

**An Exploration of Young People's Views and  
Understanding of Mental Health Difficulties**

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## **Thesis Abstract**

How young people perceive and respond to mental health difficulties will have implications for the health, wellbeing, shape of services and quality of life for their own and future generations. Understanding young people's views will be important in guiding the development of resources that support them in learning about and protecting their mental health.

The following pages present three papers which seek to facilitate a clearer understanding of what young people think and know about mental health difficulties. A review of the literature is presented in Paper 1 and indicates that this has been an under-researched area for many years. The existing literature presents an incomplete and varied account of the nature of young peoples' understanding of mental health difficulties. It indicates a need for further, high-quality research in this area to address these inconsistencies and consider the sources that might influence young people's perceptions.

Paper 2 details the empirical research that was undertaken in response to these gaps in the literature. Sixteen young people took part in a vignette-based qualitative study. Interview transcripts were analysed using Thematic Analysis. Three themes were identified: 'the experience of being unwell', 'empathy and stigma', and 'in search of truth', and two subthemes, 'cause and context' and 'helping and helplessness'. These themes are discussed in detail, and the clear strengths and gaps in young people's understanding are discussed. Implications for the development and delivery of mental health education initiatives are considered.

An executive summary of this research is presented in Paper 3. It includes recommendations to support schools and education providers in responding to recent developments in the UK which will ensure that every child is taught about mental health and wellbeing in school.

## **Paper 1: Literature Review**

### **The Nature of Adolescents' Understanding of Mental Health Difficulties: A Review of the Literature**

Word Count: 7994

This paper has been written to the standard required for submission to publication in the *Journal of Adolescence* (excluding word count). Author guidelines for manuscript submission can be found in Appendix A.



## **Abstract**

**Purpose:** It has been suggested that one in ten children and adolescents are affected by mental health difficulties, yet less than one third seek professional help and support. This review presents a current overview of empirical literature exploring adolescents' understanding and views of mental health difficulties. Understanding young people's views can help to inform awareness-raising and stigma-reducing initiatives and improve outcomes for young people's mental health.

**Method:** Thirteen studies were identified through a systematic search of EBSCO Host and Web of Science databases. The findings of each study were critically appraised, and a narrative synthesis of the data undertaken to provide a comprehensive literature review.

**Results:** Eight key areas were identified for consideration; adolescents' definitions of mental health difficulties, ability to recognise mental health difficulties, understanding of potential causes, sources of help, attitudes and stigma, and the influence of gender, cultural differences and familiarity with mental illness.

**Conclusions:** Whilst there are indications of a broad and sophisticated knowledge of mental health difficulties, there are substantial gaps and weaknesses in adolescents' understanding indicated by the presence of misconceptions and stigmatising attitudes. Contradictions in the literature are considered in relation to methodological limitations and discrepancies between studies. Implications for the findings are considered and suggestions made for future research.

## Introduction

Adolescence is defined by the World Health Organization (WHO) as the period between the ages of 10 and 19 years (WHO, 2014) and is considered one of the most rapid phases of human development, marking the transition from childhood to adulthood. It is a distinct developmental stage during which young people undergo profound biological, neurodevelopmental, psychological and social changes, and indicates a period of heightened pressure and challenge for young people.

During adolescence young people are faced with the challenge of adapting to changes in the self (including puberty, emotional and cognitive capacities, social expectations and sexual orientation) and changes in their family and friendship groups as their new identity and role within their systemic networks expand and develop (Crockett & Silbereisen, 2000). Many adolescents are also faced with institutional challenges and changes, including exam pressures, and adjusting to new structures and systems within school as they move from primary to secondary education, and then on to university or work. In order to navigate this period of heightened transition and change, a key function of adolescence is developing an integrated sense of self, comprising individualisation, separation from parents, establishing autonomy and independence, and the development of personal identity (National Research Council, 2013).

Adolescence also is viewed as a period of heightened neurological development. More recent research has challenged existing views of the adolescent brain as being biologically predisposed towards dangerous, impulsive and risky behaviours due to a maturational gap between cognitive and affective systems, suggesting instead that adolescence marks a window of opportunity where the brain is more sensitive and responsive to changes in the social environment and the presence of social affective influences than during any other period of development (Crone & Dahl, 2012). While this is especially helpful for young people in developing social competencies for adulthood, as well as in shaping their social identities, it may also leave young people particularly vulnerable to

the impact of social evaluation, peer pressure and social exclusion (Somerville, 2013), and more risky, impulsive or harmful behaviours as a result.

Due to the existing range and complexity of these developmental pressures, the introduction of additional life stressors can have a more profound impact on a young person's mental health and wellbeing during this period than at any other time in their lives (Larson & Ham, 1993; Zivin, Eisenberg, Gollust & Golberstein, 2009). Indeed, adolescence marks a period where young people are particularly vulnerable to developing mental health difficulties (Kessler et al., 2007). Worldwide, up to 20% of adolescents in any given year may experience mental health difficulties (Belfer, 2008; WHO, 2013). The age of onset for mental health disorders is reported as taking place during childhood and adolescence (Costello, Egger & Angold, 2006; Hill, 1989; Kessler et al., 2007; Roberts, Attkisson & Rosenblat, 1998; Sawyer et al., 2000), with half of all mental health problems established by the age of 14 (Belfer, 2008; Kim-Cohen, Caspi & Moffit, 2003; Kessler et al., 2005, 2007).

In the UK it has been estimated that around one in ten, approximately 850,000 children and young people, are thought to be experiencing clinically diagnosable mental health difficulties (Green, McGinnity, Meltzer, Ford & Goodman, 2004). This equates to three children in every school classroom (Layard, 2011). There has been an absence of prevalence data in the UK for many years however, and it is expected that these figures are likely to be an underestimate (Care Quality Commission, 2017). The arrival in late 2018 of the outputs of a new prevalence survey will provide a welcome update and is expected to provide a current and detailed report of the current state of children and young people's mental health in the UK.

Current evidence points to a worrying and increasing trend in the number of children and young people experiencing mental health difficulties however (Hagell, 2012; Layard, 2011). The number of young people under 18 attending A&E due to a psychiatric condition more than doubled

between 2010 and 2015 and the number of referrals to child and adolescent mental health services (CAMHS) increased by 64% between 2012 and 2015 (CentreForum Commission, 2016). This is alongside an increase in the number of young people contacting helplines for support in relation to self-harm and suicidal thoughts (Institute for Public Policy Research, 2016).

There is some debate around whether the increase in the number of young people accessing services is linked to prevalence rates or alternative factors. Increases have been linked to changes in societal and environmental pressures faced by many young people in the UK, including increasing rates of socioeconomic disadvantage (NHS England, 2016), the impact of digital technologies (NSPCC, 2014; Public Health England, 2013) and increasing educational and exam pressures placed on young people (Chamberlain, George, Golden, Walker & Bengon, 2010). An additional factor is related to the knock-on effect of an increasing number of adults, and consequently parents, experiencing mental health difficulties (NHS England, 2016). Parental depression is considered a key risk factor for the development of emotional problems in adolescents (Gardner et al., 2012). Increases could also be related to increasing public awareness of mental health problems, and the success of national anti-stigma campaigns such as Time to Change (Henderson, Stuart and Hansson, 2016) which could be encouraging more young people and their parents to report difficulties and seek support.

While the reason for the increase in young people accessing services is unclear, it stands that a worrying number of children and young people are experiencing mental health difficulties, with potentially serious and lifelong consequences. There is a clear need for early intervention and treatment of mental health difficulties in children and young people, yet it is estimated that only 25% who need treatment go on to receive it (Public Health England, 2016), and 70% of children and adolescents who experience mental health problems have not received appropriate interventions at a sufficiently early age (Children's Society, 2008). Current

figures indicate that around 460 000 referrals are being made to CAMHS each year, of which 200 000 children and young people go on to receive treatment in the NHS (Care Quality Commission, 2017). This indicates that many thousands of young people experiencing mental health difficulties are left without adequate care and support, during this critical and vulnerable period of their lives, either through being ineligible for services, or through never accessing these at all.

Without access to support, mental health difficulties can have a significant and longstanding impact on young people and society (Belfer, 2008; Jokela, Ferrie & Kivimaki, 2009; Kessler et al., 2005; Post, Leverich & Kupka, 2010), affecting a young person's education, social skills, future employment and earnings, and ability to form relationships with others (Goodman, Joyce & Smith, 2012; McGorry, Purcell, Hickie & Jorm, 2007). The potential consequences for young people failing to access or receive appropriate support are severe, with increasing rates of adolescent self-harm (Health and Social Care Information Centre, 2015; Wood, 2009) and suicide now the third leading cause of death in 15-25 year olds (Belfer, 2008). In addition to this, the socioeconomic costs of untreated mental health problems in young people represent a substantial public health burden, with previous estimates amounting up to £59,000 per year per child (Department of Health, 2011). The mounting costs to individuals, families and societies reinforces the need for a change in the way that young people's mental health needs are currently being managed.

### **Barriers to accessing mental health support**

Fear of the stigma associated with mental illness is considered a major barrier to young people accessing support (Gulliver, Griffiths & Chirstensen, 2010), and is considered a universal and disabling problem amongst both adults and children (Kaushik, Kostaki & Kyriakopoulos, 2016). There is growing evidence to suggest that another barrier to accessing support is a lack of young people's knowledge and understanding around mental health difficulties (Rickwood, Deane & Wilson, 2007), with many young people demonstrating a lack of insight

and understanding of the signs of poor mental health in the context of help-seeking (Kelly, Jorm & Wright, 2007).

There have been calls for strategies to improve adolescent help-seeking, which focus on reducing stigma and improving young people's mental health literacy (Gulliver et al., 2010). 'Mental health literacy' is a term coined by Jorm et al. (1997) and is defined as a person's knowledge and beliefs about mental health difficulties which help in the recognition, management or prevention of mental ill-health. It is associated with improved mental health status and positive help-seeking attitudes (Kelly et al., 2007; Lam, 2014; Altweck, Marshall, Ferenczi & Lefringhausen, 2015), although it remains unclear whether these attitudes translate into actual help-seeking behaviours (Gulliver et al., 2010).

### **Rationale for Review**

While there has been some substantial research looking at the reasons why young people are reluctant to access help and support from mental health professionals and services (Rickwood et al., 2007; Gulliver et al., 2010), there has been noticeably less research exploring young people's broader views and understanding of mental health difficulties, and how these might relate to their attitudes and behaviours.

Early education around mental health and illness is considered critical if attitudes are to change (Bailey, 1999). Educational resources that specifically target children's conceptions and misconceptions of mental health difficulties are likely to be of greater value and impact than those that do not (Whal, 2002). In order to develop such resources, a greater understanding of adolescents' knowledge and views of mental illness would provide an important foundation from which to build preventative and intervention-based practices, that better meet the mental health and educational needs of young people.

### **Aims of the Review**

This review aims to provide a current overview and synthesis of empirical literature concerned with adolescents' understanding of mental health

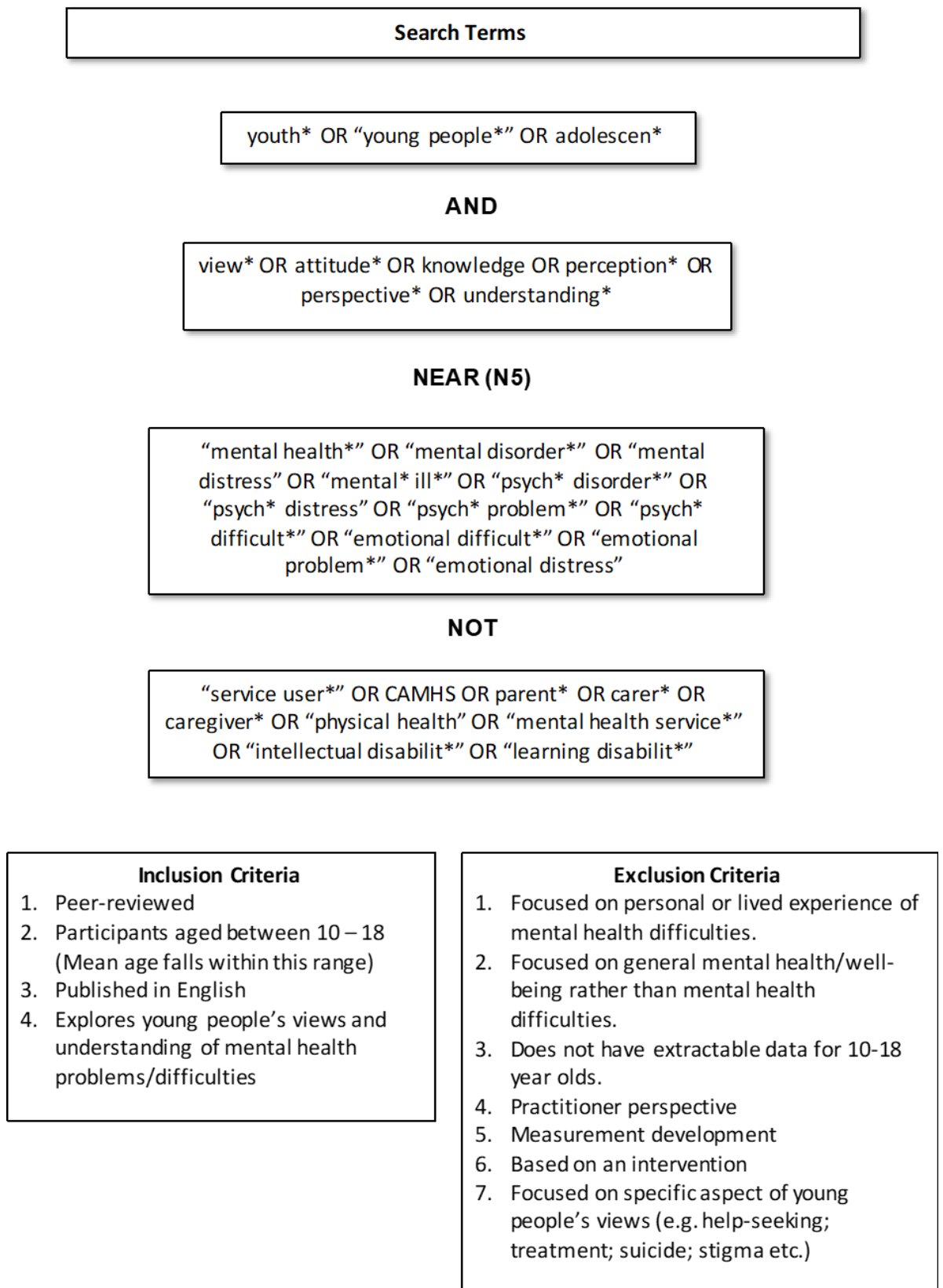
difficulties. A clearer understanding of young people's mental health knowledge and views could better inform awareness raising and stigma reducing initiatives and improve outcomes for young people's mental health. Within this review, relevant studies are described and their methodology critically appraised. A narrative synthesis of the common themes identified across the literature is presented and recommendations for future research are considered.

## **Method**

### **Search Strategy**

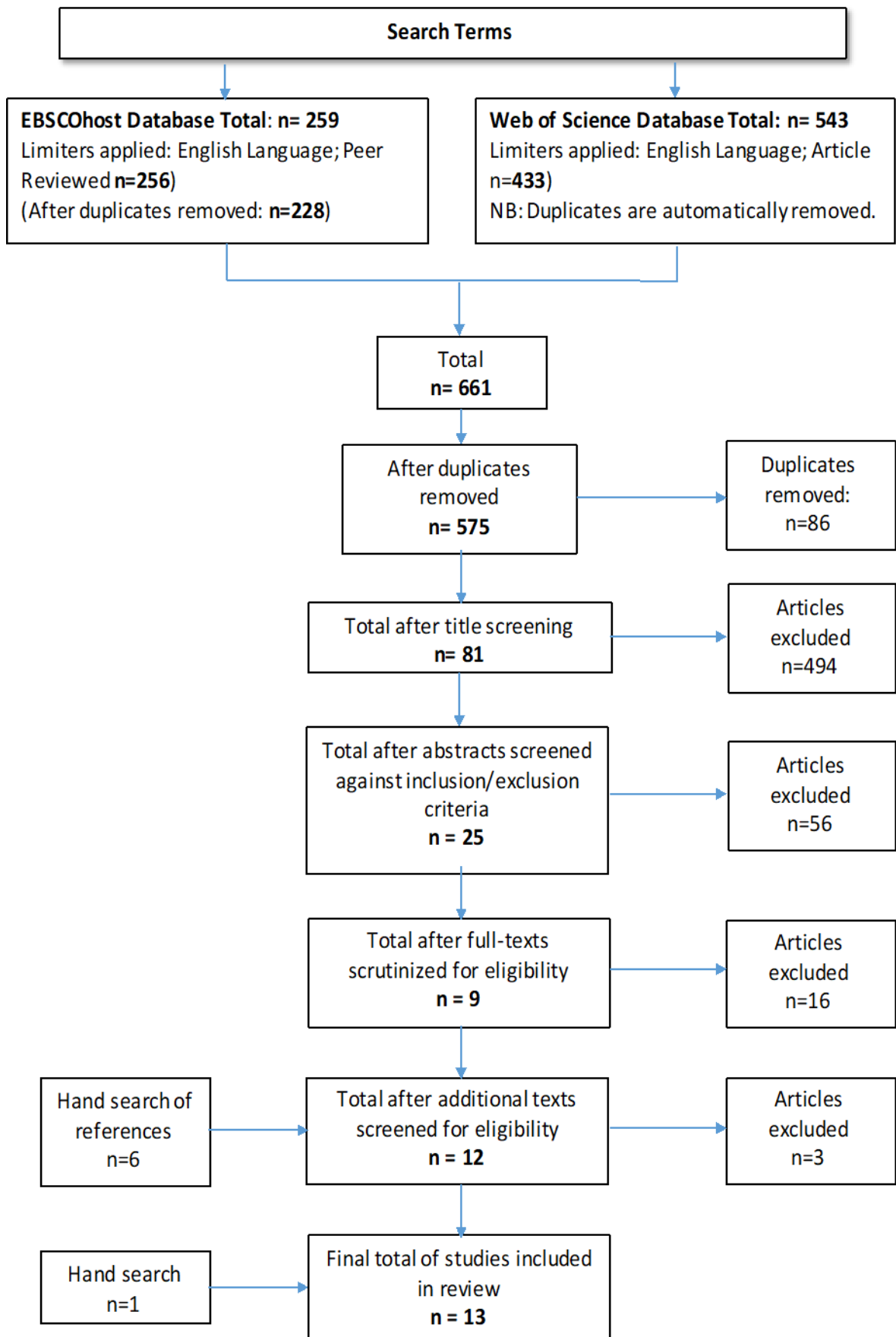
In order to explore the research question, 'what are adolescents' views and understanding of mental health difficulties?', four sets of search terms were developed (see Figure 1). The first set of search terms were used to search for young people (e.g. youth\* or young people or adolescen\*). The second set searched for the presence of perspectives (e.g. knowledge or view\* or understanding) and the third set searched for mental health related difficulties (e.g. mental health\* or mental distress or psych\* problem). The first and second set of search terms were selected to be found *near* to (within five search terms of) the third set, in order to locate research papers that specifically focused on perspectives of mental health, given that a large number of empirical papers used these terms in a widely varying array of contexts. The fourth set introduced *not* terms, to exclude research focused on young people's personal experience of accessing services for mental health difficulties, as well as the views of parents and carers, and research relating to physical health conditions and intellectual disabilities (e.g. service user\* or parent\* or learning disabil\*). An abstract search was conducted across databases. Title screening allowed for relevant papers to be retained for further screening. Identified articles were screened by abstract and each considered against the inclusion and exclusion criteria. Remaining articles were subject to full-text screening. Eligible papers were hand-searched for relevant references, also screened by title, abstract and full-text where appropriate. The screening process is detailed in Figure 2.

**Figure 1: Overview of Search Strategy**





**Figure 2: Flowchart demonstrating the literature screening process**



## **Databases**

A search of the EBSCO Host research database included papers from Psychology and Behavioural Sciences Collection, Health Business Elite, CINAHL, GreenFILE, eBook Collection, Medline and Library, Information Science and Technology Abstracts. A separate search using the Web of Science research database included papers from the Science Citation Index Expanded, Social Sciences Citation Index, Arts & Humanities Citation Index, Conference Proceedings Citation Index – Science, Conference Proceedings Citation Index – Social Science & Humanities and Emerging Sources Citation Index. A search was also undertaken using the Cochrane Library to determine whether there were any pre-existing review articles in this area. No relevant papers were found to indicate that any systematic reviews had previously been conducted.

## **Search Criteria**

In line with the aims and objectives of the review, a set of inclusion and exclusion criteria were developed to guide the hand search of database results (Figure 1).

### *Inclusion Criteria*

To meet the criteria for review, studies must have included participants aged between 10 – 18 years, meeting the criteria for adolescence, without treading too far into adult mental health research. Peer reviewed, original research articles published in English were included. Studies must also have focused on young people's views and understanding of mental health difficulties or ill-health, as opposed to general mental health and wellbeing.

### *Exclusion Criteria*

Research focusing on personal or lived experience of mental health difficulties, for example of service users, and research offering perspectives from other populations, such as practitioners, were excluded from the results. Papers were also excluded that did not have extractable data for 10-18 year olds, where 25% or more of the participants fell

outside of this age range, or the samples' mean age fell outside of this range (Gulliver et al., 2010). Research that focused on the development of psychometric measures were excluded, as well as literature focusing on specific aspects of adolescent's views, such as help-seeking, severity of diagnosis, peer exclusion and suicide, as these would fall outside of the scope of this review. Studies that focused exclusively on attitudes were excluded if this was not explored within the broader context of young people's understanding and beliefs about mental health difficulties.

## **Results**

### **Search Results**

The database search retrieved a total of 575 papers after duplicates were removed. During title screening a cautious approach was taken whereby any uncertainties around the paper's eligibility meant that it was retained for further screening. Following title screening, 81 papers remained and were screened by abstract against the inclusion and exclusion criteria. The full texts of the 25 identified papers were then examined, leaving 9 papers for review. A hand search of reference lists and subsequent screening resulted in an additional 3 relevant papers. Finally, an earlier scoping search of Google Scholar using key search terms had revealed a relevant paper that had not been identified through the database or reference list search. Following screening this paper was found to meet the essential requirements for inclusion, creating a final total of 13 papers for review. A descriptive overview of these studies is included in Appendix B, and provides details of the research aims, sampling, data collection, analysis methods and key findings.

