the right uneven distribution. Kurtosis at .595 also indicating that there is a slight deviation from the normal distribution.

6.4. Bivariate analysis for all the independent variables

The table below shows the difference in mental health for five independent variables, each being a dichotomous variable

**Table 7. All independent variables**

| | | Mental health | | | |
|---|---|---|---|---|---|
| | Independent variables | mean | N | % | SD |
| 1 | Help-seeking after physical violence | | 1063 | 100 | |
| | **Yes** | **2.483** | **81** | **7.6** | **0.70** |
| | **No** | **1.834** | **982** | **92.4** | **0.58** |
| 2 | Help-seeking after sexual violence | | 888 | 100 | |
| | **yes** | **2.195** | **117** | **13.1** | **0.67** |
| | **No** | **2.000** | **771** | **86.9** | **0.62** |
| 3 | Sexual violence | | 4242 | 100 | |
| | **yes** | **2.026** | **888** | **21** | **0.63** |
| | **No** | **1.576** | **3354** | **79** | **0.51** |
| 4 | Physical violence | | 4251 | 100 | |
| | **Yes** | **1.880** | **1063** | **25** | **0.62** |
| | **No** | **1.599** | **3188** | **75** | **0.54** |
| 5 | Gender | | 4213 | 100 | |
| | **Male** | **1.436** | **1678** | **39.8** | **0.45** |
| | **Female** | **1.827** | **2536** | **60.2** | **0.59** |
| | Total | | 4530 | 100 | |

*****p < 0,001**

The table 7 above contains the distribution of all the independent variables used in this study. Help-seeking after physical violence represents the sample of victims of physical violence. Help-seeking after sexual violence represents the sample of victims of sexual violence. Sexual violence, physical violence and gender represent the total sample of this study.

Judging from the above univariate table, the variable that had the most significant impact on young people's mental health is help-seeking after physical violence, which had a mean value of 2.483, followed by help-seeking after sexual violence. As from the table7 above help-seeking category had the greatest impact on young people's mental health.
Surprisingly, without help-seeking, sexual violence (2.026) rather had a greater impact on mental health than physical violence (1.599).

Analysis performed using the chi-square, as shown in the above bivariate table shows that all the distributions are significantly different on mental health.
The table shows that there are clear differences between the distribution of young people's mental health based on physical violence. Out of a total of 4251 who responded to questions of physical violence, 25% of them reported experiencing physical violence and had a mean score of 1.88 and a standard deviation of .62 on mental health, whiles 74% reported that they had no experience with physical violence and had a mean of 1.59 and a standard deviation of .54 on mental health. Sexual violence had 4242 respondents, 20.93% reported having experienced sexual violence and had a mean of 2.02, and a standard deviation of .63 on mental health, whiles 79.06% reported no experience with sexual violence, had a mean of 1.57 and a standard deviation of on mental health. There was a total of 888 victims of sexual violence, 13.17% sought help, had a mean score of 2.19, and a standard deviation of .67 on mental health, whiles 86.82% did not seek help, had a mean of 2.00 and a standard deviation of .62 on mental health. Out of the total of 1063 victims of physical violence, 7.61% sought help and had a mean score of 2.48 and a standard deviation of .70 0n mental health, whiles 92.38% did not seek help and had a mean score of 1.83 and a standard deviation of .58 on mental health.
Out of the total respondents, boys were 39.82%, had a mean score of 1.43 and a standard deviation of .45 on mental health, while girls were 60.1%, had a mean score of 1.82 and a standard deviation of .59 on mental health.

6.5. Correlation analysis for all the variables in the study

As can be seen in the table below, out of 15 correlations, only gender and Physical violence were not significantly correlated internally. Help-seeking after sexual violence and help-seeking after physical violence had the highest positive correlation ($r=.472$ $p<.01$), suggesting that victims who sought help after sexual violence also more likely to seek help after physical violence.

The results show that help-seeking after sexual violence and help-seeking after-physical violence had the strongest internally related correlates, followed by gender and mental health, and help-seeking after physical violence and sexual violence as well as help

The dependent variable, Mental health, was also positively associated with gender r=.333, p<.01), suggesting that girls are more likely to report symptoms of mental health problems than boys. Mental health and sexual violence are also positively associated (r=.319, r=.01), suggesting that victims of sexual violence also report symptoms of mental stress.

**Bivariate**

**Table 8. Correlation table with all variables**

| | **Mental Health** | **gender** | **Help-seeking for sexual violence** | **Help-seeking for physical violence** | **Physical violence** | **sexual violence** |
|---|---|---|---|---|---|---|
| **Mental Health** | 1 | | | | | |
| **Gender** | .333** | 1 | | | | |
| **help-seeking for sexual violence** | .153** | .104** | 1 | | | |
| **Help-seeking for phy.violence** | .199** | .102* | .472** | 1 | | |
| **Physical violence** | .214** | .06 | .093** | .153** | 1 | |
| **6. Sexual violence** | .319** | .245** | .318** | .321** | .192** | 1 |

*p < 0,05; **p< 0,01; ***p<0,001

6.6. Linear multiple regression analysis: interaction

**Table 9. Linear multiple regression analysis1**

| | Psychological distress | | | | | |
|---|---|---|---|---|---|---|
| | Model 1 | | | Model 2 | | |
| | b | SE | p | b | SE | p |
| **Sexual violence** | .306 | .021 | 0.000 | .163 | .046 | .000 |
| **Physical violence** | .225 | .019 | 0.000 | .203 | .030 | .000 |
| **Gender** | .328 | .017 | 0.000 | .297 | .020 | .000 |
| **Interaction: sexual vio. Gender** | | | | .177 | .051 | .001 |
| **Interaction: physical vio. Gender** | | | | .039 | .038 | .313 |
| **Constant** | 1.354 | .015 | 0.000 | 1.371 | .390 | |
| **$R^2$** | .197 | | | .199 | | |
| **N** | 4,175 | | | 4,175 | | |

This regression analysis is constructed as a hierarchical regression model, where variables are included sequentially. It allows you to see how new variables change the effect of the variables already included in the analysis (Elstad, Christophersen, & Turmo, 2012). This is relevant to the study's hypotheses, among other things, how gender and violence affect young people's mental health. The following explains how the hierarchical regression model is constructed and then follows a more detailed description of the results of the regression analysis.

Model 1 in the regression analysis contains the variables sex, physical violence and sexual violence. These three variables explain 19.7% of the total variations in the dependent variable. In model 2, the interaction between sexual violence and gender as well as physical violence and gender are included. The explained variance then increases to 19.9%.

Model 1 shows that sexual violence increases psychological distress by .306, and physical violence increases mental health problems by .225. These support this study's hypothesis that

violence will have a negative impact on psychological health. But we see that sexual violence increases mental health problems more than physical violence. Model 1 also shows that girls' Psychological distress increases by .328 compared to boys, which also supports the study's hypothesis that girls will experience more Psychological distress than boys. Model 1 also shows that the variable with the greatest psychological distress is gender (.328), that girls have more Psychological distress than boys, followed by sexual violence (.306) and then physical violence (.225).

Model 2 shows that all variables are significantly related to Psychological distress, the interaction between physical violence and gender. In order words, physical violence has a no different effect on Psychological distress for boys and girls; it has the same effect for both.

6.7. Regression analysis for victims of sexual violence

**Table 10. Help seeking after sex.vio (victims)**

| | **Psychological distress** | | |
|---|---|---|---|
| | Model 1 | | |
| | b | SE | p |
| **Help seeking sexual** | .156 | .056 | ,011 |
| **gender** | .463 | .056 | ,000 |
| **Constant** | 1.618 | .052 | ,000 |
| **$R^2$** | .080 | | |
| **N** | 872 | | |

In this table, the model is based on victims of sexual violence. The idea is to investigate how help-seeking behavior is related to Psychological distress among victims

We see from the table that female victims of sexual violence have more psychological distress than male victims. Also, Victims who seek help have more mental health problems than victims who do not seek help.

We see from the table that victims of sexual violence who sought help had .156 increased mental health problems. There is also significant gender difference between help-seeking and mental health, from the table boys who did not seek help but were victims of sexual violence had a constant of 1.6, which means "do not bother at all" whiles girls had 1.618+.463=2.08 "a

little bothered." When boys sought help, their mental health problems increased to 1.774 (1.618+.156), but when girls sought help, their Psychological distress reduced to 2.237, which lies between a little and pretty much bothered. In this model, help-seeking, and gender explain 8% of the variations in mental health.

What is seen here is that those who seek help have more psychological distress than those who did not seek help.

6.8.Regression analysis for victims of physical violence

**Table 11. Help seeking after physical violence(victims)**

| | **Psychological distress** | | |
|---|---|---|---|
| | Model 1 | | |
| | B | SE | p |
| **Help seeking physical** | .527 | .066 | ,000 |
| **gender** | .419 | .026 | ,000 |
| **Constant** | 1.589 | .028 | ,000 |
| **$R^2$** | .183 | | |
| **N** | 1,048 | | |

This table, the model is based on being a victim of physical violence. As in table 7, we wanted to know the help-seeking behaviors of victims of physical violence.

We see that being a victim increases a victim's mental health problems by .527. The constant is the level of mental health when all included variables are zero. So, males who are victims of physical violence but did not see help will have a mental health of 1.589, which means "not bothered at all." Girls who are victims of violence but did not seek help will have a mental health of 1.589+.419=2.00, which means "a little bothered." This means girls who are victims of physical violence have reduced mental health than boys who are also victims of physical violence.

When a boy sought help, mental health reduced by .527, 1.589+.527=2.116, "a little bothered." When a girl sought help, mental health is reduced to 2.535 (.527+.419+1.589), which lies between "a little bothered and pretty much bothered."

This means adolescents who have been exposed to physical violence have decreased mental health and that those who seek help have even more decreased mental health.

Types of violence and sources of help

**Table 12.Violence type and help seeking type**

| Physical violence% | Help-seeking Sources of help | Sexual violence% |
|---|---|---|
| 0.6 | Crisis center | 1.2 |
| 1.5 | Family counslling | 0.7 |
| 1 | Lawyer | 1.7 |
| 2.5 | Police | 3.6 |
| 2.1 | Family doctor | 3.1 |
| 1.3 | Emergency room | 1.5 |
| 0.3 | Dentist | 0 |
| 2.5 | Health service for young people | 4.3 |
| 3 | BUP | 3.9 |
| 3 | Psychologist/Psychiatrist | 6.5 |
| 1.9 | Child welfare | 1.6 |
| 2.5 | Teacher | 2.9 |
| 0.7 | Other | 3 |
| 92.8 | **No help** | 87.6 |
| 7.2 | **Sought help** | 12.4 |

We see from table13 above that sexual violence elicited more help-seeking behaviors than physical violence. This is seen from the fact that out of the 1121 victims of physical victims, only 7.2% of them sought help, and 92.8% did not seek help. But few adolescents experienced sexual violence (940) compared to physical violence; 12.4 % of them sought help. Looking at the figures in table13, except for dentists, family counseling, and child welfare, the percentage of all other sources of help was greater for sexual violence than physical violence. Interestingly, the fewer number of sexual violence victims sought more help than the larger number of physical violence victims, indicating that sexual violence elicited more help-seeking behavior

than physical violence. This also indicates that adolescents will use different sources of help for different violence victimization. For example, in this thesis, as shown above, adolescents used more of the dentist, family counseling, and child welfare services when physically violated than when sexually violated. Conversely, they used more of psychologists, Health service for young people, Family doctor, and the police services when sexually violated than when physically violated. They also used significantly other sources of help when sexually violated but not when physically violated.

The descriptive statistics show that only 7.2% of victims of physical violence sought help. The larger 92.8% of victims of physical violence did not seek help from any of the formal sources of help.

According to the descriptive statistics, only 12.4% of victims of sexual violence sought help. The majority of 87.6% of adolescents who were sexually violated did not seek help from any source. It is also seen from this result that a low rate of formal help-seeking was equally evident for both males and females.

# CHAPTER 7: DISCUSSION

The findings from this study suggest that there are significant associations between violence (sexual and physical) and mental health among young people. Young people's main sources of help-seeking when violated sexually and physically are Psychologists/Psychiatrists, BUP, Health services for young people, Police, and the family doctor. This study also revealed that young people who sought help after violence victimization reported higher levels of mental health problems than young people who experienced violence victimization but did not seek help. There were substantial gender differences in the prevalence of help-seeking behavior.

## 7.1. Summary of hypothesis

**Table 13.Hypotheses and results**

| Hypotheses | | findings |
|---|---|---|
| 1 | Violence (physical and sexual) will be negatively associated with mental health | supported |
| 2 | Females will experience higher levels of violence victimization than males | Partially supported |
| 3 | Females will report higher symptoms of mental health problems than males | supported |
| 4 | Help seeking will be negatively associated with mental health (victims who seek help will also report higher levels of mental stress than victims who did not seek help) | supported |
| 5 | Females will have higher prevalence of help seeking behavior than males | supported |

In this chapter, I will first make a summary of the main findings from the statistical analyses and state whether my study hypotheses were supported or not then after I will discuss the results in the context of violence and help-seeking and their relation to mental health. I will place much emphasis on help-seeking behavior and how help-seeking behavior can promote the mental

health of young people, and if so, how to improve the help-seeking behavior among young people.

Lastly, I will discuss some limitations and suggestions for further research in the future.

## 7.2. Findings and hypotheses

Descriptive statistics performed on sources and prevalence of formal help-seeking for young people who are victims of violence showed that the main sources of help when young people are violated are Psychologists/Psychiatrists, BUP, Teacher or Counsellor at school, Health service for young people, the police and the family doctor. I would say this resonates quite well with other studies on help-seeking behavior, which shows that the most common sources of help are informal conversations with friends, family.

The results that adolescents do not usually use crisis center, and lawyers in violence victimization are consistent with previous studies (Alonso et al., 2004; Ashley & Foshee, 2005). Maybe adolescents are not the group that goes to the crisis center and layers for help, it might relate well with adults. It gives an idea about the selection effect, that going to the crisis center or consulting a lawyer is a step-up which adolescents with severe victimization will do. Primarily using a crisis center would mean that you had to run away from someone. If someone was victimized of sexual violence at home, and the mother/father was also victimized, ending up at a crisis center would be possible. However, the most likely place to end up would be in the childcare service.