### **Quality of Research**

Each study was critically appraised using a consistent, structured approach to assess methodological quality. Qualitative studies were assessed using the Critical Appraisal Skills Programme (CASP) (Public Health Resource Unit, 2006) which provides an overview of methodological rigour for each paper (Appendix C). Each question of the CASP is scored (0-2) to indicate the presence or absence of quality

throughout different elements of the study, allowing a total credibility score out of 20 to be calculated. Due to the cross-sectional nature of the quantitative papers, these were analysed using the Crowe Critical Appraisal Tool (CCAT) (Crowe, 2013). This provides a calculated score out of 40 to represent the methodological quality of the study (Appendix D). Details relating to the quality and general characteristics of the quantitative and qualitative studies are provided below. An overview of the methodological strengths and limitations of each study, which contributed to the overall quality scores, are included in Appendix E.

## **Study Characteristics**

### *Methodologies*

Five papers examined young people's understanding and perspectives of mental health difficulties within their own age group (Burns & Rapee, 2006, Coles et al., 2016; Hennessey & Heary, 2009; Leighton, 2010; Roose & John, 2003), whilst seven papers did not specify an age range in the questions asked (Callan et al., 2013; Dogra et al., 2011; Lovett et al., 2011; Melas et al., 2013; Teng et al., 2017; Watson et al., 2005; Williams & Pow, 2007). One paper focused upon both adult and adolescent mental health difficulties (Secker et al, 1999). Seven of the thirteen studies reported quantitative findings ranging in quality from 68% to 85%. The strongest papers were those by Leighton (2010) and Burns and Rapee (2006), which showcased designs demonstrating particularly high transparency, replicability and validity. The weakest study in this group was by Watson and Lyons (2005), which in contrast utilised a design which lacked sufficient detail to ensure replicability, and failed to address ethical issues.

All quantitative papers employed a cross-sectional methodology using self-report questionnaires. Three studies made use of vignettes as a means of eliciting participants' views (Burns & Rapee, 2006; Coles et al., 2016; Leighton, 2010), while the remaining four prompted participants to respond to general questions and statements (Callan et al., 1983; Dogra et al., 2011; Watson et al., 2005; Williams & Pow, 2007). All

questionnaires were administered face-to-face in schools. Three of the questionnaires used to address participants' understanding and knowledge of mental health difficulties were developed specifically for the purposes of individual studies, and three questionnaires were adapted for an adolescent population from existing measures. Coles et al. (2016) utilised the same questionnaire developed and used by Burns and Rapee (2006). It is important to note that none of the questionnaires had been appropriately validated, referring to either the measure itself, or to its use in the population of interest. While some of the questionnaires were piloted prior to use, there remains a lack of statistical validation across the measures used. The findings from these studies may therefore be subject to measurement error (Dowrick, Wootten, Murphy & Costello, 2015). This is reflected in the quality rating for the data collection of each quantitative study, with none achieving a maximum score in this area.

Six papers were qualitative in nature, ranging from moderate (14/20) to strong (18/20) quality. The strongest studies were by Teng et al. (2017) and Melas et al. (2013) which demonstrated rigorous and transparent analysis and results sections, supported by inter-rater reliability and clear audit trails. The weakest study was by Hennessey and Heary (2009). In contrast this study lacked detail and failed to explain the process of randomisation, address inconsistent and unexpected results, or report ethical considerations.

Five studies utilised semi-structured interviews (Hennessey & Heary, 2009; Lovett et al., 2011; Roose & John, 2003; Secker et al., 1999; Teng et al., 2017) and one study qualitatively analysed the results of a questionnaire (Melas et al., 2013). All took place in participants' schools. Of the interview studies, two incorporated focus groups, one focused on individual interviews, and the remaining two used a combination of both. Vignettes were commonly used, with four studies incorporating these as a means of generating and guiding discussion (Hennessey & Heary, 2009; Lovett et al., 2011; Melas et al., 2013; Secker et al., 1999). When combined with the number of quantitative studies using vignettes, over half

of the total papers reviewed utilised this method. A range of analytical approaches were used, including thematic analysis, discourse analysis, interpretative phenomenological analysis (IPA) and content analysis. One paper did not specify an analytical approach, which had implications for the quality rating of the study (Secker et al., 1999).

It is important to note that none of the qualitative papers actively considered the role of the researcher and the impact of this on data analysis. The position of the researcher shapes all research, both qualitative and quantitative. Reflexivity, the attitude of attending to the effect of the researcher on the research process, is particularly important during qualitative data analysis given that the researcher themselves is often considered as an integral part of the research process. Different researchers will approach the coding and interpretation of the data and key themes from different positions and perspectives, which can lead to different, but equally valid, understandings of the situations being explored (Malterud, 2001). This need not affect the validity of the study, as preconceptions are not considered the same as bias, providing that the researcher demonstrates reflexivity and acknowledges these (Malterud, 2001). As none of these studies adequately demonstrates researcher reflexivity, this has implications for the overall quality ratings of each study, and should be taken into consideration when drawing conclusions from the reported findings.

### *Participants*

Research took place in a range of locations; the USA, UK, Ireland, Sweden, Nigeria, Australia and Papua New Guinea. Sample sizes ranged from 16 to 1104 adolescents, with participants recruited from a minimum of 40 schools. All but one study specified the age range of participants. Watson and Lyons (2005) recruited participants from two high schools and therefore it can be assumed that the sample were aged between 11 and 18 years of age. Participants' ages ranged from 8 to 19 years. In three studies participants' ages fell outside of this review's inclusion criteria of 10 to 18 years. In Hennessey and Heary's (2009) study it was possible to

extract appropriate data by age from the main findings. In Coles et al. (2016) and Melas et al. (2013), all data was included as the overall mean age was within the required range. Participants in the majority of studies were aged between 14 and 17 years of age.

All studies represented a mix of male and female participants, although four studies did not specify numbers of each gender. Of the studies that did, six represented a fairly even gender balance while the remaining three were skewed in favour of males or females. Limited demographic details about participants were collected across all studies, with four studies indicating only age and gender. Details from the remaining studies indicate that participants were predominantly Caucasian and recruited from a combination of urban and rural schools with a mix of high and low socio-economic status.

### **Key themes in the literature**

#### *Definitions of mental illness*

Four studies specifically explored the ways in which adolescents define mental health and mental illness (Callan et al., 1983; Lovett et al., 2011; Secker et al., 1999; Teng et al., 2017), with findings suggesting that while young people were able to understand concepts relating to mental health and wellbeing, they frequently expressed uncertainty in relation to the concept of, and terminology relating to, mental illness. Teng et al. (2017) summarised that adolescents appeared to recognise the complexities and challenges of mental health difficulties, it was common for them to struggle with defining their understanding of these, often citing contradictions and opposing ideas.

The phrase 'mental illness' was typically associated with strong negative themes, including sickness, disability, disease, unpredictability, irrationality, lesser intelligence and little prospect of recovery (Callan et al., 1983; Lovett et al., 2011; Teng et al., 2017). Secker et al. (1999) considered how young people's definitions of mental illness were more likely to be associated with deviations from social norms, i.e. from other people's expectations; than with deviations from personal norms i.e. a

person's usual, everyday behaviour. Participants defined personal norms within a context of their own experience of everyday patterns of behaviour. In this case adolescents were more likely to define a behaviour as mental illness if it was seen as unfamiliar or 'abnormal'. On the other hand, behaviours that participants could relate to in some way were less frequently defined as such, even when these were indications of a mental health difficulty (Lovett et al., 2011; Secker et al., 1999).

### *Recognition of mental health difficulties*

Seven studies considered the extent, and the ways in which, adolescents are able to recognise and identify mental health difficulties (Burns & Rapee, 2006; Callan et al., 1983; Coles et al., 2016; Leighton, 2010 and Melas et al., 2013; Teng et al., 2017). Four of these presented participants with vignettes portraying an individual experiencing specific mental health difficulties and asked participants to identify what they thought was the matter with the person in the vignette (Burns & Rapee, 2006; Coles et al., 2016; Leighton, 2010 and Melas et al., 2013). In these studies the majority of young people struggled to identify that the vignette characters were experiencing specific mental health difficulties. Burns and Rapee (2006) reported a mixed level of knowledge in relation to adolescents' ability to label depression and identify key symptoms. Coles et al. (2016) utilised the same measure of recognition, reporting that 40% of high school students could correctly identify depression, and only 1% recognised social anxiety. Similar findings were reported by Melas et al. (2013) and Leighton (2010), with 42.7% and 44.7% of adolescents recognising depression, while 34.7% and 30.3%, respectively, were able to correctly identify schizophrenia or signs of psychosis.

All seven studies reported that adolescents appeared to be better at recognising symptoms of mental health difficulties and identifying these as a problem for individuals, even if they are unable to label these with a specific diagnosis. There seemed to be widespread confusion however, regarding the recognition of mental health difficulties, with many young people incorrectly labelling symptoms and diagnoses (Coles et al., 2015;



Leighton, 2010; Melas et al., 2013). Participants were found to label schizophrenia as multiple personality disorder, addiction, amnesia or autism (Melas et al., 2013), and depression as a somatic disorder, linked to puberty or poor lifestyle choices (Coles et al., 2016; Melas et al., 2013). Teng et al. (2017) reported that the visibility and severity of signs and symptoms appeared to contribute to adolescents' recognition of mental health difficulties. Burns and Rapee (2006) noted similar findings, as 67.5% of participants recognised depression when it was associated with specific feelings of worthlessness and thoughts of suicide, compared to 33.8% when symptoms were less apparent.

#### *Causes of mental health difficulties*

Five studies considered adolescents' understanding of mental health difficulties by exploring their views and beliefs about potential causes of psychological problems (Callan, 1983; Dogra et al., 2011; Hennessy & Heary, 2009; Lovett et al., 2011; Melas et al., 2013). The most commonly cited cause across all studies was heightened stress and genetic factors. Participants in two studies also reported traumatic life events as a cause of mental health difficulties (Lovett et al., 2011; Melas et al., 2013). A variety of other social and inter-personal factors were identified across four studies, including family problems, loneliness, relationship difficulties, being bullied, bereavement and loss, and a lack of meaning or purpose (Callan, 1983; Hennessy & Heary, 2009; Lovett et al., 2011; Melas et al., 2013). Biological causes were also suggested, including brain injury (Lovett et al., 2011), lack of sleep and exercise (Melas et al., 2013) and excessive alcohol (Callan, 1983). Adolescents in two studies reported supernatural causes, including evil spirits, magic and witchcraft (Callan, 1983; Dogra et al., 2011).

#### *Attitudes and Stigma*

Adolescents' views towards people experiencing mental health difficulties were explored in six studies (Callan et al., 1983; Dogra et al., 2011; Lovett et al., 2011; Melas et al., 2013; Watson et al., 2005; Williams & Pow, 2007). Williams & Pow (2007) reported optimistic findings of 91.1% of

participants recognising that anybody can experience mental health difficulties, while 20% felt that individuals were to blame for their condition. Slightly higher numbers were reported by Dogra et al. (2011), with 32% suggesting that people with mental health difficulties were weak and to blame for their difficulties. Some studies confirmed the presence of a number of misconceptions and stereotypes. A common theme across all six studies relates to dangerousness and unpredictability, with adolescents' viewing people with mental health difficulties as being angry, aggressive, violent to others and themselves, out of control, and more likely to commit crime. The rate of young people reporting these views varied substantially, ranging from 33.5% (Williams & Pow, 2007) to 80% (Dogra et al., 2011).

Three studies reported that adolescents view people with mental health difficulties as being very different to other people as they are 'easy to spot' due to their abnormal behaviours (Watson et al., 2005) and physical appearance (Lovett et al., 2011; Callan et al., 1983). In contrast, Teng et al. (2017) report that adolescents often viewed people with mental health difficulties with skepticism due to the lack of visible indicators that there was a problem. This had led to adolescents doubting whether people were genuinely experiencing a mental health difficulty, due to the view that it was very difficult to tell from the outside if this was the case.

Eight studies specifically explored adolescent's attitudes towards people with mental health difficulties (Callan et al., 1983; Dogra et al., 2011; Lovett, 2011; Melas et al., 2013; Secker et al., 1999; Teng et al., 2017; Watson et al., 2005; Williams & Pow, 2007). A clear contrast in attitudes was revealed within and between these studies, with some adolescents responding with sympathy and understanding, and others responding with fear, aversion and avoidance. The latter was commonly associated with views of unpredictability, dangerousness, and an awareness of the stigma associated with mental health difficulties. The rate of stigmatising attitudes varied greatly across these studies, ranging from 11.5% (Melas et al., 2013) to 66.7% (Dogra et al., 2011).

Four studies reported that some adolescents would be reluctant to tell anybody if they, or somebody in their family, had a mental health difficulty (Dogra et al., 2011; Lovett et al., 2011; Watson et al. 2005; Williams & Pow, 2007). Three reported that some would avoid talking to or being around somebody with mental health difficulties (Callan et al., 1983; Dogra et al., 2011; Melas et al., 2013). In contrast to these views, Teng et al. (2017) reported a largely non-stigmatising attitude within their sample, and a high level of tolerance and understanding towards people with mental health difficulties. This is echoed across other studies, with reports of adolescents expressing compassion and sympathy in both hypothetical scenarios, and real-life situations towards people that they have known (Lovett, 2011; Secker et al., 1999; Williams & Pow, 2007).

### *Help-Seeking*

Eight studies considered adolescents' views and understanding of sources of help for mental health difficulties (Burns & Rapee, 2006; Callan et al., 1983; Coles et al., 2016; Hennessey & Heary, 2009; Leighton, 2010; Lovett et al., 2011; Melas et al., 2013; Roose & John, 2003). It was common for young people to identify that help would be appropriate if somebody was experiencing difficulties. The number of adolescents recommending help for a vignette character experiencing depression varied between 68.8% and 94% (Burns & Rapee, 2006; Coles et al., 2016; Melas et al., 2013). The nature of the mental health problem also influenced how likely young people were to recommend support and the type of support identified. Coles et al (2016) reported that 59.2% of adolescents recommended support for social anxiety, and 50% for schizophrenia.

The most commonly recommended sources of support across these studies were informal; primarily from family members, friends, and through self-help strategies (Burns & Rapee, 2006; Coles et al., 2016; Hennessey & Heary, 2009; Leighton, 2010; Melas et al., 2013; Roose & John, 2003). Recommendations for professional sources of support were less frequent. Counselling was the most common professional recommendation. Only

small numbers of young people identified GPs, psychiatrists, psychologists and other healthcare professionals as sources of support (Burns & Rapee, 2006; Callan, 1983; Coles et al., 2016; Hennessey & Heary, 2009; Leighton, 2010; Melas et al., 2013; Roose & John, 2003).

In two studies adolescents recommended medical interventions, including tablets, injections and hospital admissions (Callan, 1983; Lovett et al., 2011). A substantial number of these adolescents identified dated and authoritarian approaches to treatment of mental health difficulties, including the use of strait jackets and padded cells. Within the same studies, many other adolescents stressed the importance of gentler approaches, including the benefits of talking therapies, empathy and kindness.

Five studies also considered participants' views surrounding recovery. Lovett et al. (2011) found that adolescents were frequently pessimistic about the success of treatments such as talking therapy and medication, while Williams & Pow (2007) report that only 31.7% of adolescents think that most people recover from mental health difficulties. Both Callan et al. (1983) and Coles et al. (2016) reported that participants were generally more hopeful about the chances of recovery, and considered that this could happen within the space of a few months. Watson et al. (2005) identified a number of misconceptions around the processes by which somebody can recover however, with some adolescents recognising the role of medication, while others considered that recovery was a matter of willpower and determination, dependent upon how hard somebody tries to get better.

### *Gender Differences*

Findings from eight studies indicated substantial variations in the role of gender on young people's understanding and views of mental health difficulties (Burns & Rapee, 2006; Callan et al., 1983; Coles et al., 2016; Dogra et al., 2011; Williams & Pow, 2007; Teng et al, 2017). Four studies reported that females had greater knowledge and more accurate understanding of mental health difficulties than males (Burns & Rapee,

2006; Coles et al., 2016; Dogra et al., 2011; Williams & Pow, 2007) while three found no significant differences between the two (Callan et al., 1983; Leighton, 2010; Secker et al., 1999). Coles et al. (2016) reported that while females were found to be specifically more knowledgeable about depression, there was little difference between boys' and girls' knowledge of social anxiety.

Gender differences in help-seeking were also reported, with females more likely to recommend or offer support (Burns & Rapee, 2006; Coles et al., 2016; Melas et al., 2013; Teng, 2017) than males. Other studies found no difference (Callan et al., 1983; Leighton, 2010), but noted that females drew upon a wider variety of sources, while males were more likely to recommend informal sources of support (Leighton, 2010).

Two studies identified that the gender of a vignette character had a significant effect on adolescents' views and understanding of characters' difficulties (Burns & Rapee, 2006; Coles et al., 2016). Despite methodological similarities the studies reported contradictory findings; one study reporting greater recognition of depression in a female character, the other reporting greater recognition in a male character. Similar inconsistencies were reported in relation to adolescents' attitudes towards mental health difficulties. While males typically had more negative attitudes and misconceptions than females (Dogra et al., 2011; Watson et al., 2005; Williams & Pow, 2007), Callan et al (1983) reported the opposite. Meanwhile, Secker et al. (1999) noted gender differences in attitudes towards a vignette portraying an eating disorder, but found no other apparent gender differences in relation to vignettes portraying depression or schizophrenia.

### *Cultural Differences*

Only two studies considered the role of ethnicity and culture on adolescent's views and understanding of mental health difficulties. Callan et al (1983) reported differences between Australian and Papua New Guinean (PNG) adolescents, with many more PNG participants believing in the role of spirits and magic as causes of mental ill-health. This was

associated with differences in beliefs about the nature of mental health, sources of help and treatment, and prospect of recovery. Cultural differences in attitude were also noted, with PNG adolescents adopting a more cautious attitude than Australian adolescents. Watson et al. (2005) noted similar cultural differences, reporting that Caucasian adolescents showed less stigmatising attitudes towards mental health than adolescents of other ethnic backgrounds in the study, while being of an ethnic minority was associated with greater optimism about the prospect of recovery.

### *Familiarity*

Two studies considered the interaction of familiarity with mental health difficulties on adolescents' views and understanding. Having a family member with a mental health difficulty was associated with being less likely to hold misconceptions about the nature and course of mental health difficulties (Watson et al., 2005). Interestingly, the views of adolescents who had experienced difficulties themselves were not significantly different to their peers (Watson et al., 2005), nor was personal experience significantly associated with recognition and identification of mental health difficulties in others (Leighton, 2010). Experience of mental health difficulties was however associated with more being more flexible, informed and optimistic when considering sources of help and support.

## **Discussion**

### **Summary**

This review provides important insights into young people's understanding and views of mental health difficulties. This is an area of research that has often been overlooked, but one that is important in enhancing our understanding of why so many young people do not seek help and support for their mental health. The review identifies an interesting and varied picture of adolescent views and understanding across a range of factors. Most notably there appear to be some substantial gaps and weaknesses in young people's knowledge of mental health difficulties, particularly in relation to recognising specific difficulties, the nature of these difficulties and the impact they might have for the people experiencing them, and

appropriate sources of help and support. Given these gaps in understanding, the presence of stereotypes, contradictions, stigma and misconceptions in adolescents' views of mental health difficulties is perhaps unsurprising, as young people attempt to make sense of the complex, unfamiliar and historically stigmatised construct of mental health and illness.

A particular concern in the literature is that only very small numbers of adolescents were able to correctly identify mental health problems in others, even for relatively common mental health difficulties such as depression. Young people frequently mislabeled difficulties and misattributed their symptoms, which may indicate that through a lack of knowledge and understanding, young people can underestimate the potential severity of the difficulties that a person is experiencing. This is likely to have an additional impact on young people's attitudes towards others who are struggling, and may also reflect why many young people are more inclined to suggest informal sources rather than professional sources of help and support.

It is important to consider that research which required adolescents to correctly identify mental health difficulties from a series of symptoms is often based on hypothetical vignettes. These offer a limited amount of information which may not adequately capture the complex factors associated with a person's experience of psychological distress. Studies typically had strict criteria regarding what was considered correct or incorrect labels for each vignette, and relied on adolescent's providing a psychiatric diagnosis in order to be considered as having a good level of understanding, or 'mental health literacy'. A person's mental health literacy is therefore assessed, in part, by their knowledge of medical terms for collections of symptoms and difficulties (Jorm et al., 1997). For instance, 15% of adolescents labelled social anxiety as 'anxiety' or 'anxious' but such responses were not counted towards their mental health literacy (Coles et al., 2016). Far less importance has been placed upon a person's

ability to recognise signs and symptoms of psychological distress, and the need for appropriate help and support.

This may contribute to what is reported as low rates of recognition and understanding for a range of mental health difficulties. It also places an expectation upon young people to adhere to a medicalised model of mental health, the utility of which has been increasingly questioned, given the tendency to adopt a reductionist and pathologising approach to human mood and behaviour (Patil & Giordano, 2010). The psychiatric diagnostic manuals that it informs, namely the Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD), are considered as providing only a partial explanation for many mental health difficulties, and both the validity and clinical utility of the diagnostic criteria have been brought into question (McLeod, 2014). Yet the findings of the review indicate that young people may be more psychologically and socially minded than the scope of some methodologies allow. Adolescents were better at identifying symptoms, seeing these as an indication of a problem and recognising that a person might need support, even if they were not aware of a specific mental health difficulty. They were less likely to pathologise a person's difficulties when able to relate to their struggles and understand the reasons why they might behave the way they do, even if their behaviour was unusual or challenging. Adolescents also identified a range of social, emotional and biological causes of mental health difficulties, including the role of trauma, childhood experiences and prolonged emotional stress. While adolescents' understanding and views of mental health remains an incomplete and often confused picture, these factors indicate the foundations of a biopsychosocial awareness of mental health upon which further knowledge and awareness can be built.

### **Strengths and Limitations of the Research**

The research considered within the review represents important steps taken to understand the experiences, influences, beliefs and views of adolescents. The voice of young people in research is important, due to



their unique perspective which can introduce new ideas and address issues which adults may overlook (National Children's Bureau, 2015). Such research can be used to develop more reliable, relevant and relatable interventions and initiatives for other young people, that specifically address their needs, values and experiences.

It is important to consider the significant variations and at times contradictory findings of the studies included in this review, which limit the extent to which these findings may be applied with confidence to broader adolescent populations. These were noted particularly in relation to adolescents' attitudes, their beliefs and misconceptions, and the role of gender. While the research reviewed was methodologically acceptable and of appropriate quality, there is a great deal of variation in the research designs and analysis. It is likely that this contributed to the differences found in the results. Qualitative methods, for example, are often well placed for an in-depth exploration of participants' thoughts, views and opinions, whereas the quantitative studies utilised here provided a limited range of potential responses. This may have had an impact on how adequately participants were able to identify and express their views. Qualitative studies may however be more prone to response bias, with participants responding more favourably when in front of the researcher, when compared to a questionnaire study where participants have anonymity and thus may be more likely to respond openly. The use of specific vignettes, compared to questionnaires or interviews, also raises questions regarding how far one can generalise participants' beliefs and attitudes from a specific situation, while all may not indicate with complete accuracy how respondents would respond in real-life situations (Burns & Rapee, 2006; Leighton, 2010).

Another consideration is related to researchers' frequent use of the term 'mental illness' in a number of studies, instead of terms such as 'mental health difficulty', 'psychological problems' or 'emotional distress'. The power of language should not be underestimated, and there is a risk that using the term mental illness, or even diagnoses such as schizophrenia,

can create bias due to their medical roots, and being terms that are still heavily associated with stigma (Corrigan, 2000; Found & Duarte, 2002). A lack of consistency in the choice of language, and at times a preference for more stigmatising terms, may therefore account for some of the variation and differences in the findings.

A third consideration is the ethnic and cultural diversity across the samples of participants. Given that adolescents were recruited from seven different countries, with diverse cultural heritages, mental health care programmes, media influences, education systems, and social pressures, it is unsurprising that there were some clear cultural differences in young people's attitudes, views and perceptions of mental health difficulties. Diversity between samples can promote an increasingly global understanding of young people's understanding and views of mental health. It also becomes increasingly difficult to generalise findings from individual studies, and restricts the extent to which conclusions can be drawn and applied to other adolescent populations.

Finally, three papers explicitly noted the presence of adolescents in their sample who identified as having experienced mental health difficulties of their own. Such experiences could be expected to shape respondent's views, attitudes and understanding of mental health compared to their unaffected peers, and may present an extraneous variable when unaccounted for. Only two studies specifically considered the role of personal experience on adolescents' understanding and beliefs, yet reported no significant differences apart from in knowledge of, and attitudes towards help-seeking. Given estimates that one in ten young people experience mental health difficulties (Layard, 2010) it seems reasonable to assume that there were adolescents with personal and lived experience in every study reviewed here. As the potential impact of this was not taken into consideration in the majority of studies, the extent to which this may have contributed to the variations and contradictions within the data remains unclear. This highlights the importance of distinguishing

between the views of young people with and without lived experience of mental health difficulties.

### **Limitations of the Review**

Whilst this review represents a promising start to our understanding of adolescent views and understandings of mental health difficulties, there were substantial variations in methodology, sample size and quality of the thirteen papers identified. This presented a challenge when comparing, critiquing and analysing the data given the heterogeneity of the studies, and limited the extent to which conclusions can be drawn between groups and generalised to adolescent populations. This is in part due to the lack of standardised, validated measures that consider and explore young people's mental health knowledge and attitudes. Another limitation is the reliance on published, peer-reviewed research which increases the risk of publication bias. Finally, the review was conducted by one independent researcher, therefore the process of identifying papers and synthesizing common themes within the literature may have been influenced by subjectivity. To address this matter, a detailed and transparent approach was adopted when presenting the different stages and processes of the review,

### **Conclusion**

To date there has been only limited research exploring the broader views of young people on their understanding and perceptions of mental health and illness, and their related attitudes and behaviours. This review brings together a number of relevant studies, which provide useful and stimulating contributions to this under-researched area. The review does highlight a number of inconsistencies across the evidence base however, and indicates a need for greater clarification relating to young people's broader understanding and views of mental health difficulties. The outcomes of this review suggest that there is still some work to do in reducing stigma and improving adolescents' understanding and views of mental health difficulties. There are however some promising indications that young people's knowledge and understanding of mental health

difficulties are broader and more sophisticated than may first be apparent. There are some clear and positive foundations upon which to develop a more aware, inclusive and informed youth population. It is hoped that this could lead to a reduction in stigma and misconceptions, and create more positive attitudes towards mental health, and consequently seeking help for difficulties when needed. The review also raises the question whether 'mental health literacy' is an accurate measure of knowledge and beliefs about mental health difficulties, given its focus on diagnosis and symptoms, and less so on young people's understanding of what a mental health difficulty is, who could be at risk, and why. The latter of which would be an important consideration in the development of preventative and intervention-based practices which may better meet the mental health needs of young people.

### **Directions for Future Research**

Further research is required to contribute to this small but slowly growing area of adolescent mental health, which seeks to better understand young people's approach to mental health. This will be important given the influence of young people's understanding and attitudes on their views and intentions to seek help and support if needed. High quality research that focuses upon the voice and experience of young people, as well as research that replicates and extends prior work, will enhance the validity and reliability of the evidence base and help with clarifying the inconsistencies currently reported. There is a need to reproduce existing work to ensure that findings are replicable and more widely applicable. Research that considers and explores the role of gender and of personal experience in shaping young people's views and understanding of mental health difficulties would also be useful in addressing the inconsistencies noted in this review. Future research should also aim to establish evidence of other potential sources influencing young people's perceptions, and consider how these might be incorporated in the development of mental health education and awareness-raising initiatives.

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## **Paper 2: Empirical Research Paper**

### **Young People's Views and Understanding of Mental Health Difficulties and Directions for Education – A Thematic Analysis**

Word Count: 8137

This paper has been written in accordance with the University requirements for thesis submission and with the intention of submission for publication in *Child and Adolescent Mental Health*. Author guidelines for manuscript submission can be found in Appendix F.

## **Abstract**

**Background:** There has been a recent proposal that all children in the UK will be taught about mental health in schools (Department of Health & Department of Education, 2017). Young people's views and understanding of mental health difficulties can play a role in shaping their education to ensure this meets their needs, yet research in this area remains limited and methodologically varied.

**Method:** Sixteen young people aged fourteen to fifteen took part in interviews and were presented with vignettes representing peers experiencing mental health difficulties. Discussions took place to explore participants' views and understanding of the difficulties presented in the vignette, sources of support, and sources of mental health education.

**Results:** Following thematic analysis of the interview data, three themes were identified: The Experience of Being Unwell; Empathy vs Stigma; and In Search of Truth. Two subthemes were included: Cause and Context; and Helping and Helplessness.

**Conclusion:** Participants demonstrated a largely sophisticated and complex understanding of mental health difficulties. The findings suggest that education should focus on filling the gaps in young people's understanding, facilitating empathy and familiarity with a broader spectrum of mental health difficulties, and knowledge of professional sources of support.

**Keywords:** adolescence; mental health; health knowledge; attitudes; thematic analysis; education

## **Key Practitioner Message**

- Mental health initiatives in schools can lead to significant improvements in young people's mental health.
- Young people can make valuable contributions that inform the development of mental health education, ensuring that it meets their needs.
- Education that aids recognition of mental ill-health, awareness of professional sources of support, and uses psychologically informed models of mental health to facilitate empathy and understanding, would be relevant, meaningful and useful for young people.

## **Introduction**

Mental health initiatives in schools can lead to significant improvements in children's mental health, social and emotional skills, and reductions in anxiety, depression and bullying (Durlak, Weissberg, Dymnicki, Taylor & Schellinger, 2011). Greater knowledge and awareness of mental health and mental health difficulties are associated with more positive attitudes to help-seeking and providing help to those in need (Lo et al., 2018), knowledge of how to obtain and maintain positive mental health, reduced stigma and improved attitudes towards mental health (Stuart, 2016). This is important because the number of young people experiencing mental health difficulties is thought to be increasing (Care Quality Commission, 2017), and also because young people today will become the adults of the future. It is their beliefs and attitudes that will shape the development of services, help-seeking behaviour, and the quality of life for those experiencing mental health difficulties in years to come (Armstrong, Hill & Secker, 2000; Hinshaw, 2005).

Recent developments in the UK have placed increasing importance on exploring young people's understanding and perceptions of mental health difficulties. Building upon the plans outlined in Five Year Forward View of



Mental Health (NHS, 2016) and Future in Mind (Department of Health, 2012) to improve mental health services and support for young people, the Government's recent green paper identifies the important role that schools and colleges can play in supporting young people's mental health and wellbeing (Department of Health & Department of Education, 2017). Alongside improving the interface between schools and services, and increased training for school staff, is the proposal that all young people will be taught about mental health and wellbeing in school.

To date there have been substantial variations in, and at times an entire lack of mental health education taught in schools. This has linked to a lack of training, resources and clear guidance for schools on how to include mental health in the curriculum (YoungMinds, 2017). The move to ensure that every child learns about mental health and wellbeing in schools is a welcome one, although there remains a lack of guidance and clarification about what this will look like in the classroom. Educational resources that specifically take into account young people's understanding, beliefs and concerns, including their conceptions and misconceptions of mental health difficulties, are more likely to be successful than those that do not (Armstrong et al., 2000; Wahl, 2002). This is a particularly important consideration given that some mental health educational interventions, although leading to improvements in attitudes towards providing help, have had no significant impact on professional help-seeking attitudes or mental health stigma (Lo et al., 2018).

In the past, children and young people have rarely been involved in the development of mental health services (Roose & John, 2003), and the views of adults do not always represent those of the children and young people that services are being designed for (Lightfoot, Wright & Sloper, 1999). It is therefore important that the voice of young people informs the development of resources designed to support their knowledge of mental health and illness, taking into consideration their existing views and understanding. This will shape their education in a way that specifically

targets their needs and could lead to improved outcomes for young people now and in their future.

### *Young People's Perceptions of Mental Health Difficulties*

To date there has been limited research conducted exploring young people's views and understanding of mental health difficulties. Currently only a small number of studies have sought to uncover and understand young people's perspectives of mental health and illness, and the existing literature contains mixed reports. Some studies report that children from as young as 5 to 11 years old demonstrate a sophisticated understanding and interest in mental health difficulties (Roose & John, 2003), which improves with age and encompasses the causes, consequences, prospects of recovery and general timeline of mental illness (Fox, Buchanan-Barrow & Barrett, 2008). Findings from other studies indicate widespread conceptual confusion around young people's understanding. Teng, Crabb, Winefield and Venning (2017) identified that while 12-18 year olds appeared to understand the complexities and challenges associated with mental health difficulties, it was common for participants to struggle with defining their understanding of these, often citing uncertainty and opposing ideas about mental illness. Leighton (2010) also reported that young people aged 12 to 15 had difficulty defining mental health difficulties and distinguishing between clinical and non-clinical levels of distress.

There is also uncertainty in relation to how well young people are able to recognise and identify mental health difficulties in others. A series of vignette based studies found that only small numbers of young people could correctly identify depression (Burns and Rapee, 2006; Coles et al., 2016; Leighton, 2010) social anxiety (Coles et al., 2016) and psychosis (Leighton, 2010; Melas, Tartani, Forsner, Edhborg & Forsell, 2013), with reports of young people underestimating the severity of these difficulties. There were indications in these studies that young people were better at recognising signs and symptoms as an indication of difficulties affecting a

person's mental health however, even if they were not able to label these with an accurate diagnosis.

Despite these misunderstandings, young people commonly recognised the need for help and support for mental health difficulties. Their understanding of the support available has been more limited, with the majority of adolescents citing informal sources of support through friends and family (Burns & Rapee, 2006; Coles et al., 2016, Leighton, 2010; Melas et al., 2013). Very few young people identified professional sources of support, although it is unclear whether this is related to a lack of knowledge of available services, or attitudes towards formal help-seeking.

Young people's views and attitudes towards people experiencing mental health difficulties have also been explored, with inconsistent results. Both Williams and Pow (2007) and Teng et al. (2016) reported optimistic findings of teenagers expressing generally positive and non-stigmatising attitudes towards people experiencing mental health difficulties. Other studies reported that young people held a number of misconceptions and stereotypes about mental health difficulties, associated with more negative attitudes and increased stigma (Dogra et al., 2011; Lovett, Tamkin & Fletcher, 2011; Watson, Miller & Lyons, 2005).

Some of the confusion around young people's understanding of mental health difficulties appears to relate to differences in the study methodologies, and the researchers' perspectives on the nature of mental health difficulties. Some quantitative studies required young people to accurately label conditions in order for this to be constructed as a representation of their understanding of mental health difficulties (Burns & Rapee, 2006; Coles et al., 2016; Leighton, 2010). Some qualitative studies on the other hand have allowed for broader interpretations of young people's understanding (Fox et al., 2008; Roose & John, 2003; Teng et al., 2016). The impact and use of language, guided by researchers' own perspectives of mental health difficulties, is another important consideration, with some studies specifically asking young people about 'mental illness', and others using less stigmatising language such as

'mental health difficulties' or 'problems'. Considerable variations in the choice of terminology used when asking young people about mental health difficulties can generate different responses (Wahl, 2002), making comparisons and generalisations across the evidence base more challenging.

Variability across these studies in terms of methodologies, the wide-ranging age of participants and choice of terminology makes it difficult to draw comparisons and synthesise an understanding of young people's views and perceptions of mental health difficulties. To date there has also been very little research investigating how young people are learning about mental health, and the sources that have shaped their existing knowledge and understanding of mental health difficulties. While some studies have briefly considered that there may be some links to exposure to mental health difficulties or the media (Lovett et al., 2011; Secker, Armstrong & Hill, 1999), the evidence remains limited and inconsistent about whether these factors influence young people's perceptions. Without a clear idea of what young people's conceptions and misconceptions of mental health difficulties are, and where these ideas develop from, it remains difficult to identify the form that mental health education might take, in order to best meet young people's needs.

In summary, the evidence base that can inform the development of mental health education in schools remains incomplete, with substantial methodological variability and subsequent discrepancies in the data, indicating a need for further clarity. More recent research in this area has been conducted outside of the UK, and it is time to explore perceptions and understandings here in the light of recent social and policy changes.

### *Aims of the Study*

The present study was timely as it aimed to investigate young people's current views and understanding of mental health difficulties, and the sources that might influence their perceptions. Through developing a greater understanding of young people's existing knowledge and

perspectives, the study sought to consider the directions that future mental health education initiatives might take.

## **Method**

### *Design*

This qualitative study combined the use of vignettes with semi-structured interviews to guide discussion and facilitate an in-depth exploration of young people's understanding and views of mental health difficulties. As an under-researched area which requires clarity, a qualitative method was identified as a means of gathering detailed information which would allow for consideration of the meanings and experiences of mental health difficulties, as understood by the young people themselves. The importance of capturing the voice of young people has already been highlighted in this paper, and a qualitative approach was best suited to capturing the richness and detail of young people's experiences, and the themes that were important to them. Given the conceptual confusion noted in the literature, vignettes are useful in providing details which can make abstract concepts, such as mental health, more real and accessible (Burns & Rapee, 2006), and a number of studies in this area have reported success using this method.

The data collected was analysed using thematic analysis, which aims to identify, analyse and report patterns, or themes, across a set of data. Braun and Clarke (2006) explain how thematic analysis can be used to organise and describe data in rich detail, and can be extended to interpret different aspects of a research topic. Thematic analysis was chosen over other methods due to its flexibility and accessibility, and as it allows the researcher to see and make sense of collective or shared meanings and experiences. Rather than focusing on individual's experiences as in interpretative phenomenological analysis (IPA), thematic analysis provides a means of identifying what is common to the way a topic is talked about or experienced, and of making sense of those commonalities, as well as enabling the researcher to explore the understanding or construction of an issue, rather than the direct experience of it (Braun and Clarke, 2013).

### *Participants*

Sixteen Year 10 students took part. Gender was mixed and participants were aged between 14 – 15 years. This age range was decided as it represents the median age of adolescence (World Health Organization, 2014), while avoiding potential disruption of the research to significant assessment periods for other year groups in school. Participant characteristics are shown in Table 1. Demographic differences between the two schools included gender balance and size. Similarities included student-teacher ratios, and high levels of socio-economic status (see Table 2).

Table 1. Participant characteristics

Gender	N	%	Age	N	%	Ethnicity	N	%
Male	10	62.5	14	8	50	White British	13	81.25
Female	6	37.5	15	8	50	Asian British	3	18.75
Total	16	100		16	100		16	100

Table 2. Profiles of participating schools

	School A	School B
Approx. number of students 11 – 16 years	170	800
Male/Female ratio	1:3	10:1
Student/Teacher ratio	15:3	18:5
Approx. number of students from disadvantaged backgrounds	0	5

### *Procedure*

Four vignettes were developed for the purpose of this study (Appendix G); representing Amy and Jack who met the ICD-10 criteria for experiencing anxiety and depression, as well as Ben and Claire, who met the diagnostic criteria for psychosis. Vignettes were developed using both existing literature and clinical cases, and with a gender balance in mind. The anxiety/depression vignettes were written specifically for the study, while the psychosis vignettes were adapted from vignettes established by Jorm, Wright and Morgan (2007) and Leighton (2010) with the authors'

permissions (Appendix H). All four were submitted to and approved by a panel of professional colleagues (nine trainee clinical psychologists, two clinical psychologists and one registered mental health nurse), to ensure that the vignettes accurately depicted the mental health difficulties that they were designed to represent.

A semi-structured interview schedule (Appendix I) was developed to guide discussions relating to participants' knowledge, attitudes, and understanding of mental health difficulties, including their understanding of available support. These topics were informed by an initial literature review conducted by the author and sought to expand upon topics and questions identified in previous research exploring young people's mental health literacy (Burns & Rapee, 2006; Leighton, 2010; Coles et al., 2016). Guided by the research aims, the interview schedule included questions specifically to explore participants' views and experiences of learning about mental health difficulties.

A selective sample of all eleven independent secondary schools and academies in a county in the West Midlands were invited to take part in the study (Appendix J). These schools were chosen in favour over local authority schools due to the perception that they would have access to greater resources and less restrictions, in terms of time and extra-curriculum activities, to support independent research projects. Restricting the sample to only independent schools maintained a level of socio-demographic homogeneity across the sample. Of the eleven schools contacted, three agreed to support the research and two were successful in recruiting students to take part.

The Head Teacher of each school arranged for recruitment letters to be sent out to all eligible Year 10 students (Appendix K). When students returned the reply slip to express their interest in taking part, an email containing details of the study was sent to their parents to request parental consent (Appendix L). Once obtained, students were formally invited to take part in the study. Students with known mental health difficulties were not included in the study, as it was expected that lived experience would

lead to a person having different views of mental health to their peers, potentially affecting the accuracy of themes within the data.

Interviews took place on a one-to-one basis during school time and lasted around thirty minutes. Sessions were audio-recorded and transcribed. Vignettes were presented in order and participants were asked about the character in each story before moving onto the next vignette. Following the vignettes, the interview concluded by exploring where young people were learning about mental health, and to establish participants' views about what would be the most useful and effective way of enhancing their understanding. Care was taken not to introduce the term 'mental health' until the final part of the interview, unless raised by participants, in order to explore the language and concepts young people themselves used to describe the difficulties portrayed in the vignettes.

#### *Data analysis*

Given the limited research in this area and the exploratory nature of the proposed study, an inductive approach was used during coding and analysis to identify themes at a semantic level (Braun and Clarke, 2013). This meant that the themes identified originated from the content of the data, rather than fitting into predetermined concepts and topics that the researcher had brought to the data. In this way inductive thematic analysis is often experiential in its orientation, 'giving voice' to participants' experiences of the world around them (Braun and Clarke, 2013).

The researcher's epistemological position also introduced a social constructionist approach to the analysis. Social constructionism is the theory that knowledge, and many aspects of the world around us, exist as a result of the definitions and meanings that are given to these concepts (Losantos, Montoya, Exenim, Santa Cruz & Loots, 2016). It is interested in how people gain knowledge about the world around them, and where this knowledge comes from. Guided by social constructionism, the researcher assumed a position of 'not knowing' what participants' views and understanding of mental health difficulties would be, in order to explore



how young people constructed their knowledge and understanding of the concept of mental health difficulties.

Data collected from the interviews were transcribed verbatim and analysed using the six-phase method for thematic analysis as described by Braun and Clarke (2006) (Appendix M). As part of this process, each interview transcript was read a number of times to develop familiarisation with the data, and potential codes were generated. A systematic approach to coding allowed initial codes to be sorted into potential themes and subthemes. Themes were then reviewed, refined, defined and considered in relation to one another and the supporting data. During analysis a reflexive journal was maintained. Data checking was undertaken during analysis in collaboration with the research supervisor, in order to facilitate reflexivity and the validity of identified themes and subthemes. A number of quotes to support each theme were identified within the data. The final quotes selected for inclusion were chosen to represent a range of participants' contributions.