Alternatively, one victim reaching out to the lawyer might mean that victims of violence are much more interested in the health impact than the legal aspects.

This results from the bivariate analysis support my hypothesis that violence will be negatively associated with mental health. This is consistent with Jumper (1995), who indicated that adolescents who experience childhood sexual abuse are at increased risk for suffering a variety of health-related problems such as depression and anxiety. Miller, Wasserman, Neugebauer, Gorman-Smith, and Kamboukos (1999) found an association between physical abuse and mental health problems.

The hypothesis that females will experience a higher level of violent victimization than males is also partially supported. What it means is that the hypothesis was true for sexual violence but not for physical violence. However, the hypothesis that girls will report higher levels of mental health problems than boys were supported as this is consistent with previous research

suggesting that although boys were also violated, it is girls who are disproportionately impacted (Du Mont, Macdonald, White, & Turner, 2013). They found that boys are also sexually violated, but WHO (2013) posits that it is girls who continue to be impacted disproportionately. The significant interaction term between sexual violence and gender indicates that being a victim of sexual violence is worse for girls than for boys concerning mental health.

The hypothesis that help-seeking will be negatively associated with mental health is also supported. The meaning of this hypothesis is that victims of both physical violence and sexual violence who sought help from any of the listed sources of formal help would report more mental health problems than their counterparts who did not seek help but were as well victimized. Though the result is surprising, considering the fact that one would expect that when victims seek help, they would have an improvement in their mental health. But according to the literature, the result is not surprising; many studies found similar results (Frazier, 2000; Millar, Stermac, & Addison, 2002). The possible explanation I can see in this is the selection effect. Here, the argument is that there is a selection based on mental health and other characteristics. Thus, those who seek help are worse off to start with, compared to those who did not seek help. According to Amin, Buranosky, and Chang (2017), although physicians describe key roles in caring for sexual assault survivors, several barriers hinder their ability to fulfill these roles. One of those barriers was the fear of disclosure. They found out that survivors of violence are more likely to tell their physicians if the sexual assault involved penetration and if they identified having experienced emotional consequences. The point is that victims only seek help when their situation is worse.

This is a very important finding, as it tells that there is a gender difference in the association of violence and mental health. That although both genders might experience violence, their
In their study, greater help-seeking was positively associated with psychological abuse and threats (New & Berliner, 2000), maintaining that the odds of a survivor seeking help were increased by violence severity; thus, there is a selection as to those who seek help.
The explanation of this selection effect demonstrated by previous studies is that victims consider seeking help when their violence experience reaches a crisis (Frazier, 2000; Lipsky, Cristofalo, Reed, Caetano, & Roy-Byrne, 2012; Millar, Stermac, & Addison, 2002; New & Berliner, 2000; Rizo, Givens, & Lombardi, 2017). This is consistent with the behavioral theory of service used proposed by Andersen (1995). The theory, as discussed earlier in this study, has one of its three components that describe the level of need as a factor that influences help-

seeking behavior amongst adolescents. The level of need relates to the idea that adolescents seek help mostly when they are in crisis, meaning that they experience a severe level of victimization and or severe level of mental health problems. Some victims of violence suffer a severe drop in mental health others do not, depending on the type and intensity of the violence they have experienced. In effect, my hypothesis does not assume a comparable group of victims who sought help, and those who did not seek help.

Therefore, from the analysis, I only know that victims who sought help also reported higher symptoms of mental health problems than those who did not seek help. This does not mean that help-seeking does not have a positive impact on the victim's mental health. Other studies have reported a positive association between help-seeking and mental health (Hammack, Richards, Luo, Edlynn, & Roy, 2004; Thoits, 1986). What it can mean is that victims who sought help might have improved mental health, but because they started worse off, they might still report higher symptoms of mental health than those who did not seek help. We can take a lesson also from the developmental theory employed in this study. The idea of the developmental theory here is that support needs to be relatively stable over time for it to influence positive health outcomes. According to Sarason, Sarason, and Shearin (1986), support that influences health outcomes should be stable. Thoits (1986) remarked that social support is a potential resource, but Berg and Upchurch (2007) has also emphasized that its effectiveness depends heavily on the context.

The hypothesis that females will have a higher prevalence of help-seeking behavior than males is also supported. If I look at the previous hypothesis, which says that females will report higher symptoms of mental health problems than males, as well as they are also reporting a higher prevalence of help-seeking behaviors than males, it is in line with the selection hypothesis.

At this point, I will go to the bivariate table and discuss which of the variables had a greater impact on mental health than others.

Judging from the univariate variables in chapter four, the variable that had the greatest impact on young people's mental health is help-seeking after physical violence, which had a mean value of 2.483, followed by help-seeking after sexual violence. As it has already been discussed, the help-seeking category had the greatest impact on young people's mental health.

Surprisingly, seeking help after physical violence had the greatest impact on mental health than seeking help after sexual violence. But without help-seeking, victims of sexual violence rather

were impacted more on mental health, mean = 2.026 than victims of physical violence, mean=1.599.

In table 11 above, the model is based on being a victim of physical violence. I wanted to know the help-seeking behaviors of victims of physical violence.

I imagine if you are a male and have experienced physical violence, there is no significant association with a mental health problem (table 11). In other words, 'not bothered at all.' Then seeking help victims reported a further .527 increased in mental health problems. One would say that seeking help is not necessarily a positive one but rather negative. And then further, being a female and seeking help is even more negative. Therefore, on the face value, this finding suggests that help-seeking is not necessarily beneficial to the mental health of the young person, whether male or female, and its negative effect is more pronounced in females than in males. I have explained this through the lens of a selection effect, that looking at the previous studies, it's not necessarily that help-seeking is negative to the mental health of adolescents but that victims who seek help are likely to be in crises. For the gender difference in help-seeking on mental health, it makes sense to draw ideas from the descriptive statistics that more females were victimized than males, and hence they sought more help and reported more mental health problems. However, this is not entirely true by just looking at numbers, because a few males who were victimised could have had more mental health problems than many females if the few males experienced more severe cases of violence than females. Therefore, looking at the previous studies that I have discussed earlier, it is consistent to believe that girls experience more physical and sexual violence victimization than boys, girls seek more help for victimization than boys, and girls report more mental health problems than boys.

Equally, in table10above, If everybody was a male, that is all included variables were zero; sexual violence (constant=1.618) will have a larger effect size in mental health than physical violence (1.589). But being female sexual violence now has an even larger effect size on mental health. Gender makes a difference in mental health in both help-seeking after physical violence and help-seeking after sexual violence.

Again, the effect of help-seeking after physical violence on mental health (.527) is bigger than the effect of help-seeking after sexual violence on mental health (.156). All in all, physical violence explained more variations (18.3%) in mental health than sexual violence (8%).

Even though there was not a hypothesis that physical violence will have more explanatory value of mental health than sexual violence, the results of the linear multiple regression analysis show that effects of physical violence are three to four times larger than the effect of sexual violence on mental health. If I should operationalize this in this study, physical violence matter more than sexual violence to the young person's mental health.

Regarding the gender difference in mental health after help-seeking, this study finds as hypothesized that both males and females who are victims of physical and sexual violence are associated with decreased mental health, although the female is distinctly more important. I suggest, however, that when it comes to improving mental health, both males and females are important. However, a social worker or policymaker tasked with considering where to apply efforts or scare resources to improve mental health in adolescents could benefit from being mindful of the dynamic.

Summary of findings

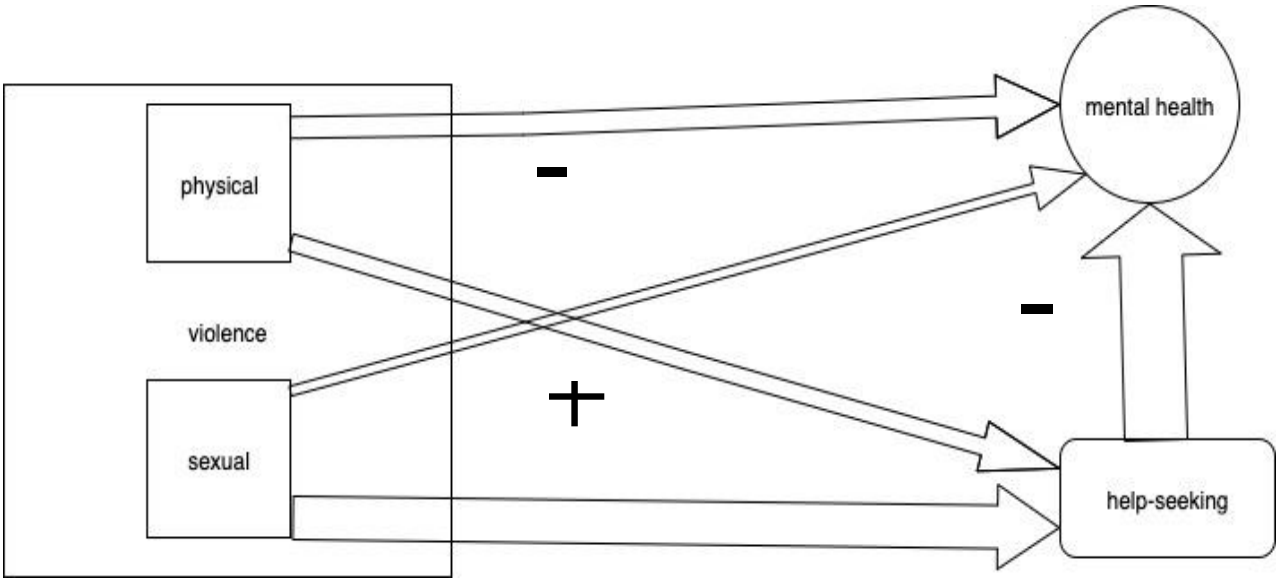



Figure 4. Summary of findings

Fig 4 above illustrates the summary of this thesis results. It indicates that adolescents experience two types of violence I investigated in this study; physical and sexual. Victimization of either or both violence has two major associations; mental health and help-seeking. Association between violence and mental health was negative and the association between violence and help-seeking was positive. With mental health, physical violence has more impact than sexual violence, seen by the difference between the size of their arrows. With help-seeking, adolescents who experienced sexual violence sought more help than those who experienced physical violence, also illustrated by the difference in sizes of their arrows. However, seeking help in both sexual and physical violence leads to more mental health problems, hence a bigger arrow.

Considering the various analysis performed in these studies, physical violence impact adolescents mental health more than sexual violence. For example, the correlation analysis in table 8, the relationship between help-seeking after physical violence and mental health had a coefficient of 0.199, but the correlation between help-seeking after sexual violence and mental health had a coefficient of 0.153, indicating that help-seeking after physical violence is highly associated with mental health than help-seeking after sexual violence. Considering the bivariate analysis in table7, physical violence had a mean score of 2.483 on mental health whilst sexual violence had a mean score of 2.195 on mental health, indicating that physical violence bothered

adolescents more than sexual violence. Considering the regression analysis performed in table 10 and 11, physical violence explained 18.3% of the variations in mental health whilst sexual violence explained only 8% of the variations in mental health. All in all, help-seeking categories had more impact on adolescents' mental health than violence categories.

## 7.5. Suggested Intervention

I am relating this study's results to social welfare and health policy. I adapted Holzmann and Jørgensen (2001) conceptual framework for Social Risk Management (SRM).
For adolescents to successfully go through the developmental stages or to meet the developmental challenges in today's world, as well as effectively deal with the adverse effects of physical and sexual violence, they require resourceful relationships and activities socially organized within a network of significant others and institutional agents distributed throughout the family, school, neighborhood and community.

Because of the interactive nature of multiple factors that lead to adolescent violence, there have been many models of intervention. Again, the risk of physical and sexual violence in this thesis is not necessarily exogenous; because of this, there should be many strategies to deal with the violence than just simply formal help services, which mostly deal with victimization.
Holzmann and Jørgensen (2001) propose a risk management framework, which consists of three strategies, three levels of formality and many actors to manage risk. Their three strategies include risk reduction, risk mitigation, and risk coping. Their three formalities include the informal sector, the market-based, and the public. The authors also suggested many actors to help fight risk; individuals, communities, governments, and international organizations.
In this thesis, an adaption of this framework follows their three risk management strategies (risk reduction, risk mitigation, and risk coping), adapted three levels of formality (family, school, and public) as well as the recognition of many actors.

The idea of using this framework in this thesis is to treat social support as a safety net and also as a springboard for the adolescent who is at the risk of physical and sexual violence. The directorate of health in 2014, published a report which states that 'we must gather and disseminate knowledge about environmental and social factors that have an impact on mental health and well-being, and this knowledge must be used as a basis for measures and used in

social planning in general. The findings of this study contribute to both the dissemination of knowledge about environmental and social factors as well as the basis for intervention.
Once violence has occurred, households and communities may be poorly equipped to handle the consequences, especially given the fact that violence is associated with mental health problems. This calls for government instruments, support from international institutions, and the world community at large. To develop a culture of physical and sexual violence prevention, we must consider other areas other than the health care system. According to the national institute of public health, 2011, health prevention and promotion include a lot of factors, which relates to so many aspects of life, involving school, living conditions, family life as well as lifestyle.

This study found that adolescent's relationships with parents, friends, and school are associated with violent victimization. Help-seeking and mental health are also significantly associated, which might be useful factors characterizing health promotion. In this thesis, physical violence was measured from the sample of parents and stepparents. Sexual violence, on the other hand, was measured from the general population, including friends, strangers as well as parents, and significant others. Both physical and sexual violence had significant associations with mental health, indicating that a successful intervention should target many aspects of adolescents' life, such as parents, friends, school, teachers, and communities. Levin (2004) reports on the International Federation of social workers' emphasis on social work that social work intervenes in situations where man interacts with his environment aimed at problem-solving. Not also forgetting that social workers apply systematic strategies to help people solve their problems. To do this, according to Levin (2004), is to focus on the relation between person and environment. This must be understood as something collective, involving the individual, family, school, and society at large. I am of the view that an application of Holzman's Social Risk Management (SRM) strategies, as used in this study can be a useful tool in tackling physical and sexual violence, because of its recognition of concepts of network, resources, and relations.

**Table 14. Social risk management framework**

Adapted conceptual framework for social risk management (Holzmann & Jørgensen, 2001)

| Arrangement strategies | family | school | public |
|---|---|---|---|
| Risk reduction | Parenting training/parental mental health | domestic violence prevention program | Social support, Legal services |
| Risk mitigation | intensive family services. | counsellor or psychologists at school | formal help services |
| Risk coping | Child placement services | counsellor or psychologists at school | Advocacy |

From the above, there are three strategies: risk reduction, risk mitigation, and risk coping. There are also three levels of formality: family, school, and public, and there are many actors. Examples of intervention in each strategy and level of formality are discussed below.

Risk reduction strategies are aimed to reduce the probability of downside risk, adolescents' physical and sexual violence. They are introduced before the risk, violence occurs. These strategies range broadly, including policies employed by the individual adolescent, the family, the school, the community, and the public at large. They involve policies regarding public health, the environment, education, and training. In this particular study, the interventions should be linked to measures to reduce the risk of adolescent physical violence in the family and sexual violence in the general population.

This study finds out that adolescent violence victimization can be associated with close family, especially physical violence, as well as the general population, in sexual violence. Adolescent's close relation with parents can be understood as an essential ground for promoting mental health and prevention of physical and sexual violence. It is of great importance to building an excellent relationship between adolescents and parents. Based on this risk reduction strategy in the family can be parenting training and parental mental health. Parenting training offers information and role modeling as well as social support to impoverished families, families that are at risk of

adolescents' physical and sexual violence. They provide information on basic childcare, problem solving, home management, and social interaction skills. The developmental theory illustrates that adolescence is a period of tumultuous time where independence and identity formation are increased. This occurs in the context of life transitions where most adolescents are in their final years of secondary education, entry into employment or higher education. Physical and sexual violence throughout this period can lead to feelings of insecurity and instability, leading to a range of poor psychological and social outcomes. Parental mental health should focus on the need to improve maternal self-esteem, stress management, and the regulation of impulsive behaviors to enhance parental ability to manage children during everyday care. This can be understood in light of the fact that good family relationships with close family can provide access to benefits and resources that have a bearing on the adolescent's positive mental health.

School can also be a ground where both strong and weak social ties can take place. Many things can be learned through the school environment and the school curricular. As put by the directorate of health's report, a good learning environment can give many good experiences that can strengthen and protect children's mental health (Directorate of Health, 2014). In the school settings, risk reduction strategies can be domestic violence prevention program-these are school-based programs on dating and domestic violence. Such programs focus on gender roles, expectations, and personal safety as well as legal statutes regarding violence. This intervention is beneficial according to the results of this thesis, where more females were victimized in both physical and sexual violence than males. It is particularly important to this thesis because the subjects studied in this thesis were final year high school students who were victims of violence. Students who will receive such programs will improve their knowledge of and attitudes about violence. According to Daro and McCurdy (1994), children can be taught to avoid abuse or to protect themselves from further abuse by reporting threatening or abusive situations and employing other learned self-protective behaviors. Particular education on sexual abuse includes the concept of body ownership, types of touching, and skills to avoid or escape from abusive situations.

In the public domain, the reduction can take the form of interventions such as social support that provide material and interpersonal resources that are of value to the recipient (Thompson, 1994). Governments should enact and enforce appropriate laws that safeguard the rights of adolescents and protect their victimization. There should be a proper definition of what

constitutes physical and sexual violence. For example, in this thesis, based on my judgment, I omitted some of the items on physical violence, such as 'my parents humiliated me'. There is no explicit agreement on what constitutes humiliation as physical violence, and that people may unknowingly commit this violence.

Risk mitigation is a strategy to decrease the potential impact of future down-side effects, such as mental distress. These strategies are also employed before violence occurs, but the aim is that if the adolescent is finally victimized, there is the need to reduce the potential impact. These strategies can also be employed in all three levels of formality. In the family, mitigation intervention includes interventions such as intensive family services. Once adolescent has been victimized, instead of child placement, they rather want to keep the family intact through the provision of therapeutic and concrete services, such as temporary rent subsidies. The idea is based on the fact that as long as the family's safety of the child can be reasonably ensured, the best place for the child to live is in their own home. As discussed, Shang (2008), reported that the family could be a great source of risk management.

In the school, mitigation strategies include many formal services such as teachers/counselors or psychologists at school or teachers in general. This study found that many a great proportion of victims of both physical and sexual violence reported to Psychologists/Psychiatrists and teachers at school. This is a wake-up call to build very good student-teacher relationships. The literature I reviewed in this study shows that many victims of violence prefer informal sources of help to formal sources, and according to Rickwood, Deane, Wilson, and Ciarrochi (2005), the reason is that in the informal sources of help such as friends and family there is already established relationships that adolescents can trust.

In public, they can be seen as the various formal help services such as Doctors, the police, lawyers, and child welfare. This study's results clearly show that these formal sources are used by victims, only that they are underused. According to the descriptive statistics, the majority of the victims of both physical and sexual violence did not use any of the listed formal sources of help. Many other studies have reported that adolescents do not have confidence in such institutions, and they don't trust that their information will be kept confidential. For example, Rickwood et al. (2005) reported that many victims in their study did not seek help because school counseling offices were situated close to school entrance that was not good for confidentiality.

Risk coping are strategies to relieve the impact of the risk once it has occurred, mainly by the individual adolescent, who is violated. But governments and significant others have important roles in assisting adolescents who are victimized to cope.

Publicly, individuals adopt advocacy services to inform the victimized of his or her legal, medical, and financial options, to validate their feelings of being victimized, to facilitate their access to community resources, to assist them in goal settings, and to provide emotional support.

In the family, one coping strategy is child placement services**.** In some cases, removal of the victimized adolescent from home becomes necessary and place in settings such as foster care or kinship care. According to Banerjee and Duflo (2012), parents do not always put their children's interest first and that the relationship between men and women in the family is not always harmonious.

This framework assumes so many actors. However, because adolescent violence victims do not usually disclose and or seek help, the role of the actors/institutions need to be considered in their capacity to best deal with the situation. Because this information asymmetry gives rise to policy failures, the relative role of these actors has to be viewed in perspectives. Because individual adolescent and their families hold the most important private information concerning violence, most of the risk-reducing management can take place at the family level. Correspondingly, the absence of a healthy family system and interaction leads to the adolescent turning to informal sources of help, which can be less effective in severe cases. It is known that the core institution for managing violence in the family. This is because there is small information asymmetry, and interaction takes place on a daily basis, and commitment can be easily verified and perhaps enforced.

Apart from the household, communities have a large stock of information privately relating to violence. Communities have often developed various informal mechanisms of risk sharing, especially in developing countries. For example, raising voices in Uganda working towards the prevention of violence against women and children, use strategies to influence power dynamics shaping relationships between women and men, girls and boys by catalyzing social change in communities.

These mechanisms provide diverse instruments for risk prevention, mitigation, and coping. However, despite their risk-sharing function, some of them may be socially undesirable because they may perpetuate dependency structures or impede economic development (Baland & Platteau, 1999). However, in many countries in the world today, the extended family has broken down, and urbanization and globalization have also affected communities in their capacity to deal with the risk of violence. This has required the introduction of alternative measures. Also, power within families is not equally distributed, the effectiveness and efficiency of the SRM may not be gender-neutral, and the legal and the informational position of the adolescent may not be secured. This raises the issue of the possibilities of governments and international organizations to positively influence SRM through legislation, monetary, and non-monetary incentives.

The capacity of individual families and communities to handle violence risk and the appropriate risk management instrument to be applied depends on the characteristics of the violence, sources, correlations, frequency, and intensity. This study examines two types of abuse; physical and sexual. The physical violence was measured from only close family relations (parents and stepparents). Sexual violence, on the other hand, was measured from the general population. Therefore, the sources of violence, according to the findings of this study, can be close family (physical violence) and the general population (sexual violence).

The risk of this two violence can be correlated. In this study, physical violence was more frequent compared to sexual violence, but their associational effects on mental health are the same, except for gender.

Wrapping up, while formal services of support should exist, there should be other programs that would give the individual adolescent the capacity to bounce out of violence. This adapted framework of social risk management views social support as not a cost, but rather an investment to help the adolescent have access to support services, avoid victimization and ultimately avoid irreversible negative effects such as mental health problems associated with the violence.

The basic trust of this framework is supported by two findings

First, being an adolescent is a risk factor for violence, both perpetrator and victimization (UN 2000). Two, adolescents are the major determinants of the peace and stability of a nation. Conversely, the degree of disorderliness and instability in society is also partly explained by adolescent (Idike & Eme, 2015)

Therefore, access to SRM instruments would tend to protect them and, thus, provide an opportunity to move out of violence.

The importance of SRM strategies is an example of embedded paternalism and better understood through the idea 'resilience,' which proposes that the density and diversity of resources and assets available to individuals shape their response to violence (Grych, Hamby, & Banyard, 2015). Resilience is conceptualized as maintaining psychological health despite exposure to violence (Grych et al., 2015).This is associated with post-traumatic growth, a healthy outcome that occurs when an individual experiences a stressful event. It is believed to be a protective factor; self-regulation, secure attachment, and neighborhood collective efficacy. This, according to Grych et al. (2015), involves the individual, family, peer, and the community. It proposes the idea that an individual's psychological health after exposure to violence is a product of characteristics of the adversity, the assets and the resources available to them, and their behavioral response. The relationship amongst these variables is that individuals who have the assets and resources to deal with the violence will tend to function better over time, whereas those who do not will be increasingly vulnerable to violence. Assets mean characteristics of a person that promotes healthy functioning, and resource means sources of support outside of the person. Both assets and resources are reciprocally related.

Drawing from the developmental theory as used in this thesis, resilience involves the capacity of the individuals to call on their internal strengths, engage with others and look for external resources to successfully transform stressful situations or adversities into opportunities to learn and thrive. The developmental literature explains how healthy psychological and social development in children is dependent on resources in their environment, notably relationships with adults such as family members and teachers. It is through these interactions that shape how children will learn to manage adversities in life. Situating the SRM framework alongside resilience and developmental perspectives provides a greater understanding of this thesis and the usefulness of the SRM strategies. As individuals develop the interactive experiences, they have had with relational and contextual resources, both good and bad cement the strategies they would use to manage adversities. The combination of individual assets, the meanings they attach to the resources, and the meanings they attach to events shape the ways they would take to achieve a particular set of health-related outcomes. Based on the notion that humans will strive to find meaning in experiences under any condition, the attitude people have towards adversity is an important way in which challenging experiences are interpreted. The

developmental theory states that important fundamental interactions occur early in life, but this process continues to develop and evolve our life through continued interactions with others and the environment. This supports the resilience theory, in that the social interactions the individual experience is consequently internalized, informing the meaning people will ascribe to challenges as well as resources they draw on and the strategies, they would implement to manage these challenges. According to the developmental theory, as used in this thesis, under normal circumstances individual's development occurs through interactions with parents, friends, and society at large; this becomes their personal attributes, which is necessary for their development over time. According to the resilience theory, under adverse circumstances (such as violence), individuals development occurs through interactions with parents, friends, and society at large; this becomes their personal attributes, which is necessary for the outcome over time.

On the face value, the best social risk management is to make sure that the risk (violence) does not occur (risk reduction). Risk mitigation comes next since the effects of the violence are decreased ex-ante. Risk coping is the residual strategy if everything else has failed. However, because each of these strategies has direct and opportunity cost, full reliance on risk reduction or risk mitigation may not be efficient or feasible. On this note, I recommend that attention should be given to each of these strategies.

### 7.6. Limitations of the study

Taking into consideration the findings of this study, it becomes imperative to aknowledge its shortcomings.

#### 7.6.1. Causality

In this thesis, I tested for the association between several variables. One of them is to see the association between violence and mental health. The idea was that young people who experience violence are more likely to report mental health problems than their counterparts who did not experience the violence. Another was to see the association between help-seeking behaviors and mental health, the idea being that victims who seek help will report higher mental stress than those who did not. Causality cannot be inferred from the regression analysis. This study has established an association between variables but not the direction of the association.

In other words, this study does not speak to the influence on one variable by another; it can only show that they correlate. This result cannot tell us whether violence influence mental health problems or mental health problems influence violence. However, I have reviewed a number of pieces of literature in chapter 2 that supports the idea that it is violence that is more likely to lead to mental health problems. To test for causality, researchers usually conduct an experiment; they call Randomized Control Trials (RCT). They trust that this experiment has the capacity to ascertain causality because they have controlled for the control group and experimental groups, which are randomized with rigorous conditions that take care of confounding variables (Ringdal, 2103). In this study, the experiment would be impossible, considering the randomization process. It would be unethical to assign young people to groups of sexually violated groups and non-sexually violated groups in order to investigate their mental health difference. According to Ringdal (2013), the longitudinal study could be another study that can permit some cautious degree of causality, because according to him, the time-based order of the variables can be established. This is more so because, in a longitudinal study, data are collected in at least two points in time so that the change between the different times can be examined. This study encounters the causality limitation based on its cross-sectional data. However, it should be mentioned that other longitudinal studies have found that violence predicts mental health outcomes of young people.

This study builds on the understanding that young people's mental health can be associated with many variables; amongst them is violence, which I have investigated in this study. As I have described above that this study does not test for causality between the variables, it, however, assumes a bottom-up approach, in that I believe that adolescents who report violence victimization are likely also to report mental health distress than their counterparts who have no experience with violence. However, others argue that it is rather a top-down approach, in that adolescents with mental health problems are more likely to be victimized. For example, a mentally ill adolescent female is more likely to experience rape than non-mentally ill adolescent females. With this argument, this study is limited to explain mental health and violence from a top-down approach. A longitudinal study design would be appropriate to investigate this direction of the association.

### 7.6.2. Generalization

This study's results are limited to Norway's final year high school students between the ages of 18-19 years. They are mostly attending general studies. So everyone attending vocational studies are excluded, and everyone that has dropped out of school is also excluded. This should not be an inherent problem of this study, as most studies usually take a sample of a population as its feasible. The caution here is that the results may not apply to young people in other countries or other age groups.