### *Ethical Consideration*

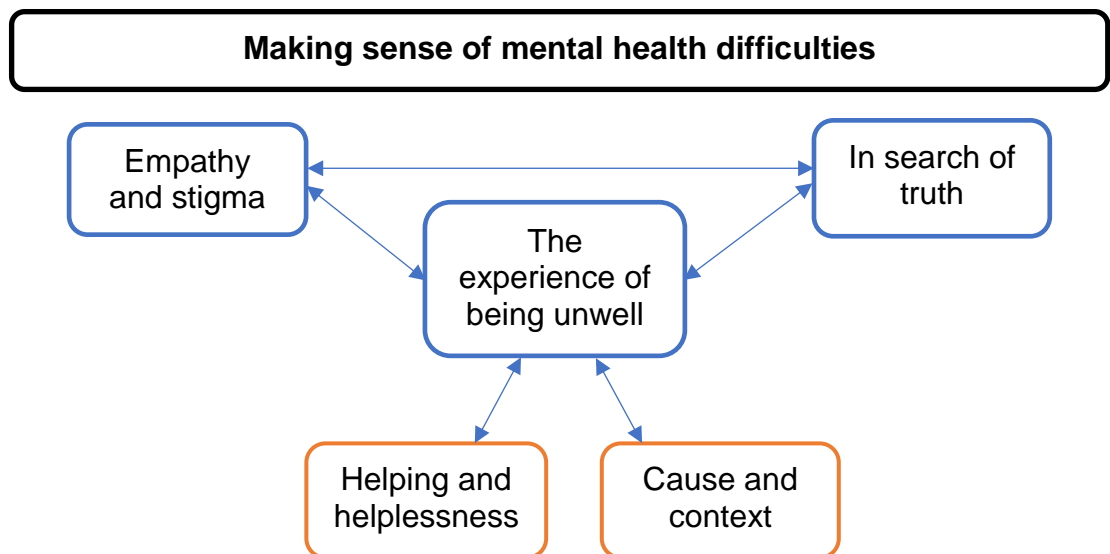
Ethical approval for the study was granted by Staffordshire University's Research Ethics Committee (Appendix N). Full written informed consent was obtained from each participant (Appendix O and P). Participants were fully debriefed (Appendix Q) and data was anonymised to protect the privacy and confidentiality of each young person.

## **Results**

The data collected reflected the complexity of young people's perceptions of mental health difficulties. Three themes were identified, *the experience of being unwell*, containing two subthemes, *cause and context*; *helping and helplessness*; and *empathy and stigma*, and *in search of truth*. Each theme has been presented and expanded upon separately, although given the complexity and broad nature of the research topic themes were inextricably interlinked. The relationship between themes is demonstrated when assembled beneath a central organising concept, or overarching

theme, of *young people's quest to make sense of mental health difficulties*, as shown in Figure 1. Quotes accompanied by a pseudonym are provided to illustrate the themes and interpretations made.

Figure 1: Thematic map demonstrating the relationships between overarching theme, main themes and sub-themes.



### **The experience of being unwell**

This theme relates to how young people described mental ill-health, its course over time, and the difference between psychological ill health and a temporary response to a difficult or stressful situation. It includes some ideas about the nature of ill health in terms of thoughts, feelings and behaviour. The two sub-themes feed into this with ideas about the causes of mental ill-health, and how to help somebody who is unwell.

All participants identified that at least some, if not all of the characters were experiencing some degree of emotional or mental health difficulty which they would need some support with;

*“Everyone can get anxious from time to time about a lot of things but, experiencing it regularly, you should be able to have that as something you can be helped with.” – Neel.*

Deciding whether a character was experiencing mental health difficulties was often related to whether participants viewed a character's difficulties as a reaction to a specific stressful situation, such as receiving bad grades or bullying, or whether they viewed these as an indication of the character being unwell. There was often greater confusion between these two concepts in relation to the psychosis vignettes. The following extracts demonstrate two participants' differing perceptions of Claire's experience of psychosis.

*"I don't think it's really a condition, but maybe it was influenced by something she found on the internet, because there's a lot of studies that have been saying about cyber bullying. Maybe she doesn't have a lot of friends or people to support her, so she's just overthinking it a lot."* – Rani

*"She has maybe either, like it might be schizophrenia if she's thinking that people are trying to kill her, like voices in her head or something. Or maybe it's like paranoia? Like really severe anxiety."* – Jenna

As indicated here, young people typically attempted to assign the experience of being unwell to a diagnosis of some kind. Diagnoses were often offered tentatively, particularly for the psychosis vignettes, where young people expressed the most uncertainty and confusion. They were generally more confident using the terms depression and anxiety than other diagnoses, and indicated greater familiarity and knowledge of these difficulties;

*"Anxiety, because she is having trouble sleeping, and she started shaking when she doesn't do very well. And she just thinks she's useless. It's quite obvious that she might have depression because there's been a change. Going from really talkative and friendly to quite sad and tearful is one of the symptoms for it."* - Bryony

Despite some variation between vignettes, a common theme when discussing the experience of mental ill-health was that this was something that affected a person's mindset and the way that they might view themselves and the world around them:

*“An illness, something that just changes the mind and changes the perception of other things. They might be seeing something as more of a threat than it is, seeing yourself as something that you’re not. Its altering your true perception, so your true self.” – Robert*

*“A problem in someone’s mind that’s making them think differently to how everything is. They don’t see everything how it is, they see it a lot worse.” – Kade*

This indicates a relatively sophisticated understanding of the experience of mental health difficulties, as young people identified how being unwell was associated with difficulties affecting internal cognitive processes and perceptions.

A change in a person’s usual behaviour was unanimously identified by young people as an indication that somebody might be unwell. Social withdrawal, altered sleep and changes in mood were frequently identified as warning signs. The experience of being unwell was typically associated with the view that mental health difficulties would last a long time and continue to get worse if a person did not receive any help.

*“He’ll end up missing his key exams. Later, I think he won’t be able to get a job and he’ll just, he won’t become anything, that maybe he would have wanted to before this happened.” – Eli*

Despite this, there was optimism that with the right support people would recover. Young people were generally aware that even with support, recovery would take some time, indicating an understanding of the severity and complexity associated with the experience of mental health difficulties.

### **Cause and context**

This sub-theme relates to ideas about the causes of mental ill-health and the ways in which young people viewed individual factors in the context of wider family, community and social factors. Participants identified a diverse range of both internal and external factors as being potential

causes for why somebody might become unwell. All of the young people taking part identified external, socio-environmental factors as contributing to the experiences described in the vignettes. The most common of these were bullying and cyberbullying, and also included difficulties at home, social isolation, trauma and abuse, bereavement, educational pressures, and the weight of peer pressure and societal expectations.

*“I think it’s a set of experiences, or sometimes even one experience, like it really impacts you. It just changes how you look at how your life’s going because it makes you change the type of person you are.” – Lewis*

There was a common perception that a person’s individual characteristics might leave them at risk of developing mental health difficulties. Many young people suggested that having low self-esteem, being introverted or having a more negative outlook on life could lead to a person being at risk of becoming unwell. While some young people viewed this as an inherently internal trait, the majority of participants identified a link between environmental factors and internal psychological experiences, such as bullying or abuse contributing to low self-esteem.

*“So it might be due to how they’re brought up and maybe they might have encountered abuse when they were little, which set the foundation for their mindset as they grew up.” – Jacob*

There was less mention of biological causes of mental health difficulties, and these were often cited with less certainty;

*“I don’t know whether it’s something he could maybe be born with?” – Rani.*

A few participants considered the biological pressures of adolescence, suggesting that puberty might lead to a chemical imbalance which could affect a person’s mood;

*“She’s a teenager and going through all of her hormones and stuff, maybe it’s just an imbalance?” – Neel.*

Biological causes were suggested alongside environmental or external causes, representing the young people's efforts to make sense of the causes of mental health difficulties through consideration of a range of interacting contextual factors.

### **Helping and helplessness**

This sub-theme represents the importance of help and support for people experiencing mental health difficulties, but also young people's difficulty in knowing how to help. The most commonly recommended forms of support came from informal sources, including friends and family, social support and self-help. Participants identified peer support and friendship as important for somebody experiencing mental health difficulties, alongside a frequent desire to help if it was a friend or another student in their class. Peer support took the form of problem-solving, providing emotional support, reassurance, and distracting them from their difficulties.

*“Ask him what’s going on in his mind to make him want to do all these things, and if he feels able to talk about them, just find a solution so he doesn’t feel as though he’s got to do that kind of thing.” – Maya*

*“I’d try and find out what’s happening. Try and prevent it from affecting her. Keep trying to cheer her up basically.” – Charlotte*

While for some this indicated an underestimation of the complexity of mental health difficulties, for most this reflected a desire to do their best using the skills that they had, while simply not knowing how else to help. This desire to help was associated with an internal conflict, with participants recognising the reality that they would struggle to support somebody experiencing mental health difficulties.

*“I think that’s definitely hard, especially for the friends of these people, because we’re also teenagers, it’s not like we’re fully mature of anything so certainly we’d not be the best of help.” – Kade*

It was common for young people to think about getting adults involved when they felt unable to help themselves. Familiar adults, such as

teachers and parents, were often suggested as sources of support and perceived as having knowledge about what to do and power to help. Many participants expressed that they did not know what professional support was available, or how to access this without adult intervention. For some there was a perception of adults as being gatekeepers to other forms of support;

*“If he talked to someone they would be able to, like a teacher or parent, they would be able to put him in contact with someone who could help.” - Jenna*

There were only a small number of instances where participants identified medical sources of support, such as medication or speaking to their GP. This was associated with a lack of familiarity and uncertainty about what support was available and how this might help.

*“I don’t know if there is things like tablets and stuff that could help? I think there is, tablets that can calm you down and stuff. So maybe if he went to the doctors he would be able to have those and stuff like that.” – Byrony.*

Participants unanimously identified talking support as being helpful for somebody experiencing mental health difficulties, whether this was offered formally through ‘counselling’ or ‘therapy’, or informally through friends and family. This was seen as an opportunity to feel supported and reassured, less isolated, develop new perspectives, and share worries or difficulties from the past.

*“People have said a problem shared is a problem halved, and that is true. When you talk to someone about it and it just feels like, a weight has been lifted off your shoulders.” – Byrony*

This recognition of the value of inter-personal and emotional support for mental health difficulties sits in line with participants’ general perception of mental health difficulties as being context-driven, rather than biologically-driven experiences.

## **Empathy and stigma**

Almost all of the participants responded to some or all of the vignette characters with empathy and concern, with many attempting to put themselves in the characters' shoes and reflecting upon how it might feel to live with their experiences and difficulties.

*"If I thought, or if I was believing that someone was trying to kill me, and no-one believed me, I would - I don't know how. I'd have no-one to turn to, I'd be really alone and sad. If I was trying to put myself in perspective, I'd find it really difficult to try and ask someone, 'this is happening to me, can you help me?'"* – Neel

As demonstrated here, even when behaviours appeared very strange to the young people, many were able to use empathy as a process of making sense of and normalising what the other person was experiencing, and why they might be responding in a certain way. It was also associated with young people identifying feelings of loneliness, sadness, confusion and fear, and connecting with the lived experience of mental health difficulties. This was observed as an active, evolving process that unfolded during the interviews as young people sought to make sense of the characters' internal struggles.

*"Maybe he watches people having arguments and that's making him sort of feel threatened? And he's thinking that the only way to solve things is violence, or shouting, which if he's put into a situation where that's what he's surrounded with, he's going to kind of adapt to the environment. And if he feels threatened he kind of feels like he needs to defend himself, so he feels like its him against the world, and he needs to stay in his own space where he's safe."* – Amir

Some young people expressed difficulty understanding another person's mental health experiences, particularly when they felt unfamiliar with the behaviours described in the vignettes, such as hearing voices. It was common for young people to perceive the characters as being 'different' or 'strange', particularly Ben and Claire. When this was accompanied by



young people struggling to make sense of a character's difficulties, they typically expressed that they would avoid them and be less willing to help. For one young person this was associated with her perception of Claire as having more control over her behaviour and capacity to change this if she wanted to.

*“She could stop saying people are trying to kill her, and then she could create more friends and then that could therefore make her better. She’s making rumours that aren’t true and it’s going to be broadcast across the tele, which is kind of weird.”* – Jacob

Participants were often aware of the stigma associated with mental health difficulties, and of the impact this could have for people experiencing it. Many young people suggested that other people were likely to respond to people experiencing mental health difficulties with avoidance or rejection. The use of stigmatising language, such as ‘crazy’, ‘freak’ or ‘weirdo’, was used to express how other people would perceive the characters in the vignette.

Some young people considered how a lack of understanding of mental health difficulties would mean that people were less likely to be accepting and supportive, and people could then become a target for humiliation, social exclusion or bullying;

*“Some people would probably laugh at her because they don’t think that’s a real thing. Not everyone is accepting of mental problems. They don’t think that they exist.”* – Alice.

While one participant identified inequalities in the way that mental health difficulties are represented and portrayed in society, and how this could maintain negative attitudes towards certain types of mental health difficulties that people experience;

*“With Amy, she was the most normal view we see of mental illness, but with people like Claire and the people shutting themselves away, it is*

*happening, but I don't feel like it's represented as much, so people would see it as a bit stupid, and not as much as a mental illness.” – Robert*

Participants' awareness of wider societal attitudes towards mental health difficulties being inherently negative was often based upon their own observations of stigma taking place, either in school, in public or on social media.

*“On social media, I do think there's a lot of jokes around mental illness and stuff like that and... that's definitely not positive. There's a problem with the kind of ignorance around mental illness.” – Matt*

### **In search of truth**

The final theme related to young people's search for truth; going beyond seeking knowledge and looking instead to uncover the truth and reality of mental health difficulties. Participants cited a range of different sources that they felt had helped them to learn what they currently knew and understood about mental health difficulties. The most common was personal experience of a friend or a family member's experience of anxiety or depression. As one young person explained, this had helped her to develop greater insight and awareness of people's difficulties;

*“People that I know, people that have dealt with things. Some of my close friends have, and they've enlightened me about different things.” – Alice*

Other sources included television documentaries and news programmes, as well as discussions and articles on social media. Four participants expressed that it had been helpful to read about people's lived experiences, either online or in books. Other participants shared that they had learnt about mental health during assemblies or specific classes, although there were inconsistent reports from students in the same school about whether this had taken place;

*“In school assemblies, they emphasise mental health quite a bit.” – Lewis*

*“In year 8, 9 and 10 we haven't done anything on it, and that can maybe be the time when it's most needed.” – Amir*

There was a general call for more education. Many participants reflected on the lack of sources available, and that while mental health was starting to be talked about more frequently, it remained “*quite a taboo subject*” – Ellie.

Five young people felt that despite increasing access to information about anxiety and depression, there remained a lack of information about more complex mental health difficulties.

*“You should put it in plain sight, rather than hiding it. I think it needs to not be censored as well. Like, to protect people, because it's not, like...easy. It's not innocent.” – Alice*

The young people interviewed expressed a desire to learn more about mental health difficulties, requesting education that offered insight, new perspectives, and greater understanding, as well as new knowledge.

*“I want to really know what's going on, all the details of it, just so like, you would know how to help if you see someone. Understand the things they're feeling.” – Eli*

School was frequently suggested as a platform where this learning could take place. Suggestions included learning from mental health professionals and service users, workshops, assemblies, and specific classes focused on mental health. All of the participants identified benefits to education, including helping people to identify if they are experiencing difficulties, knowing how to access support if needed, being able to help others in need, and reducing stigma. One young person summarised the importance of education and understanding;

*“I think maybe in the curriculum there should be a lesson of some kind that would educate people about maybe what to do, how to deal with it, how to notice it, and then how to help people with it, 'cause then if you've got*

*people that can help themselves and others, you've kind of got a community that can provide for themselves and there won't really be an issue.*" – Alex

## **Discussion**

The findings of this thematic analysis provides a current and up-to-date insight into how young people in the UK understand and view mental health difficulties. It makes an original contribution to the evidence base by considering the sources young people have been using to learn about mental health difficulties, and their views about mental health education. Participants in the study demonstrated an awareness of the complexities and challenges associated with mental health difficulties. They often held sophisticated and thoughtful views, demonstrating compassion and emotional insight as they sought to make sense of the complex constructs and experiences associated with mental health difficulties.

Previous studies have noted similar sophistication in younger childrens' understanding of mental health difficulties (Dixon, Murry & Daiches, 2012; Roose & John, 2003) and how this appears to develop over time (Fox et al., 2008; Hennessey & Heary, 2009). Participants in the current study were a few years older and this may reflect their ability to be able to specifically define mental health difficulties as a process that affects internal cognitive processes and the way that a person might perceive themselves, others and the world around them. This level of insight has not previously been recognised in this age group, with Teng et al. (2016) noting instead older adolescent's difficulty in grasping the complexities associated with understanding mental illness. This contrast may reflect differences in the researchers' perspectives about mental health difficulties, or in the characteristics of the young people that took part. It may also indicate cultural differences, with the latter study taking place with Australian youth, and may reflect differences in the way that mental health difficulties are portrayed, represented and taught about in different societies.

While there were inconsistencies observed in the participants' abilities to recognise whether somebody was experiencing mental health difficulties, when they identified that a person was unwell their responses were generally those of acceptance, tolerance and empathy. As in previous studies, participants were able to suggest a range of possible causes for characters' emotional difficulties, mainly focusing upon external, socio-environmental factors (Bailey, 1999; Hennessy & Heary, 2009; Melas et al., 2013) and less so on biological or internal causes (Fox et al., 2008). What was interesting was how participants conceptualised an interaction between environmental, social and psychological processes, identifying how external factors could contribute to internal psychological processes that could then lead to somebody becoming unwell. This brings to mind the psychological processes model (Kinderman, 2005, 2009), proposing that biological and social factors, together with a person's experiences, lead to mental health difficulties through the combined impact that these have on internal psychological processes. The model emphasises the complex, interconnected nature of these factors. Young people's ability to conceptualise and make sense of the experience of mental health difficulties in this way has not been observed before, and further emphasises the sophistication of participants' understanding.

The prevalence of empathy in participants' responses was interesting given that a number of studies indicate that adolescents struggle with empathy due to the relatively late development of the prefrontal cortex in the adolescent brain (Morelli, Rameson & Lieberman, 2012). More recent research challenges these findings, reporting that teenagers are capable of being empathic as empathy develops during adolescence (Allemand, Steiger and Fend, 2015), although a multitude of factors, including detrimental beliefs and values internalised by young people, and lower levels of emotional awareness, may contribute to a lack of empathy being observed (Crone & Dahl, 2012; Rieffe & Camodeca, 2016). Previous research also suggests that teenage boys tend to demonstrate less empathy than girls (Van der Graaff et al., 2014), however in the present study both boys and girls expressed similar levels of empathy. In this case

both boys' and girls' expression of empathy may be linked to higher levels of emotional awareness, which may have contributed to participants' willingness to take part in a study exploring emotional well-being.

Previous research has also reported that girls tend to express more concern, and recognise a need for support for those experiencing mental health difficulties, more than boys (Coles et al, 2016; Dixon et al, 2012; Secker et al, 1999). In the current study both genders identified a need for support for mental health difficulties, and a wish to support both male and female peers in need. Possible explanations for the current findings include socio-economic background and school experience. Higher socio-economic status has been associated with greater knowledge and endorsement of accessing mental health support in adults (Wyllie et al, 2012). As the male participants came from relatively affluent family backgrounds and attended independently funded schools, the majority from a same-sex school, this may have had an influence on their access to mental health related information and experiences, and their perception of support for emotional difficulties compared to boys from lower socio-economic backgrounds. The extent to which the schools in the study promoted and encouraged peer support, disclosure of personal difficulties and accessing of pastoral support may also have contributed to the particularly empathic, supportive and insightful views of male participants in this study compared to previous research.

As in previous studies, the most frequently recommended sources of support were informal, and recommendations for professional support were less common (Coles et al., 2016; Melas et al., 2013; Leighton, 2010; Burns & Rapee, 2006). Participants expressed uncertainty and a lack of knowledge about professional sources of support, but a clear desire to know more about how to help, particularly given the importance placed upon peer support and being able to help a friend experiencing difficulties. This indicates an avenue where mental health education could lead to improvements in young people's help-seeking behaviours, through developing their knowledge about where and how to access professional

support. It could also enhance the provision of peer support, if young people become more confident in identifying and recommending professional sources of support, encouraging one another to access this when needed.

Familiarity, describing knowledge and/or experience with a phenomenon, has also been associated with more positive attitudes towards mental health difficulties (Corrigan et al., 2001, Watson et al., 2005). It is unsurprising that greater familiarity with depression and anxiety, and less familiarity with psychosis, was noted in participants' responses given the greater prevalence of these difficulties in the general population (Stansfeld et al., 2016). A lack of familiarity was not necessarily a barrier to empathy, willingness to help or recognising that characters were experiencing mental health difficulties, although some participants did struggle to recognise and make sense of the difficulties described, particularly in the psychosis vignettes. Participants identified a lack of sources enabling familiarity with a broader spectrum of mental health difficulties, and called for greater visibility, diversity and honesty in the way that mental health difficulties are represented in the information available to them. While it is important that more common mental health difficulties remain at the forefront of mental health education, the broader spectrum of mental health difficulties should not be neglected. This could enable young people to feel more confident in applying their existing knowledge, insight and empathy to the more complex, severe and challenging difficulties that people can experience.

The level of understanding, insight and compassion that the young people in the study demonstrated however indicates that something in the system is already working well. Young people can adopt non-stigmatising and empathic responses to individuals who experience mental health difficulties, despite a lack of formal education in this area. This could reflect increasing levels of social awareness and tolerance towards mental health difficulties, following the success of anti-stigma and awareness raising campaigns in the UK such as Time to Change (Henderson et al.,

2016). It may also be related to the prevalence of social media, and the increasing accessibility of information for young people.

There is work to be done however, as there were notable gaps and uncertainty in young people's knowledge and understanding of mental health difficulties. Based upon the findings of this study, the role of education in schools should not seek to alter, but instead enhance young people's knowledge and insight by building upon and reinforcing what is already there. This could be done by providing access to the information that young people need to fill the gaps in their understanding. Where education seeks to improve young people's mental health through improved recognition, help-seeking and attitudes towards people experiencing mental health difficulties, then the results of this study indicate that being able to recognise the broader signs of mental ill-health, knowing when and how to access support, and improving attitudes through promoting a more psychological model of mental health difficulties would be valuable areas to focus upon.

### *Strengths and Limitations*

A particular strength of this research was the opportunity to place young people's views, experiences and voices at the heart of the study. Participants themselves expressed the value and importance of research that encourages learning and discussion about mental health, and an enthusiasm for further research of this type to take place (Appendix R).

A limitation of the study refers to the validity of vignette studies. While care was taken to enhance the construct and internal validity of the vignettes, and ensure that they accurately portrayed mental health difficulties in young people, these were not real life examples. The external validity and extent to which participant's responses would accurately represent their responses to real world scenarios remains unclear. Despite this, participants' responses in vignette studies should not necessarily be interpreted as representative of their responses to such experiences in the real world, but as a strong predictor for these responses, given the circumstances encompassed by the vignette (Evans et al., 2015).



The research also focused predominantly on young people's responses to other young people experiencing mental health difficulties. While mental health difficulties were discussed more broadly at the end of interviews, there may be differences in the way young people respond to adults experiencing mental health difficulties.

The complexity of young people's views and understanding of mental health difficulties, and the empathy demonstrated, may also be a specific feature of the group of young people who took part. It is likely that participants had a greater interest and knowledge of mental health difficulties than typical students as they had volunteered to take part in the study, which may have contributed to the findings. The location of the study in privately funded schools also meant that all of the participants came from relatively affluent backgrounds. While this creates a more homogenous sample, it is also not possible to generalise the findings to all young people of a similar age. Students from lower socio-economic backgrounds and local authority funded schools are likely to have difference life experiences to students from independently funded schools and wealthier backgrounds, particularly given the detrimental impact of deprivation on mental health (Elliott, 2016). Although generalisability is not the intention of a thematic analysis, it is important that further research continues to take place in this area with children of diverse ages, cultures, socio-economic and educational backgrounds, to consolidate and strengthen the evidence base in a way that broader and more representative statements about young people's understanding of mental health difficulties can then be possible.

A final consideration is the role of the researcher in the interpretation of the data. Reflexivity is inherent to the very nature of qualitative research, in which the researchers' own experiences, perceptions, attitudes and beliefs will inevitably shape their interpretation of participants' experience (Palaganas et al., 2017). The researchers' own role and assumptions about the data can also influence the selection of data presented. Efforts were made to ensure that all participants were represented in the data

presented in this paper, and a reflective journal was maintained throughout analysis to identify and reduce the impact of potential bias. A reflexive statement is included in Appendix S and outlines the researchers position in undertaking this research, which should be taken into account when interpreting the findings.

### *Implications for Clinical Practice*

The findings of this study are important for Clinical Psychologists, particularly given the Government proposal for improved joint working between schools and child and adolescent mental health services (CAMHS). Clinical Psychologists can offer leadership in developing and enhancing interventions, initiatives and services that will improve the mental health and wellbeing of the population (British Psychological Society, 2014), including influencing the development of mental health education that meets the needs of young people.

Alongside previous research, the findings suggest that young people have difficulty accessing formal sources of support, preferring instead informal support. This indicates a need for psychologists and services to consider how they might make themselves more visible and accessible to young people. An increase in joint working with schools may be an opportunity for Clinical Psychologists and other mental health professionals to meet with young people, to be directly involved in the delivery of their mental health education, and sharing information about the sources of support and services available to them. As young people continue to indicate a preference for informal sources for support, this suggests a need for clinicians to consider ways in which interventions are designed and offered to young people, such as peer based support groups, increased early intervention and prevention strategies, online sources of support, or support that is available in informal settings.

### **Conclusion**

In the light of recent proposals for mental health education to become a mandatory requirement in schools across the UK, the research here

provides a current and detailed insight into young people's understanding and perceptions of mental health difficulties. The findings suggest that young people can hold a remarkably detailed understanding, and psychologically informed insight, awareness and compassion, particularly towards peers experiencing mental health difficulties. The research also identified potential gaps in young people's understanding, and participants' were often aware of the limits of their understanding, actively requesting opportunities to learn more about the lived experience of mental health difficulties and how to help somebody in need. These findings provide direction for future educational initiatives, with a view to enhancing young people's existing understanding of mental health difficulties. Where nurtured, this provides hope for a more informed, accepting and inclusive society in the years to come.

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Wyllie, C., Platt, S., Brownlie, J., Chandler, A., Connolly, S., Evans, R., Kennelly, B., Kirtlie, O., Moore, G., O'Connor, R. & Scourfield, J. (2012). *Men, suicide and society. Why disadvantaged men in mid-life die by suicide*. Retrieved 14 July 2018 from <https://www.samaritans.org/sites/default/files/kcfinder/files/Men%20and%20Suicide%20Research%20Report%20210912.pdf>

YoungMinds (2017). *Wise up - prioritising wellbeing in schools*. Retrieved 14 July 2018 from <https://youngminds.org.uk/media/1428/wise-up-prioritising-wellbeing-in-schools.pdf>

### **Paper 3: Executive Summary**

Word Count: 2990

This paper is not intended for publication. It has been written in the style of a report aimed at education providers, secondary schools and local education authorities.

## Background

This report presents findings from a study exploring young people's views and understanding of mental health difficulties. The study also considered the ways in which young people were learning about mental health, and the implications for future educational initiatives. The number of young people experiencing mental health difficulties is thought to be increasing<sup>1</sup>. It has been estimated that one in ten children and young people in England had a diagnosable mental health difficulty. This is equivalent to three children in every classroom<sup>2</sup>. The results of a new prevalence survey will be released later this year, and these figures are expected to have grown<sup>3</sup>.

In response to this worrying trend, mental health education can significantly improve young people's overall mental health in a number of ways<sup>4</sup>. These include increasing knowledge of what contributes to positive mental health, awareness of the signs of mental ill-health, reducing stigma towards those experiencing difficulties<sup>5</sup>, and encouraging more positive attitudes to seeking help when unwell<sup>6</sup>. How and what young people learn about mental health is important, as this will influence the way that they respond to any difficulties that they or others are experiencing. As they grow and become the future adults of society, this will have implications for the way that mental health difficulties, and the people experiencing them, are viewed and responded to.

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<sup>1</sup> CentreForum Commission on Children and Young People's Mental Health: State of the Nation. London: UK, 2016.

<sup>2</sup> Green, H., McGinnity, A., Meltzer, H., Ford, T., & Goodman, R. Mental health of children and young people in Great Britain, Basingstoke: Palgrave Macmillan, 2014.

<sup>3</sup> Care Quality Commission. Review of children and young people's mental health services: Summary of recent policy and literature. London: UK, 2017.

<sup>4</sup> Durlak, J.A., Weissberg, R.P., Dymnicki, A.B., Taylor, R.D., Schellinger, K.B. The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. *Child Development*. 2011; 82, 1, 405-432.

<sup>5</sup> Stuart, H. Reducing the stigma of mental illness. *Global Mental Health*. 2016; 3, 17.

<sup>6</sup> Lo, K., Waterland, J., Todd, P., Gupta, T., Bearman, M., Hased, C. & Keating, J.L. Group interventions to promote mental health in health professional education: a systematic review and meta-analysis of randomised controlled trials. *Advances in Health Sciences Education: Theory and Practice*. 2018; 23, 2, 413-447.

Schools can play a vital role in improving young people's mental health and well-being. While the provision of mental health education in schools is slowly beginning to improve, there has been a reported lack of resources, clear guidance and support for schools to include mental health in the curriculum<sup>7</sup>. The delivery of mental health programmes in schools has been patchy, and as a result many students will have received limited or no guidance about their mental health and wellbeing.

The UK Government has recently announced a proposal that every young person in England will learn about mental health and wellbeing at school<sup>8</sup>. While there are currently no guidelines stating what this will look like in the classroom, it is widely recognised that students are more likely to engage with education that is accessible, personalised and flexible, and tailored to their age, culture and social context<sup>9</sup>. In order for it to be successful, it is essential that mental health education is designed and taught in a way that is relevant and meaningful to young people<sup>10</sup>. One way that this can be done is by listening to what young people already think and know about mental health difficulties, finding out what they don't know, and considering how and what they want to learn about mental health.

The current study was developed due to a lack of research and clarity in this area. While some studies have found that young people have a relatively good understanding and positive attitudes towards mental health difficulties<sup>11</sup>, others have found the opposite<sup>12</sup>. Much of this research has taken place outside of the UK, with the most recent study here dating back to 2011. An up to date exploration of young people's views and

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<sup>7</sup> YoungMinds. Wise Up - Prioritising Wellbeing in Schools. YoungMinds. London; 2016.

<sup>8</sup> Department of Health & Department of Education. Transforming Children and Young People's Mental Health Provision: A Green Paper. Crown Copyright; 2017.

<sup>9</sup> Ibid

<sup>10</sup> Wahl. Children's views of mental illness: A review of the literature. *Psychiatric Rehabilitation Skills*. 2002; 6, 2, 134-158.

<sup>11</sup> Roose, G.A. & John, A.M. A focus group investigation into young children's understanding of mental health and their views on appropriate services for their age group. *Child: Care, Health and Development*, 2003; 29, 6, 545-550.

<sup>12</sup> Coles, M.E., Ravid, A., Gibb, B., George-Denn, D., Bronstein, L.R. & McLeod, S. Adolescent Mental Health Literacy: Young People's Knowledge of Depression and Social Anxiety Disorder. *Journal of Adolescent Health*, 2016; 58, 57-62.

understanding of mental health difficulties was timely. This would provide important insights that could guide the development of resources that help young people learn about, and protect, their mental health.

The aims of this study were to:

- Explore young people's current views and understanding of mental health difficulties
- Consider the sources that young people already use to learn about mental health difficulties
- Identify directions for future mental health education initiatives

### **Method**

Young people's understanding, views and ways of learning about mental health difficulties were explored during one-to-one interviews. Sixteen Year 10 students from two independent secondary schools took part. Both schools agreed to participate following an invitation sent out to all eleven independent secondary schools in a county in the West Midlands. Ethical approval for the study was granted by Staffordshire University's Research Ethics Committee.

Interviews took place during school hours and lasted around thirty minutes. Participants were informed about the study and had volunteered to take part. Both individual and parental consent was obtained for each participating student. Interviews were audio recorded and transcribed. The data of each young person taking part was anonymised for confidentiality.

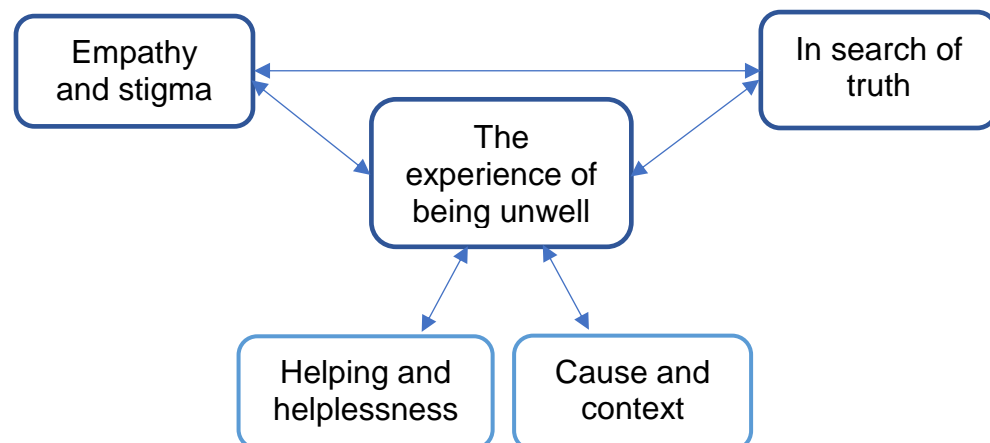
Participants were given four vignettes, or short-stories, of fictional young people experiencing either anxiety and depression, or signs of psychosis. After reading each vignette, participants were asked questions to explore their knowledge, attitudes, and understanding of the character's mental health difficulties, and what help they might need. Participants were also asked where they had learnt about mental health difficulties, and what they thought would help young people learn more about these.

Interview data was analysed using thematic analysis. This method was used to identify, analyse and report patterns in the data. During analysis these patterns were synthesised into key themes. Each theme aimed to capture the voice of the young people who took part, reflecting their combined views, understanding or learning needs relating to mental health difficulties.

### Key Findings

Analysis of the qualitative data resulted in three key themes being identified: 1) *the experience of being unwell*; 2) *empathy vs stigma*; and 3) *the search for truth*. The first of these themes included two subthemes, describing additional important patterns related to this theme: *cause and context*; and *helping and helplessness*. A visual representation of the themes and subthemes is presented in Figure 1.

Figure 1: Map of key themes and subthemes relating to young people's views and understanding of mental health difficulties.



#### *The Experience of Being Unwell*

- The young people demonstrated clear attempts to make sense of the vignette character's different experiences of being unwell.

- Participants generally recognised that vignette characters were experiencing mental health difficulties even if they did not, or were unable to specifically name these.
- Young people demonstrated a sophisticated understanding of mental health difficulties, as something that might lead to a person having a more negative or anxious mind-set, affecting the way that they view themselves and the world around them.
- Mental health difficulties were recognised as being different to a short-term reaction to a stressful situation. A small number of young people felt that some characters were reacting to a stressful situation, such as bullying, rather than being unwell.
- Young people were less familiar, and expressed the most confusion and uncertainty, in relation to the psychosis vignettes. They were more familiar and confident with recognising anxiety and depression.
- There was a general recognition that mental health difficulties could last a long time and have long term consequences for a person without appropriate support.

### *Cause and Context*

- Participants unanimously identified that environmental and social factors could contribute to mental ill-health. Most participants suggested that such experiences could lead to internal psychological changes and leave someone at risk of experiencing mental health difficulties.
- A small number of participants suggested internal, biological causes of mental ill-health, such as a chemical imbalance, or it being something a person was born with.



### *Helping and Helplessness*

- All of the young people felt that somebody would need help and support in order to recover from mental ill-health.
- Participants unanimously recommended peer support and talking support.
- Most participants suggested informal talking support from friends and family. Some participants suggested formal talking support, such as counselling or therapy.
- Many young people expressed a desire to help a friend or classmate if they were unwell. Most also said that it would be difficult to help somebody due to feeling unskilled and unsure how to help.
- The majority of participants expressed that they did not know what professional support was available.
- It was common for young people to want to refer on to a familiar adult, such as a parent or teacher, who they felt would know how to help.
- A small number of participants suggested medical sources of support, such as taking medication or seeing a GP.

### *Empathy and Stigma*

- Participants generally expressed empathy and concern for people experiencing mental health difficulties.
- The use of empathy was seen to help young people make sense of and understand a character's behaviours and experiences. Empathy facilitated acceptance and helped young people to normalise what they had initially observed as odd or unusual behaviour.

- Empathy was associated with young people expressing a desire to help another young person with mental health difficulties.
- Perceiving a person as having control over their behaviour and a capacity to change this if they wanted was associated with less empathy and a wish to avoid a person experiencing difficulties.
- Most participants were aware of and had observed the societal stigma associated with mental health difficulties.
- Many young people felt that stigma would mean that people with mental health difficulties would be treated less favourably. There was a widespread view that that this was unfair and that negative stereotypes needed to be challenged.

#### *In Search of Truth*

- Young people expressed a desire to learn more about mental health difficulties, to be able to understand the lived the experience and know how to help.
- Participants identified a range of sources that had informed their understanding of mental health difficulties. The most common was from personal experience of a friend or family member with mental health difficulties.
- Social media, reading about people's lived experiences, or specific sessions at school were other sources of information. Reports of the availability of school based learning were inconsistent.
- Young people expressed that there was a general lack of information available to them, and that mental health difficulties other than anxiety and depression were particularly underrepresented.

- All participants expressed a desire to learn more, identifying clear benefits to improved mental health education. This included being able to recognise mental health difficulties, knowing how to access support, being able to help others, and reducing stigma.
- School was the most commonly suggested platform for further mental health education to take place.

Following the interviews, many participants shared that they had enjoyed taking part in the study and expressed that further opportunities to take part in research about mental health and well-being would be both helpful and of interest to them. This emphasises the importance of involving young people in research and inviting them to take part in broader discussions around mental health.

### **Conclusion**

In summary, the young people in this study demonstrated an understanding of the complexities and challenges associated with mental health difficulties. The findings suggest that despite a lack of formal mental health education in the UK, young people can hold remarkably sophisticated, non-stigmatising and psychologically informed views of mental health difficulties. For the young people in the study this was associated with awareness, compassion and insight into the challenges and difficulties associated with living with mental ill-health. Empathy and familiarity with mental health difficulties was often related to a desire to want to help others in need, although young people expressed a lack of knowledge of professional sources of support. This and gaps in their understanding, including difficulty differentiating between mental health difficulties and stress, and the extent to which someone is blamed for their mental health difficulties, indicate areas where education may be of the most benefit to young people.

This study also provides evidence in support of young people wanting to learn more about mental health difficulties. Alongside a greater

understanding of the strengths and gaps in their knowledge of mental health difficulties, understanding what the young people in this study want to learn, and how they want to learn it, can inform the direction that educational initiatives might take. Participants identified benefits to learning about mental health, for both themselves and others, which suggests an optimistic outlook for engaging young people in mental health education in school. The results of the study suggest that where education is delivered in a way that feels relevant and useful to young people, and is tailored to their needs, that there is an opportunity to enhance young people's existing understanding of mental health difficulties. Education that nurtures young people's drive to learn, understand, and support one another has the potential to foster a more inclusive, informed and accepting community of young people, whilst improving their overall mental health and wellbeing.

### **Recommendations**

The results of this study help to identify ways in which mental health education might develop when it becomes mandatory for all schools to teach students about mental health and wellbeing. The following recommendations have been produced in line with the findings of the study and are informed by the views and wishes of the young people who took part.

- *The broader spectrum of mental health difficulties:* Education should support young people to recognise the signs and symptoms associated with a broader range of mental health difficulties. Education need not focus on diagnostic categories, however young people may benefit from an awareness of how mental health difficulties can present in many different ways. This would increase familiarity with a wider range of indicators of mental ill-health, helping to reduce stigma and facilitate help-seeking when needed.
- *Understanding what causes mental health difficulties:* Educational programmes that are based upon a psychological model of

understanding mental health difficulties<sup>13</sup> may be helpful in reinforcing and supporting young people's existing views and understanding. A psychological model takes into account the complex, interconnected nature of biological, social and psychological factors. Education that supports young people's understanding of the causes of mental health difficulties, and why somebody might become unwell, could help to increase empathy, promote helping behaviours, and improve attitudes towards people experiencing mental health difficulties<sup>14</sup>.

- *Sources of support:* Young people can be empowered to care for their own and others' mental health through the provision of information about both formal and informal sources of support. Information about how to help somebody they are worried about, the types of professional support available, what to expect from services and how to access these, will be important in helping young people to feel confident in accessing or signposting others to support when needed.
- *Sources of information and understanding:* Examples of real life experiences of living with mental health difficulties, and contact with mental health professionals as part of young people's education, may help to facilitate understanding, empathy and awareness of support. This may also lead to improved attitudes towards help-seeking and those who experience mental health difficulties.

## Dissemination

The full research article offering further details of the completed study is due to be submitted to the journal *Child and Adolescent Mental Health*<sup>15</sup>. This executive summary will be made available to the schools that took

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<sup>13</sup> Kinderman, P. A psychological model of mental disorder. *Harvard Review of Psychiatry*. 2005; 13, 4, 206-217.

<sup>14</sup> The National Academics of Sciences, Engineering, and Medicine. *Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change*. Washington, DC: The National Academies Press; 2016.

<sup>15</sup> *Child and Adolescent Mental Health*, Wiley Online Library. Details available from <https://onlinelibrary.wiley.com/journal/14753588>

part in the study, and those that expressed an interest in the findings during the recruitment stage. Copies will also be disseminated to local education authorities in England, to be shared with secondary schools within their locality at their discretion.

### **Limitations**

It is important to note that there are specific limitations to the completed study and thus this report. These include:

- Participants were aged 14-15 and attended privately funded secondary schools in one area of the UK. These factors may have influenced their particular views and understanding of mental health difficulties. As a result it is not possible to generalise the findings of this study to all young people.
- The young people who took part appeared to be particularly motivated and interested in mental health. The results of this study may reflect these particular characteristics, and it is possible that other young people will not express the same willingness to engage in mental health education initially.
- Interview data predominately focused on young people's responses and attitudes towards other young people experiencing mental health difficulties. There may be differences in how young people respond to adults in similar situations.

## Appendix A: Journal Submission Guidelines for Paper 1

### JOURNAL OF ADOLESCENCE

The Journal of the [Foundation for Professionals in Services to Adolescents](#) (FPSA)



**Review articles:** We are keen to encourage authors to submit review articles on topics where there is a need for a new overview of existing research. As with other formats, the focus should be explicitly on adolescence, and on shedding light on young people's development. The journal is not prescriptive about how reviews should be undertaken, but the methods used should be clear. Reviews should not exceed 5000 words. The word count includes the body of the article, but not the abstract, references, tables, figures or appendices. Further information about writing reviews for the Journal of Adolescence can be found [here](#). Occasionally the editors will commission review pieces if they feel there is a particular gap in the literature that needs filling, or to complement a Special Issue. If authors would like to discuss their plans for a review article, please contact the Editor through the journal mailbox [joa@elsevier.com](mailto:joa@elsevier.com) in the first instance.

**GENERAL STYLE:** The Journal follows the current American Psychological Association style guide. Papers that are not submitted in APA style are likely to be returned to authors. You are referred to their Publication Manual, Sixth Edition, copies of which may be ordered from <http://www.apa.org/pubs/books/4200066.aspx>, or APA order Dept, POB 2710, Hyattsville, MD 20784, USA, or APA, 3 Henrietta Street, London, WC3E 8LU, UK. There are also abbreviated guides freely available on the web. Text should be written in English (American or British usage is accepted, but not a mixture of these). Italics are not to be used for expressions of Latin origin, for example, *in vivo*, *et al.*, *per se*. Use decimal points (not commas); use a space for thousands (10 000 and above). If (and only if) abbreviations are essential, define those that are not standard in this field at their first occurrence in the article: in the abstract but also in the main text after it. Ensure consistency of abbreviations throughout the article.