One of the most important things in a study is to be sure that you actually measured what you intended to measure. One of the types of validity I would like to discuss in relation to this study is content validity, the extent to which a measure represents all aspects of a given construct. In this study, I set out my research questions, which were no the design of the questions for the ungvold data collection. I tested for the association between help-seeking and mental health among adolescents in Norway. The limitation here is that help-seeking was not fully captured in the ungvold data. The sources of help-seeking in the ungvold data used in this study were particularly designed for Norway. Even in Norway, there are other formal sources that young people who experience violence seek help, which was not captured in the ungvold data. Again, violence, as used in this study, was an adaptation of the conflict tactic, which did not include the full aspects of violence originally developed. However, it must also be mentioned that this does not compromise the vitality of this study's results as many studies adapt to some original scales to make it appropriate for the context. Particularly in this study, I didn't use three items of physical violence in the ungvold data, based on the fact that they were not relevant for help-seeking. Looking at mental health, one would ask 'what to measure'? There may be so many aspects of mental health that victims of violence are dealing with but not captured in HSCL. Against this background, people may report their current mental state; thus, memories and mental health problems are prominent at the time of the study. Even other aspects of life that are not necessarily about violence can have an association with mental health (Diener, Scollon, & Lucas, 2009). Talking about adolescents, this becomes very important. Reason being that life as an adolescent, considering the developmental theory employed in this study, highlights that adolescent is a state of tumultuous development, where the adolescent goes through so many changes which are not stable. One limitation here is that mental health may take direction in the form of adolescents with himself/herself. However, the remedy employed in this study is that it employees a larger sample that can even out this challenge.

A related problem to what is described above is response bias, the chance that respondents will be affected by feelings of expectations. Socially desirable responding may contribute to more positive answers, while mental stress can put a gloomy perspective on the questions. However, a school of thought argues that this problem should not affect the comparable effect sizes between the independent variable. An associated limitation is the objectivity and accuracy problems when it comes to self-report data. At the same time, in social work, the aim is on the subjective views of the respondents. More so, in this study, the instruments that are used, such as HCSL is validated and reliable, considering its success in several other studies.

### 7.7. Suggestions for further research

This study contributes to the general understanding of violence, mental health, and help-seeking in young people, and whiles it answers some questions, it also brings out new ones concerning help-seeking and mental health. The hypotheses concern the relative contributions that violence and help-seeking make to young people's mental health.

As this study is cross-sectional, it prompts the question of which long-term mental health outcome can be associated with violence and help-seeking, especially as this study's theory posits that violence can lead to long-term mental health problems. A longitudinal study to examine this phenomenon would be an optional extension of the research question in this thesis.

Again, although it was hypothesized that help-seeking would be negatively associated with mental health, it was basically based on the existing literature, this study confirms this hypothesis. However, we expect help-seeking to have a positive impact on the mental health of victims of violence. A further study is needed to understand why help-seeking is negatively associated with mental health among youth. This study does not produce the nuances in the relationship; thus, it's not possible for this cross-sectional study to investigate what really are the factors leading to this association. My explanation for this negative association between help-seeking and mental health was based on past studies. It will be interesting to design a longitudinal study for this population. A longitudinal study would also help to understand the position of developmental theory, as it assumes that social support, which has positive health outcomes, should be relatively stable.

In this master thesis, I investigated only two types of violence; physical and sexual. But adolescents have connections all over the internet and have joined other virtual communities or social media. It would be interesting to include a dimension of internet-related violence or social media violence when considering the mental health of adolescents.

At the policy level, it would be useful to possess some aggregate knowledge about what help services improve the mental health of young people who are victimized by violence, as well as which actual service they receive when they use these formal help service providers, so that efforts to improve the lives of young people can be put in place as part of proactive public health outreach

# CHAPTER 8: CONCLUSION

There is an identified trend of mental health decline amongst adolescents, especially girls (Cowlishaw et 2004). The decline in adolescent's mental health exposes society's weakness in adolescent's wellbeing. Violence, as investigated in this study, has been shown to be one of the factors that is associated with mental health decline amongst adolescents. Norway has put up efforts to provide various forms of help for adolescents who might be victims of violence. Unfortunately, this study has validated what several studies have shown that adolescents generally do not seek help even when help is available. In this study, I took the position of looking at how help-seeking behavior amongst adolescents might be relevant in understanding the association between violence and mental health. Using a quantitative methodology, primary data was collected by NOVA in 2015 called the ungvold survey from Norwegian high school students who were in their final year of study. Given that this study sought to explore the associations between violence and mental health and help-seeking and mental health, I used developmental and behavioral service use theories as the theoretical frameworks for this study. Their analytical prowess provided analytical utility in making sense of the data collected. Embedded in developmental theory is the simple idea that development occurs in stages and are interconnected, that any disruptions such as violence in any stage are likely to affect the continuous development of the next stages, which is why the experience of violence during childhood still has an effect on mental health during adulthood. In the same line of reasoning, social support (help services) has a developmental perspective, that for it to be effective, it has

to be relatively stable over time. Thus, the developmental theory is appropriate in explaining both the association between violence and mental health as well as the association between help-seeking and mental health. The supplementary theory, behavioral service used, also proposes three essential components of help-seeking behavior. One of the three components that I find it very relevant in this thesis is the "level of need." This component illustrates that victims of violence would most likely seek help if the violence is very severe in such a way that victims may not be able to cope by themselves. This partly explains why many adolescents who experience physical and sexual violence may not seek help.

This study finds out that there is an association between violence and mental health and that this association is negative in that adolescents who reported having experienced violence victimization also reported more mental health problems than adolescents who did not report an experience of violence victimization. However, seeking help as a victim of violence was not a positive one but also negative, in that victims who sought help reported higher levels of mental health problems than victims who did not seek help. And although one expects reasonably that seeking help and finding one should help reduce mental health problems. There are two schools of thought that explain this result. First of all, is the numerous research findings that report that victims who seek help are also those who experience most problems or those whose victimization and mental distress reach a crisis. Thus, those who seek help are a selection of severe cases of victimization and mental health problems. In that case, even if they improve in seeking help, their improvement is still worse than those who did not seek help because those who did not seek help might have experienced a milder form of victimization or psychological distress.

The second school of thought is the developmental theory as employed in this thesis, which builds on the previous school of thought. That, for social support to have a positive health outcome, it must be relatively stable over time. As this study used cross-sectional data, I was not in a position to validate these two perspectives. What is very clear and consistent with previous studies is that help-seeking is negatively associated with mental health; thus victims of sexual and physical violence who seek help also report more mental health problems than victims of physical and sexual violence who did not seek help among Norwegian adolescents.

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Appendix

| Are you a boy or a girl? |
|---|
| ○ Boy |
| ○ Girl |

| How old are you? |
|---|
| ○ 18 years old |
| ○ 19 years old |
| ○ 20 years old |
| ○ 21 years old or older |

| Which education program are you following? |
|---|
| ○ Sports and physical education |
| ○ Music, dance and drama |
| ○ Specialization in general studies |
| ○ Design, arts and crafts |
| ○ Electricity and electronics |
| ○ Healthcare, childhood and youth development |
| ○ Media and communication |
| ○ Agriculture, fishing and forestry |
| ○ Service and transport |
| ○ Technical and industrial production |
| ○ Supplementary program for general university and college admissions certification |

| Where are you and your parents born? | You | Your mother | Your father |
|---|---|---|---|
| Norway | ○ | ○ | ○ |
| In another Nordic country | ○ | ○ | ○ |
| In another European country | ○ | ○ | ○ |
| Asia | ○ | ○ | ○ |
| Africa | ○ | ○ | ○ |
| South America | ○ | ○ | ○ |
| North America/Oceania | ○ | ○ | ○ |

| Are your father/mother currently working? (if he/she is on leave or sick at the moment, think about what he/she ordinarily does) | Fathers work | Mothers work |
|---|---|---|
| Yes, works full time | ○ | ○ |
| Yes, works part time | ○ | ○ |
| Unemployed | ○ | ○ |
| Staying at home | ○ | ○ |
| Receiving disability benefits or on occupational rehabilitation | ○ | ○ |
| In education or schooling | ○ | ○ |
| Retired | ○ | ○ |
| Other | ○ | ○ |

| Which education do you think your father and your mother has? Tick off for the highest education level. If the education has not been completed in Norway, consider how it would be translated into the Norwegian educational system. (Pick the highest education) | Fathers education | Mothers education |
|---|---|---|
| University or college | ○ | ○ |
| General studies in high school | ○ | ○ |
| Vocational studies in high school | ○ | ○ |
| Junior high school | ○ | ○ |
| Less than junior high school | ○ | ○ |
| Don’t know | ○ | ○ |

| Financially, has your family been well off or badly off over the past two years? |
|---|
| ○ We have been well off the whole time |
| ○ We have generally been well off |
| ○ We have neither been well of or badly off |
| ○ We have generally been badly off |
| ○ We have been badly off the whole time |
| ○ The economy has varied a lot |

| Have your family lived in public housing while you were growing up? |
|---|
| ○ Yes |
| ○ No |
| ○ Don’t know |

| Below there are described different ways teenagers may have experienced their parents during childhood. Tick off the option corresponding the best for you. If your parents are very different, or you see one parent more than the other, think about the parent you spend the most time with. | Stemmer svært godt | Stemmer ganske godt | Stemmer ganske dårlig | Stemmer svært dårlig |
|---|---|---|---|---|
| They have liked me to make my own decisions | ○ | ○ | ○ | ○ |
| They have tried to control everything I did | ○ | ○ | ○ | ○ |
| They have been overprotective of me | ○ | ○ | ○ | ○ |
| They have not talked to me very much | ○ | ○ | ○ | ○ |
| They have appeared to understand my problems and worries | ○ | ○ | ○ | ○ |
| They did not seem to understand what I needed or wanted | ○ | ○ | ○ | ○ |
| They haven't used enough time with me | ○ | ○ | ○ | ○ |
| They let me decide things for myself | ○ | ○ | ○ | ○ |
| They have tended to baby me | ○ | ○ | ○ | ○ |
| They have been affectionate to me | ○ | ○ | ○ | ○ |
| They have not helped me as much as I needed | ○ | ○ | ○ | ○ |

| Do your parents drink alcohol? | Father | Mother |
|---|---|---|
| No | ○ | ○ |
| Rarely | ○ | ○ |
| Usually about once a week | ○ | ○ |
| Usually several times a week | ○ | ○ |
| Every day | ○ | ○ |

| Do your parents smoke? | Father | Mother |
|---|---|---|
| Yes, daily | ○ | ○ |
| Yes, sometimes | ○ | ○ |
| No, never | ○ | ○ |

| Har du noen gang sett foreldrene dine tydelig beruset? | Far | Mor |
|---|---|---|
| Aldri | ○ | ○ |
| 1 gang | ○ | ○ |
| 2-4 ganger | ○ | ○ |

| | | |
|---|---|---|
| 5-10 ganger | ○ | ○ |
| Mer enn 10 ganger | ○ | ○ |

| *Would you say that your FATHER has alcohol or drug problems?* |
|---|
| ○ No, not at all |
| ○ To a very small degree |
| ○ To a certain degree |
| ○ To a considerable degree |
| ○ Yes, definitely |
| ○ Used to have, but not now |

| *Would you say that your MOTHER has alcohol or drug problems?* |
|---|
| ○ No, not at all |
| ○ To a very small degree |
| ○ To a certain degree |
| ○ To a considerable degree |
| ○ Yes, definitely |
| ○ Used to have, but not now |

| The last time you received grades in your school report, which grades did you receive? | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| Written Norwegian | ○ | ○ | ○ | ○ | ○ | ○ |
| English | ○ | ○ | ○ | ○ | ○ | ○ |
| Mathematics | ○ | ○ | ○ | ○ | ○ | ○ |

| Think about the past month. How many full days have you been absent from school in this period? | None | 1 day | 2 days | 3-4 days | 5-6 days | 7-10 days | More than 10 days |
|---|---|---|---|---|---|---|---|
| Because of illness | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Because of truancy | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| For other reasons | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

| How many years of education are you planning on doing? |
|---|
| ○ High school |
| ○ Technical school or master craftsman’s certificate |
| ○ College or university |
| ○ Haven’t decided yet |
| ○ Other |

| Have you ever been in contact with any of the following help services? | Yes | No |
|---|---|---|
| The child welfare service | ○ | ○ |
| The children's and young people's psychiatric outpatient clinic | ○ | ○ |
| The educational and psychological counselling service | ○ | ○ |
| Psychologist/psychiatrist | ○ | ○ |
| Family care | ○ | ○ |
| Crisis center | ○ | ○ |
| Children's Advocacy Center | ○ | ○ |
| Others | ○ | ○ |

| Have you heard or seen **your mother** be exposed to any of this from your father/stepfather or her boyfriend/partner? | Daily | Weekly | Monthly | A few times | Once | Never |
|---|---|---|---|---|---|---|
| She has been scolded | ○ | ○ | ○ | ○ | ○ | ○ |
| She has been insulted or humiliated | ○ | ○ | ○ | ○ | ○ | ○ |
| She has been threatened by violence | ○ | ○ | ○ | ○ | ○ | ○ |
| She was shoved or shaken violently | ○ | ○ | ○ | ○ | ○ | ○ |
| She was pulled by the hair or pinched | ○ | ○ | ○ | ○ | ○ | ○ |
| She was slapped | ○ | ○ | ○ | ○ | ○ | ○ |
| She was hit with the fist | ○ | ○ | ○ | ○ | ○ | ○ |
| She was hit with an object | ○ | ○ | ○ | ○ | ○ | ○ |
| She got beaten up | ○ | ○ | ○ | ○ | ○ | ○ |
| She was exposed to something else violent | ○ | ○ | ○ | ○ | ○ | ○ |

*ROUTING: ONLY TO THOSE WHO REPORTED THAT THEIR MOTHER HAS BEEN EXPOSED TO AT LEAST ONE VIOLENT ACT FROM THEIR FATHER/STEPFATHER*

| How old were you when this happened? You can tick off more than one box. |
|---|
| ☐ Under 5 years old |
| ☐ 6-10 years old |
| ☐ 11-13 years old |
| ☐ 14 years old or older |