Manuscripts must be typewritten using double spacing and wide (3 cm) margins. (Avoid dull justification, i.e., do not use a constant right-hand margin). Ensure that each new paragraph is clearly indicated. Present tables and figure legends on separate pages in separate electronic files. If possible, consult a recent issue of the Journal to become familiar with layout and conventions. Number all pages consecutively

**Appendix B: Summary of Papers Identified Through the Literature Search Exploring Adolescent’s Understanding of Mental Health Difficulties**

No	Reference and Location	Study Type and Aim	Age	N	Data Collection and Analysis	Findings
1	Teng, Crabb, Winefield & Venning (2017)  Australia	Qualitative  To gain insight into young people’s perceptions and experiences of mental health and illness.	12-18	16 students (4 schools)  56% Female  44% Male	Semi-structured interviews  Thematic analysis	Three key themes: Definitions of Mental Health, Mental Health and Illness in Real Life, Attitudes/Behaviours Towards Someone with a Mental Illness.  Tensions between perceptions of mental health concepts and reality. A lack of visible markers of mental health and illness represented significant challenge to young people’s understanding of how to approach mental health among their peers.
2	Coles, Ravid, Gibb, George-Denn, Bronstein & McLeod (2016)  USA	Quantitative  Replicating and extending prior work examining mental health literacy of adolescents for depression and anxiety.	14-19  Mean 16.05	1104 students, (1 school)  48.4% Female  51.6% Male	Friend in Need Questionnaire Revised, Strengths & Difficulties Questionnaire.  Coding, Chi Squared tests, 2x3 ANOVAs, binary logistic regression analysis.	Majority of participants did not recognise depression or social anxiety disorder in a vignette. Greater recognition of depression than social anxiety. Girls had higher rate of mental health literacy than boys. Greater recognition of depression in male vignette character. No gender differences found for social anxiety.
3	Melas, Tartani, Forsner, Edhborg & Forsell (2013)  Sweden	Qualitative with some quantitative analysis  Examining levels of mental health literacy and altruistic behaviour	15-19  Mean 16.1	426 students (2 schools)  62.6% Female  36.1% Male	Vignette based questionnaire  Mixed methods. Content analysis.	Relatively low levels of mental health literacy. 42.7% identified depression and 34.7% identified schizophrenia. Depression recognised more often by females. 22.5% recommended professional help for depression and 32.6% for schizophrenia.



No	Reference and Location	Study Type and Aim	Age	N	Data Collection and Analysis	Findings
		among adolescents		1.6% Unknown	Themes derived, and percentages compared using statistical analysis.	Altruistic behaviours found among 58.2% of participants, more so in females. Stigmatising attitudes towards schizophrenia in 11.5% of participants.
4	Dogra, Omigbodun, Adedokun, Bella, Ronzoni & Adesokan (2011) Nigeria	Quantitative  Establishing young people's views and knowledge about mental health and illness.	10-18  Mean 14.8	145 students (4 schools)  52.1% Female  47.9% Male	Cross-sectional questionnaire based survey.  Chi Squared test of independence analysis.	Participants lacked knowledge of mental health and illness and showed negative attitudes towards mentally ill people. May be related to the significant social distance that participants demonstrate towards individuals with mental health difficulties.
5	Lovett, Tamkin & Fletcher (2011) England, UK	Qualitative  Exploring children's understanding and beliefs about mental illness and where these ideas emerged from.	10-18	52 students (4 schools)	Focus groups. Drawings and word play used for younger group (10-15) and brief vignettes used for the older age group (16-18)  Discourse Analysis	Difficulty distinguishing between mental illness and learning disabilities. Schizophrenia commonly identified as a mental illness, although often associated with 'split personality', 'unpredictability' and 'personality change'. Mental illness often associated with stigmatizing attitudes and perceptions. Stereotypical views and fear of mental illness often cited.
6	Leighton (2010) England	Quantitative  Examining levels of mental health literacy	12-15	208 students (6 schools)  50% Female	Vignette based questionnaire.	Participants had difficulty distinguishing and defining mental illness and mental health problems. Experience of mental health problems not associated with being able to define a mental

No	Reference and Location	Study Type and Aim	Age	N	Data Collection and Analysis	Findings
		among adolescents.		46.2% Male 3.8% Unknown	Mixed methods analysis – content and statistical analysis. Chi Squared, Friedman test and Wilcoxon Signed Ranks test.	health difficulty. Significant association between gender and problem definition in only one vignette. Being female and prior experience of mental health problems associated with flexibility in choices of sources of help, and perceived benefits of help.
7	Hennessy & Heary (2009) Ireland	Qualitative Exploring children's beliefs about the causes of psychological problems and their beliefs about sources of help	8-15 Mean 11.4	116 students (1 school) 50% Female 50% Male	Vignettes and focus groups or individual interviews. Interview responses coded; Chi Squared tests of homogeneity	Children of all ages able to offer range of explanations for behaviours in the vignettes (internal and external causes). Majority thought that behaviour could change, and help could be provided by friends/family. Developmental changes in children's understanding of common psychological problems. Older children more likely to recommend friends as a source of support for depression.
8	Williams & Pow (2007) Scotland	Quantitative Exploring teenagers' knowledge and attitudes towards mental health and people with mental health problems.	15-16	496 students (3 schools) 51% Female 49% Male	Cross-sectional survey Chi Squared, Mann-Whitney and Kruskal Wallis tests.	Boys reported lower levels of knowledge and different sources of stress than girls. Negative attitudes more common among boys than girls. Boys less likely to think that an understanding of mental health is important, less likely to want to know more about mental health and twice as likely to think they'd already been given enough education in this area.

No	Reference and Location	Study Type and Aim	Age	N	Data Collection and Analysis	Findings
9	Burns & Rapee (2006)  Australia	Quantitative  Examining adolescents' mental health literacy and ability to recognise depression in peers.	15-17	202 students (2 private schools)  39.6% Female  60.4% Male	Friend in Need Questionnaire (vignette based).  Responses coded, two-way ANOVA	Mixed ability when recognising and labelling depression, most able to differentiate between depressed and non-depressed scenarios in terms of severity and expected recovery time. Girls demonstrated higher mental health literacy. Participants did not consider doctors appropriate helpers for a depressed peer. A large number rated family as an important source of help.
10	Watson, Miller & Lyons (2005)  USA	Quantitative  Exploring dimensions of mental illness stigma and examining effects of social characteristics	Not specified	415 students (2 schools)	Attitudes Toward Serious Mental Illness Scale – Adolescent Version  Factor analysis, varimax rotation. Factor based scale scores, independent samples t-tests.	Five factors identified relating to attitudes towards mental illness: Threat, Social Control/Concern, Wishful Thinking, Categorical Thinking, Out of Control.  Girls had less negative attitudes than boys. Racial and ethnic differences in attitude relating to social control of individuals labelled with mental illness, and concern of personally developing a mental illness. Familiarity related to more positive attitudes to mental illness.
11	Roose & John (2003)  England	Qualitative  To explore children's understanding of the concept of mental health and their opinions of appropriate services for their age-group	10-11	16 children (2 primary schools)	Focus groups  Interpretive Phenomenological Analysis	Four themes: Continuum of difficulties, Access to support, Ideal service for this age, Gender. Participants showed sophisticated understanding of mental health, many behaviours considered indications of a serious problem. Participants distinguished between physical and mental health and were aware of issues that can lead to problems for children their age. Friends and family are recognised as primary sources of support.

No	Reference and Location	Study Type and Aim	Age	N	Data Collection and Analysis	Findings
12	Secker, Armstrong & Hill (1999)  Scotland	Qualitative  Exploring ways in which young people construct their understanding of mental illness	12-14	102 students (4 schools)	Semi-structured focus groups and individual interviews  Unspecified qualitative analysis	Participants used personal experiences to separate behaviours that they could identify with from those that they could not. If behaviours could be understood young people were reluctant to label this as mental illness. Behaviours identified with but not considered normal were 'psychological problems'. Behaviour that was difficult to identify with was 'mental illness'.
13	Callan, Wilks & Forsyth (1983)  Australia and Papua New Guinea (PNG)	Quantitative  To identify attitudes and beliefs about the nature, characteristics and treatment of mental illness.	16-17	133 PNG high school students  57.1% Male 42.9% Female  144 Australian high school students, two schools.  64.6% Male 35.4% Female	Cross-sectional questionnaire survey.  Factor analysis with varimax rotation. 2x2 factorial discriminant analysis. Coding of qualitative responses.	Both groups suggested hereditary and environmental causes of mental illness. PNG students also cited witchcraft and sorcery. Both recognised the role of modern medicine and some traditional medicine. Australian students generally had more favourable attitudes, PNG students more cautious. PNG students more likely to associate disruptive, violent behaviours with mental illness, but also more hopeful about recovery.

### Appendix C: CASP Quality Scores for Each Qualitative Paper in the Literature Review

No.	Criteria	Critical Appraisal Skills Programme					
		Teng et al. (2017)	Melas et al. (2013)	Lovett et al. (2011)	Hennessey & Heary (2009)	Roose & John (2003)	Secker et al. (1999)
1	Clear statement of aims	Y	Y	Y	Y	Y	Y
2	Is qualitative appropriate	Y	Y	Y	Y	Y	Y
3	Design appropriate to the aims	Y	Y	Y	Y	Y	Y
4	Recruitment strategy appropriate	Y	Y	Y	P	Y	Y
5	Data collection addressed research issue	Y	Y	P	Y	P	Y
6	Role of researcher adequately considered	N	N	N	N	N	N
7	Ethical issues considered	Y	Y	Y	P	Y	Y
8	Data analysis sufficiently rigorous	Y	Y	P	P	P	P
9	Clear statement of findings	Y	Y	P	P	Y	Y
10	Valuable research	Y	Y	Y	Y	Y	Y
	Total (Out of 20)	18	18	15	14	16	17

Key		Points
Y	Yes	2
P	Partially met	1
N	No	0

**Appendix D: Crowe Critical Appraisal Tool (CCAT) Quality Scores for Each Quantitative Paper in the Literature Review**

Category Item (0-5)	Coles et al. (2016)	Dogra et al. (2011)	Leighton (2010)	Williams & Pow (2007)	Burns & Rapee (2006)	Watson & Lyons (2005)	Callan et al. (1983)
1. Preliminaries	4	5	4	4	5	4	4
2. Introduction	5	5	5	4	5	3	4
3. Design	4	4	5	4	4	3	4
4. Sampling	4	3	4	4	3	3	3
5. Data Collection	4	4	4	4	4	4	4
6. Ethical Matters	4	3	4	3	3	1	1
7. Results	3	4	4	4	5	4	4
8. Discussion	3	5	4	3	5	5	4
9. Total	31	33	34	30	34	27	28
10. Percentage	80%	83%	85%	75%	85%	68%	70%

Colour Coding Key		Points
	Meets all key criteria	5
	Meets most of the key criteria	4
	Meets some of the key criteria	3
	Meets all of the basic criteria	2
	Meets some of the basic criteria	1
	Meets none of the required criteria	0

**Appendix E: Table summarising the main methodological strengths and limitations of the papers selected for review.**

No.	Authors	Strengths	Limitations
1	Teng, Crabb, Winefield & Venning (2017)	<ul style="list-style-type: none"> <li>• Considers novel aspects of authenticity around mental illness and diagnosis.</li> <li>• Clearly identifies and considers scope for future policy and practice.</li> <li>• Semi-structured interview schedule included for transparency.</li> <li>• Depth of data increased by use of quotes.</li> <li>• Need for and use of data saturation identified and explained.</li> <li>• Detailed sample and recruitment sections.</li> <li>• Inter-rater reliability in analysis.</li> <li>• Audit trail used to enhance and monitor qualitative rigour.</li> </ul>	<ul style="list-style-type: none"> <li>• Limited global generalizability due to sample characteristics.</li> <li>• No explanation given relating to the development of the interview schedule.</li> <li>• Sample bias: All participants were involved in a mental wellbeing programme at school which may have led to their views and understanding of mental health difficulties being more favourable than an average young person.</li> <li>• Some participants indicated personal experience of MH difficulties. May also bias the response of these participants. The number of participants with personal experience is unspecified.</li> <li>• Themes not taken back to participants to check for grounding.</li> </ul>
2	Coles, Ravid, Gibb, George-Denn, Bronstein & McLeod (2016)	<ul style="list-style-type: none"> <li>• Replicates and extends existing research to strengthen existing claims.</li> <li>• Clear recruitment strategy</li> <li>• Demonstrated validation of measure of mental health literacy.</li> <li>• Clear background to the study provided.</li> <li>• Inter-rater reliability considered.</li> <li>• Good consideration of limitations (transparency) and future direction.</li> </ul>	<ul style="list-style-type: none"> <li>• Unclear aims. Although an extension of previous mental health literacy research is stated, the specific aims of the study are not explicitly stated.</li> <li>• Risk of type 1 errors due to large number of statistical tests on the data.</li> <li>• Strengths and Difficulties Questionnaire used but no reported results from this in the analysis.</li> <li>• Vignettes not included for transparency.</li> <li>• Limited ethical information or considerations provided.</li> </ul>

3	Melas et al. (2013)	<ul style="list-style-type: none"> <li>• Aims and objectives of the study clearly specified and explained.</li> <li>• Relatively large sample provided.</li> <li>• Open ended questions were coded and inter-rater reliability checked.</li> <li>• In depth description and explanation for analysis – increased rigour and replicability.</li> <li>• Details of vignettes and questionnaire provided.</li> </ul>	<ul style="list-style-type: none"> <li>• Asking participants ‘is everything fine with John?’ could create a leading question.</li> <li>• No approval from ethics committee due to this not being required in country of study.</li> <li>• Statistical analysis used to compare percentages across different groups, but the type of tests used are not specified.</li> <li>• Weak reporting of statistical analysis. P values provided but lack of group data for context in the main text.</li> </ul>
4	Dogra et al. (2011)	<ul style="list-style-type: none"> <li>• Clear statement of aims within the abstract.</li> <li>• Context for the setting in which the research took place is provided.</li> <li>• Consideration of implications for interventions and awareness raising for boys and girls.</li> <li>• Clear information provided on study design, recruitment, sample, instruments and procedure which increases replicability.</li> <li>• Measures culturally adapted and explanation for this given.</li> <li>• Detailed explanation given for choice of statistical tests.</li> <li>• Response rate provided.</li> <li>• Limitations cleared identified – transparency.</li> </ul>	<ul style="list-style-type: none"> <li>• Participants selected by school principals – potential bias if certain young people are selected to take part over others.</li> <li>• No explanation for missing data.</li> <li>• Recruitment limited to 41 students per school, yet up to 19 sets of data were received from pupils over 18 years old. This was excluded from the final data set, indicating a potential flaw in the recruitment design.</li> <li>• Questionnaires offer a restricted range of responses, may affect the range and representation of participants’ views.</li> <li>• English and Yoruba questionnaires used but unclear how accurately statements translate between these two languages. May affect participants’ responses depending on the questionnaire they received.</li> </ul>



5	Lovett, Tamkin & Fletcher (2011)	<ul style="list-style-type: none"> <li>• Novel inclusion of drawings and word-play as a means of facilitating discussion and eliciting participants' views – contributing to evidence base of innovative and creative research methods.</li> <li>• Inter-rater reliability used – two researchers used to identify and compare themes.</li> <li>• Transparency regarding the studies' limitations.</li> <li>• Use of quotes provides depth to the findings of the study.</li> </ul>	<ul style="list-style-type: none"> <li>• Gender and age mix of sample not specified, nor mean age provided.</li> <li>• 'mental illness' term used in data collection may elicit stigma in responses.</li> <li>• Some participants selected by head teacher – may introduce bias.</li> <li>• Different data collection methods used for older and younger age groups. Insufficient detail given for this choice, and the impact on data.</li> <li>• No consideration of sources of attitudes in the research findings which was one of the study aims.</li> <li>• Scenario examples not provided, nor details of discussion prompts for the focus groups – affects replicability.</li> </ul>
6	Leighton (2010)	<ul style="list-style-type: none"> <li>• Aims and objectives clearly identified and supported by the literature.</li> <li>• Clear critique and justification for methodology provided.</li> <li>• Validation of vignettes with clinicians and in pilot study.</li> <li>• Response rates, confidence intervals and significance levels all clearly specified for transparency.</li> <li>• Considers reasons for low completion rate.</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of cultural diversity within the sample may affect generalisability.</li> <li>• Low overall response rate – reasons for this are not discussed.</li> <li>• Some 'substantial minorities' reported but figures not provided for these.</li> <li>• Substantial number of participants had experience of mental health difficulties – may skew the data.</li> <li>• Some contradictory findings to existing research lack discussion for why this may be the case.</li> </ul>
7	Hennessy & Heary (2009)	<ul style="list-style-type: none"> <li>• Clear explanation provided for use of vignettes and the validation of these.</li> <li>• Response rates included.</li> <li>• Inter-rater reliability during data analysis.</li> </ul>	<ul style="list-style-type: none"> <li>• Potential gender bias. Male character in ADHD vignette and female character used in depression vignette.</li> </ul>

		<ul style="list-style-type: none"> <li>• Clear consideration of the study's limitations is provided.</li> <li>• Key Practitioner Message at beginning of paper provides useful and clear message for practitioners.</li> </ul>	<ul style="list-style-type: none"> <li>• Randomisation process not explained – implications for reliability.</li> <li>• Lack of clear method of analysis identified.</li> <li>• No explanations offered for unexpected and non-significant findings for two out of three mental health difficulties.</li> <li>• Ethical considerations not mentioned.</li> </ul>
8	Williams & Pow (2007)	<ul style="list-style-type: none"> <li>• Good explanation for development of vignette.</li> <li>• Clear reporting of data using figures and tables – transparency of raw data.</li> <li>• Confidence intervals and odds ratios provided.</li> <li>• Measures had established validity and reliability from previous pilot studies.</li> <li>• Clear ethical considerations identified and established.</li> </ul>	<ul style="list-style-type: none"> <li>• No demographic details for the sample provided</li> <li>• Response rate not included</li> <li>• Sample not representative – only 20% from high deprivation schools, compared to 40% from low deprivation schools.</li> <li>• Questions asked to indicate if participants had knowledge of mental health difficulties, without exploring what constituted, and the extent of, this knowledge – participant effects may mean more favourable responses.</li> </ul>
9	Burns & Rapee (2006)	<ul style="list-style-type: none"> <li>• Good, detailed and thorough background to the study and prior research provided.</li> <li>• Response rates included</li> <li>• Identified problems with previous vignette methodologies and adapted current study to tackle this.</li> <li>• Open ended responses lend more depth and detail to responses than prior vignette studies.</li> <li>• Vignettes included – enhances replicability and transparency.</li> </ul>	<ul style="list-style-type: none"> <li>• Gender imbalance in the sample – only 39.6% female. This limits generalisability.</li> <li>• Lack of ethnic diversity in the sample also affects generalisability.</li> <li>• Potentially leading questions used (e.g. 'what do you think the matter with...?')</li> <li>• The questionnaire developed is not validated – validity and reliability of the measure unclear.</li> </ul>

10	Watson & Lyons (2005)	<ul style="list-style-type: none"> <li>• Clear description and explanation for use of psychometric measure.</li> <li>• Good range of demographic information collected and detailed.</li> <li>• Missing data identified indicating transparency, and consideration provided as to why this may be the case.</li> <li>• Clear presentation of the data and factor analysis.</li> <li>• Consideration of future direction of research and strategies aimed at improving adolescents' attitudes.</li> </ul>	<ul style="list-style-type: none"> <li>• Convenience sample – pupils selected by school principle and may not be representative.</li> <li>• Participants recruited in two different settings, either before a well-being related presentation or during a standard class. This could potentially bias the data from those about to receive the presentation.</li> <li>• Lack of discussion and identification of ethical considerations.</li> <li>• Unclear whether the questionnaire/measure used was an existing measure or one developed specifically for the study. There is a lack of discussion around the validity and reliability of the measure.</li> </ul>
11	Roose & John (2003)	<ul style="list-style-type: none"> <li>• Explanation provided for choice of methodology lends transparency.</li> <li>• Inclusion/exclusion criteria addressed.</li> <li>• Good, clear ethical considerations and explanation of the extra steps taken to address these.</li> <li>• Researcher notes the importance, and general lack, of young people's voices in research and the need for more of this.</li> <li>• The use of participants' quotes lends depth and support for key findings.</li> <li>• Clear, detailed consideration of clinical implications.</li> </ul>	<ul style="list-style-type: none"> <li>• No details provided for the content and structure of the focus groups that took place – severely limits replicability and validity of the study.</li> <li>• Four themes mentioned but only three adequately discussed.</li> <li>• Missing demographics, response rates, gender balance of sample – limits generalisability.</li> <li>• IPA utilised but researcher does not acknowledge reflexivity and potential influence on the results.</li> <li>• Characteristics of the sample not considered in relation to the findings. Not all children may be as sophisticated in their understanding as the authors assume.</li> </ul>

12	Secker, Armstrong & Hill (1999)	<ul style="list-style-type: none"> <li>• Clear introduction, background and aims of the study provided.</li> <li>• Justification and explanation for methodological choices included.</li> <li>• Vignettes and interview questions included enhances transparency and replicability.</li> <li>• Clear ethical considerations made regarding consent.</li> <li>• Use of quotes in the results provides depth to the findings and enhances understanding.</li> <li>• Results presented in a way that clearly addresses each study aim.</li> </ul>	<ul style="list-style-type: none"> <li>• Response rate is estimated rather than a clear figure.</li> <li>• Gender imbalance and lack of demographic data for the sample reduces generalisability of the data.</li> <li>• Unclear how sample selected may indicate bias.</li> <li>• Unclear what method of analysis was used to identify themes within the data – implications for rigour.</li> <li>• No inter-rater reliability or checking of themes.</li> <li>• Authors do not indicate the limitations of their study.</li> </ul>
13	Callan, Wilks & Forsyth (1983)	<ul style="list-style-type: none"> <li>• Previous research and knowledge used to develop questionnaire to be culturally relevant.</li> <li>• A combination of structured and open-ended questions provides increased depth of data as questionnaire progresses.</li> <li>• Detailed cultural considerations for differences within the results.</li> <li>• Contradictory findings are discussed and explored in relation to prior research.</li> </ul>	<ul style="list-style-type: none"> <li>• Limited 4 point Likert scale restricts the range of possible responses from participants.</li> <li>• No mention of ethical considerations or steps taken to address these.</li> <li>• Gender imbalance in sample is unrepresentative (over 60% male).</li> <li>• Questionnaire not included for reference, reduces replicability.</li> <li>• Lack of confidence intervals and effect sizes in analysis.</li> <li>• No discussion of limitations of clinical applications.</li> </ul>

## Appendix F – Journal Submission Guidelines for Paper 2



### Author Guidelines

1. Contributions from any discipline that further clinical knowledge of the mental life and behaviour of children are welcomed. Papers need to clearly draw out the clinical implications for mental health practitioners. Papers are published in English. As an international journal, submissions are welcomed from any country. Contributions should be of a standard that merits presentation before an international readership. Papers may assume any of the following forms: Original Articles; Review Articles; Measurement Issues; Innovations in Practice.

2. Submission of a paper to *Child and Adolescent Mental Health* will be held to imply that it represents an original article, not previously published; that it is not being considered for publication elsewhere; and that if accepted for publication it will not be published elsewhere without the consent of the Editors.