*ROUTING: ONLY TO THOSE WHO REPORTED THAT THEIR MOTHER HAS BEEN EXPOSED TO AT LEAST ONE VIOLENT ACT FROM THEIR FATHER/STEPFATHER*

| | Yes | No |
|---|---|---|
| Have your mother been injured/had bruises caused by violence she was exposed to at home, without needing medical care? | ○ | ○ |
| Have your mother been injured by violence she was exposed to at home so she needed medical care? | ○ | ○ |

| Have you seen your mother be exposed to violence from someone else than your father/stepfather, or her boyfriend/partner? |
|---|
| ○ Yes |
| ○ No |

*ROUTING: ONLY TO THOSE WHO REPORTED THAT THEY HAVE SEEN OR HEARD THAT THEIR MOTHER HAVE BEEN EXPOSED TO VIOLENCE FROM SOMEONE ELSE THAT THEIR FATHER/STEPFATHER*

| Who did this? |
|---|
| ☐ My brother/stepbrother |
| ☐ My sister/stepsister |
| ☐ My mothers' parents |
| ☐ My fathers' parents |
| ☐ My mothers' siblings |
| ☐ Other relatives |
| ☐ Others |

*ROUTING: ONLY TO THOSE WHO REPORTED THAT THEIR MOTHER HAS BEEN EXPOSED TO AT LEAST ONE VIOLENT ACT FROM THEIR FATHER/STEPFATHER*

| Can you with your own words describe what kind of violence you have seen or heard your mother be exposed to at home? |
|---|
| |

| Have you heard or seen **your father** be exposed to any of this from your mother/stepmother or his girlfriend/partner? | Daily | Weekly | Monthly | A few times | Once | Never |
|---|---|---|---|---|---|---|
| He has been scolded | ○ | ○ | ○ | ○ | ○ | ○ |
| He has been insulted or humiliated | ○ | ○ | ○ | ○ | ○ | ○ |
| He has been threatened by violence | ○ | ○ | ○ | ○ | ○ | ○ |
| He was shoved or shaken violently | ○ | ○ | ○ | ○ | ○ | ○ |
| He was pulled by the hair or pinched | ○ | ○ | ○ | ○ | ○ | ○ |
| He was slapped | ○ | ○ | ○ | ○ | ○ | ○ |
| He was hit with the fist | ○ | ○ | ○ | ○ | ○ | ○ |
| He was hit with an object | ○ | ○ | ○ | ○ | ○ | ○ |
| He got beaten up | ○ | ○ | ○ | ○ | ○ | ○ |
| He was exposed to something else violent | ○ | ○ | ○ | ○ | ○ | ○ |

*ROUTING: ONLY TO THOSE WHO REPORTED THAT THEIR FATHER HAS BEEN EXPOSED TO AT LEAST ONE VIOLENT ACT FROM THEIR MOTHER/STEPMOTHER*

| How old were you when this happened? You can tick off more than one box. |
|---|
| ☐ Under 5 years old |
| ☐ 6-10 years old |
| ☐ 11-13 years old |
| ☐ 14 years old or older |

*ROUTING: ONLY TO THOSE WHO REPORTED THAT THEIR FATHER HAS BEEN EXPOSED TO AT LEAST ONE VIOLENT ACT FROM THEIR MOTHER/STEPMOTHER*

| | Yes | No |
|---|---|---|
| Have your father been injured/had bruises caused by violence he was exposed to at home, without needing medical care? | ○ | ○ |
| Have your father been injured by violence he was exposed to at home so he needed medical care? | ○ | ○ |

| Have you seen your father be exposed to violence from someone else than your mother/stepmother, or his girlfriend/partner? |
|---|
| ○ Yes |
| ○ No |

*ROUTING: ONLY TO THOSE WHO REPORTED THAT THEY HAVE SEEN OR HEARD THAT THEIR FATHER HAVE BEEN EXPOSED TO VIOLENCE FROM SOMEONE ELSE THAT THEIR MOTHER/STEPMOTHER*

| Who did this? |
|---|
| ☐ My brother/stepbrother |
| ☐ My sister/stepsister |
| ☐ My mothers' parents |
| ☐ My fathers' parents |
| ☐ My mothers' siblings |
| ☐ Other relatives |
| ☐ Others |

*ROUTING: ONLY TO THOSE WHO REPORTED THAT THEIR FATHER HAS BEEN EXPOSED TO AT LEAST ONE VIOLENT ACT FROM THEIR MOTHER/STEPMOTHER*

| Can you with your own words describe what kind of violence you have seen or heard your father be exposed to at home? |
|---|
| |

| Have **your mother/stepmother** ever done any of the following against you. | Daily | Weekly | Monthly | A few times | Once | Never |
|---|---|---|---|---|---|---|
| Yelled at you | ○ | ○ | ○ | ○ | ○ | ○ |
| Scolded you | ○ | ○ | ○ | ○ | ○ | ○ |
| Insulted or humuliated you | ○ | ○ | ○ | ○ | ○ | ○ |
| Threw, hit, or kicked something | ○ | ○ | ○ | ○ | ○ | ○ |
| Threatened you with violence | ○ | ○ | ○ | ○ | ○ | ○ |
| Pushed you, or shook you violently | ○ | ○ | ○ | ○ | ○ | ○ |
| Pulled hair on you or pinced you | ○ | ○ | ○ | ○ | ○ | ○ |
| Slapped you | ○ | ○ | ○ | ○ | ○ | ○ |
| Hitted you with the fist | ○ | ○ | ○ | ○ | ○ | ○ |
| Hitted you with an object | ○ | ○ | ○ | ○ | ○ | ○ |
| Beaten you up | ○ | ○ | ○ | ○ | ○ | ○ |
| Done any other violent act towards you | ○ | ○ | ○ | ○ | ○ | ○ |

*ROUTING: ONLY TO THOSE WHO REPORTED AT LEAST ONE VIOLENT ACT FROM THEIR MOTHER/STEPMOTHER*

| How old were you when this happened? You can tick off more than one box. |
|---|
| ☐ Under 5 years old |
| ☐ 6-10 years old |
| ☐ 11-13 years old |
| ☐ 14 years old or older |

*ROUTING: ONLY TO THOSE WHO REPORTED AT LEAST ONE VIOLENT ACT FROM THEIR MOTHER/STEPMOTHER*

| Was it mother, stepmother, or both who did this? |
|---|
| ○ Mother |
| ○ Stepmother |
| ○ Both |

| Have your **mother/stepmother** ever… | No, never | Yes, once | Yes, several times |
|---|---|---|---|
| …used violence against you that caused bruises/physical injuries? | ○ | ○ | ○ |
| …used violence against you that caused you to be in pain the next day? | ○ | ○ | ○ |
| …used violence against you that caused you to need medical assistance? | ○ | ○ | ○ |

*ROUTING: ONLY TO THOSE WHO REPORTED BEING INJURED AS A RESULT OF VIOLENCE FROM THEIR MOTHER/STEPMOTHER*

| Was it mother, stepmother, or both who did this? |
|---|
| ○ Mother |
| ○ Stepmother |
| ○ Both |

*ROUTING: ONLY TO THOSE WHO REPORTED BEING INJURED AS A RESULT OF VIOLENCE FROM THEIR MOTHER/STEPMOTHER*

| *If YES, about how old were you the <u>first time</u> this happened?* |
|---|
| ○ Under 5 years old |
| ○ 6-10 years old |
| ○ 11-13 years old |
| ○ 14 years old or older |

| Have you ever seen or heard that your mother/stepmother has used physical violence against a sibling? |
|---|
| ○ No, never |
| ○ Yes, once |
| ○ Yes, more than once |

| Have **your father/stepfather** ever done any of the following against you. | Daily | Weekly | Monthly | A few times | Once | Never |
|---|---|---|---|---|---|---|
| Yelled at you | ○ | ○ | ○ | ○ | ○ | ○ |
| Scolded you | ○ | ○ | ○ | ○ | ○ | ○ |
| Insulted or humuliated you | ○ | ○ | ○ | ○ | ○ | ○ |
| Threw, hit, or kicked something | ○ | ○ | ○ | ○ | ○ | ○ |
| Threatened you with violence | ○ | ○ | ○ | ○ | ○ | ○ |
| Pushed you, or shook you violently | ○ | ○ | ○ | ○ | ○ | ○ |
| Pulled hair on you or pinced you | ○ | ○ | ○ | ○ | ○ | ○ |
| Slapped you | ○ | ○ | ○ | ○ | ○ | ○ |
| Hitted you with the fist | ○ | ○ | ○ | ○ | ○ | ○ |
| Hitted you with an object | ○ | ○ | ○ | ○ | ○ | ○ |
| Beaten you up | ○ | ○ | ○ | ○ | ○ | ○ |
| Done any other violent act towards you | ○ | ○ | ○ | ○ | ○ | ○ |

*ROUTING: ONLY TO THOSE WHO REPORTED AT LEAST ONE VIOLENT ACT FROM THEIR faTHER/STEPMFATHER*

| How old were you when this happened? You can tick off more than one box. |
|---|
| ☐ Under 5 years old |
| ☐ 6-10 years old |
| ☐ 11-13 years old |
| ☐ 14 years old or older |

*ROUTING: ONLY TO THOSE WHO REPORTED AT LEAST ONE VIOLENT ACT FROM THEIR faTHER/STEPMFATHER*

| Was it father, stepfather, or both who did this? |
|---|
| ○ Father |
| ○ Stepfather |
| ○ Both |

| Have your **father/stepfather** ever… | No, never | Yes, once | Yes, several times |
|---|---|---|---|
| …used violence against you that caused bruises/physical injuries? | ○ | ○ | ○ |
| …used violence against you that caused you to be in pain the next day? | ○ | ○ | ○ |
| …used violence against you that caused you to need medical assistance? | ○ | ○ | ○ |

*ROUTING: ONLY TO THOSE WHO REPORTED BEING INJURED AS A RESULT OF VIOLENCE FROM THEIR FATHER/STEPFATHER*

| Was it father, stepfather, or both who did this? |
|---|
| ○ Father |
| ○ Stepfather |
| ○ Both |

*ROUTING: ONLY TO THOSE WHO REPORTED BEING INJURED AS A RESULT OF VIOLENCE FROM THEIR FATHER/STEPFATHER*

| *If YES, about how old were you the first time this happened?* |
|---|
| ○ Under 5 years old |
| ○ 6-10 years old |
| ○ 11-13 years old |
| ○ 14 years old or older |

| Have you ever seen or heard that your father/stepfather has used physical violence against a sibling? |
|---|
| ○ No, never |
| ○ Yes, once |
| ○ Yes, more than once |

| My parents are: |
|---|
| ○ Married |
| ○ Cohabiting |
| ○ Divorced/separated |
| ○ Have never been married or cohabiting |
| ○ Other |

| *If your parents are divorced or have separated, how old were you when this happened?* I was (year) |
|---|
| |

| Who are you living with now? |
|---|
| ○ With my parents |
| ○ Mostly with my mother |
| ○ Mostly with my father |
| ○ About the same amount of time with my mother and with my father |
| ○ The extended family (grandparents or other relatives) |
| ○ Foster home/foster parents |
| ○ No one (living alone) |
| ○ Shared house/apartment or lodgings shared with others |
| ○ Together with my cohabitant/spouse |
| ○ Other, e.g., institution |
| ○ Only with my mother |

| If you during your upbringing have had another living situation, who have you then been living with? |
|---|
| ○ With my parents |
| ○ Mostly with my mother |
| ○ Mostly with my father |
| ○ About the same amount of time with my mother and with my father |
| ○ The extended family (grandparents or other relatives) |
| ○ Foster home/foster parents |
| ○ No one (living alone) |
| ○ Shared house/apartment or lodgings shared with others |
| ○ Together with my cohabitant/spouse |
| ○ Other, e.g., institution |
| ○ Only with my mother |
| ○ Only with my father |

| How many brothers do you have? |
|---|
| ○ None |
| ○ 1 |
| ○ 2 |
| ○ 3 or more |

| How many sisters do you have? |
|---|
| ○ None |
| ○ 1 |
| ○ 2 |
| ○ 3 or more |

| How tall are you? I am about (cm) |
|---|

| |
|---|
| |

| How much do you weigh? I weigh about (kg) |
|---|
| |

| When you started to mature physically, did this start earlier or later compared with others your age (of the same gender)? |
|---|
| ○ Much earlier |
| ○ Somewhat earlier |
| ○ A litte bit earlier |
| ○ List most others |
| ○ A little bit later |
| ○ Somewhat later |
| ○ A lot later |

*ROUTING: QUESTIONS TO A RANDOM HALF OF THE PARTICIPANTS*

| Have you been exposed to any of this **against your will**? | Before turning 13 | | | After turning 13 | | |
|---|---|---|---|---|---|---|
| | No, never | Yes, once | Yes, more than once | No, never | Yes, once | Yes, more than once |
| Someone has exposed themselves indecently for you | ○ | ○ | ○ | ○ | ○ | ○ |
| Someone has groped you | ○ | ○ | ○ | ○ | ○ | ○ |
| You have touched yourself in front of somebody | ○ | ○ | ○ | ○ | ○ | ○ |
| You have touched someone else | ○ | ○ | ○ | ○ | ○ | ○ |
| You have masturbated in front of someone | ○ | ○ | ○ | ○ | ○ | ○ |
| You have had sexual intercourse | ○ | ○ | ○ | ○ | ○ | ○ |
| You have had oral sex | ○ | ○ | ○ | ○ | ○ | ○ |
| You have had anal sex | ○ | ○ | ○ | ○ | ○ | ○ |
| You have had some other form of sex | ○ | ○ | ○ | ○ | ○ | ○ |

*ROUTING: QUESTIONS TO A RANDOM HALF OF THE PARTICIPANTS*

| Have you been exposed to any of this **against your will**? | Before turning 13 | | | After turning 13 | | |
|---|---|---|---|---|---|---|
| | No, never | Yes, once | Yes, more than once | No, never | Yes, once | Yes, more than once |
| Been touched in a sexual manner against your will | ○ | ○ | ○ | ○ | ○ | ○ |
| I have touched someone in a sexual manner against your will | ○ | ○ | ○ | ○ | ○ | ○ |
| Someone has coerced you into sexual acts against your will | ○ | ○ | ○ | ○ | ○ | ○ |
| Tried to force you to sexual intercourse or oral sex | ○ | ○ | ○ | ○ | ○ | ○ |
| Forced or threatened you into having sexual intercourse | ○ | ○ | ○ | ○ | ○ | ○ |
| Forced or threatened you into having oral sex | ○ | ○ | ○ | ○ | ○ | ○ |
| Forced or threatened you into having anal sex | ○ | ○ | ○ | ○ | ○ | ○ |
| Put fingers or objects into your vagina or anus | ○ | ○ | ○ | ○ | ○ | ○ |
| Someone have had sex with you against your will when you were sleeping or were too drunk to resist | ○ | ○ | ○ | ○ | ○ | ○ |
| Been touched in a sexual manner against your will | ○ | ○ | ○ | ○ | ○ | ○ |
| I have touched someone in a sexual manner against your will | ○ | ○ | ○ | ○ | ○ | ○ |

*ROUTING: ONLY TO THOSE WHO REPORTED BEING EXPOSED TO AT LEAST ONE UNWANTED SEXUAL EPISODE*

| Consider the first time you were exposed to an unwanted sexual episode. About how old were you when it happened? Age (years old) |
|---|
| |

*ROUTING: ONLY TO THOSE WHO REPORTED BEING EXPOSED TO AT LEAST ONE UNWANTED SEXUAL EPISODE*

| About how old was the person that did this to you? Age (years old) |
|---|
| |

*ROUTING: ONLY TO THOSE WHO REPORTED BEING EXPOSED TO AT LEAST ONE UNWANTED SEXUAL EPISODE*

| Was it a man/boy or a woman/girl that did this to you? |
|---|
| ○ Man/boy |

| |
|---|
| ○ Woman/girl |

*ROUTING: ONLY TO THOSE WHO REPORTED BEING EXPOSED TO AT LEAST ONE UNWANTED SEXUAL EPISODE*

| Who was the person that did this to you? |
|---|
| ○ A friend |
| ○ Girlfriend/boyfriend |
| ○ A stranger |
| ○ An acquaintance |
| ○ An instructor or leader at a leisure activity |
| ○ A teacher/employed at the school or the kindergarden |
| ○ Brother |
| ○ Sister |
| ○ Father |
| ○ Stepfather/mothers partner |
| ○ Mother |
| ○ Stepmother/fathers partner |
| ○ Grandfather |
| ○ Grandmother |
| ○ An other relative |

*ROUTING: ONLY TO THOSE WHO REPORTED BEING EXPOSED TO AT LEAST ONE UNWANTED SEXUAL EPISODE*

| When this happened, was alcohol included? |
|---|
| ○ No |
| ○ Yes, both the other(s) and myself were intoxicated |
| ○ Yes, I was intoxixated |
| ○ Yes, the other(s) were intoxicated |

*ROUTING: ONLY TO THOSE WHO REPORTED BEING EXPOSED TO AT LEAST ONE UNWANTED SEXUAL EPISODE*

| Can you describe what happened and who was involved (without mentioning a name)? |
|---|
| |

*ROUTING: ONLY TO THOSE WHO REPORTED BEING EXPOSED TO AT LEAST ONE UNWANTED SEXUAL EPISODE*

| When you think back at the incident, does any of the following descriptions fit what happened? | Very true | Quite true | Not very true | Not true at all |
|---|---|---|---|---|
| Was too small/young to understand | ○ | ○ | ○ | ○ |
| Participated voluntarily, but regretted later | ○ | ○ | ○ | ○ |
| I was tricked | ○ | ○ | ○ | ○ |
| I was persuaded | ○ | ○ | ○ | ○ |
| I was exposed to mild coercion | ○ | ○ | ○ | ○ |
| I was exposed to heavy coercion | ○ | ○ | ○ | ○ |
| I was withheld | ○ | ○ | ○ | ○ |
| I was threatened with violence | ○ | ○ | ○ | ○ |
| I got hit or injured | ○ | ○ | ○ | ○ |

*ROUTING: ONLY TO THOSE WHO REPORTED BEING EXPOSED TO AT LEAST ONE UNWANTED SEXUAL EPISODE*

| Have you experienced more than one unwanted sexual episode? |
|---|
| ○ Ja |
| ○ Nei |

*ROUTING: ONLY TO THOSE WHO REPORTED BEING EXPOSED TO more than ONE UNWANTED SEXUAL EPISODE*

| Consider the last time you were exposed to an unwanted sexual episode. How old were you when it happened? I was (years old) |
|---|
| |

*ROUTING: ONLY TO THOSE WHO REPORTED BEING EXPOSED TO more than ONE UNWANTED SEXUAL EPISODE*

| About how old was the person that did this to you? Age (years old) |
|---|
| |

*ROUTING: ONLY TO THOSE WHO REPORTED BEING EXPOSED TO more than ONE UNWANTED SEXUAL EPISODE*

| Was it a man/boy or a woman/girl that did this to you? |
|---|
| ○ Man/boy |
| ○ Woman/girl |

*ROUTING: ONLY TO THOSE WHO REPORTED BEING EXPOSED TO more than ONE UNWANTED SEXUAL EPISODE*

| Who was the person that did this to you? |
|---|
| ○ A friend |
| ○ Girlfriend/boyfriend |
| ○ A stranger |
| ○ An acquaintance |
| ○ An instructor or leader at a leisure activity |
| ○ A teacher/employed at the school or the kindergarden |
| ○ Brother |
| ○ Sister |
| ○ Father |
| ○ Stepfather/mothers partner |
| ○ Mother |
| ○ Stepmother/fathers partner |
| ○ Grandfather |
| ○ Grandmother |
| ○ An other relative |

*ROUTING: ONLY TO THOSE WHO REPORTED BEING EXPOSED TO more than ONE UNWANTED SEXUAL EPISODE*

| When this happened, was alcohol included? |
|---|
| ○ No |
| ○ Yes, both the other(s) and myself were intoxicated |
| ○ Yes, I was intoxixated |
| ○ Yes, the other(s) were intoxicated |

*ROUTING: ONLY TO THOSE WHO REPORTED BEING EXPOSED TO more than ONE UNWANTED SEXUAL EPISODE*

| Can you describe what happened and who was involved (without mentioning a name)? |
|---|
| |

*ROUTING: ONLY TO THOSE WHO REPORTED BEING EXPOSED TO more than ONE UNWANTED SEXUAL EPISODE*

| When you think back at the incident, does any of the following descriptions fit what happened? | Very true | Quite true | Not very true | Not true at all |
|---|---|---|---|---|
| Was too small/young to understand | ○ | ○ | ○ | ○ |
| Participated voluntarily, but regretted later | ○ | ○ | ○ | ○ |
| I was tricked | ○ | ○ | ○ | ○ |
| I was persuaded | ○ | ○ | ○ | ○ |
| I was exposed to mild coercion | ○ | ○ | ○ | ○ |
| I was exposed to heavy coercion | ○ | ○ | ○ | ○ |
| I was withheld | ○ | ○ | ○ | ○ |
| I was threatened with violence | ○ | ○ | ○ | ○ |
| I got hit or injured | ○ | ○ | ○ | ○ |

*ROUTING: ONLY TO THOSE WHO REPORTED BEING EXPOSED TO more than ONE UNWANTED SEXUAL EPISODE*

| Now we would like you to think about when you grew up, and answer how often the different statements fitted for you in your upbringing. | Never true | Rarely true | Sometimes true | Often true | Very often true |
|---|---|---|---|---|---|
| I didn't have enough to eat | ○ | ○ | ○ | ○ | ○ |
| I had to wear dirty clothes | ○ | ○ | ○ | ○ | ○ |
| My parents were too drunk or high to take care of the family | ○ | ○ | ○ | ○ | ○ |
| I knew there was someone to take care of me and protect me | ○ | ○ | ○ | ○ | ○ |
| There was somebody to take me to the doctor if I needed it | ○ | ○ | ○ | ○ | ○ |
| Someone in my family helped me feel important or special | ○ | ○ | ○ | ○ | ○ |
| I felt loved | ○ | ○ | ○ | ○ | ○ |
| People in my family looked out for each other | ○ | ○ | ○ | ○ | ○ |
| People in my family felt close to each other | ○ | ○ | ○ | ○ | ○ |
| My family was a source of strength and support | ○ | ○ | ○ | ○ | ○ |
| People in my family called me "stupid," "lazy," or "ugly" | ○ | ○ | ○ | ○ | ○ |
| I thought that my parents wished that I had never been born | ○ | ○ | ○ | ○ | ○ |
| People in my family said hurtful or insulting things to me | ○ | ○ | ○ | ○ | ○ |
| I felt that someone in my family hated me | ○ | ○ | ○ | ○ | ○ |
| I believe that I was emotionally abused | ○ | ○ | ○ | ○ | ○ |

*ROUTING: ONLY TO THOSE WHO REPORTED BEING EXPOSED TO more than ONE UNWANTED SEXUAL EPISODE*

| Does this suit your life? | Yes | No |
|---|---|---|
| My parents have threatened me with violence as part of my upbringing | ○ | ○ |
| My parents have used violence against me as part of my upbringing | ○ | ○ |

| How many friends do you have who you can trust, and who you can tell your secrets to? |
|---|
| ○ None |
| ○ 1 |
| ○ 2-3 |
| ○ 4-5 |
| ○ More than 5 |

| How many friends do you have that you can do things together with, but cannot tell your secrets? |
|---|
| ○ 1-5 |
| ○ 6-10 |
| ○ 11-20 |
| ○ More than 20 |

| | Yes | No | Not sure |
|---|---|---|---|
| While a teenager, have you ever been in love with a girl? | ○ | ○ | ○ |
| While a teenager, have you ever been in love with a boy? | ○ | ○ | ○ |

| Do you have a girlfriend/boyfriend? |
|---|
| ○ No, but I used to have a girlfriend/boyfriend |
| ○ No, I have never had a girlfriend/boyfriend |
| ○ Yes, I have a girlfriend now |

*ROUTING: ONLY TO THOSE WHO REPORTED HAVING A GIRLFRIEND/BOYFRIEND NOW OR WHO NEVER HAVE HAD A GIRLFRIEND*

| How old are your girlfriend/boyfriend? Age (years old) |
|---|
| |

| Think about the attitudes in your family. | Yes | No |
|---|---|---|

| | | |
|---|---|---|
| Do your family approve of you having a girlfriend/boyfriend? | ○ | ○ |
| Do your family approve of you having sex without being married? | ○ | ○ |

| Have you ever had any sexual experiences with a boy or a girl? | With a girl | | With a boy | |
|---|---|---|---|---|
| | Yes | No | Yes | No |
| Gotten horny or sexually turned on towards the person you were with | ○ | ○ | ○ | ○ |
| Made out («tongue kiss» etc.) | ○ | ○ | ○ | ○ |
| Touched each others' upper body | ○ | ○ | ○ | ○ |
| Touched each others' genitals | ○ | ○ | ○ | ○ |

| Have you ever had sexual intercourse? |
|---|
| ○ Yes |
| ○ No |

*ROUTING: ONLY TO THOSE WHO REPORTED HAVING HAD SEXUAL INTERCOURSE*

| How old were you the first time you had sexual intercourse? Age (years old) |
|---|
| |

*ROUTING: ONLY TO THOSE WHO REPORTED HAVING HAD SEXUAL INTERCOURSE*

| About how many persons have you had sexual intercourse with? Total |
|---|
| |

*ROUTING: ONLY TO THOSE WHO REPORTED HAVING HAD SEXUAL INTERCOURSE*

| About how many persons have you had sexual intercourse with during the last 12 months? Total |
|---|
| |

| Before you turned 16 years old, did you have sexual contact with someone at least 5 years older than yourself? |
|---|
| ○ Yes |
| ○ No |

| If yes on the question above – Was it a man/boy or a woman/girl? |
|---|
| ☐ Man/boy |
| ☐ Woman/girl |

| After you turned 16 years old, have you had sexual contact with someone that was under 16 years old? |
|---|
| ○ Yes |
| ○ No |

| If yes on the question above, was it a boy or a girl? |
|---|
| ☐ Boy |
| ☐ Girl |

| People differ in their sexual attraction to other people. What best describes your feelings? |
|---|
| ○ Only attracted to girls |
| ○ Mostly attracted to girls |
| ○ About the same to girls and boys |
| ○ Mostly attracted to boys |
| ○ Only attracted to boys |
| ○ Not sure |

| Do you consider yourself to be heterosexual or gay/lesbian or none of the above? |
|---|
| ○ Heterosexual |
| ○ Gay/lesbian |
| ○ Bisexual/a bit of both |
| ○ Not sure what label describes me |
| ○ Neither |
| ○ I don’t want to use such labels on myself |
| ○ Haven’t thought about it |
| ○ Don’t know what it means |

| Have you ever drunk alcohol (more than just tasted)? |
|---|
| ○ No |
| ○ Yes |

*ROUTING: ONLY TO THOSE WHO REPORTED THAT THEY HAD DRUNK ALCOHOL*

| How old were you the first time that you drank alcohol (more than just tasted)? I was (years old) |
|---|
| |

| How many times during the last year (last 12 months) have you done or experienced any of the following related to your use of alcohol? | None | Once | 2-4 times | 5-10 times | More than 10 times |
|---|---|---|---|---|---|
| Argued with or insulted someone | ○ | ○ | ○ | ○ | ○ |
| Gotten into a fight | ○ | ○ | ○ | ○ | ○ |
| Suddenly found yourself in a place that you could not remember getting to | ○ | ○ | ○ | ○ | ○ |
| Gotten so drunk that you couldn't stand upright | ○ | ○ | ○ | ○ | ○ |
| Suffered an injury or accident that required medical care | ○ | ○ | ○ | ○ | ○ |
| Been exposed to violence that resulted in visible marks or injuries | ○ | ○ | ○ | ○ | ○ |
| Hurt yourself on purpose | ○ | ○ | ○ | ○ | ○ |
| Destroyed things on purpose/committed vandalism | ○ | ○ | ○ | ○ | ○ |
| Been funnier and happier than you normally are | ○ | ○ | ○ | ○ | ○ |
| Gotten on better with people | ○ | ○ | ○ | ○ | ○ |
| Vomited because you had drunk to much | ○ | ○ | ○ | ○ | ○ |
| Used hash/marihuana or other illicit drugs (e.g., amphetamine, ecstasy, cocaine) | ○ | ○ | ○ | ○ | ○ |
| Had sexual intercourse without using contraception | ○ | ○ | ○ | ○ | ○ |
| Had voluntary sex that you later regretted | ○ | ○ | ○ | ○ | ○ |
| Been sexually exploited without being able to provide resistance because you were very drunk | ○ | ○ | ○ | ○ | ○ |
| Exploited or pressured someone sexually | ○ | ○ | ○ | ○ | ○ |