3. Manuscripts should be submitted online. For detailed instructions please go to: [http://mc.manuscriptcentral.com/camh\\_journal](http://mc.manuscriptcentral.com/camh_journal) and *check for existing account* if you have submitted to or reviewed for the journal before, or have forgotten your details. If you are new to the journal *create a new account*. Help with submitting online can be obtained from Prabha Choubina at ACAMH (e-mail [prabha.choubina@acamh.org](mailto:prabha.choubina@acamh.org))

4. Authors' professional and ethical responsibilities *Disclosure of interest form*  
All authors will be asked to download and sign a full Disclosure of Interests form and acknowledge this and sources of funding in the manuscript.

#### *Informed consent and ethics approval*

Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB), including adherence to the legal requirements of the study country. Within the Methods section, authors should indicate that 'informed consent' has been appropriately obtained and state the name of the REC, IRB or other body that provided ethical approval. When submitting a manuscript, the manuscript page number where these statements appear should be given.

5. Manuscripts should be double spaced and conform to the house style of *CAMH*. The first page of the manuscript should give the title, name(s) and address(es) of author(s), and an abbreviated title (running head) of up to 80 characters. Specify the author to whom correspondence should be addressed and provide their full mailing and email address.

*Summary:* Authors should include a structured Abstract not exceeding 250 words under the sub-headings: Background; Method; Results; Conclusions.

*Keywords:* Please provide 4-6 keywords (use [MeSH Browser](#) for suggestions).

*Key Practitioner Message:* (in the form of 3-6 bullet points) should be given below the Abstract, highlighting what's known, what's new and the direct relevance of the reported work to clinical practice in child and adolescent mental health.

6. Papers submitted should be concise and written in English in a readily understandable style, avoiding sexist and racist language. Original Articles should not exceed 5,500 words, including References and Tables. Occasionally, longer articles may be accepted after negotiation with the Editors. Authors should include a word count of their paper.

7. Authors who do not have English as a first language may choose to have their manuscript professionally edited prior to submission; a list of independent suppliers of editing services can be found at [http://authorservices.wiley.com/bauthor/english\\_language.asp](http://authorservices.wiley.com/bauthor/english_language.asp). All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

8. Headings: Original articles should be set out in the conventional format: Methods, Results, Discussion and Conclusion. Descriptions of techniques and methods should only be given in detail when they are unfamiliar. There should be no more than three (clearly marked) levels of subheadings used in the text.

9. All manuscripts should have an Acknowledgement section at the end of the main text, before the References. This should include statements on the following:

*Study funding:* Please provide information on any external or grant funding of the work (or for any of the authors); where there is no external funding, please state this explicitly.

*Conflicts of interest:* Please disclose any conflicts of interest of potential relevance to the work reported for each of the authors. If no conflicts of interest exist, please include an explicit declaration of the form: "The author(s) have declared that they have no competing or potential conflicts of interest".

*Contributorships:* Please state any elements of authorship for which particular authors are responsible, where contributorships differ between the author group. (All authors must share responsibility for the final version of the work submitted and published; if the study includes original data, at least one author must confirm that he or she had full access to all the data in the study, and takes responsibility for the integrity of the data and the accuracy of the data analysis). Contributions from others outside the author group should also be acknowledged (e.g. study assistance or statistical advice) and collaborators and study participants may also be thanked.

10. For referencing, *CAMH* follows a slightly adapted version of APA Style <http://www.apastyle.org/>. References in running text should be quoted showing author(s) and date. For up to three authors, all surnames should be given on first citation; for subsequent citations or where there are more than three authors, 'et al.' should be used. A full reference list should be given at the end of the article, in alphabetical order.

References to journal articles should include the authors' surnames and initials, the year of publication, the full title of the paper, the full name of the journal, the volume number, and inclusive page numbers. Titles of journals must not be abbreviated. References to chapters in books should include authors' surnames and initials, year

of publication, full chapter title, editors' initials and surnames, full book title, page numbers, place of publication and publisher.

11. Tables: These should be kept to a minimum and not duplicate what is in the text; they should be clearly set out and numbered.

12. Figures: Any figures, charts or diagrams should be originated in a drawing package and saved within the Word file or as an EPS or TIFF file. See <http://authorservices.wiley.com/bauthor/illustration.asp> for further guidelines on preparing and submitting artwork. Titles or captions should be clear and easy to read.

13. Footnotes should be avoided, but end notes may be used on a limited basis.

## **Appendix G - Vignettes**

**Amy**

Amy is 14 years old. Over the past few months she has become very quiet and now often finds reasons not to spend time with her friends like she used to. Amy was a friendly, talkative student but now she seems sad and tearful. She has been having trouble sleeping and is finding it difficult to concentrate in class which has been affecting her school work. When a teacher was handing out pieces of homework that had been marked, Amy started shaking and looked like she was going to be sick. Amy became very upset when she got a lower grade than usual. Nothing anybody said seemed to cheer Amy up. Amy just kept saying that she is 'useless' and that she 'might as well give up.'

### **Ben**

Ben is 15 and over the past year he has been missing more and more days of school. He has recently stopped attending altogether. Over the last six months Ben has stopped seeing his friends and begun locking himself in his bedroom and refusing to eat with the family or to have a bath. His parents also hear Ben walking about in his bedroom at night while they are in bed. Even though they know he is alone, they have heard Ben shouting and arguing as if someone else is there. When they try to encourage him to do more things, he whispers that he won't leave home because he is being spied upon by the neighbours.

### **Jack**

Jack is 14 and a member of the school football team. Over recent months Jack has become noticeably moody and quick to anger. He has stopped doing things he enjoys, including football. He says that he's just not interested in it, or anything else, lately. Jack has not been sleeping well and often wakes up during the night, sweaty and in a state of panic. He seems tired, tense and easily wound up and he has started getting into fights at school. In class Jack will often sink into a very low mood and sit with his head on the desk for an entire lesson, not responding to anyone.

### **Claire**

Claire is 15 and lives at home with her parents, and is studying for her GCSEs. She has an older sister who is away at University. Claire has always been a shy and sensitive person. Her work is suffering as she is becoming increasingly concerned that other students at school are planning to kill her and that this is part of a wider conspiracy that is being talked about on the internet, and which is being broadcast over several television channels.

## **Appendix H: Permission from Authors to Use Vignettes**



**From:** [REDACTED] Leighton  
**Sent:** 06 July 2017 10:22:58 (UTC+00:00) Dublin, Edinburgh, Lisbon, London  
**To:** HEFFERNAN Elsa  
**Subject:** Re: Exploring Adolescents' Understanding of Mental Health Issues - Thesis Paper Request

Good Morning Elsa

Happy Thursday.

I would be happy for you to use my vignette about Mark in your study ☐ I would also be very interesting in hearing how your research progresses...

May your day go well.

Kind regards  
[REDACTED]

On 4 Jul 2017, at 11:31, HEFFERNAN Elsa <[hu000651@student.staffs.ac.uk](mailto:hu000651@student.staffs.ac.uk)> wrote:

Hi Sharon,

It's good to hear from you and thank you so much for sending across a copy of your published paper, it's really helpful and so relevant to what I'm doing at the moment. My research is taking a qualitative approach to young people's understanding and views about mental health, and I am planning on using vignettes as a way of generating discussion about mental health difficulties. While developing the vignettes I have looked at a few different sources from similar studies, and I wondered whether it would be at all possible to use one of your vignettes in my own study? I have been struggling to find many existing vignettes that portray psychosis in young people, and I think that your vignette about Mark is a really good example of this.

Kind regards,

Elsa

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**From:** Anthony Francis Jorm <[REDACTED]>  
**Date:** 6 April 2017 at 14:24:14 BST  
**To:** HEFFERNAN Elsa <[hu000651@student.staffs.ac.uk](mailto:hu000651@student.staffs.ac.uk)>  
**Subject:** Re: Permission to Use Psychosis (Adolescent) Vignette

On 6 Apr 2018, at 12:38, [REDACTED] > wrote:

Hello Elsa

Yes, you have permission to use the vignette.

Best wishes for your project.

Regards

Tony Jorm

On 6 Apr 2017, at 9:32 pm, HEFFERNAN Elsa <[hu000651@student.staffs.ac.uk](mailto:hu000651@student.staffs.ac.uk)> wrote:

Dear Professor Jorm,

My name is Elsa Heffernan and I am a clinical psychology doctoral student from the DClinPsy course run by Staffordshire University in the UK. I am writing to you to request whether I may have your permission to use a vignette that you and your colleagues previously developed in your research 'Beliefs about appropriate first aid for young people with mental disorders: Findings from an Australian national survey of youth and parents.'

My research as part of my doctoral thesis aims to explore young people's views and understanding of mental health difficulties. It has been granted ethical approval from the university and I am working closely with two secondary schools. I will be conducting interviews with students aged 14 to 15, in order to identify any common themes relating to their understanding and perceptions of mental health difficulties (specifically mixed anxiety and depression, and psychosis). It is my hope that the results might help to identify ways forward in the development of mental health education initiatives for young people in the UK.

I am planning on using a number of vignettes to facilitate discussions with the young people taking part, and your vignette portraying psychosis in an adolescent would be extremely useful for this purpose, particularly as an existing and successful measure. With this in mind, might it be possible to have your permission to use this particular vignette in my research?

Many thanks for your consideration,

Kind regards,

Elsa Heffernan  
Professional Doctorate in Clinical Psychology  
Staffordshire University

## **Appendix I: Semi-Structured Interview Schedule**

*Due to the semi-structured nature of the interview, the researcher may ask participants to expand upon topics of interest to the study, or offer prompts or clarification should a participant feel unsure about a question being asked. The interview schedule acts as a guide as it is recognised that participants may go on to freely discuss topics relevant to the vignette without the need for the prompts provided by other questions in the interview schedule.*

1. What's your first impression of (name)?
2. What do you think might be causing (name) to be acting like this?
3. How would you react to (name) if he/she was in your class at school?
4. Do you know anybody like (name)?
5. If (name) was your friend what would you do?
6. How long do you think they will be like this?
7. What do you think would help (name) feel better?

*After all vignettes completed:*

8. Do you think any of the characters you've read about are experiencing difficulties with their mental health? – Who? Why?
9. Where is the main place that you've heard or found out about mental health difficulties?
10. What do you think would help young people to learn more about mental health/emotional wellbeing?

**Appendix J: Invitation to Head Teachers regarding School Participation in the Study**



Date

Dear (Head Teacher's Name),

I am a Trainee Clinical Psychologist at Staffordshire University undertaking my Professional Doctorate in Clinical Psychology. During the current school year I will be carrying out research looking at young people's views of mental health difficulties in their peers.

Guiding this research is the concern that 13% boys and 10% of girls aged 11 to 16 will experience symptoms of emotional ill-health, and reports that half of adults with long-term mental health difficulties first experience symptoms by the age of 14. Young people often do not feel able to talk about their difficulties, and many do not seek help when it is needed most. By learning about our teenagers' views of mental health, and identifying where they are most likely to look for help, advice and information, we can guide the development of future educational interventions for improving mental health awareness and support for young people experiencing difficulties.

The project would involve me coming into your school and meeting individually with some Year 10 students who have agreed to take part. They would be asked to read some short stories about fictional young people experiencing emotional difficulties, and then asked a few questions about what they think of the person in each story. This would take about thirty minutes for each student to complete.

Students will be reassured that there are no right or wrong answers, and that they do not have to participate if they don't want to. All responses would remain confidential and no young person or school will be named or identifiable in any written reports. All participants would be informed about the support available within school, and encouraged to access this or to speak to a teacher should they have any concerns about their own emotional well-being. In the event of a student disclosing something during the study that raises concern about their safety I would pass this onto the school. I would also send a letter to parents to obtain consent for their child to take part before any student participates.

If you would be willing for your school to take part in the research please let me know and I can arrange to discuss the project with you further. My contact details can be found below and I would be very grateful for your help and your time. I am offering sessions on the role of clinical psychologists, and the routes for studying and pursuing a future career in psychology for all schools that participate should you feel that this would be of value for any of your students.

Please do not hesitate to contact me if you have any further questions.

Yours sincerely,

Elsa Heffernan  
Trainee Clinical Psychologist  
Professional Doctorate in Clinical Psychology, Staffordshire University  
Email: [hu000651@student.staffs.ac.uk](mailto:hu000651@student.staffs.ac.uk)

## Appendix K: Participant Recruitment Letter



Dear student,

Are you interested in taking part in a psychology study for young people?

**Study Title: Young People’s Views of Emotional Well-Being**

My name’s Elsa and I am a Trainee Clinical Psychologist from Staffordshire University. I’d like to invite you take part in some research that I am doing with Year 10 students. The study involves reading four short stories about young people who are having some emotional difficulties. Afterwards I will ask you some questions to find out your views about the people in the stories. I’m really interested in your opinion, so there are no right or wrong answers!

The study will take approximately 30 minutes and your Head Teacher has agreed that students in your year can take part during school time. You may be aware that I have sent a letter to your parent(s) to tell them about the study and to make sure that they are happy for you to take part too.

If you are interested in taking part please let your teacher know, or return the slip below to your School Reception. Your school will arrange a time for you to meet with me and you will be able to find out more about the study before deciding if you would like to take part. If this is during class time your teacher will be informed that you are to be excused while you are taking part in the study.

If you have any questions about taking part in the study you can contact me via email: [hu000651@student.staffs.ac.uk](mailto:hu000651@student.staffs.ac.uk)

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I am interested in taking part in the study: Young People’s Views of Emotional Well-Being.

Full name: \_\_\_\_\_

Signature: \_\_\_\_\_



Dear parent/guardian,

I am a Trainee Clinical Psychologist studying at Staffordshire University and I am interested in the emotional well-being of young people. I am writing to tell you about some new research I will be carrying out at your child's school in the near future as part of my doctoral thesis. If, after reading the information below, you are happy for your child to participate in my research **please respond to the school confirming this by email, or complete and return the attached reply slip to the school office by (DATE)**. If you do not return the slip or email the school your child will not be invited to take part in the research.

Young people often do not feel able to talk about their difficulties, and many do not seek help when it is needed most. This research aims to learn more about what young people think about difficulties affecting emotional well-being, and identify where they are most likely to look for help, advice and information.

If both you and your child agree to them taking part, they will be invited to attend a session at school where they will be asked to read some short stories about fictional young people who are experiencing some difficulties affecting their emotional well-being. After each story I will ask them a few questions to find out what they think about the person in the story, and what they think might help in that situation. The session will be audio-recorded and will last around thirty minutes. All students will be told about the study and what it will involve before being asked if they would like to take part.

Your child will be reassured that they do not have to participate if they don't want to. They will also be reassured that they can change their mind at any point if they decide they no longer want to take part.

All responses will be anonymised and kept confidential. When the findings of the research are written up no names will be included. All students who take part will be informed that if they share something during the study that raises concern that they or someone else is at risk the school will be informed. Students will also be encouraged to speak with their teacher or school counsellor/pastoral support, and advised where to access more information, if they have any concerns.

This study has the approval of the school's Head Teacher who is happy for this research to take place. If you have any questions or concerns please get in contact with me by email [hu000651@student.staffs.ac.uk](mailto:hu000651@student.staffs.ac.uk), or my project Supervisor, Professor Peter Oakes via [peter.oakes@staffs.ac.uk](mailto:peter.oakes@staffs.ac.uk) and we would be very happy to discuss this with you.

Yours faithfully,

Elsa Heffernan  
Trainee Clinical Psychologist

**Parental Consent Form**  
**Project Title: Young People's Views of Emotional Well-Being**

**Researcher's Name: Elsa Heffernan**

Please read the following information carefully, then email or return the slip at the bottom of the page to the school office if you agree that your child may take part in this study.

- I have read and understood the information sheet for the above project and have had the opportunity to contact the researcher/research supervisor and ask questions about the research.
- I understand that my child will be asked to read some short stories about young people's emotional well-being and they will be asked questions about what they think of the young people in the stories.
- I understand that my child may withdraw from participating in the study whilst it is in progress if they so wish and their data will be destroyed.
- I understand that my child will be fully protected in accordance with the Data Protection Act of 1998, and in compliance with the British Psychological Society ethical guidelines, and that their data will be kept confidential and anonymous until they are securely destroyed.
- I understand that if I or my child would like their data to be removed from the study after they have taken part, this will be possible by contacting the researcher before 30<sup>th</sup> November 2017, after which point all data will have been processed and included in the study.
- I understand that my child's name and personal details will be anonymised in any report based on this study. I agree that any the data provided may be used in the researcher's report and possibly used for publication in academic journals.

-----

As the parent/guardian/ of \_\_\_\_\_

I agree that my child can take part in this study: Young People's Views of Emotional Well-Being.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date \_\_\_\_\_

## Appendix M: Thematic Analysis

### Step 1: Transcription and Step 2: Familiarisation with the data, identifying potential codes

Transcript	Initial coding/noting
<p>Participant: Erm, well when it starts with just he's missing a few days of school, it might of.. started off a little bit, it might have felt quite bad but then now he's stopped attending altogether over the like.. and over the last six months he's stopped seeing his friends, it must be quite a really big problem in part of his life if he's, can't attend school and he can't see any friends, and he's locking himself in his bedroom, then the.. whatever is happening, his like hallucinations or, if he's really not well then.. its got worse and worse.</p> <p>Interviewer: Absolutely, it sounds as though its been growing for, for a little while.</p> <p>Participant: Yeah, exactly.</p> <p>Interviewer: And what do you think might make someone become unwell, like Ben?</p>	<p>Getting worse over time</p> <p>Impact of mental health difficulties</p> <p>Defining mh difficulties (being unwell)</p> <p>Getting worse over time</p> <p>External causes (stress)</p>



<p>Participant: Erm.. maybe just.. erm.. a lot of stress again, maybe.. maybe not.. not being able to talk to anyone about how he's actually feeling.. like.. he, he's missing school but maybe nobody asked him why he was missing school? And his.. friends might not have been supportive as they could have been.. and he started to feel more alone and then started seeing people.</p>	<p>Importance of talking support Bottling up emotions Lack of social support/Isolation and loneliness (potential cause) Making sense of the experience (hallucinations)</p>
<p>Interviewer: So you've described how things might have started off with one thing, and over time its built up for him?</p>	
<p>Participant: Yeah, it's a lot of weight on his shoulders.</p>	<p>Internal + external causes = Increasing pressures</p>
<p>Interviewer: Absolutely.. And, with how Ben's coping with things at the moment, how do you think other people are going to react to him?</p>	<p>Empathy with the experience Other peoples reactions - fear, worry</p>
<p>Participant: Erm, they're going to be quite scared and erm, unsure why he's walking around his bedroom at night when they know he's alone, they'll be worried about him but.. they</p>	<p>Other people won't understand Not knowing how to help Internal barriers to recovery- isolating self</p>

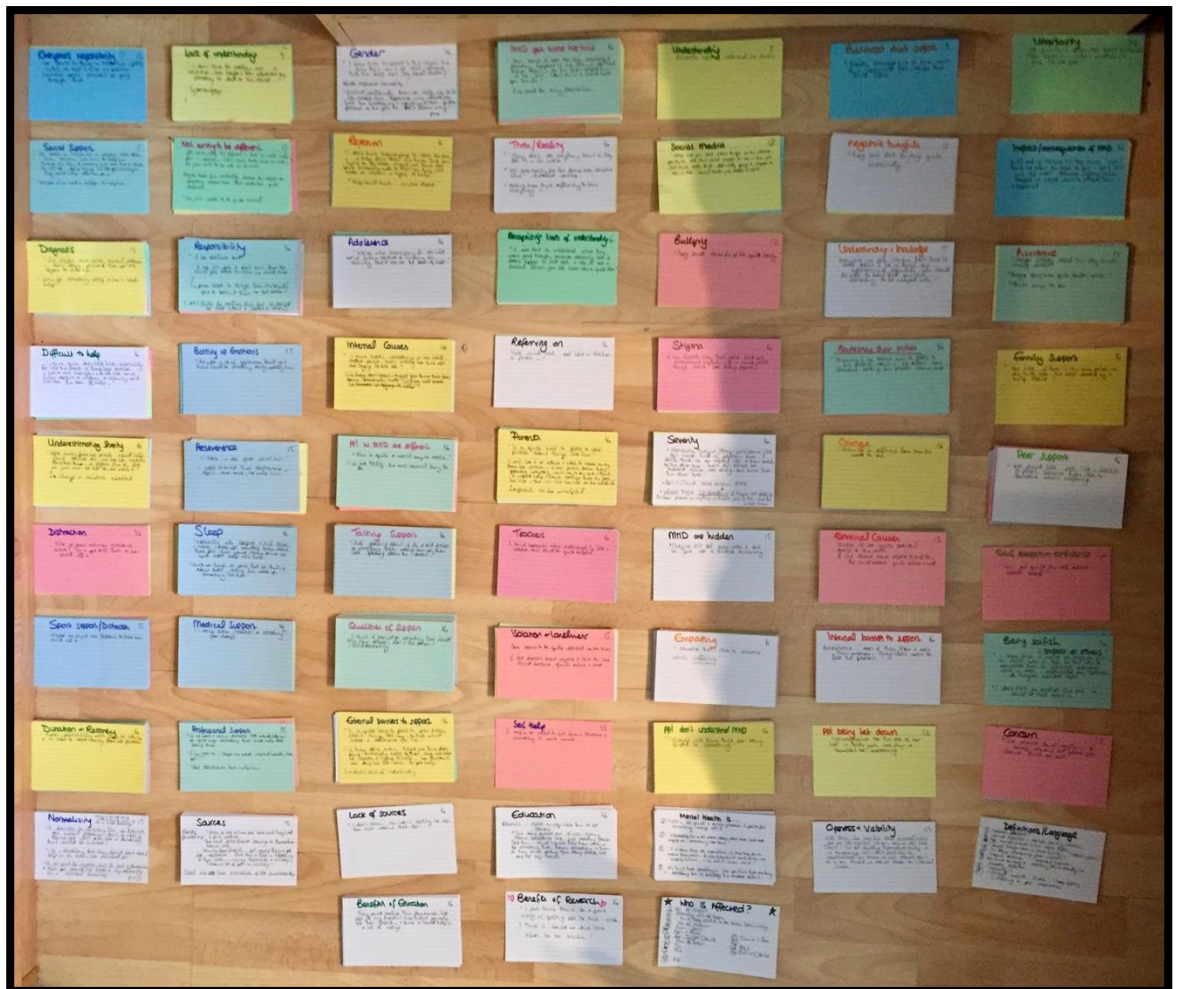


### Step 3: Codes identified across the dataset

Diagnosis	Social support
External causes	Defining mental health difficulties
Internal causes	Referring on
Difficult to help someone	Negative thoughts
Duration and recovery	Distraction
Peer support	Sport support
Talking support	Bullying
Qualities of support	Social media
Isolation and loneliness	Education
Empathy	Sources of learning
People with mental health difficulties are different	Other people don't understand mental health difficulties
Internal barriers to support	Normalising
Responsibility	Openness and visibility
Benefits of education	Lack of information
Severity	Distorted perception of reality
Sleep	Benefits of research
Noticing a change	Language
Adolescence	People are being let down
Stigma	Underestimating severity
Avoidance	Family support
Respecting someone's wishes	Confidence and self-esteem
Knowledge/understanding	Rejection
Getting worse over time	Gender
Parents	External barriers to support
Teachers	Professional support
Uncertainty/unfamiliarity	Perseverance
Medical support	Selfishness
Long term impact	Bottling up emotions
Mental health difficulties are hidden	Recognising limits of own understanding
Showing concern	Lack of understanding

### Step 3: Working with codes

- To illustrate each code, quotes from each transcript were transferred to a colour-coded card and numbered with a participant identifier. The colour was determined by which vignette or part of the interview that the code and associated quote had been drawn from.
  - o Amy (Anxiety/depression vignette): Red
  - o Ben (Psychosis vignette): Blue
  - o Jack (Anxiety/depression vignette): Green
  - o Claire (Psychosis vignette): Yellow
  - o General statements about mental health, and statements related to sources of education/ learning: White
- Cards were grouped together based upon the codes to identify the frequency of recurring codes across the data set.



### Step 3: Further work with codes

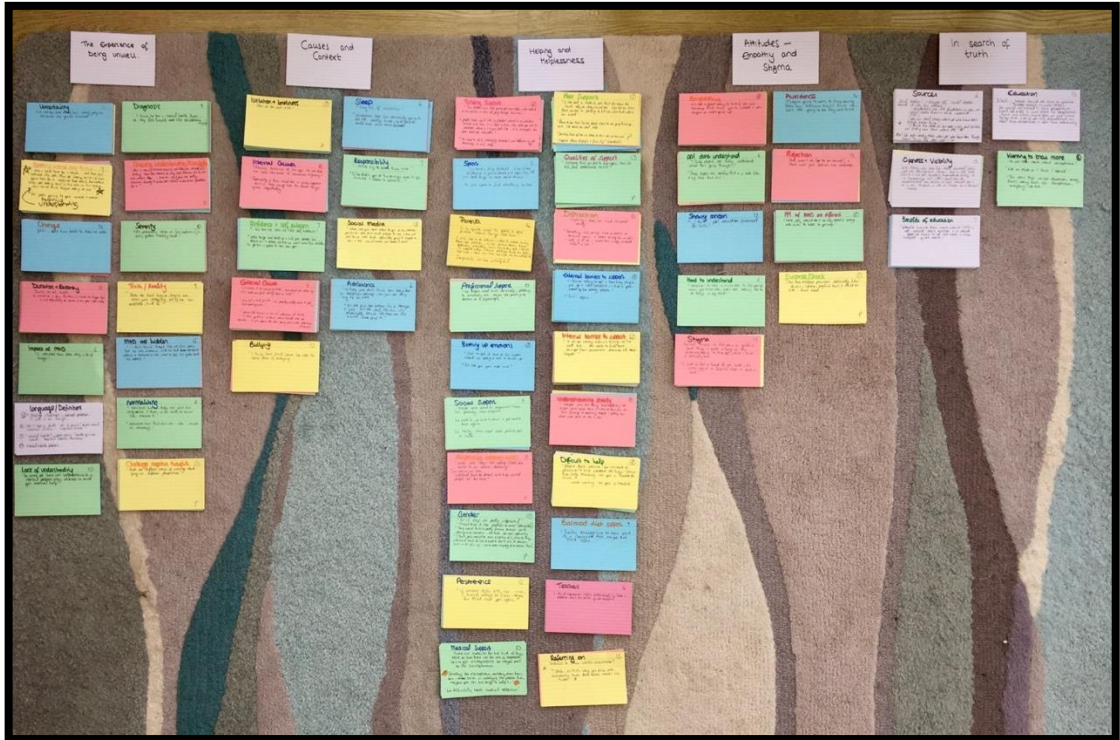
Table displaying the number of codes generated in relation to each part of the interview to identify patterns across vignettes. This table also shows the number of participants (N) whose interview data the codes were generated from.

Codes	Amy	Ben	Jack	Claire	General/ Education	Total Codes	N= (/16)
1. Diagnosis	10	10	11	10	0	41	13
2. External Causes	14	13	15	13	8	63	16
3. Internal Causes	5	8	6	12	5	36	16
4. Difficult to Help Someone	7	8	3	7	3	28	14
5. Duration and Recovery	11	12	8	10	1	41	16
6. Peer Support	15	10	10	11	1	47	15
7. Talking Support	11	10	8	10	2	41	16
8. Qualities of Support	8	10	8	9	1	36	15
9. Isolation and Loneliness	8	11	6	13	2	40	15
10. Empathy	8	11	6	9	3	37	14
11. People with MHD are Different	4	10	3	5	7	29	16
12. Internal Barriers to Support	14	8	5	6	4	37	15
13. Responsibility	7	7	5	4	1	24	13
14. People Don't Understand Mental Health Difficulties	6	5	4	4	1	20	10
15. Severity	2	7	5	7	1	22	12
16. Sleep	4	5	7	0	1	17	12
17. Noticing a Change	10	2	9	1	2	24	14
18. Adolescence	4	3	10	2	5	24	13
19. Stigma	3	3	1	5	4	16	9
20. Avoidance	5	3	5	4	1	18	8
21. Respecting Someone's Wishes	4	2	2	0	2	10	8
22. Knowledge/Understanding	2	4	6	1	1	14	9
23. Getting Worse Over Time	3	10	2	5	0	20	11
24. Parents	0	8	1	6	1	16	11
25. Teachers	7	3	5	0	1	16	10
26. Uncertainty/Unfamiliarity	2	5	4	2	2	15	11
27. Medical Support	2	7	3	2	0	14	9
28. Long Term Impact	0	2	2	2	1	1	7
29. Distorted Perception of Reality	0	2	1	9	2	14	10
30. Underestimating Severity	2	2	3	5	1	13	8
31. Family Support	0	0	2	7	0	9	7
32. Confidence/Self Esteem	3	1	1	1	1	7	4
33. Rejection	2	2	3	5	0	12	9

34. Gender	0	1	2	0	1	4	4
35. External Barriers to Support	1	3	4	2	1	11	9
36. Professional Support	1	4	1	3	0	9	7
37. Perseverance	2	3	3	3	1	12	10
38. Selfishness	0	1	1	0	0	2	2
39. Bottling up Emotions	1	1	5	0	0	7	5
40. Recognising Limits of Understanding	1	2		3	1	7	5
41. Lack of Understanding	1	4	2	5	0	12	7
42. Showing Concern	2	0	1	0	0	3	3
43. Social Support	1	3	2	2	0	8	5
44. Mental Health Difficulties are Hidden	2	0	2	2	1	7	5
45. Referring On	2	2	0	2	1	7	5
46. Negative Thoughts	3	1	1	3	3	11	7
47. Distraction	2	0	3	4	0	9	6
48. Sport Support	1	0	0	11	0	12	11
49. Bullying	2	2	0	4	1	9	6
50. Social Media	0	0	0	3	0	3	3
51. Education	0	0	0	0	15	15	15
52. Sources of Learning	0	0	0	0	16	16	16
53. Benefits of Education	0	0	0	1	13	15	14
54. Normalising Mental Health Difficulties	2	3	2	1	4	12	5
55. Openness and Visibility	0	0	0	0	5	5	5
56. Lack of Sources	0	1	0	1	5	7	6
57. Defining Mental Health Difficulties	0	0	0	0	11	11	11
58. Benefits of Research	0	0	0	0	2	2	2
59. Language	0	0	0	0	13	13	13
60. People Are Being Let Down	0	0	0	1	0	1	1

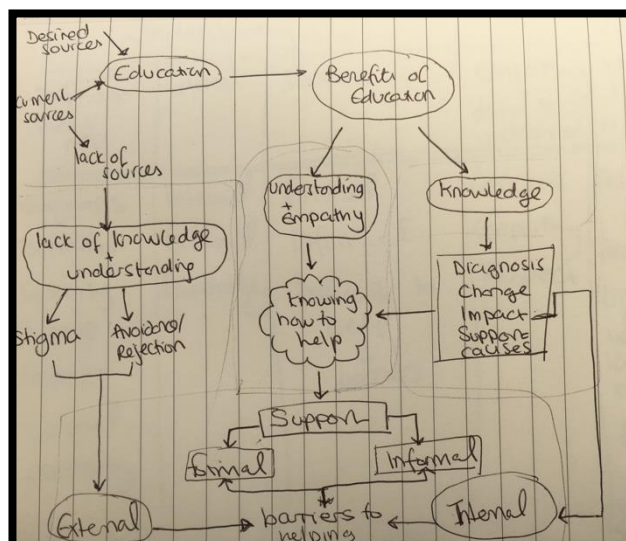
## Step 4: Searching for and identifying themes

The coded extracts were grouped together beneath potential themes. This was an evolving process where codes were arranged and rearranged as themes were identified, modified and refined. This process continued through step 5 and was repeated until the researcher was satisfied that the themes adequately captured the essence of the associated coded data.



## Step 5: Reviewing Themes

Themes were reviewed and considered in relation to one another. During this process, two themes were redefined into subthemes due to the way in which they connected with another theme that had been identified.



**Step 5: Reviewing themes and supporting codes**

<b>The experience of being unwell</b>	<b>Cause and context</b>	<b>Helping and helplessness</b>
Diagnosis Knowledge/understanding Uncertainty/unfamiliarity Getting worse over time Noticing a change Severity Duration and recovery Long term impact Language Defining mental health difficulties Negative thoughts	Internal causes External causes Confidence and self-esteem Sleep Social media Adolescence Bullying	Talking support Peer support Qualities of support Parents Teachers Distraction Professional support Difficult to help Referring on Sport Social support Medical support
<b>Empathy and stigma</b>	<b>In search of truth</b>	
Empathy Avoidance Rejection Isolation/loneliness Other people don't understand Showing concern Underestimating severity Stigma Lack of understanding People being let down People with mental health difficulties are different Normalising mental health difficulties	Sources of learning Education Openness and visibility Wanting to know more Benefits of education	



**Step 6: Example of development of a Theme based upon a selection of coded extracts.**

**Theme: The experience of being unwell**

<b>Participant Number</b>	<b>Code</b>	<b>Key Cross Reference</b>	<b>Indicative quotations</b>	<b>Notes</b>
1, 2, 3, 4, 6, 7, 8, 9, 10, 12, 13, 14, 15,	Diagnosis	Alice (Ben)	“Maybe he’s like schizophrenic or something? Cause he’s like shouting at people but there’s no-one there. Erm, maybe it’s depression? Erm, I would have said insomnia, if he’s awake at night.”	Labelling mental health difficulties as part of making sense of characters’ experiences
		Amir (Ben)	“He’s a bit paranoid, he’s got paranoia. He may have an actual mental health problem.... Something like schizophrenia?”	
		Matt (Ben)	“Social anxiety? ...He’s shouting and arguing, you might get like a split personality.”	
		Jenna (Amy)	“She obviously has anxiety, it might have started off with depression and then led into anxiety... You kind of overthink everything and everything starts to feel really, like, panicky and like, you think something’s going to happen.”	
		Neel (Amy)	“She could be depressed? Not spending time with her friends, that’s like something that is a common sign.”	
1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16	Duration/Recovery	Bryony (Claire)	“She might feel like that for quite a long time, unless she did anything about it.”	Mental health difficulties last a long time, duration dependent upon cause, recovery possible.
		Charlotte (Claire)	“As long as she has these people in her life that she thinks are talking about her, then she’ll have it for quite a while.”	
		Maya (Ben)	“It depends on how bad his situation really is, but with the right help, like to be properly better maybe, I don’t know like.. like, six months or something? To be completed get rid of all like, even these thoughts of doing things.”	

		Robert (Jack)	“There’s the whole idea of it will pass, but I just think it’s stupid to leave it to pass and just hope for the best, so it could go on forever, it depends if and when he gets help.”	
2, 6, 7, 10, 11, 13, 14	Long term impact	Matt (Ben)	“It could get to the point where he wouldn’t even go out to the shop to go and buy stuff to sustain himself... he’d just slowly starve because he wouldn’t be able to do anything.”	Awareness of potential severity and long term impact in adult life
		Amir (Claire)	“She’s not going to get good GCSE grades so then she’s not going to be able to get a job, and then it’s just going to be worse later in life.”	
		Bryony (Jack)	“It might feel good for the short term, but in the long term it could affect so many things, like if you get too angry you could end up with a criminal record, or something like that.”	
4, 6, 7, 8, 10, 11, 12, 13, 14, 15, 16	Defining mental health difficulties	Alex (General)	“It’s not really emotional, it’s something you can’t control and it automatically happens. It’s usually in a negative way, it’s like, usually quite a bad thing, it can affect a person negatively.”	A negative experience, affecting a person’s mindset, aspirations, motivation, perceptions.
		Lewis (General)	“If you’re mentally healthy it means that you still have, you still want to go out there and live your life normally, or what you think is normal, what you think is fine. You still have some sort of ambition and you can still have a goal that you want to achieve.”	
		Amir (General)	“The way that your mind’s functioning or it’s thinking. Maybe its not thinking in a way that would be normally considered normal.”	
		Ellie (General)	“It’s how they see themselves, it’s how they think about themselves, it’s how they think what others are saying to them, and it’s all in their mind.”	

## Appendix N: Ethical Approval and Amendment Letters



Faculty of Health Sciences

### ETHICAL APPROVAL FEEDBACK

<b>Researcher name:</b>	Elsa Heffernan
<b>Title of Study:</b>	Exploring young people's views and understandings of mental health difficulties
<b>Status of approval:</b>	Approved

Thank you for addressing the committee's comments. Your research proposal has now been approved by the Faculty's Ethics Panel and you may commence the implementation phase of your study. You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site.

A handwritten signature in black ink that reads 'Dr Peter Kevern'.

**Signed:** Dr Peter Kevern  
Chair of the Faculty of Health Sciences Ethics Panel

**Date:** 18.1.17



**Faculty of Health Sciences**

**ETHICAL APPROVAL FEEDBACK**

<b>Researcher name:</b>	<b>Elsa Heffernan</b>
<b>Title of Study:</b>	Exploring Young People’s Views and Understandings of Mental Health Difficulties
<b>Award Pathway:</b>	<b>DClinPsy</b>
<b>Status of approval:</b>	<b>Amendment approved</b>

Thank you for your correspondence requesting approval of a minor amendment to the vignettes you intend to use in your study

Your amended application is approved. We wish you well with your research.

**Action now needed:**

Your amendment has now been approved by the Faculty’s Ethics Panel.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel in writing of any significant divergence from this approved proposal.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site

**Signed:** Dr Peter Kevern  
Chair of the Faculty of Health Sciences Ethics Panel

**Date:** 7.8.17

## Appendix O: Participant Information Sheet



### Participant Information Sheet

#### Young People's Views of Emotional Well-Being

Please read this information carefully and ask me anything that is not clear, or if you want to know more. Take a bit of time to decide if you want to take part. It is up to you if you want to be involved. If you don't then that's fine and you can go back to your class.

#### **Why are you doing this research?**

Many young people will have concerns about their emotional wellbeing, and many don't receive any help with this. When we say emotional wellbeing, we mean how good a person feels in themselves, and how well they are able to cope and get on with the demands of everyday life. I want to find out what young people think about emotional wellbeing, and where young people are learning about it.

#### **Why have I been asked to take part?**

As a young person your thoughts and opinions about emotional wellbeing are really important. Your Head Teacher has agreed that your school can take part in the study and I have also sent a letter home to your parents or guardians to tell them about what you would be doing today and to make sure they were happy for you to join in too.

#### **What will I be asked to do?**

You will be shown four short stories about young people who are experiencing some sort of difficulty. After each story I will ask you a few questions about the story. The questions are about what you think, so there really are no right or wrong answers, just your opinion. The study should take about thirty minutes to complete. I will be recording your answers on voice-recorder, but this is only to help me remember what you have said.

#### **Who will see my information?**

Only I will listen back to our recording and all of your answers will be stored securely on a password-protected memory stick. After the study I will write up your answers and these will be kept confidential, so your name will not be included and nobody else will know your answers. If you share anything that makes me worried about your well-being, to make sure that you get the support you might need then I would need to pass this on to one of your teachers.

#### **Do I have to take part?**

No, you don't have to take part. If you don't want to continue at any time you are free to stop. You don't have to give a reason and can simply tell me that you have finished. If you decide to stop this will not affect your school work in any way.

If you decide not to take part and stop now, then you are very welcome to contact me via email if you change your mind or have any questions:

Elsa Heffernan: [hu000651@student.staffs.ac.uk](mailto:hu000651@student.staffs.ac.uk)

## Appendix P: Consent Form



### Participant Consent Form

School Name:

Participant Identification Code:

**Title of Study: Young People's Views of Emotional Well-Being**

**Name of Researcher: Elsa Heffernan**

Please read the information below carefully and write your initials in the box if you agree with the statement.

Please initial box

- I have read the information sheet about the study. I have had the opportunity to think about the information, ask questions and have had these answered appropriately.

- I understand that taking part is voluntary and that I am free to stop at any time without giving any reason.

- I agree to take part in the above study.

Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

## Appendix Q: Participant Debrief Sheet



### Debrief Sheet

Thank you so much for answering my questions. You have been really helpful and I will be able to learn a lot about what young people think and know about emotional wellbeing and mental health.

#### **What will you do with the responses from the study?**

I will be able to see what young people know about emotional wellbeing and mental health, and the different types of support that are available for anybody who might need help with this. I will also be able to look into whether there are certain places that young people are learning about mental health, and whether some of these are more helpful than others.

#### **What if I change my mind about being in the study?**

If you decide that you would like to have your answers taken out of the study after completing the study you can let your teacher know and they will get in touch with me, or you can contact me directly using the details below. This should be done before 30<sup>th</sup> November 2017 as all information will have been included in the study after that time.

#### **How do I contact you if I want to do this or if I have any questions?**

You, your teacher or your parents can contact me or my academic supervisor and we will be very happy to help:

Elsa Heffernan  
Trainee Clinical Psychologist  
Staffordshire University  
Email: [hu000651@student.staffs.ac.uk](mailto:hu000651@student.staffs.ac.uk)

Professor Peter Oakes  
Academic Supervisor  
Staffordshire University  
Email: [peter.oakes@staffs.ac.uk](mailto:peter.oakes@staffs.ac.uk)

#### **What if I feel concerned about my own emotional well-being after taking part in the study?**

It is likely that some young people taking part in the project will be experiencing emotional well-being difficulties themselves. If any part of the study has made you feel concerned and you would like to talk to somebody about this, please speak to a teacher who you trust or contact your school's pastoral support. Any contact you have with them will be treated sensitively and they are there to help support you with any concerns you might have.

The contact details for emotional wellbeing support at your school are:  
<inserted here on an individual school basis.>

If you don't want to speak to somebody at school you might find it helpful to speak to a parent or family member at home, or you can speak to your GP for advice. Speaking to your GP is also very helpful if you feel that you would like some longer term support. They can discuss the different options with

you, and put you in contact with helpful services who support young people like yourself with their emotional wellbeing and mental health.

Alternatively you can find out more information about sources of help and support using the following webpages:

**Young Minds:** [www.youngminds.org.uk](http://www.youngminds.org.uk)

**Mind:** <http://www.mind.org.uk/information-support/guides-to-support-and-services/children-and-young-people/>



## **Appendix R – Feedback from Young People Regarding Their Participation in the Research**

*“We need more things like this to be honest, just being pulled out of class, talking about something like, just reading stories like this, could almost help people realise it’s something that, there’s something in them. Or they could realise ‘this story sounds like one of my friends.’” – Matt*

*“I think it’s really good that there are people trying to make sure that everyone is completely fine, and I think it’s a really, really good cause because reading these stories, it really does make you realise how these people are feeling and it’s really important that stuff like the research like this as well go on, to make sure everyone is feeling a lot better.” – Lewis*

*“I just think this is, it’s a good way of getting people to talk. Yeah, I think it should be done more often, to be honest.” – Kade*

*“There should be more opportunities like this one that you can, they can go to and see what it’s like. So these stories are definitely a good example.” – Rani*

## **Appendix S: Reflexive Statement**

The researcher is a 32 year old, white British female working as a Trainee Clinical Psychologist within an NHS setting. The researcher holds an interest in adolescent mental health. These are based upon her experiences of her own and others' mental health needs, and the challenges associated with these, whilst growing up, and her experience of working in an inpatient setting with young people experiencing complex and severe mental health difficulties.

The researcher understands mental health difficulties within the context of a psychological model, which suggests that mental health difficulties are a result of a combination of biological, social and environmental, and the impact of these on internal psychological processes. The research took place in privately funded secondary schools, while the researcher was educated in a state funded secondary school. This could have potentially influenced the way that schools were contacted and recruited to take part in the study.

The researcher was aware that these factors, alongside her age, appearance and professional role may have had an influence on data collection, analysis and interpretation of the results. It is not possible to determine the extent to which the researcher impacted on the dialogue and disclosures of each participant, however the researcher sought to make use of her professional skills to build rapport in order to facilitate disclosure with each participant during interviews. The researcher also sought to summarise and check her understanding of each participants' responses after each key statement or reflection.

Preconceptions were identified within a reflexive journal maintained during the research process, including an assumption that young people would have a limited understanding and hold a number of misconceptions and stereotypes about mental health difficulties due to a lack of structured education. Validity checks were carried out throughout the research process, during interviews, supervision and the assigning of themes chosen to illustrate key points, to ensure that these preconceptions were not imposed upon the findings of the study.