*ROUTING: ONLY TO THOSE WHO REPORTED HAVING HAD voluntary sex that THEY later regretted*

| You answered that you have had voluntary sex that you later regretted when drinking alcohol. Can you tell what happened and why you later regretted the act? |
|---|
| |

*ROUTING: ONLY TO THOSE WHO REPORTED HAVING BEEN sexually exploited without being able to provide resistance because THEY were very drunk*

| You answered that you have been sexually exploited without being able to provide resistance when drinking alcohol. Can you tell what happened and who did this to you (without mentioning a name)? |
|---|
| |

*ROUTING: ONLY TO THOSE WHO REPORTED HAVING Exploited or pressured someone sexually*

| You answered that you have exploited or pressured someone sexually when drinking alcohol. Can you tell what happened and who was involved (without mentioning a name)? |
|---|
| |

| Have you ever… | No, never | Yes, once | Yes, more than once |
|---|---|---|---|
| …on purpose taken an overdose of pills or some other medication? | ○ | ○ | ○ |
| …hurt yourself, e.g., by cutting yourself? | ○ | ○ | ○ |
| …on purpose tried to kill yourself? | ○ | ○ | ○ |

*ROUTING: ONLY TO THOSE WHO REPORTED THAT THEY HAD HURT THEMSELVES OR TRIED TO KILL THEMSELVES*

| Have you ever… | No, never | Yes, once | Yes, more than once |
|---|---|---|---|
| Have you ever ended in the emergency room because you intentionally hurt yourself? | ○ | ○ | ○ |
| Have you ever ended in the hospital because you intentionally hurt yourself? | ○ | ○ | ○ |
| Have you ever ended in the hospital because you tried to kill yourself? | ○ | ○ | ○ |

*ROUTING: ONLY TO THOSE WHO REPORTED THAT THEY HAD HURT THEMSELVES OR TRIED TO KILL THEMSELVES*

| Adolescents can hurt themselves for different reasons. Were any of these the case for you? |
|---|
| ☐ Could not stand my thoughts |
| ☐ Wanted to escape from an unbearable situation |
| ☐ Wanted to die |
| ☐ Lost the control of myself |
| ☐ Regretted something I had done |
| ☐ Wanted to make someone feel guilt |
| ☐ Wanted to know if anyone really cared about me |
| ☐ Argued with my girlfriend/boyfriend |
| ☐ Broke up with my girlfriend/boyfriend |
| ☐ Don’t remember/don’t know |

| Think about the last time you hurt yourself – can you describe the incident? |
|---|

| |
|---|
| |

| The following questions is about food and the body. Decide what corresponds the best for you. | Always | Often | Rarely | Never |
|---|---|---|---|---|
| I am preoccupied with the desire to be thinner | ○ | ○ | ○ | ○ |
| I engage in dieting behavior | ○ | ○ | ○ | ○ |
| I feel uncomfortable after eating | ○ | ○ | ○ | ○ |
| I vomit after I have eaten | ○ | ○ | ○ | ○ |
| I have gone on eating binges where I feel that I may not be able to stop | ○ | ○ | ○ | ○ |
| I give too much time and thought to food | ○ | ○ | ○ | ○ |
| I feel that food controls my life | ○ | ○ | ○ | ○ |

| The age of sexual consent is today 16 years old. What do you thing the age of sexual consent should be? |
|---|
| ○ 18 years old |
| ○ 17 years old |
| ○ 16 years old |
| ○ 15 years old |
| ○ 14 years old |
| ○ 13 years old or lower |

| Have you done any of the following during the last 12 months? | No | Yes, once | Yes, more than once |
|---|---|---|---|
| Broken in somewhere to steal something | ○ | ○ | ○ |
| Been in a fight using weapons (e.g., a knife) | ○ | ○ | ○ |
| Threatened someone into giving you money or things | ○ | ○ | ○ |
| Illegally spray-painted or tagged walls, buildings, trains, buses, etc. | ○ | ○ | ○ |
| Taken something from a show without paying | ○ | ○ | ○ |
| Deliberately damaged or broken window panes, bus seats, post boxes, etc. (vandalism) | ○ | ○ | ○ |
| Payed for sexual favors with money or gifts | ○ | ○ | ○ |
| Exposed yourself indecently against their will | ○ | ○ | ○ |
| Groped someone against their will | ○ | ○ | ○ |
| Coerced or forced someone to masturbate you | ○ | ○ | ○ |

| | | | |
|---|---|---|---|
| Coerced or forced someone into having sexual intercourse | ○ | ○ | ○ |
| Coerced or forced someone into having oral sex | ○ | ○ | ○ |
| Coerced or forced someone into having anal sex | ○ | ○ | ○ |
| Used tablets (prescription drugs) to get intoxicated | ○ | ○ | ○ |
| Used hash or marihuana | ○ | ○ | ○ |
| Used other kinds of illicit drugs (amphetamine, heroin, cocaine, ecstasy) | ○ | ○ | ○ |
| Taken part in teasing, threatening, or freezing out of other young people at school or in your free time | ○ | ○ | ○ |
| Expose someone to sexual harassment | ○ | ○ | ○ |
| Threatened someone with violence | ○ | ○ | ○ |
| Scratched or pulled the hair on someone | ○ | ○ | ○ |
| Slapped someone | ○ | ○ | ○ |
| Hit or kicked someone | ○ | ○ | ○ |

*ROUTING: ONLY TO THOSE WHO REPORTED HAVING SCRATCHED OR PULLED THE HAIR ON SOMEONE, SLAPPED SOMEONE, OR HIT OR KICKED SOMEONE DURING THE LAST 12 MONTHS*

| You answered that you have scratched, pulled the hair, slapped, hitted or kicked someone during the last 12 months: Who did you do this to? |
|---|
| ☐ Adolescent acquiantances |
| ☐ Unknown adolescents |
| ☐ Girlfriend/boyfriend |
| ☐ Brother |
| ☐ Sister |
| ☐ Mother |
| ☐ Father |
| ☐ Another adult in the family |
| ☐ Other adults |

| Have you done any of the following to get something in return (like things, money, help with something)? | Have done it | Would like to do it | Neither of the above |
|---|---|---|---|
| Showed your genitals | ○ | ○ | ○ |
| Gotten photographed or filmed nude | ○ | ○ | ○ |
| Masturbated/touched someone | ○ | ○ | ○ |
| Had oral sex | ○ | ○ | ○ |
| Had intercourse | ○ | ○ | ○ |
| Had anal sex | ○ | ○ | ○ |

| | | | |
|---|---|---|---|
| Gotten photographed or filmed in sexual situations | ○ | ○ | ○ |

| **In the last 30 days**, I have been cyberbullied in these ways. | Never | Once | A few times | Several times | Many times |
|---|---|---|---|---|---|
| Someone posted mean or hurtful comments about me online | ○ | ○ | ○ | ○ | ○ |
| Someone posted a mean or hurtful picture online of me | ○ | ○ | ○ | ○ | ○ |
| Someone posted a mean or hurtful video online of me | ○ | ○ | ○ | ○ | ○ |
| Someone created a mean or hurtful web page about me | ○ | ○ | ○ | ○ | ○ |
| Someone spread rumors about me online | ○ | ○ | ○ | ○ | ○ |
| Someone threatened to hurt me through a cell phone text message | ○ | ○ | ○ | ○ | ○ |
| Someone threatened to hurt me online | ○ | ○ | ○ | ○ | ○ |

| **In the last 30 days**, I have cyberbullied others in these ways: | Never | Once | A few times | Several times | Many times |
|---|---|---|---|---|---|
| I posted mean or hurtful comments about someone online | ○ | ○ | ○ | ○ | ○ |
| I posted a mean or hurtful image online of someone | ○ | ○ | ○ | ○ | ○ |
| I posted a mean or hurtful video online of someone | ○ | ○ | ○ | ○ | ○ |
| I spread rumors about someone online | ○ | ○ | ○ | ○ | ○ |
| I threatened to hurt someone online | ○ | ○ | ○ | ○ | ○ |
| I threatened to hurt someone through a cell phone text message | ○ | ○ | ○ | ○ | ○ |
| I created a mean or hurtful web page about someone | ○ | ○ | ○ | ○ | ○ |

| Think about the time **before** you turned 13. Have someone your own age exposed you to any of this? | Daily | Weekly | Monthly | A few times | Once | Never |
|---|---|---|---|---|---|---|
| I have been exposed to teasing, threats, or ostracism | ○ | ○ | ○ | ○ | ○ | ○ |
| I have been exposed to sexual harassment | ○ | ○ | ○ | ○ | ○ | ○ |
| I've been threatened with violence | ○ | ○ | ○ | ○ | ○ | ○ |
| I've been hit without getting bruises | ○ | ○ | ○ | ○ | ○ | ○ |

| | | | | | | |
|---|---|---|---|---|---|---|
| I have gotten bruises or injuries as a result of violence without needing medical assistance | ○ | ○ | ○ | ○ | ○ | ○ |
| I have been injured so badly due to violence that I needed medical assistance | ○ | ○ | ○ | ○ | ○ | ○ |

| Think about the time **after** you turned 13. Have someone your own age exposed you to any of this? | Daily | Weekly | Monthly | A few times | Once | Never |
|---|---|---|---|---|---|---|
| I have been exposed to teasing, threats, or ostracism | ○ | ○ | ○ | ○ | ○ | ○ |
| I have been exposed to sexual harassment | ○ | ○ | ○ | ○ | ○ | ○ |
| I've been threatened with violence | ○ | ○ | ○ | ○ | ○ | ○ |
| I've been hit without getting bruises | ○ | ○ | ○ | ○ | ○ | ○ |
| I have gotten bruises or injuries as a result of violence without needing medical assistance | ○ | ○ | ○ | ○ | ○ | ○ |
| I have been injured so badly due to violence that I needed medical assistance | ○ | ○ | ○ | ○ | ○ | ○ |

*ROUTING: ONLY TO THOSE WHO REPORTED HAVING BEEN EXPOSED TO VIOLENCE FROM SOMEONE THEIR OWN AGE BEFORE TURNING 13*

| You answered that you have been exposed to violence from someone your own age **before** turning 13. Who did this to you? |
|---|
| ☐ Friends or acquaintances |
| ☐ Unknown adolescents |
| ☐ Girlfriend/boyfriend |
| ☐ Brother |
| ☐ Sister |

*ROUTING: ONLY TO THOSE WHO REPORTED HAVING BEEN EXPOSED TO VIOLENCE FROM SOMEONE THEIR OWN AGE AFTER TURNING 13*

| You answered that you have been exposed to violence from someone your own age **after** turning 13. Who did this to you? |
|---|
| ☐ Friends or acquaintances |
| ☐ Unknown adolescents |
| ☐ Girlfriend/boyfriend |
| ☐ Brother |
| ☐ Sister |

*ROUTING: ONLY TO THOSE WHO REPORTED HAVING BEEN EXPOSED TO VIOLENCE FROM A GIRLFRIEND/BOYFRIEND BEFORE OR AFTER TURNING 13*

| You answered that you have been exposed to violence from a girlfriend. Can you describe what happened? |
|---|
| |

| Have you used violence against someone your own age (after you turned 13 years old)? |
|---|
| ○ No, never |

| |
|---|
| ○ Against a friend or acquaintance |
| ○ Against someone you did not know |
| ○ Against a girlfriend/boyfriend |
| ○ Against a brother |
| ○ Against a sister |

| Have an adult in your family ever hit you on purpose? |
|---|
| ○ No, never |
| ○ Yes, once |
| ○ 2—4 times |
| ○ 5—10 times |
| ○ More than 10 times |

*RoUTING: only to those who reported having been hit by an adult family member*

| You answered that an adult in your family have hit you on purpose. Who did this to you? |
|---|
| ☐ Father |
| ☐ Stepfather/mothers partner |
| ☐ Mother |
| ☐ Stepmother/fathers partner |
| ☐ Brother |
| ☐ Sister |
| ☐ Grandfather |
| ☐ Grandmother |
| ☐ Another relative |

*RUTING: kun til de som HADDE BLITT SLÅTT AV EN VOKSEN I SIN FAMILIE*

| You answered that an adult in your family have hit you, about how old were you the first time this happened? |
|---|
| ○ Under 5 years old |
| ○ 6—10 years old |
| ○ 11—13 years old |
| ○ 14 years old or older |
| ○ Don't remember |
| ○ Not relevant/have not experienced this |

| Below are some questions about your opinion of yourself. Decide | Corresponds very well | Corresponds quite well | Corresponds quite poorly | Corresponds very poorly |
|---|---|---|---|---|

| whether the statements correspond to you. | | | | |
|---|---|---|---|---|
| I am not happy with the way I look | ○ | ○ | ○ | ○ |
| I wish my body was different | ○ | ○ | ○ | ○ |
| I wish my physical appearance was different | ○ | ○ | ○ | ○ |
| I think I am good looking | ○ | ○ | ○ | ○ |
| I really like my looks | ○ | ○ | ○ | ○ |

| Have you had any of these health issues during **the past month**? | Never | A few times | Many times | Daily |
|---|---|---|---|---|
| Headache | ○ | ○ | ○ | ○ |
| Neck and shoulder pain | ○ | ○ | ○ | ○ |
| Joint and muscle pain | ○ | ○ | ○ | ○ |
| Stomach ache | ○ | ○ | ○ | ○ |
| Nausea/feeling sick | ○ | ○ | ○ | ○ |
| Palpitations | ○ | ○ | ○ | ○ |

| Below there are listed different troubles and problems one can have once in a while. During **the past week**, have you been bothered by any of these things? | Not bothered at all | A little bit bothered | Quite a bit bothered | Extremely bothered |
|---|---|---|---|---|
| Suddenly scared for no reason | ○ | ○ | ○ | ○ |
| Feeling fearful | ○ | ○ | ○ | ○ |
| Faintness, dizziness, or weakness | ○ | ○ | ○ | ○ |
| Nervousness or shakiness inside | ○ | ○ | ○ | ○ |
| Heart pounding or racing | ○ | ○ | ○ | ○ |
| Trembling | ○ | ○ | ○ | ○ |
| Feeling tense or keyed up | ○ | ○ | ○ | ○ |
| Headaches | ○ | ○ | ○ | ○ |
| Spells of terror or panic | ○ | ○ | ○ | ○ |

| Below there are listed different troubles and problems one can have once in a while. During **the past week**, have you been bothered by any of these things? | Not bothered at all | A little bit bothered | Quite a bit bothered | Extremely bothered |
|---|---|---|---|---|
| Feeling restless, can't sit still | ○ | ○ | ○ | ○ |
| Feeling low in energy—slowed down | ○ | ○ | ○ | ○ |
| Blaming yourself about things | ○ | ○ | ○ | ○ |
| Crying easily | ○ | ○ | ○ | ○ |
| Loss of sexual interest or pleasure | ○ | ○ | ○ | ○ |
| Poor appetite | ○ | ○ | ○ | ○ |
| Difficulty falling asleep, staying asleep | ○ | ○ | ○ | ○ |
| Feeling hopeless about the future | ○ | ○ | ○ | ○ |
| Feeling blue | ○ | ○ | ○ | ○ |

| Below there are listed different troubles and problems one can have once in a while. During **the past week**, have you been bothered by any of these things? | Not bothered at all | A little bit bothered | Quite a bit bothered | Extremely bothered |
|---|---|---|---|---|
| Feeling lonely | ○ | ○ | ○ | ○ |
| Thoughts of ending your life | ○ | ○ | ○ | ○ |
| Feeling trapped or caught | ○ | ○ | ○ | ○ |
| Worrying too much about things | ○ | ○ | ○ | ○ |
| Feeling no interest in things | ○ | ○ | ○ | ○ |
| Feeling everything is an effort | ○ | ○ | ○ | ○ |
| Feeling of worthlessless | ○ | ○ | ○ | ○ |
| Been angry or aggressive | ○ | ○ | ○ | ○ |

| Have you ever had an experience that were so frightening, terrifying, or upsetting that you during **the last month** have … | Yes | No |
|---|---|---|
| Avoided certain places, persons, or activities to not be reminded of this experience? | ○ | ○ |
| Lost interest in activities that you liked to do or that used to be important to you? | ○ | ○ |
| Felt more distant or detached from other people? | ○ | ○ |
| Sensed that it is difficult to be fond of or caring for others? | ○ | ○ |
| Felt that planning for the future is of no use? | ○ | ○ |
| Had problems falling asleep or woke up to early after this experience? | ○ | ○ |
| Become easier startled or scared by regular noises or movements? | ○ | ○ |

| How would you consider your own health? |
|---|
| ○ Very well |
| ○ Well |
| ○ Neither well or poor |
| ○ Poor |
| ○ Very poor |

| Below is a list of statements. Do one or more of these fit your situation? |
|---|
| ☐ I don't see well |
| ☐ I don't hear well |
| ☐ I have trouble walking |
| ☐ I have trouble concentrating |
| ☐ I easily get tired or sleepy |
| ☐ No, none of the above |

*ROUTING: ONLY TO THOSE WHO REPORTED HAVING A HEALTH PROBLEM*

| Do any of these challenges cause you to be absent from school? |
|---|
| ○ Yes |
| ○ No |

| Do you have a chronic disease or disability (e.g., asthma, CP, epilepsy)? |
|---|
| ○ No |
| ○ Yes |

*RUTING: kun til de som hadde en kronisk sykdom eller funksjonsnedsettelse*

| Which chronic disease/disability do you have? |
|---|
| |

*RUTING: kun til de som hadde en kronisk sykdom eller funksjonsnedsettelse*

| Do any of these challenges cause you to be absent from school? |
|---|
| ○ Yes |
| ○ No |

| Think about how you have felt during **the last month**. How have you thought and felt about yourself, and | Totally agree | Somewhat agree | Neither agree nor disagree | Somewhat disagree | Totally disagree |
|---|---|---|---|---|---|

| about important people around you. Tick off whether you agree or not to the statements below. | | | | | |
|---|---|---|---|---|---|
| I reach my goals if I work hard | ○ | ○ | ○ | ○ | ○ |
| I am at my best when I have clear aims and objectives | ○ | ○ | ○ | ○ | ○ |
| I have some friends/family members that usually encourage me | ○ | ○ | ○ | ○ | ○ |
| I am satisfied with my life up till now | ○ | ○ | ○ | ○ | ○ |
| In my family, we share views of what is important in life | ○ | ○ | ○ | ○ | ○ |
| I easily make others feel comfortable around me | ○ | ○ | ○ | ○ | ○ |
| I know how to reach my goals | ○ | ○ | ○ | ○ | ○ |
| I always make a plan before I start something new | ○ | ○ | ○ | ○ | ○ |
| My friends always stick together | ○ | ○ | ○ | ○ | ○ |
| I feel comfortable with my family | ○ | ○ | ○ | ○ | ○ |

| Think about how you have felt during **the last month**. How have you thought and felt about yourself, and about important people around you. Tick off whether you agree or not to the statements below. | Totally agree | Somewhat agree | Neither agree nor disagree | Somewhat disagree | Totally disagree |
|---|---|---|---|---|---|
| I easily find new friends | ○ | ○ | ○ | ○ | ○ |
| When it is impossible for me to change certain things, I stop worrying about them | ○ | ○ | ○ | ○ | ○ |
| I am good at organizing my time | ○ | ○ | ○ | ○ | ○ |
| I have some close friends/family members that really care about me | ○ | ○ | ○ | ○ | ○ |
| In my family, we agree on most things | ○ | ○ | ○ | ○ | ○ |
| I am good at talking to new people | ○ | ○ | ○ | ○ | ○ |
| I feel competent | ○ | ○ | ○ | ○ | ○ |
| In my family, we have rules that simplify everyday life | ○ | ○ | ○ | ○ | ○ |
| I always have someone that can help me when I need it | ○ | ○ | ○ | ○ | ○ |

| Think about how you have felt during **the last month**. How have you thought and felt about yourself, and about important people around you. Tick off whether you agree or not to the statements below. | Totally agree | Somewhat agree | Neither agree nor disagree | Somewhat disagree | Totally disagree |
|---|---|---|---|---|---|
| When I have to choose between several options I almost always know what will be right for me | ○ | ○ | ○ | ○ | ○ |
| My family view the future as positive, even when very sad things happen | ○ | ○ | ○ | ○ | ○ |
| I always find something fun to talk about | ○ | ○ | ○ | ○ | ○ |
| My belief in myself gets me through difficult times | ○ | ○ | ○ | ○ | ○ |
| In my family, we support each other | ○ | ○ | ○ | ○ | ○ |
| I always find something comforting to say to others when they are sad | ○ | ○ | ○ | ○ | ○ |
| When things go badly I have a tendency to find something good that can come out of it | ○ | ○ | ○ | ○ | ○ |
| In my family, we like to do things together | ○ | ○ | ○ | ○ | ○ |
| I have some close friends/family members that value my qualities | ○ | ○ | ○ | ○ | ○ |

| Some need to think very thorougly before they act, while others act very spontaniously. Tick off for the answer that best corresponds to the way you have felt **the last 12 months**. | Does not correspond | Corresponds a bit | Corresponds completely |
|---|---|---|---|
| I like to act spontaneously | ○ | ○ | ○ |
| I am rather quick and sloppy than thorough and elaborate | ○ | ○ | ○ |
| I usually make decisions after thorough consideration | ○ | ○ | ○ |
| People tell me I am methodical and systematic in everything I do | ○ | ○ | ○ |
| I plan and organize things in detail | ○ | ○ | ○ |
| I am a careful person | ○ | ○ | ○ |
| I often act on the spur of the moment | ○ | ○ | ○ |

*ROUTING: QUESTION TO A RANDOM HALF OF THE BOYS*

| **How many of the following statements do you agree with:**<br>— Every human should be considered equal according to the law.<br>— I think it is completely OK to exploit the social welfare system.<br>— The belief in global warming is grossly exaggerated<br>— I would rape a girl if I knew I wouldn't get caught<br>— Climate fees are necessary to improve the environment |
|---|
| ○ None |
| ○ 1 statement |
| ○ 2 statements |
| ○ 3 statements |
| ○ 4 statements |
| ○ 5 statements |

*ROUTING: QUESTION TO A RANDOM HALF OF THE BOYS*

| **How many of the following statements do you agree with:**<br>— Every human should be considered equal according to the law.<br>— I think it is completely OK to exploit the social welfare system.<br>— The belief in global warming is grossly exaggerated<br>— Climate fees are necessary to improve the environment |
|---|
| ○ None |
| ○ 1 statement |
| ○ 2 statements |
| ○ 3 statements |
| ○ 4 statements |

*ROUTING: ONLY TO THOSE WHO GOT THE QUESTION WITH FOUR STATEMENTS*

| Tick off the statements you agree with: | Agree | Disagree |
|---|---|---|
| I drive too fast when I don't think I will get pulled over for speeding | ○ | ○ |
| All humans will have a better life if economic resources were evenly distributed in the world | ○ | ○ |
| I would rape a girl if I knew I wouldn't get caught | ○ | ○ |
| Soccer players deserve higher salaries than nurses | ○ | ○ |

| Below you see a list of qualities people might have. How well do these qualities fit you? | Does not correspond at all 1 | 2 | 3 | 4 | Does absolutely correspond 5 |
|---|---|---|---|---|---|
| Defends my beliefs | ○ | ○ | ○ | ○ | ○ |
| Feminin | ○ | ○ | ○ | ○ | ○ |
| Independent | ○ | ○ | ○ | ○ | ○ |
| Does not use harsh language | ○ | ○ | ○ | ○ | ○ |
| Makes decisions easy | ○ | ○ | ○ | ○ | ○ |
| Sensitive to the needs of others | ○ | ○ | ○ | ○ | ○ |
| Strong personality | ○ | ○ | ○ | ○ | ○ |
| Understanding | ○ | ○ | ○ | ○ | ○ |
| Forceful | ○ | ○ | ○ | ○ | ○ |
| Has leadership abilities | ○ | ○ | ○ | ○ | ○ |
| Eager to soothe hurt feelings | ○ | ○ | ○ | ○ | ○ |
| Warm | ○ | ○ | ○ | ○ | ○ |
| Dominant | ○ | ○ | ○ | ○ | ○ |
| Tender | ○ | ○ | ○ | ○ | ○ |
| Willing to take a stand | ○ | ○ | ○ | ○ | ○ |
| Loves children | ○ | ○ | ○ | ○ | ○ |
| Aggressive | ○ | ○ | ○ | ○ | ○ |
| Friendly | ○ | ○ | ○ | ○ | ○ |
| Willing to take risks | ○ | ○ | ○ | ○ | ○ |

| If you have been the victim of physical violence/physical abuse, have you been in contact with any of the following help services? |
|---|
| ☐ Not relevant, have never been victimized |
| ☐ Crisis center |
| ☐ Family care |
| ☐ Laywer |
| ☐ The police |
| ☐ General practitioner |
| ☐ Emergency room |
| ☐ Dentist |
| ☐ School nurse/the Young people’s clinic |
| ☐ The children’s and young people’s psychiatric outpatient clinic |

| |
|---|
| ☐ Psychologist/psychiatrist |
| ☐ The child welfare service |
| ☐ Children's Advocacy Center |
| ☐ Teacher, school councellor or someone else at school |
| ☐ Others |
| ☐ Have been exposed to physical violence/physical abuse, but did not contact anybody |

| Hvis du har vært utsatt for seksuelle overgrep (f.eks. voldtekt, voldtektsforsøk, beføling), har du som følge av dette vært i kontakt med noen av disse instansene? |
|---|
| ☐ Not relevant, have never been victimized |
| ☐ Crisis center |
| ☐ Family care |
| ☐ Laywer |
| ☐ The police |
| ☐ General practitioner |
| ☐ Emergency room |
| ☐ Dentist |
| ☐ School nurse/the Young people's clinic |
| ☐ The children's and young people's psychiatric outpatient clinic |
| ☐ Psychologist/psychiatrist |
| ☐ The child welfare service |
| ☐ Children's Advocacy Center |
| ☐ Teacher, school councellor or someone else at school |
| ☐ Others |
| ☐ Have been exposed to sexual abuse, but did not contact anyone |

| Was the physical violence/the sexual assault reported to the police? |
|---|
| ○ Yes |
| ○ No |
| ○ Don't know |

*ROUTING: ONLY TO THOSE WHO REPORTED THAT THE PHYSICAL VIOLENCE / sexual ABUSE WAS NOT REPORTED TO THE POLICE*

| If the incident(s) was not reported, what was the reason for this? |
|---|
| ☐ It was too trivial |
| ☐ It was a private matter, not a police matter |
| ☐ It would not help me much |
| ☐ Afraid of not being believed |
| ☐ I didn't think the police would be very obliging |
| ☐ The police recommended not pressing charges |
| ☐ It would only lead to more violence/abuse |
| ☐ Didn't want it to be a trial |
| ☐ Afraid someone in the family should find out |
| ☐ My family didn't want the incident to be reported |
| ☐ I didn't want anyone to find out about it |
| ☐ I wasn't believed |
| ☐ Other |
| ☐ Don't know |

*ROUTING: ONLY TO THOSE WHO REPORTED THAT THE PHYSICAL VIOLENCE / sexual ABUSE WAS REPORTED TO THE POLICE*

| Did the case(s) appear in court? |
|---|
| ○ No |
| ○ Yes, and the accused person/the person who did it was convicted |
| ○ Yes, but the accused person/the person who did it was found not guilty |
| ○ Don't know |

| How would you consider your experience with answering the questions about violence and abuse in this questionnaire? | Totally agree | Somewhat agree | Somewhat disagree | Totally disagree |
|---|---|---|---|---|
| The questions were uncomfortable | ○ | ○ | ○ | ○ |
| The questions got me to think about several things I haven't thought about before | ○ | ○ | ○ | ○ |
| The questions can affect in unfortunate ways | ○ | ○ | ○ | ○ |
| I think the questions were too private | ○ | ○ | ○ | ○ |
| The questions address important issues | ○ | ○ | ○ | ○ |

| If you have any comments to the questionnaire you can write them here: |
|---|
| |